New York State Managed Long-Term Care Data Transparency Project

nylag.org/MLTCdatatransparency

This project, for the first time, makes data public that shows how New York State Medicaid Managed Long-Term Care plans spend billions of Medicaid dollars.

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Executive Summary

Nearly 300,000 New Yorkers depend on Medicaid home care and other services from Managed Long-Term Care (MLTC) plans that received $15.5 billion in premiums in 2020. While New York State (NYS) makes some MLTC data public, there is a huge gap that this webpage aims to fill by posting selected data from Managed Medicaid Cost and Operating Reports (MMCOR) Reports filed by each MLTC plan. While MMCOR data is used for rate-setting, it should also be publicly available to inform consumers when making choices about plans, and to hold plans accountable for providing sufficient services to enable New Yorkers to remain in their homes, not in institutions. This data is essential to monitor New York’s “rebalancing” efforts to reduce institutionalization, as required by the Americans with Disabilities Act (ADA).

Selected MMCOR data from the 2017 and 2018 MMCOR reports is posted in four interactive visualizations [“viz”], viewable for each plan statewide or by region, and can be downloaded for further analysis. A fifth visualization, based on NYS Open Data (https://health.data.ny.gov/) shows changes in the number and demographics of people enrolled in the many MLTC plans.

This report reviews the various State public reports on MLTC and explains why the MMCOR reports fill an important gap. Existing reports include data on the functional needs of MLTC members for each plan, but do not show how and with what services each MLTC plan is meeting those needs—whether with community-based or nursing home services, and with what amounts of home care. The data also highlights regional differences in the types and amounts of services authorized.

This project models how New York State should publish MMCOR data annually on its Open Data website in an interactive format, and include it in its reports and consumer guides. The State must improve monitoring of whether plans are meeting members’ needs with community-based services, reward plans that excel in “Rebalancing” indicators and penalize those that fail.

Summary of Findings:

1. No Long-Term Care Services Were Provided for a Significant Number of Members, With Large Variation Between Plans and Regions
2. Most Plans Authorize Few Hours of Home Care per Month for Most Members & High Hours for Very Few
3. Most Plans Make a Profit

4. Existing State Reports of Rebalancing Data on an Aggregate Statewide Basis Mask Striking Differences Between Plans and Regions in Nursing Home Usage in MLTC
5. Higher Usage of CDPAP Compared to Personal Care Services Upstate Points to Lack of Network Capacity in Some Plans for Personal Care
6. Data Anomalies Exist in MMCOR Data
7. Sparse Data is Publicly Reported on Racial and Ethnic Differences in Plan Enrollment and Service Use – Necessary to Address Racial Disparities

**Recommendations:** New York Legal Assistance Group (NYLAG) calls on New York State to:

1. **Post plan-specific MMCOR data on its Open Health Data website** ([https://health.data.ny.gov/](https://health.data.ny.gov/)) in an interactive format, viewable by region or statewide. This data should also be included in all DOH reports and consumer guides on MLTC.

2. **Update Rebalancing indicators** in light of the carve-out of nursing home care from the MLTC benefit package, to better track the rate at which plan members who are admitted to nursing homes either return home with MLTC services or are disenrolled because of a long-term nursing home stay.
   
   a. **All rebalancing indicators should be broken down by plan and region**, rather than presented only on a statewide aggregate level.
   
   b. **Data collection must be improved to track and publicly report racial disparities** in access to community-based long term care services compared to institutional services.

   c. **All data must be made public** in all DOH reports and consumer guides on MLTC and the NYS Open Health Data website.

   d. **NYS should adopt at least three new evidence-based MLTSS quality measures released by CMS in 2018, which focus on the use of institutional care by MLTSS health plans**, adapted to track impact of carving-out Nursing Facility [NF] care from the MLTC benefit package:

      i. **Rate of Admission of Members to a NF from the Community**

      ii. **Minimizing Institutional Length of Stay** - Short-term NF stays that result in a successful discharge to the community.

      iii. **Successful vs. Unsuccessful Transition After Long-term Institutional Stay**: Percentage of long-term stays that result in successful transitions to the community, compared to the percentage of members who were disenrolled because of a long-term NF stay, and of those, the number who re-enrolled within six months.

      iv. **Number of Enrollees Who, Immediately Before Enrolling in the MLTC Plan, Were in a NF**
3. **Appeals and Grievances** – Improve Public Reporting of Data on Numbers and Outcomes of each Level of Appeal, with a Breakdown of the Most Common Issues for each plan and region. High reversal rates in appeals should be used in Quality Metrics and Quality Incentives.

4. **Require Timely Reporting and Tracking of Unstaffed Cases, Sanction Plans for inadequate Network Capacity, and Improve Support for CDPAP Program** which is Essential for Adequate Staffing, Particularly Upstate.

5. **Improve Monitoring of Timeliness of Plan Response to Member Requests for Services.**

6. **Make Risk Adjustment of Quality Data More Transparent.**

7. **Revise Rate Setting Methodology to Counteract the Disincentive Inherent in the Capitation Model that Deters Plans from Authorizing Higher Levels of Care Needed to Live Safely in the Community.**
I. Managed Medicaid Cost and Operating Reports (MMCOR) Reports—Filling Some of the Gaps in MLTC Data

This project makes public for the first time data from Managed Medicaid Cost and Operating Reports (MMCOR) that MLTC plans file with NYS DOH quarterly. Plans must file a statewide MMCOR report and a separate report for each of four regions in the state in which they operate (See Appendix A - list of counties in each region). See sample year-end statewide 2018 report for one MLTC plan posted at https://nylag.org/MMCOR_Sample Report 2018. The 31 tables of data in each report have extensive financial data, including the amount of each revenue source and the amount spent on every service and administrative cost. The reports also have service data, including the amount of different types of home care, nursing home and other services provided, the number of enrollees receiving each service, and the number of nursing home admissions with length of stay and reasons for discharge.

This report reviews the existing State public reports on MLTC, which include data on the functional needs of MLTC members for each plan, but not how each MLTC plan is meeting those needs—most importantly, whether with community-based or nursing home services. The MMCOR data fills that gap showing just how many hours of each home care service each plan is providing in each region of the state, how many enrollees were admitted to nursing homes in the report period, and more. If the functional data shows a plan has many high-need members, represented by a high Nursing Facility Level of Care "NFLOC" score, this increases the plan’s payment. But does the State monitor whether higher payment rates result in more services, if needed for members to live safely in the community? Quality Incentives and rates should incentivize providing community-based services commensurate with functional need and penalize excessive usage of nursing home care.

**MMCOR Data Included in This Project**

This project posts data from selected exhibits of MMCOR reports for 2017 and 2018 for partially capitated MLTC plans. The MMCOR data was obtained through a Freedom of Information request, which is the only way it is released to the public. Annual reports for one year are not available until late the next year. Due to resource limitations and unforeseen delays, this project could not include data for 2019 or 2020, and does not include data for MAP, PACE and FIDA plans. Also, only selected Exhibits are posted.

DOH releases the reports in a format that requires a professional to analyze in order to compare plans. See sample year-end statewide 2018 report for one MLTC plan at https://nylag.org/MMCOR_Sample%20Report 2018. This Project converted PDF reports to Microsoft Excel, and then combined them for uploading to a database. While MMCOR reports for more recent years are released electronically, comparing the reports is still virtually

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2 See 10 NYCRR § 98-1.16(a - h). While plans file the reports quarterly, the MMCOR reports filed for the fourth quarter include final data for the entire calendar year. These year-end reports go through a reconciliation process between the Plan and the State, and are usually ready for release under a Freedom of Information request by the fall of the following year. This project uses only the fourth quarter reports that contain data for the entire year.
impossible for a consumer, family member or advocate. The plans, either individually or through their trade associations, have the resources to hire data analysts to obtain and analyze the data, such as at https://www.nyshcddata.com/mltc-data/. However, these data compilations are proprietary, and available solely to plans or providers, not to the public.

The Five Online Interactive Visualizations

Selected MMCOR data is posted in four interactive visualizations that the user may view on a statewide basis or for any of the four geographic regions in the state, and for either 2017 or 2018. The user may select to view and compare certain types of revenue, expenses, or services, choosing to view the data by number (such as total expenditures for a particular service) or by percentage (such as the percentage of “member months” in which enrollees received more than 700 hours per month of personal care. See the Glossary to learn about “member months” and “member years.” The data can be downloaded for further analysis. A fifth visualization uses NYS Open Health Data (https://health.data.ny.gov/) to show changes in the number of people enrolled in each MLTC plan over time, with changes in demographics as well.

This project lacked the resources to post all of the data contained in the MMCOR reports. Some of the data from four MMCOR exhibits about nursing home usage is not visualized, but is described below. It is hoped that the sample of data posted here will illustrate the need for the State to add plan-specific MCCOR data to its Open Data website and to its annual MLTC reports and consumer guides, to fill gaps in that data. Also, we recommend some changes in the MMCOR reports to improve the quality and completeness of the data in order to better track “rebalancing” and address racial disparities in access to community-based long term care.

II. Background about Managed Long Term Care (MLTC):

1. MLTC is a Type of “Managed Care” -- What is Managed Care?

Medicaid has two different models for how services are authorized and paid for. Under the Fee For Service (FFS) model, providers are paid directly for each service they provide, but some services such as personal care must be authorized first by the local Department of Social Services that administers Medicaid locally (hereinafter “local DSS”). Under the managed care model, the State pays managed care plans such as Managed Long Term Care (MLTC) plans a monthly fixed capitation rate or “per member per month” (PMPM) premium. The plans decide which services and how many hours of home care to provide for each member. The plan then pays health care providers that they contract with (“in-network”) to provide the services. The plan receives the same fixed capitation PMPM rate regardless of the amount of home care or other services the plan authorizes. The capitation rates vary between plans, and may also vary by geographic region. The annually adjusted rates are calculated by State-contracted actuaries under a complex formula.4

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3 See the Glossary in Appendix B or many of these terms and acronyms.

4 Rates must be actuarially sound and be designed to reasonably achieve a medical loss ratio standard of at least 85 percent for the year. 42 C.F.R. §§ 438.4, 438.8 (see glossary). MLTC rates are in part based on...
2. 2011 Medicaid Redesign Mandates Enrollment in MLTC Plans

In 2011, on the recommendation of Governor Cuomo’s Medicaid Redesign Team (MRT) that sought “managed care for all,” New York Public Health Law § 4403-f was amended to require adult Medicaid recipients who have Medicare and need Medicaid personal care services [PCS], Consumer Directed Personal Assistance Program services [CDPAP] or other long term care services to join Managed Long-Term Care [MLTC] plans in order to obtain these services. (They are called Dual Eligibles –see Glossary). MLTC plans are a type of “managed care” health insurance plan that contracts with NYS to provide a package of Medicaid services listed below. Most adults who do not have Medicare are required to enroll in a “mainstream” Medicaid managed care plan (see glossary). The 2011 changes required them to obtain PCS and CDPAP services from these plans, rather than the local DSS. Some adult Medicaid recipients are exempt from MLTC and/or from mainstream plan enrollment, and may access home care services through their local DSS, on a Fee For Service basis.

3. MLTC Service Package

The MLTC service package includes Medicaid Community-Based Long Term Care services (CB-LTC) and some additional Medicaid services:

- Home care services including PCS, CDPAP, Private Duty Nursing, Home Health Care (include home health aide, visiting nurse, in-home physical, speech, and occupational therapy)
- Social and medical model Adult Day Health Care
- Durable medical equipment and medical supplies, including orthopedic footwear, enteral formula, and incontinent supplies
- Personal emergency response system
- Hearing aids, eyeglasses, non-emergency medical transportation
- Four medical specialties: audiology, podiatry, dentistry and optometry
- Outpatient physical, speech, and occupational therapy
- Care management
- Short-term nursing home care -- Starting in August 2020, members are disenrolled from the MLTC plan if they have been in a nursing home for three months, are approved for Institutional Medicaid by the local DSS, and do not have an active discharge plan. See more about this change in the section below.

4. Three Types of MLTC plans

There are three types of MLTC plans that fall into two categories based on whether the plans provide Medicare services in addition to Medicaid services:

1. Partial capitation – “Regular MLTC plans.” Most consumers (85.6% in July 2022) choose partially capitated MLTC plans, which receive one capitation payment to provide the MLTC

“encounter data” showing past services provided, MMCOR data (subject of this report), and are “risk-adjusted to take into account the characteristics of enrollees including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees...” NYS Public Health Law § 4403-f, subd. 8.
service package described above. Members of partially capitated MLTC plans keep their Medicare coverage separate, choosing either Original Medicare or a Medicare Advantage plan. MLTC members receive other Medicaid services on a Fee-For-Service basis outside the plan, such as payment of the Medicare hospital deductible or Part B coinsurance for outpatient care, lab tests, and other acute and primary care. This project posts data from these plans.

2. **Fully capitated**: About 14.4 percent of consumers are in “fully capitated” plans, which are all-in-one plans that receive two separate capitation payments, one for all Medicare services and the other to cover all Medicaid services, including the MLTC package. In NYS there are two types of fully capitated plans:
   a. **Medicaid Advantage Plus (MAP)** plans combine in one plan a Medicare Advantage Special Needs Plan designed for Dual Eligibles (“Dual-SNP”), that provides all Medicare services, with an MLTC plan, and add all other Medicaid services.
   b. **PACE plans** are only for those age 55 plus who need a nursing home level of care. They also provide all Medicaid and Medicare services.
   c. “FIDA” was a third type of fully capitated plan, created under a demonstration program that ended in 2019. A different FIDA program remains active that is solely for Dual Eligibles who have Developmental Disabilities, FIDA-IDD. See [https://icannys.org/icanlibrary/a-plan-for-me-fida-idd/](https://icannys.org/icanlibrary/a-plan-for-me-fida-idd/).

See the [lists of current plans by region](https://nymedicaidchoice.com/program-materials) posted by NY Medicaid Choice at [https://nymedicaidchoice.com/program-materials](https://nymedicaidchoice.com/program-materials) (scroll down to *Health Plan Lists* – Long Term care plans). **Also see Appendix C for** a list of plans with plan name and abbreviation used in the online visualization, with ownership changes, closings, and mergers (also posted at [https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf](https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf)).

5. **Major Changes Since Mandatory MLTC Enrollment Began in 2012**

1. **Growth**

   In 2012, mandatory enrollment in MLTC plans began for adult dual eligibles who need home care services. Since then, combined enrollment in all three types of MLTC plans has increased seven-fold, from 43,500 in 2011 to 290,536 in July 2022. Some plans operate in many regions of the state, and some operate only in one. Plans vary greatly in size. Some plans have closed or merged with or were acquired by other plans, with more mergers imminent. All partially capitated MLTC plans receive some new enrollees through auto-assignment by New York Medicaid Choice, the enrollment broker under contract with NYS DOH. Only certain individuals are auto-assigned – those who received Medicaid personal care or CDPAP services through a different managed care plan or their local county Medicaid agency, and then were required to

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enroll in an MLTC plan. These include those receiving “Immediate Need” services from their local DSS, who are required to enroll in an MLTC plan after 120 days.

2. Carve-In and Carve-Out of Nursing Home Care

In 2015, long-term nursing home care was “carved in” to the MLTC benefit package, meaning that MLTC enrollees remained in their plans even if they were permanently placed in a nursing home; the plan paid for the nursing home care out of its capitation premium. Also, people who were never in an MLTC plan, who were permanently placed in nursing homes, were required to enroll in MLTC plans once institutional Medicaid was approved.

In 2020, implementing a 2018 amendment to the law,6 long term nursing home care was “carved out” of the MLTC benefit package. Starting in April 2020, nursing home residents approved for institutional Medicaid, who had not been in MLTC plans before, are no longer assigned to an MLTC plan; their nursing homes bill Medicaid on a fee for service basis. Since August 2020, over 20,000 MLTC members have been disenrolled from their plans after three months in a nursing home once they have been approved for institutional Medicaid. Since then, DOH disenrolls MLTC members from their plans in three batches each a year, if they have been approved for institutional Medicaid and were in the nursing home for 3 months. Members who either the plan or the nursing home identify as having an active discharge plan should not be disenrolled. See more about this change at [http://www.wnylc.com/health/entry/199/](http://www.wnylc.com/health/entry/199/).

**Consumer concerns:** Members who are seeking to return home are disenrolled if the plan or nursing home failed to identify them as having an active discharge plan, sabotaging them from returning home. While they should receive notice of their right to appeal, many do not receive these notices in the nursing home. Consumer advocates also caution that carving long-term nursing home care out of the MLTC package exacerbates the incentive inherent in the capitation model that leads plans to deny high-hour care to members who need it to remain in the community. If these individuals are disenrolled after a three-month nursing home stay, the plan is relieved of a high-cost enrollee—whether in a nursing home or receiving home care.

3. Default Enrollment into MAP Plans

In April 2021, NYS began automatically assigning *mainstream Medicaid managed care members* to MAP plans when they become enrolled in Medicare, if they had been receiving Medicaid CB-LTC services from the mainstream plan. The system is called “default enrollment,” which means the consumer receives notice of the right to opt out of the enrollment and select alternate Medicare and Medicaid coverage. If they do not opt out, they are auto-assigned to the MAP plan “aligned” with their Medicaid managed care plan, meaning both plans are run by the same insurance company. See more at [http://www.wnylc.com/health/entry/226/](http://www.wnylc.com/health/entry/226/). From April 2021 to July 2022, MAP enrollment increased by 20 percent to 34,357, likely due to default enrollment, and will likely increase more going forward. See n. 5.

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6 NYS Public Health Law section 4403-f, subd. 7(b)(v)(13).
III. What Public Data about MLTC Plan Performance is Available, and What are the Gaps?

The NYS Department of Health (DOH) publishes and posts some data and reports, which, while appearing extensive, have large gaps. First, DOH issues an annual “Managed Long Term Care Report” (“DOH MLTC Report”), most recently for 2019.\(^7\) Data in these reports is also posted on the NYS Open Health Data website at [https://health.data.ny.gov/](https://health.data.ny.gov/) and in consumer MLTC guides at [https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/](https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/). Second, DOH files an annual report with CMS, the federal Medicaid agency, for the state’s 1115 Waiver, which authorizes all managed care plans in NYS including MLTC. The most recent report was for 2019 [“1115 Report”].\(^8\) Third, DOH recently started posting a Medical Loss Ratio report for all plans, as required by federal regulations.\(^9\) As described further below, these reports lack any service utilization data showing how plans address their members’ needs. The MMCOR reports contain much of this missing information.

1. DOH MLTC Reports & NYS Open Data Website Appear Extensive but Have Gaps

The DOH MLTC Reports (supra, n. 8), and the same data the State also posts online, have critical gaps.

a. The DOH MLTC report lacks “service utilization data including changes in the level, hours, frequency, and types of services and providers... formatted to allow comparisons between plans...” as required the NY Public Health Law.\(^10\) The tables in the DOH MLTC Report, which DOH also posts on its NYS Open Health Data website in an interactive format (at [https://health.data.ny.gov/browse](https://health.data.ny.gov/browse) type “MLTC” in search field), contain important information about member needs, but say nothing about how the plans address these needs, which both violates the NYS Public Health Law and dilutes their usefulness. See n. 10.

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\(^9\) Available at [https://www.health.ny.gov/health_care/managed_care/reports/](https://www.health.ny.gov/health_care/managed_care/reports/), click on last dropdown titled Medical Loss Reports.

The DOH MLTC report is primarily based on two sources: a member satisfaction survey and the “Community Health Assessment” (CHA), which is the nurse’s assessment using the Uniform Assessment System NY (UAS-NY) assessment tool, with which the plan develops a plan of care. The MLTC Reports, and the same data that is also posted on the Open data website, have extensive data showing member need, but no data on how the plans meet that need. For example, the MLTC Reports and Open Data website\(^{11}\) have plan-specific data on the percentage of members who had one or two or more hospital or nursing home admissions, the percentage of members who were independent in “activities of daily living” (ADL) including locomotion, bathing, and transferring, the “Nursing Facility Level of Care” (NFLOC) score, which is a composite functional scale from zero to 48, with 48 showing the highest level of need, the percentage of members who were continent and continent or cognitively intact, and the percentage of members who live alone. Another table purportedly demonstrates the “effectiveness” of care, showing the risk-adjusted percentage of members who did not experience falls that resulted in injury, or who did not have an emergency room visit in the last 90 days, the percentage of members who received dental, hearing and eye exams and flu vaccines (latter not covered by MLTC). The table indicates whether the plan’s score is higher or lower than the statewide average. Tables 8 and 12 summarizes a member satisfaction survey.

However, the reports say nothing about how the plans responded to the documented member needs – what types and amounts of home care and other community-based long term care services did the plan provide, and how many members received only nursing home care? Did plans with more members with a high NFLOC score showing a high level of functional need, or a higher percentage of members who lived alone, provide more home care? Of those members who were admitted to a nursing home, how many returned home with home care services? All of these factors are vital to monitor the plan’s compliance with their contracts and with the federal goals of “rebalancing” long term care to increase community-based services relative to nursing home use, as required by the ADA as interpreted in the *Olmstead* case. The plans’ Quality Incentives are based on data in the MLTC Reports, which means plans are rewarded for the functional needs of their members but not for how they meet those needs\(^{12}\).

b. Aggregate Nursing Home Placement Data Masks Differences Between Plans and Regions.

The DOH MLTC Reports and Open Data site do include some aggregate statewide data on the number of MLTC members admitted to nursing homes, but, significantly, fail to break it down by plan or by region, precluding comparisons between plans required by the Public Health Law. See n. 10. The **2019 DOH MLTC Report showed 10.3% of all MLTC members were then in nursing homes**, and that **12% of all members had at least one nursing home admission during the year, 66% of which were for permanent placement** (Table 2, p. 10).

In its recent report, Mathematica warned, “Aggregate state-level rebalancing measures mask differences across populations and regions within states.”\(^{13}\) The MMCOR findings below show

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\(^{11}\) See 2019 DOH MLTC Report at n 8, Tables 2, 4, 5, 6, 7, 8 and 12.

\(^{12}\) See link to 2019 MLTC Report in n 8, at Section VII, at p. 45.

that the rate of nursing home usage is far higher in some regions and plans compared to the state wide aggregate percentages now reported. Nursing home admission data should be publicly reported for each MLTC plan for each region in which it operates.

c. MLTC Reports Cherry-Pick Responses to Consumer Surveys, which Fail to Ask Key Questions. A consumer critique of the DOH MLTC Reports published in 2013 observed that the 2012 DOH MLTC Report presented the most favorable findings of consumer surveys, omitting less positive findings such as the fact that higher need respondents in poorer health were significantly more likely to raise concerns about services than those in good health. These criticisms are still valid, as these annual reports have not changed in any material way since then.\textsuperscript{14} Then, as now, the Reports also fail to include any meaningful utilization data, such as the amount of home care services provided to address member needs and the number of members in nursing homes.

d. Timeliness of Access to Care Should Not Be Measured Solely by Member Survey Data. State law requires the MLTC reports to include timeliness of access to care. The sole source of data used to report on timeliness are member surveys, with no separate reporting by plans. Member survey questions on timely access focus timely access to dental care and whether a nurse appeared on time for a home visit (Table 8). While important, they do not ask whether the plan responded promptly to an enrollee’s request for an increase in home care, or to a request to reinstate services needed to return home from a rehab stay (2019 MLTC Report Tables 8, 12). The Open Data version of the survey results report member being surveyed as to whether in the last 6 months the home care aide, visiting nurse, or care manager usually or always arrived on time. The timeliness of these different providers should not be conflated in one question, since only a home care aide, not a care manager or visiting nurse, is relied on to assist a member with basic daily tasks like walking and toileting. Moreover, there are more accurate ways for plans and DOH to monitor timely access to care, described in our recommendations below.

e. Risk Adjustment – Lack of transparency
Much of the data included in the DOH MLTC Reports and Open Data sites is risk-adjusted, which may be necessary to account for age and other factors that affect outcomes, “so that states and health plans are accountable for outcomes that are directly influenced by how well they provide timely access to high quality HCBS.\textsuperscript{15}” However, for full transparency, a clear explanation of the methodology of each plan’s risk score for each region in which it operates should be publicly available. Also, the data should be publicly available both in risk-adjusted form and in its original form. A higher risk score contributes to higher capitation rates, so should also result in more services. With only risk-adjusted data reported, this correlation cannot be observed or measured.


\textsuperscript{15} Mathematica HCBS Quality Measures, id. at n. 13, at p. 8.
f. Measures of Performance Over Time
The DOH MLTC Reports purport to measure a plan’s success in improving members’ functional status by measuring “performance over time.” “[A] positive over-time measure outcome is defined as a member demonstrating either improvement or stability in level of functioning/symptoms over the measurement period.” The 2019 Report compares assessments done in 2018 and the first half of 2019, but excludes initial enrollee assessments and nursing home assessments, which, given the high number of enrollees in nursing homes excludes a large pool. The table shows the percentage of members who remained stable or demonstrated improvement or decline in toileting, dressing, continence, other ADLs, and in their NFLOC score.\(^\text{16}\) While the data is risk-adjusted, the implication is still suspect that a decline or stability in these ADLs or the NFLOC score over time can be attributed to the plan, given that MLTC members by definition have chronic long-term conditions that generally get worse and not better. Risk adjustment makes the data opaque. Moreover, the data does not accurately measure plans’ effectiveness in addressing member needs. Is the plan providing adequate home care to address incontinence, whether by assisting the consumer in using the bathroom or a commode, or by promptly changing incontinent pads? The State should find better ways to measure plan effectiveness in providing truly person-centered care that promotes independence.

2. NYS DOH Consumer Guides
Much of the same data in the DOH MLTC Reports is also posted in “consumer guides” at https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/, which are available through 2019. The site says no reports will be produced for 2020 or 2021 because the data is drawn from nurse assessments that were suspended due to the pandemic. A star rating from 1 to 5 stars is given for each plan on various indicators based on the same member satisfaction survey and assessments used for the MLTC Reports described above. As in the MLTC Reports, these star ratings are risk adjusted, but with no explanation of what this means, defeating transparency. The same “performance over time” and timely access to care measures appear as in the MLTC Reports, which have questionable utility for the reasons stated above.

Missing from these guides is any information showing each plan’s relative usage of community-based care and nursing home care, the number and outcomes of grievances and appeals, timeliness of processing authorizations, staffing capacity, and other information described in this report. Also, though consumer guides are published for six regions, they each appear to use the same aggregate statewide data, which masks important regional variations that affect access to care.

3. NYS DOH 1115 Waiver Reports to CMS, the Federal Medicaid Agency
Under the terms of the 1115 waiver, DOH is required to file quarterly and annual reports with CMS on all of the managed care programs authorized under the 1115 Waiver.\(^\text{17}\) These include

\(^{16}\) DOH MLTC Report, supra, n. 8, at pp. 35-41. The same data is posted in Open Data -- MLTC: ADL Stable or Improved by Plan,” at https://health.data.ny.gov/Health/MLTC-ADL-Stable-or-Improved-by-Plan/rv48-8cyx.

\(^{17}\) See n. 9 for link to 1115 Reports. The 1115 waiver is governed by the Special Terms & Conditions (“STC”) which are CMS’ terms for NYS to operate managed care and MLTC programs. The STC are posted on https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm -- at the dropdown
both MLTC plans and mainstream managed care plans, which enroll Medicaid recipients who do not have Medicare or other third-party health insurance. Most but not all mainstream members are under age 65 (See n. 5). The 1115 Reports primarily focus on the mainstream managed care plans, with little information about MLTC plans. The information on grievances and appeals and on “rebalancing” efforts reveals large gaps in these reports regarding MLTC.

Beside monthly enrollment figures, the only plan-specific MLTC data in the 1115 Report is the Critical Incident report for the third quarter of 2019 (see 1115 Report at pp. 57-58). The number of critical incidents of different types are reported for each plan, the most frequent being those resulting in hospitalization or in the need for other medical treatment. The table shows the incidents as a percentage of enrollment for each plan, the highest being Prime MLTC (11.45% enrollees had a critical incident) and VNA (Nascentia) (2.40%). Several plans had the lowest incidence at 0.00% (Montefiore, iCircle, Fallon MLTC & PACE, Total Senior Care).

**Appeals and Grievance Data**
The CMS STC requires quarterly 1115 reports to include, “The total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.” See n. 17, 4/1/2022 STC at p. 50. Of the three levels of MLTC appeals, the 1115 Reports include only data on the first level – the internal plan appeal– with the disposition but no listing of the top five reasons. Notably, the 1115 Reports include no data on MLTC Fair Hearings requested, their dispositions, or the top 5 reasons for these requests, even though some aggregate data is included for mainstream plans. 1115 Report p. 43. 18 The reports include no data on External Appeals before the NYS Dept. of Financial Services – the number requested, their outcomes, or the top 5 reasons, neither for mainstream nor MLTC plans. The sole MLTC data for which the reports include the top 5 reasons are complaints to the State DOH “TAC” MLTC Complaint line, for which there were 3009 in the year ending 9/3/2019, of which 20% were about Aide Service (p. 27). The number of internal MLTC complaints is reported, but with no dispositions nor any breakdown of the top five reasons. All of the data is aggregate – none is reported by plan. See Recommendations to include plan-specific data for each region.

**Rebalancing Efforts to Shift from Institutional to Community Care**
As required by the CMS 1115 STC, n. 17 at p. 50, the DOH 1115 Report for 2019 (n. 9 at p. 28) has a table dedicated to “rebalancing efforts,” which is meant to measure the State’s progress in shifting long term care services from institutions to the community. The data is aggregate statewide, not broken down by plan or region. Though the report is described as and is

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required to be an annual report, it appears to report data only for one quarter of each year.\textsuperscript{19} The following table combines the MLTC Rebalancing data from the last three annual DOH 1115 reports. See n. 9. The 1115 Report does not attribute the source of the data, but it appears to be from MMCOR reports Exhibits A1-A4 described below and/or a rebalancing report filed separately by MLTC plans with DOH pursuant to their contract.

The numbers in the table below reported to CMS lack any context so are not helpful in capturing rebalancing progress. See evidence-based recommendations below to adopt recent CMS recommendations to show these numbers of enrollees per 1000 member months, rather than just providing a number with no context. Also, annual data should be provided rather than solely data for one quarter. See n. 19. And the rebalancing data for each plan and region should be reported rather than aggregate statewide data. See recommendations below.

**Table 1. Rebalancing Efforts – excerpt from DOH 1115 Reports to CMS 2017-2019**

<table>
<thead>
<tr>
<th>Rebalancing Efforts</th>
<th>7/17-9/17</th>
<th>7/18-9/18</th>
<th>7/19-9/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Enrollees to the Plan from a nursing home transitioning to the community</td>
<td>527</td>
<td>955</td>
<td>279</td>
</tr>
<tr>
<td>Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community</td>
<td>2,954</td>
<td>2,418</td>
<td>2,350</td>
</tr>
<tr>
<td>New Enrollees permanently placed in a nursing home who remain in a nursing home\textsuperscript{20}</td>
<td>3,168</td>
<td>2,062</td>
<td>2,392</td>
</tr>
<tr>
<td>Current plan enrollees who were in nursing homes as permanent placements at the end of the third quarter</td>
<td>15,216</td>
<td>16,732</td>
<td>18,255</td>
</tr>
</tbody>
</table>

*Source: DOH 1115 Reports to CMS 2017-2019, see n. 9, supra.*

Plans report additional nursing home usage data in the MMCOR reports, described below, that should be included to track Rebalancing efforts. DOH needs to monitor plan behavior in light of the incentives created by carving out long-term nursing home care from the benefit package, which compound the inherent incentives of the capitation model to deny costly CB-LTC services. See Recommendations.

\textsuperscript{19} The CMS 1115 STC, n. 15 at pp. 47-50 requires the state to include the rebalancing data in each quarterly 1115 report. Though it requires data for the fourth quarter to be listed separately from the annual data in the Annual report, the DOH 1115 report includes only data for the 3\textsuperscript{rd} quarter.

\textsuperscript{20} This data point has become obsolete, since long-term nursing home care was “carved out” of the MLTC benefit package, as approved by CMS in December 2019. In April 2020, new assignment of these nursing home residents to MLTC plans stopped. Since August 2020, over 20,000 MLTC members who had been in nursing homes for more than three months were disenrolled from MLTC plans. See [http://www.wnylc.com/health/entry/199/](http://www.wnylc.com/health/entry/199/) and Recommendations below for how the rebalancing reports must be adjusted in light of this change.
4. **Medical Loss Ratio Reports ("MLR")**

DOH recently began posting Medical Loss Ratio reports as required by CMS (42 CFR § 438.8). The numerator is the sum of all incurred claims for services and expenditures for “activities that improve health care quality.”21 The denominator is the premium revenue minus plan’s federal, state, and local taxes and licensing and regulatory fees. Id. NYS has set a minimum MLR of 86 percent for MLTC and most other Medicaid plans. The remaining 14 percent can be spent on administrative expenses, which plans report in MMCOR Schedule D-3, D-3A and D-3B, classified as “allowable” and “non-allowable.” These are not visualized in this project. See Glossary (Appendix B) and sample 2018 MMCOR Report Posted online. The two MLTC plans with an MLR below 86% in 2018-19 were required to remit part of their profit or excess income (Integra and Prime Health Choice). Appendix D is a table that shows the MLR’s posted on the DOH website sorted from low to high for SFY 2017-18. The last 2 columns add the MLRs for SFY 2018-19.

The DOH MLR reports do not disclose the source, which are presumably based on MMCOR data or “encounter data.” The MLR figures calculated for 2018 by this project, highlighted in blue in Appendix D, are slightly different than the DOH figures. The figures are shown in the MMCOR Consolidated Finance visualization for 2018, selecting Medical Loss Ratio in the Select Metric selector (see [https://nylag.org/mmcor-consolidated-finance-table/](https://nylag.org/mmcor-consolidated-finance-table/)). The differences between the DOH calculations and those by this project may be due to different time periods (calendar year vs. fiscal year,) or a difference in the MLR formula, or the “credibility adjustment” (see 42 C.F.R. 438.8).

**IV. About the Five Visualizations and Nursing Home Data in MMCOR Not Visualized in this Project**

The following section describes each visualization or “Viz,” and identifies the source for the data. For detailed navigation tips, please click on the link for each viz and scroll down below the interactive graph. All of the data is from the MMCOR reports in 2017 and 2018 for partial capitation MLTC plans, except for Viz Number 5, which is from NYS Open Health Data ([https://health.data.ny.gov/](https://health.data.ny.gov/)). For most of the viz’s the user may view and download the data by region (statewide or one of four regions) and year (2017 or 2018). Next, the report describes some of the MMCOR data about nursing home usage that this project lacked resources to visualize online.

Please see Appendices to this report that explain some terms used in the visualizations:

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21 MLR Reports for SFY 2017-18 and 2018-19 are available at [https://health.ny.gov/health_care/managed_care/reports/](https://health.ny.gov/health_care/managed_care/reports/) - scroll down to *Medical Loss Ratio Reports.* The general definitions are posted at [https://health.ny.gov/health_care/managed_care/reports/mlr_lob/2018-19_sum_def.htm](https://health.ny.gov/health_care/managed_care/reports/mlr_lob/2018-19_sum_def.htm). The PDF report posted on DOH website for SFY 2017-18 lists the plans alphabetically, which makes it difficult to compare plans by MLR. The first and columns in the table below sort the DOH MLR data from low to high MLR. The columns in the middle highlighted in blue show the 2018 MLR as calculated by this project based on the MMCOR data. We recommend that DOH post the reports in EXCEL and/or on the Open Data website in interactive format.
A. Appendix A: The list of counties in each of the four regions (also posted at https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf.
C. Appendix C: A list of plans for which data is included in this project, showing changes in plan names or abbreviations used in the visualizations, changes in ownership and plan closings. Also posted at https://nylag.org/wp-content/uploads/2022/09/Upload-C-MLTC-Plan-Name-Chart.pdf.

1. MMCOR Consolidated Finance Table
https://nylag.org/mmcor-consolidated-finance-table/

*Data source: MMCOR Schedule B – Revenue and Expense statement*

In eight tabs, view the amounts of each type of plan revenue and of each type of expense—both for services and for administrative expenses. See a more detailed description of each tab and the terms used online. To view and compare the monthly capitation rates for each plan, in the *Select Metric* selector, select “Medicaid Premium PMPM” for the base MLTC monthly premium and “Total Premium PMPM” that adds add-on’s for Spenddown and NAMI, Recruitment and Retention of home care workers, Quality Incentive Pool Award, Quality Incentive VAPP, and Minimum Wage. See MMCOR Instructions for definitions posted on main project webpage.

2. Home Care Member Years by Hourly Category Table
https://nylag.org/home-care-member-years-by-hourly-category/

*Data source: MMCOR Exhibits A5 (Personal Care Hours year to date) and A7 (CDPAP Hours Year to Date).*

The plans report the number of member months in which they provided three different types of home care (PCS, CDPAP, and “Home Health Care”) in seven different ranges of hours, from under 79 hours per month to over 700 hours per month. Note that PCS hours include hours of Home Health Aide if they provided no health-related services.22 We did not include Home Health hours in this viz (from *Exhibit A6 -- PCS and Home Health Hours year to date*) because *Home Health* is so broadly defined to include Private Duty Nursing as well as visiting nurse and physical/occupational therapy, which are authorized in visits, not hourly shifts, and even pharmaceutical costs for IV therapies. See glossary for complete definition. We recommend separately tracking the number of enrollees receiving Private Duty Nursing and the amount of hours authorized.

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22 DOH MMCOR instructions for 2021 are posted at https://nylag.org/wp-content/uploads/2022/09/UPLOAD-A-2-2021-Q4-MLTCCR-Instructions-FINAL.pdf. The definition of Home Health has remained the same since at least 2010, for which the instructions are on file with NYLAG. The expenditures and number of members receiving Home Health services and their cost are included in the *Long Term Care Services and Service Expenditures* viz.
Table 2: Sample Care Plans in Each of the Seven Ranges of Hours of Home Care

The seven ranges of hours may not seem logical, as they describe the hours per month, while most care plans are described in hours per week. Using 4.3 weeks in an average month, here are examples of care plans for each hourly grouping:

<table>
<thead>
<tr>
<th>Hour grouping (hrs. per month)</th>
<th>Max. hours/week @ 4.3 weeks/mo.</th>
<th>Typical Care Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-79</td>
<td>18</td>
<td>4 hrs x 4 days, 3 hrs x 6 days</td>
</tr>
<tr>
<td>80-159</td>
<td>37</td>
<td>7 hrs x 5 days; 5 hrs x 7 days; 6 hrs x 6 days</td>
</tr>
<tr>
<td>160-239</td>
<td>55</td>
<td>8 hrs x 5 days + 7 x 2 days; or 7 x 7</td>
</tr>
<tr>
<td>240-319</td>
<td>74</td>
<td>8-10 hrs x 7 days; or 12 hrs x 5 + 7 x 2</td>
</tr>
<tr>
<td>320-479</td>
<td>111</td>
<td>24-hour live-in x 7 = 91 hours/week; 12 x 7 days</td>
</tr>
<tr>
<td>480-699</td>
<td>162</td>
<td>16 x 7; 2 x 12 x 5 days = 12 x 2</td>
</tr>
<tr>
<td>700+</td>
<td>168</td>
<td>2 12-hour/shifts x 7 days</td>
</tr>
</tbody>
</table>

See the online viz for navigation tips. Note the difference when you view numbers of Member Years receiving each level of hours or the percentage of the plan’s member years authorized for each level of hours.

The data can be downloaded for more analysis. See download instructions on main webpage. Download a sample Excel worksheet in which combined 2018 PCS and CDPAP data has been downloaded for each region at https://nylag.org/wp-content/uploads/2022/09/Upload-D-MMCOR-PCS-CDPAP-Hours-by-Member-Years-All-regions-2018.xlsx.

3. MMCOR Long Term Care Service Mix Table
https://nylag.org/mmcor-long-term-care-service-mix/

DATA Source: MMCOR Exh. C – Number of Enrollees Receiving Services – 2018 only

This shows the number or percentage of a plan’s enrollees who used different long-term care services during 2018, such as the number who were in a Nursing Facility (NF) for the entire year, or the number who used only one of the home care services – PCS, CDPAP, or Home Health – or a combination of two of these services. Again, Home Health Care is broadly defined to include not only home health aide and private duty nursing services, which like PCS and CDPAP are authorized by the hour, but also nursing and therapies, which are authorized on a per visit basis. MMCOR instructions tell plans to include Home Health Aide services in their PCS figures, if no health-related tasks were provided. Home Health Care also includes the number that received NF services along with one or more of the home care services during the year.
4. MMCOR Service Expenditures
https://nylag.org/mmcor-service-expenditures/

Data source: MMCOR Schedule B

This data uses the same financial data as in the MMCOR Consolidated Finance Table, except it shows solely expenditures on services, not administrative expenses and revenue. User may select to view data by number or percentage, region, and year. Other navigation tips are below the viz on the website.

Note: The percentage of expenditures shown on a selected service is solely the percentage of those services you selected to view in the Filter Service selector. In order to view the percentage of all plan service expenditures spent on a particular service, you must choose All Services in the Filter Service selector. For example, if you select to view Adult Day Health Care and Social Day Care statewide for Centers Plan in 2018, 96.47 percent of the expenditures for these two services was for Social Day Care. If viewing all services, though, 4.73% of all of the plan’s services were for Social Day Care and 0.20% on Adult Day Health Care.

5. Medicaid Plan Enrollment Table
https://nylag.org/medicaid-plan-enrollment/

Data source: NYS DOH Open Health Data – https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3

This visualization was not part of this project and is posted here with permission of Public Signals LLC. The 11 tabs of this visualization show month to month changes in NYS Medicaid enrollment generally and in MLTC and other types of Medicaid managed care plans. Tabs also show changes in demographic mix in the various plans by age and race. You can select the Month and Year of data to view.

Because this table was not developed specifically for this Project, much of the data concerns enrollment in “mainstream” Medicaid managed care plans, which, as of November 2021, had nearly 5.4 million members who are mostly children, families, and adults under age 65. While normally members are disenrolled from these plans when they become enrolled in Medicare, most have remained enrolled in these plans because of special protections during the ongoing Public Health Emergency.

Note that the 11 Economic Regions on this graph are not the same as the four (4) regions used for the MMCOR data (See Appendix A.). No listing of counties in each economic region is posted on DOH Open Health Data (https://health.data.ny.gov/).

Warning: To find MLTC plans, in the Plan Type Selector, select one or more of the following four types (see the glossary for definitions)

- Medicaid Advantage Plus (MAP), PACE, or FIDA (Full Capitation plan that ended 12/31/2019)
- Partial MLTC (SELECT “Partial MLTC” and NOT Partial Cap nor FFS Partial Cap)
**Dual Status and Age:** We do not recommend you solely filter the data by *Dual status* (*Dual Eligible* – see Glossary) or by *Age*, since people with Medicaid-only and people under age 65 are in MLTC plans. Also, some Dual Eligibles and people age 65+ are in mainstream Medicaid managed care plans—either because they do not have Medicare or because of special rules during the pandemic. However, once you select the *Plan Types* suggested above, you can then view age, race, and Dual status among members of the four types of MLTC plans.

**Plan Changes tab** shows the growth or drop in enrollment over time since 2009 for each plan. Select the four MLTC *Plan Types* listed above to view their enrollment changes, and you may then view by Economic Region, race/ethnicity, age, and gender.

6. **Nursing Home and other MMCOR Data Not Visualized in this Project**

This project lacked the resources to visualize all of the data that MLTC Plans report in MMCOR, including data about nursing home usage. Four exhibits of the MMCOR reports include extensive information about usage of nursing home care, described below, which should be made public through Open data, in the MLTC Reports and consumer guides. More of this data should also be reported to CMS in the 1115 reports. Now that long-term nursing home care has been removed from the benefit package, beginning in 2020, it is even more important to monitor the number of MLTC enrollees admitted to nursing homes who return home with their length of stay, and the number of enrollees admitted to nursing homes who were disenrolled from the MLTC plan because of a long-term nursing home stay. Also, reports should include how many new enrollees joined the plan who were in a nursing home at the time of enrollment; this is an important data point for rebalancing goals, as it tracks plans’ willingness to enroll members who may need higher amounts of home care to return to the community. The Exhibits described here can be viewed in the sample 2018 statewide MMCOR report posted at https://nylag.org/MMCOR_Sample_Report_2018.

We suspect these MMCOR Exhibits described below, along with a Rebalancing Report plans file pursuant to their contract with DOH that is also not made public, are the undisclosed source of the Rebalancing data in the DOH 1115 Report described above.

1. **Exh. A1 -- Analysis of Enrolled Population** - shows

   a. **Number of enrollees who were permanently placed in nursing homes ["NH"] and the number living in the community**, at the end of the prior year and of the current year (No. 03101, 03104), with the net shifts in each group (03105).

   b. **Number of enrollees who newly enrolled during the year—and of those, how many enrolled from the community and how many from being permanently placed in nursing homes** (03102). The latter figure—the number who enrolled but were permanently placed in nursing homes—should now be ZERO because permanent nursing home care is no longer an MLTC benefit. However, reports should still track how many people in nursing homes enrolled in the MLTC plan and returned home.

   c. **Number of enrollees who disenrolled during the year, voluntarily or involuntarily, and of those, how many were in the community and how many were permanently placed in nursing homes** (03103).
2. Exh. A2 - *Analysis of Enrolled Population By County*: number of *member months* in which enrollees were permanently placed in a nursing home versus living in the community, broken down for each county in the plan’s service area. This data should be compiled and publicly posted for each plan by county, so that consumers can see each local plan’s track record in offering community-based rather than institutional services in their county. This exhibit lacks the same detail as Exh. A1 such as the number of enrollees placed in nursing homes during the year as opposed to the number who were already in nursing homes when they enrolled, but the added data by county is illuminating.

3. Exh. A3 - *Hospital and Nursing Facility [NF] Utilization*: total number of admissions to a NF by quarter, and the total number of days of NF care with a breakdown by days covered by Medicare, by Medicare and the MLTC plan, and solely by the MLTC plan. The number of days of respite care in a NF is also reported.

4. Exh. A4 - *Nursing Facility Discharges*: number of enrollees discharged from a NF, broken down by the length of the stay for six time periods ranging from under 30 days to more than 1 year. Instructions tell plans to include only enrollees for whom the plan paid all or part of the cost, excluding discharges after a stay that was totally covered by Medicare. Since Medicare fully covers only 20 days of rehabilitation, this rule excludes the shortest stays, but also excludes longer stays for members with Medigap plans covering the Medicare coinsurance.

   For each of the six length of stay time periods, the report further breaks down, for each quarter, the number of discharges resulting from the member’s death and the number discharged for an “other” reason. We recommend that the “Other” category should be broken down to specify the number of enrollees who returned home still enrolled in the plan, the number who were involuntarily disenrolled from the plan with the number for each reason (long-term nursing home stay hospitalized for 45 days, etc.), and the number that voluntarily disenrolled. See more observations and recommendations below.

V. Observations and Findings About the MMCOR Data Alone and in Relation to Other MLTC Data

1. **No Long-term Care Services Were Provided for a Significant Number of Members, With Large Variation Between Plans and Regions**

   The *Long Term Care Service Mix* viz shows the percentage or number of member months in which six different services or combinations of long-term care services were provided. “No Services” on this graph is a figure that was calculated by this Project, subtracting the total number of enrollees the plan reported as receiving any of the six listed long-term care services from the total number of enrollees the plan reported in the same exhibit. A significant variation can be seen between regions, even for the same plan.
Table 3. Percent of Members Receiving No Long-term Care Services in 2018 by Plan and Region (selected plans)  
Source: [https://nylag.org/mmcor-long-term-care-service-mix/](https://nylag.org/mmcor-long-term-care-service-mix/)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Statewide</th>
<th>NYC Metro</th>
<th>Mid-Hudson</th>
<th>NE Western</th>
<th>Rest of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>VNS</td>
<td>14.74%</td>
<td>13.50%</td>
<td>9.58%</td>
<td>33.73%</td>
<td>25.0%</td>
</tr>
<tr>
<td>UnitedHealth</td>
<td>33.92%</td>
<td>30.54%</td>
<td>NA</td>
<td>47.23%</td>
<td>24.12%</td>
</tr>
<tr>
<td>Hamaspik</td>
<td>29.27%</td>
<td>29.27%</td>
<td>29.27%</td>
<td>33.73%</td>
<td>25.0%</td>
</tr>
<tr>
<td>VNA</td>
<td>3.04%</td>
<td>NA</td>
<td>NA</td>
<td>1.81%</td>
<td>4.64%</td>
</tr>
<tr>
<td>Fidelis</td>
<td>22.06%</td>
<td>19.74%</td>
<td>29.06%</td>
<td>22.13%</td>
<td>24.92%</td>
</tr>
<tr>
<td>Alphacare</td>
<td>29.67%</td>
<td>29.67%</td>
<td>NA</td>
<td>47.23%</td>
<td>24.12%</td>
</tr>
<tr>
<td>Village Care</td>
<td>18.82%</td>
<td>18.82%</td>
<td>NA</td>
<td>47.23%</td>
<td>24.12%</td>
</tr>
<tr>
<td>Fallon</td>
<td>19.27%</td>
<td>19.27%</td>
<td>NA</td>
<td>19.27%</td>
<td>47.23%</td>
</tr>
</tbody>
</table>

Highlighted cells show that the percentage of a plan’s members with no services was higher in certain regions than for the same plan using statewide figures.

The NYS Comptroller recently released a report finding that $2.8 billion was paid to MLTC plans that provided little or no services to their members (see Comptroller MLTC Report at n. 3, supra). For example, the report cites that from 2015 until the pandemic began in 2020, nearly 60,000 members received less than 60 days of CBLTC services in a 6-month period. The Comptroller noted, the “…Department does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period....”

The MMCOR data along with Encounter Data (see glossary) should enable DOH to monitor the extent that plans are providing no or minimal services. The Comptroller’s interest was in recouping funds for the State, but they also recommend that DOH “…should consider a process to determine the reasons such limited services were received, and ensure members are receiving the required level of care as well as determine if members were properly assessed.” Since the pandemic began in 2020, the number of enrollees receiving no services increased substantially. That these figures were so high even before 2020 is extremely concerning.

CMS recently issued a [Managed Long Term Services and Supports Access Monitoring Toolkit](http://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html) that has numerous recommendations for how states can hold plans to “Service fulfillment standards.” The toolkit identifies metrics that plans should report and that states may include in a public quality dashboard. See recommendations below. Such reports would track access to care far more accurately than the current surveys that ask members whether, as a group, their aide, care manager, and visiting nurse usually or always arrived on time in the last six

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2. Most Plans Authorize Few Hours for Most Members & High Hours for Very Few
(See [https://nylag.org/home-care-member-years-by-hourly-category/](https://nylag.org/home-care-member-years-by-hourly-category/))

If plans of care were distributed along a classic bell curve, one would expect few members receiving the lowest and highest of the seven ranges or “buckets” of hours per month that the plans report, with most enrollees receiving hours in the middle. On the contrary, the distribution for most plans resembles a cliff, with most members receiving hours in the two lowest buckets, with decreasing numbers of members receiving hours in the higher ranges. This pattern is even more pronounced outside of the NYC Metro and Mid-Hudson regions.

The graph below shows the ranges of hours provided by all MLTC plans in 2018, on a statewide basis. The visualization is much clearer when viewed online.

**Table 4. 2018 Statewide Plans Combining Personal Care and CDPAP Hours**

<table>
<thead>
<tr>
<th>Home Care Type</th>
<th>Region</th>
<th>Year</th>
<th>Total/MF with Home Care 0 to 27,863.5 and Null values</th>
<th>Plan Multiple values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care Type</td>
<td>Region</td>
<td>Year</td>
<td>Total/MF with Home Care 0 to 27,863.5 and Null values</td>
<td>Plan Multiple values</td>
</tr>
</tbody>
</table>

[Distribution of Adjusted Enrollees (Member Years) by Hours per Month of Home Care]

The graph below shows the ranges of hours provided by all MLTC plans in 2018, on a statewide basis. The visualization is much clearer when viewed online.

Download the data allows a closer look at the number of hours plans authorize. A sample download posted online combines Personal Care and CDPAP services in 2018, with five tabs for each of the four regions and statewide data. Available at [https://nylag.org/wp-content/uploads/2022/09/Upload-D-MMCOR-PCS-CDPAP-Hours-by-Member-Years-All-regions-2018.xlsx](https://nylag.org/wp-content/uploads/2022/09/Upload-D-MMCOR-PCS-CDPAP-Hours-by-Member-Years-All-regions-2018.xlsx). The Statewide 2018 data for combined CDPAP and PCS reveals:

- Only two plans authorized the highest bucket of **700+ hours**, representing 24-hour care
in two 12-hour shifts, in more than 3 percent of member months -- Independence Care Systems (ICS) (5.60%) and United Healthcare (7.68%). Nine plans authorized 700+ hours for 1 – 2.11% member months and 19 plans were under 1 percent.

- Combining the top two "buckets" of hours (over 479 hours per month), which includes 24-hour "split-shift" care 5 days/week or 16 hours x 7 days, the same pattern is shown. ICS and UnitedHealth were the only plans authorizing 480+ hours for more than 7 percent of member months (ICS 7.33% and UnitedHealth 11.17%). Only 8 of the other 28 plans authorized this amount of hours for more than 2 percent of member months.

- Combining the four top highest buckets of hours, representing more than 239 hours per month, ICS was at the top, authorizing this amount for 46.35% of its enrollees. The other 29 plans authorized this amount for less than 30% of member months, with 11 plans authorizing that amount for fewer than 9 percent of their members.

- Combining the two lowest buckets of hours, 9 plans authorized under 160 hours per month for over 85% of member months which approximates the number of members. 160 hours/month includes authorizations of 5 hours x 7 days or 7 hours x 5 days. The plan with the highest percentage at this level is Prime Health Choice at 96.21% followed by Senior Network Health (92.33%), Elderwood (91.79%), Integra (88.31%), iCircle (88.22%), and Senior Whole Health (88.21%). In contrast, ICS authorized the fewest member months under 160 hours/mo. -- 32.58%. The remaining 20 plans authorized between 40% - 80% of all member months under 160 hours/mo.

Table 5 below is another view of the same data, showing the percentage of member years authorized at each of the seven ranges of hours. The highest buckets are the black (700+ hours/mo.) and gray (480-699 hours/mo.) areas on the far left. The pink (80-159 hours/mo.) and red (1-79 hours/mo.) areas on the far right are the two lowest ranges. Viewing the data online allows user to highlight different ranges of hours, plans, or view data by region.

The NYS Comptroller's Report, supra at n. 3, also noted plans giving little service -- less than 60 days of CBLTC services in a 6-month period. This averages out to 10 days per month or 2 days per week. That low frequency of service is exactly what plans authorize in service plans under 80 hours per month – the lowest bucket of hours captured on the MMCOR reports. Viewing the downloaded 2018 data on the Excel document posted on the website, nine MLTC plans authorized less than 80 hours per month for more than 50% of their members statewide. In the NE Western region, all 11 MLTC plans authorized fewer than 80 hours per month to more than 40% of their enrollees, and 6 of those plans for more than 60% of their enrollees.

The Comptroller recommended that DOH “…should consider a process to determine the reasons such limited services were received, and ensure members are receiving the required level of care as well as determine if members were properly assessed.” NYS Comptroller Report, supra n. 3 at p. 13. DOH responds that they will “monitor MLTC enrollees to ensure they are properly assessed and are receiving the appropriate level of care.” Supra n. 3 at p. 13. MMCOR data enables DOH to monitor adequacy of service plans. Patterns of low hour authorizations should be correlated with high nursing usage to flag patterns of insufficient CB-LTC services, prompting further investigation. This data should be made public.
Table 5. Distribution of Hours of Home Care Service by Plan

<table>
<thead>
<tr>
<th>Hourly Categories</th>
<th>700+ hours</th>
<th>480-699 hours</th>
<th>320-479 hours</th>
<th>240-319 hours</th>
<th>160-239 hours</th>
<th>80-159 hours</th>
<th>1-79 hours</th>
</tr>
</thead>
</table>

Showing Percentages of Member Years, by Categorized Monthly Hours of Home Care, Home Care Type: All, Statewide, 2018, Range of Number of Adjusted Enrollees (Member Years) = 0 to 27,864
3. Most Plans Make a Profit

In 2018, 23 of 30 partially capitated MLTC plans had positive net income after paying all medical as well as administrative expenses (see MMCOR Consolidated Finance Table). Note that administrative expenses include not only salaries and rent, but also advertising, marketing, contributions and donations, lobbying expenses, entertainment costs, interest, fines and penalties, and state income taxes.

Five plans with the highest net income in 2018 were Centers Plan for Healthy Living with $69 million, then Fidelis, Integra, Healthfirst, and Wellcare, all with net revenue over $30 million. Of the seven plans that had negative net income, three later closed: Guildnet, United HealthCare and Independence Care Systems. The other four remain open: Kalos, Evercare, Healthplus, and Senior Whole Health.24

The Medical Loss Ratio figure posted on the DOH website, though not defined the same as net income, largely correlate with a plan’s net income. The three plans that closed, listed above, had negative net income and also had MLR figures of more than 100%, meaning they spent more on services and other expenses than they received in revenue. At least some of the plans that closed, especially Independence Care Systems, also had better rebalancing indicators, reflected by lower nursing home utilization and higher proportion of members authorized with higher number of hours. DOH should closely examine what these plans did right to keep members at home, and what reforms are needed in the rate-setting methodology to incentivize plans to provide the care necessary to keep members out of nursing homes, countering the disincentive created by capitation.

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24 Despite its losses in 2018, Senior Whole Health was acquired by Molina in December 2020. Healthplus is now called Empire BlueCross BlueShield HealthPlus and, with the entire Empire BCBS company, was recently acquired by Anthem


Table 6. 2018 Statewide Plans – Net Revenue sorted from High to Low

Comparing Plans, Selected Revenue Figures

4. Existing State Reports of Rebalancing Data on an Aggregate Statewide Basis Mask Striking Differences Between Plans and Regions in Nursing Home Usage in MLTC

In its recent report, Mathematica cautioned, “Aggregate state-level rebalancing measures mask differences across populations and regions within states” (see n. 13 at p. 6). This observation holds true in New York. The 2019 DOH MLTC Report, supra, n. 8, reported that 10.3% of all MLTC members were then in nursing homes, and that 12% of all members had at least one nursing home admission during the year, 66% of which were for permanent placement (Table 2, p. 10). However, the MMCOR data shown in the middle two columns in the chart below shows that plans in two upstate regions that include 48 counties spent much more on nursing facility care than on community-based care. Table 7 below, using 2018 data shown in the MLTC Service Expenditures viz – (https://nylag.org/mmcor-service-expenditures/), shows that in the Rest of State region that covers 32 upstate counties, 71.96% of all service expenditures were for Nursing Facility care, and in the NE-Western region with 16 upstate counties, 61.44% of all service expenditures were for nursing home. These compared to 13.94% for plans in NYC region (which includes Long Island and Westchester) and 20.35% statewide. See Appendix A for counties in Regions. New York’s progress in achieving federal rebalancing goals must be measured and reported for each plan and each region, as aggregate statewide figures reported in 1115 Waiver reports and annual reports to the legislature are misleading.
Table 7: Regional Differences in Percentage of Plan Enrollees in Nursing Facilities and Percentage of Service Expenditures on NF Services - 2017-18

<table>
<thead>
<tr>
<th>Region</th>
<th>% Enrollees in NH</th>
<th>% Service Expenditures on Nursing Facility</th>
<th>% Member Mos. in NF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>NYC (includes L.I &amp; Westchester)</td>
<td>6.0%</td>
<td>13.83%</td>
<td>13.94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.9%</td>
</tr>
<tr>
<td>Mid-Hudson/No. Metro (6 counties)</td>
<td>19.3%</td>
<td>34.41%</td>
<td>34.10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17.5%</td>
</tr>
<tr>
<td>NE-Western (16 counties)</td>
<td>37.6%</td>
<td><strong>61.44%</strong></td>
<td><strong>62.16%</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>34.1%</td>
</tr>
<tr>
<td>Rest of State (32 counties)</td>
<td>47.7%</td>
<td><strong>71.74%</strong></td>
<td><strong>71.96%</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>43.5%</td>
</tr>
<tr>
<td><strong>Statewide</strong></td>
<td><strong>10.9%</strong></td>
<td>20.07%</td>
<td>20.35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>10.4%</strong></td>
</tr>
</tbody>
</table>

Source: Columns 1 and 4 from MMCOR Exh. A1 and A2, 2017, not visualized in this project, on file with NYLAG. Columns 2 and 3 from [https://nylag.org/mmcor-service-expenditures/](https://nylag.org/mmcor-service-expenditures/).

Table 8 below illustrates the same data, showing the percentage of service expenditures spent on nursing home care (shaded in gold), personal care (pink) or CDPAP (blue).
Table 8: Regional Differences in Percentage of Service Expenditures on Nursing Facility Services - 2018. SOURCE: MMCOR Data 2018 - https://nylag.org/mmcor-service-expenditures/

GOLD is Nursing Facility care, blue is CDPAP and pink is personal care.

Even in the NYC Metro area, where nursing home usage is relatively low, plans vary to the extent they authorize nursing facility care versus community-based care. Viewing the https://nylag.org/mmcor-long-term-care-service-mix/ viz for the NYC Metro area for 2018, five of 21 plans had 10% or more member months in nursing facilities (MetroPlus was the highest with 17.7%, followed by UnitedHealth, Archcare, HealthPlus, and VNS Choice). Six plans had under 2% of member months in nursing facilities, including Guildnet and ICS that since closed, Alphacare that merged in 2018 with Senior Whole Health, Extended, Integra, Montefiore, and Village Care.

Part of the reason for more nursing home care in 2017-2018 can be attributed to the policy then in effect that "carved in" long term nursing home care into the MLTC benefit package. Some NF residents had been auto-assigned to the plan, so the plan had no role in their placement or decision to stay permanently. Since long-term nursing home care was carved out of the benefit package in 2020, and 20,000 NF residents were disenrolled from MLTC plans, it should be easier to track usage of NF services by plans. Every plan enrollee in a NF is now admitted to the NF while being a member of the plan, so the plan plays a role in the admission decision, and in some cases, failing to reinstate or increase services to enable the member to return home, and in ultimately disenrolling the person based on a long-term stay. Plans must be accountable for such action and inaction.
The following tables from the downloaded 2018 MMCOR data illustrate the significance of whether rebalancing data is presented by number or percentage. Table 9 shows the number of enrollees statewide receiving only Nursing Facility services. Fidelis and VNA (Nascentia) had the highest and roughly the same number of enrollees solely receiving nursing facility care. Table 10 shows that Elderwood surpassed VNA/Nascentia in the percentage of members receiving nursing facility care only (shown in dark green) (62.69% vs. 56.31%), followed by Erie Niagara/Kalos (33.25%). Only 16.25% of Fidelis members received NF care statewide, but this low statewide percentage masks a higher percentage of Fidelis members receiving only NF care upstate--33.44% of members in “Rest of State” region compared to 6% in the NYC Metro region.

Table No. 9. Number of Enrollees only Receiving NF Services – Statewide
**Table 10** Percent of Enrollees Receiving the Various Long Term Care Services – Statewide 2018

**High Percentage of Enrollees Receiving NF Care Should Trigger Further Investigation by DOH of Adequacy of CB-LTC Services Authorized.** A high percentage of expenditures by a plan for nursing facility care, or high number of enrollees admitted to nursing homes, should be flagged by DOH for additional monitoring. DOH should look at the correlation between the amount of hours of home care being provided and nursing home usage. The MMCOR data demonstrate that plans with higher rates of nursing home usage also authorize fewer hours to enrollees. Similarly, plans with a low Medical Loss Ratio should not only be required to repay part of their capitation, but should be audited and sanctioned for failing to authorize and provide sufficient CB-LTC services.

A relationship between high-hour care and high Medical Loss Ratio is apparent. Of the four plans with MLR’s above 100%, meaning that they spent more than 100% of their revenue on services, three (Guildnet, United Healthcare and Independence Care Systems (ICS)) provided relatively high hours of home care services (PCS and CDPAP) to more members, and less nursing home care, than many other plans. This means they were serving more high-need members in their homes rather than in nursing homes, helping the State meet the federal goals of rebalancing long term care. Instead of being rewarded, they were forced to close. See Recommendations for adjustments in rate setting.

Also, DOH should correlate the placement numbers with the results of Minimum Data Set (MDS) 3.0 Section Q questions that ask every resident if they are interested in talking to someone about the possibility of returning to the community.
5. Higher Usage of CDPAP Compared to Personal Care Services Upstate Point to Lack of Network Capacity in Some Plans for Personal Care

Looking at the Long Term Care Services viz in each region reveals that the use of CDPAP services is much higher than PCS upstate. For example, in 2018, 10.31% of Fidelis members in the NYC Metro Region received CDPAP services compared to 17.78% receiving PCS and 39.84% received combined PCS and HHA services. In the NE Western region, 34.6% of Fidelis members received CDPAP compared to 2.77% receiving PCS and 12.17% receiving combined PCS and HHA services. Table 8 above shows the regional differences even more clearly, comparing blue (CDPAP) and pink (personal care) areas. The higher use of CDPAP reflects not only a preference for CDPAP but also the severe aide shortage for personal care services upstate, even in 2018 before the COVID-19 pandemic. It is well known that the aide shortage has become more severe statewide, including New York City. State policies should encourage the CDPAP program given its critical role in boosting service capacity.

6. Data Anomalies Exist in MMCOR Data

There were anomalies in the data that appeared to be reporting errors, but we chose to post the data as reported. For example, reports for partially capitated MLTC plans inexplicably contained some PACE data, even though they do not provide any PACE services. Viewing the Home Care Hours visualization for 2017, the percentage of all Metroplus member months authorized at the highest amount – over 700 hours/month – was 60% for personal care and 50% for CDPAP. This may be explained because the plan had low enrollment, which could result in high percentages, but it is not clear. DOH works with plans to clean up the MMCOR data, but some errors remain. Making the data public could improve the quality and validity of the data.

7. Sparse Data is Publicly Reported on Racial and Ethnic Differences in Plan Enrollment and Service Use – Necessary to Address Racial Disparities

While the 2019 DOH MLTC Report, supra n 8, includes some aggregate demographic data of the MLTC population with race, gender, age, and language breakdown, there is no breakdown by type of plan (partial vs. full capitation), region, individual plan, or by institutional status – of enrollees in nursing homes compared to the community. Such racial data is essential to address racial disparities in long term care. See our recommendations. The NYS Open Data site has some granular data, visualized in the Medicaid Enrollment viz, with racial and ethnic composition of each plan. The table below shows that in NYC in Nov. 2021, the percentage of members who are Hispanic is generally higher in one company’s Medicaid Advantage Plus (MAP) plan than in its MLTC plan. This is also shown on the bar graph on the following page, where the dark green color blocks represent the number of Hispanic members in the plan. More detailed data is available in the online visualization.
Table 11: Percentage of Plan Enrollees who are Hispanic – Comparing MLTC vs. MAP Plans

<table>
<thead>
<tr>
<th>Company</th>
<th>% MAP members Hispanic</th>
<th>% MLTC members Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthfirst/Senior Health Partners</td>
<td>68.31%</td>
<td>50.86%</td>
</tr>
<tr>
<td>VNS</td>
<td>49.98%</td>
<td>33.49%</td>
</tr>
<tr>
<td>Senior Whole Health</td>
<td>49.14%</td>
<td>28.50%</td>
</tr>
<tr>
<td>Elderplan (Homefirst)</td>
<td>47.26%</td>
<td>33.26%</td>
</tr>
<tr>
<td>Healthplus</td>
<td>40.57%</td>
<td>35.16%</td>
</tr>
<tr>
<td>Elderserv (Riverspring)</td>
<td>39.44%</td>
<td>12.60%</td>
</tr>
<tr>
<td>Centers Plan</td>
<td>36.36%</td>
<td>24.28%</td>
</tr>
<tr>
<td>Fidelis</td>
<td>35.46%</td>
<td>32.76%</td>
</tr>
</tbody>
</table>

State and CMS should look into the reasons for this disparity, and look at racial and ethnic differences in services provided. Advocates have observed that some enrollees do not understand the difference between these plan models, and did not realize their choice of Medicare providers is restricted to those in the plan's network. Some may be enticed into joining MAP plans by marketing incentives like over the counter cards. Given the sharp disparities, these enrollment practices should be investigated.

Additionally, racial disparities in community-based long term care access cannot be addressed without a racial and ethnic breakdown of members permanently placed in nursing homes, including those disenrolled because of a long-term nursing home stay, compared to members living in the community, including those who are placed temporarily and return home with MLTC services reinstated.
TABLE 12.  RACIAL and ETHNIC MIX – MLTC and MAP PLANS  Nov. 2021

Managed Long Term Care Partial Capitation – NYC – Nov. 2021

VI. Recommendations

1. New York State should post plan-specific MLTC MMCOR data on its Open Health Data website (https://health.data.ny.gov/) in an interactive format, viewable by region or statewide. Transparency about this data is essential for public accountability, to assist consumers in making plan choices, and to track measures that demonstrate compliance with the Americans with Disabilities Act (ADA), as interpreted in the Olmstead decision of the United States Supreme Court (https://www.ada.gov/olmstead/olmstead_about.htm).
   - Data highlighted in this report should also be included in the annual MLTC Reports, Consumer guides, 1115 Reports to CMS, and should be the basis for Quality Metrics and Incentives.

2. Rebalancing indicators now reported in the MMCOR Reports and in DOH Reports must be updated in light of nursing home care being carved out of the MLTC benefit package, to better track the rate at which members of each plan who are admitted to nursing homes either return home with MLTC services or are disenrolled because of a long-term nursing home stay.
   a. All rebalancing indicators should be broken down by plan and region, rather than presented only on a statewide aggregate level, which masks differences between regions and plans.
   b. Data collection must be improved to track and publicly report racial disparities in long term care services. COVID-19 illuminated the racial inequity in long term care. In late 2020, 73% of New York nursing homes with a relatively high share of Black residents reported one or more COVID-19 deaths, compared with 54% of nursing homes with a lower share of Black residents, and with 59% of all NYS nursing homes. A 10% gap was evident comparing New York nursing homes with a relatively high share of Hispanic residents with facilities with a low share. Comprehensive and intersectional data collection and reporting is essential to identify disparities in access to services that prevent institutionalization and develop strategies and policies to address those disparities. New York should follow the lead of California and other states to create a public Long-Term Services and Supports Data Transparency Dashboard. MMCOR

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reports or encounter data should be adapted to include racial breakdown in the key data points relating to rebalancing.

Numerous recommendations for how the state can improve collection and transparent use of data to improve equity in HCBS can be found in a December 2021 report of the California Health Foundation.26

Minnesota has created an interactive LTSS Dashboard that tracks some race and ethnicity data in the various HCBS programs.27 Statewide or by county, the user may compare the race, ethnicity, age, and language data for each of the various HCBS programs to the racial makeup of the overall population for the region. The dashboard shows the relative number receiving LTSS in an institution compared to in the community. The dashboard is by no means perfect; there is no race and ethnicity data of the nursing home population, no tracking of nursing home admission or discharge rates by race and length of stay, or tracking of nursing home admission rates for each HCBS program. It is still a starting place for New York.

All of the rebalancing data recommended above should be reported by race and ethnicity. Are plans disenrolling more members because of a long-term nursing home stay who are People of Color? Racial and ethnic data for new members enrolled in the plan is also critical—for those enrolled who had been in the community and those who enroll from a nursing home stay.

c. **All data must be made public** in the annual DOH MLTC Reports, NYS Open Health Data, and Consumer Guide.

d. **NYS should adopt at least three new evidence-based MLTSS quality measures released by CMS in 2018, which focus on the use of institutional care by MLTSS health plans**, adapted to track the impact of carving out NF care from the MLTC benefit package. See “Mathematica HCBS Quality Measures,” supra, n 13 at page 7. The MMCOR reports, having not been updated in many years, need to be modified to implement these measures. This data should specifically be included in Rebalancing data in DOH 1115 and other reports and should be made public by plan and region. The three indicators are:

   i. **Rate of Admission of MLTC Members to a Nursing Facility (NF) from the Community**, counted per 1000 member months. Data is broken down by length of stay in the NF

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(short, medium and long) and age group, allowing risk adjustment based on age factor.

- MMCOR Exh. A3 reports the total number of admissions to a NF by quarter for the year, and the number of days of NF care. The report should be updated to track the number of unique enrollees represented by these reported admissions to take into account multiple admissions for an enrollee.

- MMCOR Exh. A1, which asks the plan to report the number of enrollees in the community and the number permanently placed in NFs, should be updated to add the number that were admitted to a NF while enrolled in the plan, with their length of stay using the short, medium, and long periods recommended by CMS.

ii. **Minimizing Institutional Length of Stay**: Percentage of enrollees admitted for short-term stays in a NF that result in a successful discharge to the community, defined as lasting for 60 or more days in the community.

- MMCOR Exh. A4 now reports the number of enrollees discharged from a NF by length of stay, but only if Medicare did not pay the entire cost of the NF stay. The report only asks the plan to identify the number of NF discharges that ended in death or for “other” reason. This report should be updated to break down “other” discharges to identify the number who returned home still enrolled in the plan, the number of members disenrolled from the plan while in the NF, specifying the number disenrolled for a long-term nursing home stay, and the number disenrolled because of a 45-day hospital stay, or for other reasons. Also, whether to exclude all NF stays paid fully by Medicare should be re-evaluated, at least for those that exceeded 20 days.

- Neither MMCOR nor other reports now specifically track the number of enrollees successfully discharged, the length of the NF stay before returning home, and the length of time they remain at home before a hospital or rehab stay. This information should be added.

iii. **Successful vs. Unsuccessful Transition After Long-term Institutional Stay**: CMS recommends tracking the percentage of enrollees in long-term stays that result in successful transitions to the community, defined as lasting 60 or more days. The length of time these enrollees remain at home before a hospital or rehab stay is not now reported, and would need to be added to the report.

- We recommend tracking the percentage of members who were disenrolled because of a long-term nursing home stay, comparing this to the number of successful transitions to the community.
• Also, members who were disenrolled because of a long-term nursing home stay have the right to re-enroll within six months.\footnote{This right to reinstatement within 6 months is set forth in the CMS letter approving the amended Special Terms & Conditions of the 1115 waiver, dated Dec. 19, 2019, available at \url{https://www.health.ny.gov/health_care/managed_care/appextension/2019-12-19_cms_stc.htm}. It is also in the 10-day notice from NY Medicaid Choice, available at \url{https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma06_att_i.pdf}, but not in the 30-day notice sent by plans, available at \url{http://www.wnylc.com/health/download/793/}.} Plans should report the number of enrollees reinstated under this policy.

iv. **Number of Enrollees Who Were Previously in a Nursing Home and Newly Enrolled in an MLTC Plan:** The Mathematica indicators focus on admission of existing enrollees to NFs, and do not capture the extent to which consumers enroll in plans who, at the time they seek enrollment, are in a nursing home. The carve-out of nursing home care makes it more imperative to track this data — and reward plans who excel on this indicator.

e. **A Plan’s High Nursing Home Utilization While Authorizing Low Hours of Home Care Services Should trigger DOH Investigation** of Improper Assessment Practices and sanctions for under-utilizing home care services. This should include monitoring whether plans are improperly denying sufficient community-based long term care services including Private Duty Nursing (see more about that below), Home Health Aide, PCS and CDPAP needed to avoid nursing home placement.

f. **Improved Reporting and Monitoring is Needed of the Number of Voluntary and Involuntary Disenrollments, broken down by the various grounds for disenrollment:** Plans should report the number of disenrollments, broken down by whether they are voluntary or involuntary, and by the reason — long-term nursing home stay, behavior by consumer or family, 45-day hospital stay, moved out of the service area, no receipt of CB-LTC services for 30 days, death.

   • Given the MMCOR data, also shown in the OSC Report, showing the number of plans in which no services were provided during a report period, DOH should monitor disenrollments based on lack of CB-LTC services received in 30 days.

   • More scrutiny is needed of plan referrals to disenroll members who were in a nursing home for more than three months. Advocates have reported that consumers are disenrolled despite having an appeal pending of the plan’s denial of requested services needed to return home. Oversight is needed because it is up to the plan or nursing home to designate whether the consumer has an “active discharge plan,” and because members in nursing homes do not receive notices of the disenrollment sent to their homes. Plans should be required to demonstrate whether the consumer requested or the plan offered services to return home, and what barriers prevented a safe discharge home.
• Policies and procedures are needed to implement a member’s right to re-enroll within six months after being disenrolled for a long-term nursing home stay (see n. 28, supra).

g. **Change MMCOR Definition of Home Health Care Services so that Private Duty Nursing is Reported Separately:** The MMCOR instructions require plans to report Private Duty Nursing expenditures and authorizations under the broad definition of Home Health Care expenses, so that this service cannot be tracked separately from “...therapeutic and preventive nursing services” provided by a visiting nurse. Under the same umbrella also falls in-home rehabilitation therapies and pharmaceutical costs for IV therapies. The costs of a home health aide are reported as Personal Care if the aide is performing only personal care services with no health-related tasks.

Private duty nursing services, like PCS and CDPAP, are authorized in shifts by the hour and should be tracked in the same distributions of hours per month as PCS and CDPAP. All the other services in the Home Health Care category, such as a visiting nurse or rehabilitation therapist, are authorized by the visit, which is not comparable. Private Duty Nursing is essential for some consumers to avoid nursing home placement, but is expensive, so plans often fail it to authorize it in adequate amounts, or even at all. It is critical for measuring rebalancing to accurately track the number of members receiving these services and the cost. The NYS Budget for SFY 2022-23 increases the rates for Fee-For Service private duty nursing but not in managed care, preserving the disincentive inherent in the capitation model that deters plans from authorizing these services because of their high cost.

We also recommend that rate mechanisms such as stop-loss be used to counter the disincentives caused by capitation. See more below.

h. **MLTC plan Quality Metrics and Quality Incentive Awards should reward plans that excel in the “Rebalancing” indicators** described above and penalize those that fail.

3. **Appeals and Grievances—Plan-Specific Data on Numbers and Outcomes of Each Level of Appeal, with a Breakdown of the Most Common Issues, Should be Publicly Reported.** As discussed above, DOH’s reports to the legislature and 1115 Reports to CMS lack sufficient data on MLTC appeals and grievance issues and outcomes--they include no data on issues and outcomes of MLTC Fair Hearings or External Appeals reviewed by NYS Dept. of Financial Services, pursuant to NYS Insurance Law.

A high reversal rate of adverse plan determinations signals arbitrary or improper decision-making at the initial level, which the State as well as the public should be able to monitor. The number of appeals filed at each level, their outcome, and the top five reasons for the

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29 To ensure that data reflects actual outcomes, reports should classify a member’s withdrawal of an appeal request as favorable to the member if the plan agreed to grant the requested relief. See Medicaid Matters NY MLTC Fair Hearing Report, n. 18, supra, which observed that for fair hearing decisions that reported a hearing as settled by stipulation or withdrawn, the actual outcome must be gleaned from the language of the decision,
appeals, should be included in DOH MLTC Reports, 1115 Report, and Consumer Guides on a plan--and region-specific basis.\textsuperscript{30} The composite reporting of plan appeals now used in the 1115 report masks important differences between plans and regions. High reversal rates should be used in Quality Metrics and Quality Incentives.

4. **Require Timely Reporting and Tracking of Unstaffed Cases, Sanction Plans for inadequate Network Capacity, and Support CDPAP Program as Essential to Meet Capacity Requirements.** The State should adopt recommendations made in the recent CMS LTSS Toolkit, n. 25, supra, to hold plans to “Service fulfillment standards” for which plans report metrics to track timely access to authorized services. Plan data should be posted on a public quality dashboard. Performance could include the maximum wait time for home care services to be initiated after authorization (Texas requires a plan to initiate services within 7 days for 90% of members authorized for PCS). Id. Plans should submit a Monthly Unstaffed Case Report or a Late & Missed Visit report. CMS LTSS Toolkit at p. 36. The State should cross-reference complaints and grievances against the plan’s reports to validate completeness of the plan’s reports. Electronic Visit Verification can also be used to track timely delivery of services, which the plan would aggregate by region and report to DOH. Id. Some states require a Utilization Report to track members who have been without LTSS for various periods of time, with an explanation of why the services were not provided and when they are expected to begin (see CMS Toolkit at pp. 35).

Plan requests to disenroll members, especially for not receiving services in 30 days, should be scrutinized to ensure the reason was not the plan’s lack of provider capacity.

The State should better support the CDPAP program which is essential for adequate staffing statewide and especially outside of NYC.

5. **Improved Monitoring of Timeliness of Plan Response to Member Requests for Services.** Timely access to services includes tracking whether plans meet deadlines in their contracts and federal regulations for processing requests for services. See 42 CFR § 438.210. As stated above, member surveys, even if improved with more targeted questions about timeliness of home care, should not be the only way to monitor timely access. More robust indicators should be reported and included in MLTC Reports, Open Data, and consumer guides, and incorporated in Quality metrics and Quality Incentive awards.

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\textsuperscript{30} Since “Aide Service” was the top of 5 issues for complaints to the DOH complaint unit, per the 1115 Report for DOH TAC Complaint line, this category should be further broken down into at least 3 groups: Appeals of denials of increases in home care, appeals of reductions in home care hours, and quality issues such as lack of staffing or lateness.
a. Track time for plan to approve or deny member requests for new or increased services, differentiating requests for expedited authorizations from standard-time ones, and differentiating requests made by members temporarily in nursing homes.

b. Track and make public plan-specific member complaints to the Plan and to the DOH Complaint unit, rather than aggregate statewide number of complaints now reported in the 1115 Reports. These figures should be made public by plan, and should break down the “home care” issues to differentiate staffing problems from other access issues (see n. 32 and 1115 Report, supra, n. 9).

c. DOH or its external reviewer should conduct “desk reviews of service authorizations,” as described in the CMS LTSS Access Monitoring Toolkit, with detailed reviews of MLTSS plan records to review processing time, and dates and methods of enrollee notifications about denials or changes.” Supra, n. 25.

6. **Risk Adjustment of Quality Data Should be More Transparent.** Much of the data in the MLTC Report and Open Data sites is risk-adjusted, without full transparency on the methodology, which is only partially explained in an appendix to the MLTC Report. The adjustments are still opaque. We recognize that risk adjustment may be necessary, but the data should be publicly available both in risk-adjusted form and in its original form for transparency, with the methodology fully explained. If plan receives a higher capitation payment because of higher-need enrollees, it should be expected to provide more services as well.

7. **Revise Rate Setting Methodology to Counteract the Disincentive Inherent in the Capitation Model that Deters Plans from Authorizing Higher Levels of Care Needed to Live Safely in the Community.** The fact that the service costs of four plans with MLR’s above 100% in 2018 exceeded their revenue – leading them to close – shows the need for a stop-loss mechanism or community-based rate cell that ensures funds are available for high-cost services for members who are outliers on the continuum of need. These would include members who need Private Duty Nursing (PDN) services, discussed above, who are not even tracked now. Such mechanisms are necessary to counteract the disincentive that is inherent in capitation that leads plans to cherry-pick, deterring plans from enrolling high need members and from providing sufficient hours of home care to avoid institutionalization.

The recently enacted Medically Fragile PDN rates for adults will not improve access to this service for consumers who must be in MLTC or mainstream plans, unless plans are required to pay these rates, which were enacted only for those in FFS. Carving out PDN services from the benefit package or creating a stop loss mechanism for members determined to need PDN services above a benchmark number of hours per week could ensure consumer access. Such mechanisms could ensure that the rate paid for PDN in MLTC or MMC plans is the same as the enhanced rate just approved in the State budget for FFS. DOH could track should track the effectiveness in the above payment mechanisms for reducing institutionalization–by both enabling consumers to return home from nursing homes and preventing their placement in the first place.
Appendix A

Four Regions of New York State: List of Counties in Each Region

<table>
<thead>
<tr>
<th>New York Metro</th>
<th>Mid-Hudson / Northern Metro</th>
<th>Northeast / Western</th>
<th>Rest of State</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>Dutchess</td>
<td>Madison</td>
<td>Cayuga</td>
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<td>Orange</td>
<td>Onondaga</td>
<td>Schuyler</td>
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<td>Sullivan</td>
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<td>Fulton</td>
<td>Seneca</td>
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<td>Putnam</td>
<td>Montgomery</td>
<td>Columbia</td>
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<td></td>
<td>Rockland</td>
<td>Rensselaer</td>
<td>Steuben</td>
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<td>Cortland</td>
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<td></td>
<td></td>
<td>Warren</td>
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</tbody>
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Source: NYS DOH, MLTC MMCOR Instructions, Appendix A, on file with NYLAG
Appendix B
MLTC Data Transparency Project

Glossary

https://nylag.org/MLTCdatatransparency/

NOTE: This glossary does not contain every term used in the visualizations. See the MMCOR Report instructions, posted at https://nylag.org/wp-content/uploads/2022/09/UPLOAD-A-2-2021-Q4-MLTCCCR-Instructions-FINAL.pdf, for definitions of some of the terms, such as types of revenue and expenditures.

Administrative expenses: Plans report “allowable administrative expenses” in MMCOR Schedule D-3, D-3A and D-3B - not visualized in this project: rent, salaries and fringe (administrative), legal fees, utilization mgt. and quality improvement, travel, advertising, marketing, finance, auditing and actuarial, claims processing, provider relations, recruitment and contracting, member services, MIS systems, telephone, postage, printing and stationery, equipment rental, boards and association fees, insurance except for real estate, payroll taxes, collection and bank service charges, other taxes (excluding federal income tax and real estate), Intake and Enrollment, Employee recruitment, retention and contracting, franchise taxes.

“Nonallowable” administrative costs include contributions and donations, lobbying expenses, entertainment costs, interest, fines and penalties, uncollected spenddown and NAMI, state income taxes.

Capitation – The government pays Managed Long Term Care (MLTC) plans a “capitation payment” or “premium” to provide all services in the plan’s service package. This payment is the same amount “Per Member Per Month” (PMPM), calculated by State-contracted actuaries using a complex formula. The capitation model is in contrast to the “Fee For Service” model, where each provider bills Medicaid directly for each service. In capitated plans, the plan contracts with and pays providers in its “provider network.” There are two types of MLTC plans with different capitation payments:

- “Full capitation” -- the plan receives two separate capitation payments – one for all Medicare services and one for all Medicaid services. These plans provide all Medicare and Medicaid services, including all Community-Based Long-Term Care services (see definition), nursing home care, hospitalization, outpatient care, physician, supplies, labs, etc. In NYS, these are Medicaid Advantage Plus (MAP) and PACE plans. See more about types of MLTC plans at https://icannys.org/icanlibrary/what-is-mltc/#4.

- “Partial capitation” -- the plan receives one capitation payment to provide a package of Medicaid services, which include all Medicaid Community-Based Long-Term Care services (see definition), short-term nursing home care, and a few other Medicaid services (dental, vision, podiatry, audiology, hearing aids, eyeglasses, durable medical equipment, physical/occupational/speech therapy, medical supplies, non-emergency medical transportation). MLTC members receive other Medicaid services on a Fee-For-Service basis outside the plan, such as payment of the Medicare hospital deductible or Part B coinsurance for outpatient care. Members receive their Medicare services separately, with their choice of Original Medicare or Medicare Advantage. In NYS, most MLTC plans are of this type and are sometimes referred to as “regular” MLTC plans. See more about types of MLTC plans at https://icannys.org/icanlibrary/what-is-mltc/#4.

• **NOTE ON TERMS USED** in the [https://nylag.org/medicaid-plan-enrollment/] (VISUALIZATION): To view data for Partial Capitation MLTC plans, select “Partial MLTC,” not “PARTIAL CAP PLAN” or “FFS Partial Cap.” “PACE” and “MAP” are labeled with those acronyms.

• **View the MLTC PMPM rates in the Finance table** - [https://nylag.org/mmcor-consolidated-finance-table/]. In the Select Metric selector, select “Medicaid Premium PMPM” for the base MLTC monthly premium and “Total Premium PMPM” that adds to the Medicaid Premium extra payments for Spenddown and NAMI, Recruitment and Retention of home care workers, Quality Incentive Pool Award, Quality Incentive VAPP and Minimum Wage. See MMCOR Instructions for definitions, available at [https://nylag.org/wp-content/uploads/2022/09/UPLOAD-A-2-2021-Q4-MLTCCR-Instructions-FINAL.pdf].

Community-Based Long-Term Care [CB-LTC] services refers to the package of Medicaid services provided outside of nursing homes for people who need assistance with activities of daily living. This is the core service package for MLTC plans, and includes personal care, Consumer Directed Personal Assistance Program (CDPAP), Private Duty Nursing, and Adult Day Health Care – both medical model and social model. The Medicaid Assisted Living Program (ALP) is not part of the MLTC benefits package as of 2022, and is available on a Fee-for-Service basis with prior approval of the local Medicaid agency.

**Consumer Directed Personal Assistant Program (CDPAP):** An alternative Medicaid home care model in which the consumer hires, schedules, trains, supervises and can terminate a “personal assistant,” whose hours are authorized by an MLTC or managed care plan or a local Medicaid agency. The personal assistant may be the consumer’s family member (other than a spouse or a parent if the consumer is a minor) and is paid by a Fiscal Intermediary that contracts with the plan or local Medicaid program. In contrast, in the traditional Personal Care Service model, the personal care aide is employed by a licensed home care services agency (LHCSA), under contract to a plan or local Medicaid agency. See [https://cdpaanys.org/resources/about-cdpa/] and at [http://www.wnylc.com/health/entry/40/].

**Combined Home Care Hours:** Where a visualization gives the option to view data by this category, the data includes Personal Care services, CDPAP, and, in some cases, home health care.

**Community Health Assessment (CHA)** – The nurse’s assessment using the Uniform Assessment System NY (UAS-NY) assessment tool, which is used by the plan to develop a plan of care. Under the new “NY Independent Assessor” (“NYIA”) system, since May 16, 2022, the initial CHA for a new enrollee is conducted not by a plan nurse but by a nurse employed by Maximus in its NYIA program. At an unspecified date in the future, CHAs conducted for annual reassessments will also be conducted by NYIA nurses, but in the meantime are conducted by plan nurses. See more about NYIA at [https://nyaia.com/en] and [http://www.wnylc.com/health/news/85/](http://www.wnylc.com/health/news/85/) and [https://www.health.ny.gov/health_care/medicaid/redesign/nyia/](https://www.health.ny.gov/health_care/medicaid/redesign/nyia/).

**Dual Eligibles** - People who have both Medicaid and Medicare, which means, by definition, they are either age 65+ or have been determined to be disabled or blind, and are low-income.

**Encounter Data** – Under 42 C.F.R. 438.2, data transmitted by plans that records the receipt of any item(s) or service(s) by an enrollee under a contract between a State and an MCO that is subject to the requirements of 42 C.F.R. §§ 438.242 (requiring that the data be a complete and accurate representation of the services provided to the enrollees under the contract” and 438.818. This state-validated data is used in federal and state monitoring and in rate setting.

**Home Health Care** – refers to a group of services provided by Certified Home Health Agencies (CHHA). Unlike other MLTC CB-LTC services, these services may also be reimbursed by Medicare,
though in lower amounts and with different eligibility standards. The MMCOR instructions tell plans to report as Home Health Care services “therapeutic and preventive nursing services, private duty nursing, home health aide services and rehabilitation therapies. Includes pharmaceutical costs for IV therapies.” Home Health Aides, like Personal Care Aides, are employed by Licensed Home Care Services Agencies (LHCSA), but their certification and training is at a slightly higher level, including certain health-related tasks. See NYS DOH Home Health Aide Scope of Tasks, http://www.leadingagency.org/linkservid/086226dd-f154-009a-541f4722d38b4641/showmeta/0/ (2009).

**NOTE on Home Health Care in MMCOR Reports and Visualizations** – The MMCOR instructions tell plans to include home health aide services under the Personal Care category “if the aide is performing only personal care services with no health-related tasks (vital signs, transferring with hoyer lift, stable dressings, ostomy care, prepare meals for complex diets, maintenance exercise programs).” MMCOR Instructions. Also, the Instructions state, “Home Health Care is reported with both an hourly and a per visit unit cost for the service.” See Recommendations in the Report to report private duty nursing separately, not bundled with other services categorized as home health care.

**Incurred but Not Reported (IBNR):** Payable medical claims that have been incurred because a covered health service has been provided, but the billing process is not yet complete.

**Licensed Home Care Services Agencies (LHCSAs)** – a private home care services agency licensed pursuant to Public Health Law Section 3605 to provide home health aide or personal care services. LHCSAs are generally not Medicaid providers, but serve as subcontractors with a Certified Home Health Agency (CHHA) or an MLTC plan. They may be for-profit or non-profit.

**Mainstream Medicaid Managed Care:** Insurance plans that are paid a monthly premium ("capitation" or “per member per month” rate) by the New York Medicaid program to approve and provide all Medicaid services, including acute, primary and long-term care, including personal care, CDPAP, private duty nursing services, and nursing home care. Most members are children, families and adults under age 65 because these plans exclude those who have Medicare, other Third-Party Health Insurance, or an income “spend-down,” with some exceptions.

**Managed Long Term Care (MLTC):** Insurance plans that are paid a monthly premium ("capitation" or “per member per month” rate) to provide Medicaid Community-Based Long-Term Care and some other Medicaid services. Most adult Dual Eligibles are required to enroll in an MLTC plan to receive community-based long-term care services. They may choose a fully capitated or partially capitated plan. See Capitation above. For more information see http://www.wnylc.com/health/entry/114/ and fact sheets at http://www.wnylc.com/health/entry/202/.

**Medicaid:** The Medical Assistance (Medicaid) program is a public health insurance program operated by New York State in cooperation with the Federal government, with costs shared by the federal and state government, and in some cases, with a local contribution. Eligibility is based in part on financial need, residency and immigration status, with different eligibility rules for people who are age 65 and older or who have been determined to be disabled, compared to younger people who are not disabled.

**Medicaid Advantage Plus (MAP):** A type of MLTC plan that is “fully capitated” - see Capitation.

**Medicaid Managed Care Operational Reports (MMCOR):** Reports that all MLTC and other Medicaid managed care plans are required to file with the New York State Department of Health, reporting all expenses, income, and services. Each plan files a statewide report and a separate report for each geographic region in which it operates. The last quarterly report of each year includes data for the
Medical Loss Ratio (MLR): The percentage of premium revenue spent on services as opposed to administrative costs. 42 CFR § 438.8. DOH now posts MLR Reports for are available at https://health.ny.gov/health_care/managed_care/reports/ - scroll down to Medical Loss Ratio Reports.

Member Months (MM): Plans report much of the MMCOR data by “Member Month,” which “is equivalent to one person for whom the plan has recognized capitation-based premium revenue for one month.” MMCOR Instructions. This figure adjusts for turnover so that plans whose enrollees stay enrolled or receive certain services for shorter or longer periods can be appropriately compared. For example, MMCOR Exhibit A-5 reports the number of “member months” in which the plan provided personal care services in each of seven different groupings of hours/month, ranging from < 80 hours/month to 700+ hours/month. If the plan gave 700+ hours/mo. of personal care to 100 members for 2 months in the year, it would be misleading to say that 100 members received 700+ hours of personal care. Instead, the plan would report it provided 700+ hours for 200 member months. Exhibit A-5 and Exhibit A-7 for CDPAP, is used for the “Home Care Member Years by Hourly Category” visualization.

Member Years (MY): Member Years = Member Months divided by 12. We have divided the number of member months by 12 to approximate the number of members who are enrolled in a plan or who are receiving a particular service. If the plan reports providing 700+ hours of personal care in 200 member months, for example, this would be shown as 16.7 member years (200/12 months). By using this formula uniformly in every instance where the plan reports “member months,” it gives a fair representation of the number of members authorized for a particular service. It standardizes plan enrollment figures to account for different enrollee turnover rates and mid-year changes in service amounts and is intended to be less technical and more readily understood than Member Months.

Nursing Facility (NF) or Skilled Nursing Home (SNF): Nursing Homes

Nursing Facility Level of Care (NFLOC) score -- a composite functional scale from 0 – 48, with 48 showing the highest level of need. Based on findings in the nurse Community Health Assessment.


Personal Care Services (PCS): The primary type of Medicaid home care service provided in New York State. Certified PCS aides are employed by Licensed Home Care Services Agencies (LHCSAs), which in turn contract with MLTC plans or local Medicaid agencies. Most adults who have Medicare must obtain PCS from MLTC plans. Those without Medicare who are in Mainstream Medicaid Managed Care plans obtain the service from those plans. Some Medicaid recipients who are excluded or exempt from enrolling in MLTC obtain PCS from local Medicaid agencies. For the applicable law, regulations, and policies for authorizing these services in NYS see http://www.wnylc.com/health/entry/7/.

• NOTE on PCS in Visualizations – The MMCOR instructions tell plans to include home health aide services in reporting PCS services “if the aide is performing only personal care services with no health-related tasks (vital signs, transferring with hoyer lift, stable dressings, ostomy care, prepare meals for complex diets, maintenance exercise programs).” This
definition is partly incorrect in that PCS aides may also assist with transferring with a hoyer lift. See NYS DOH, Personal Care Scope of Tasks (1994), available at http://www.wnylc.com/health/download/46/.

**Premium:** See *Capitation* definition.

**Rebalancing:** Federal goal of achieving a more equitable balance between the share of Medicaid spending and use of long term services and supports (LTSS) delivered in home and community-based settings relative to institutional care. CMS issues annual reports on progress on rebalancing LTSS, with the most recent report issued in 2021 with 2019 data, available at https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf, posted on https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html. For FY 2019, NYS ranked 13th in the percentage of all LTSS expenditures spent on HCBS (63%) (2021 Report at pp. 16).

**Region:** MLTC plans must file a separate MMCOR report for each of four regions in the state in which the plan operates. See list of counties in each region in App. A. In each visualization, the user may choose to view “STATEWIDE” data or data solely for one of four geographic regions. If a plan operates in more than one region, only the data for the selected region will appear if one region is selected.

**Spenddown/NAMI:** The total amount of monthly income that the local Medicaid agency determines the enrollee must pay toward the cost of their care. The “NAMI” is the term used in nursing home budgeting. Note that this is not the amount the plan actually collects – the amount should not be reduced by what is not collections. Plans should report uncollected amounts as bad debt on Schedule D-3, which is not visualized in this project.
# Appendix C

## MLTC Plan Names Used in MMCOR Visualizations - Partial Capitation Plans Only

### With Changes in Names and Plan Ownership (since 2015 and pending) and Service Area

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Name or Abbreviation used in Visualizations</th>
<th>Service Area by County (2022)</th>
<th>Ownership &amp; control / Plan Closings &amp; Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Better Health</td>
<td>Aetna</td>
<td>NYC except Staten Island, Nassau, Suffolk</td>
<td><a href="https://www.aetnabetterhealth.com/ny/board">https://www.aetnabetterhealth.com/ny/board</a></td>
</tr>
<tr>
<td>AgeWell New York</td>
<td>AgeWell</td>
<td>NYC except Staten Island, Nassau, Suffolk, Westchester</td>
<td>In Oct. 2022 - will close and merge into Senior Whole Health, which is owned by Molina <a href="https://agewellnewyork.com/about/">https://agewellnewyork.com/about/</a></td>
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<tr>
<td>Alphacare</td>
<td>Alphacare</td>
<td>Closed (NYC, Westchester)</td>
<td>Merged into Senior Whole Health early 2018</td>
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<td>ArchCare Community Life</td>
<td>Archcare</td>
<td>NYC (all boroughs), Putnam, Westchester</td>
<td><a href="https://www.archcare.org/health-plans/community-life/information-members">https://www.archcare.org/health-plans/community-life/information-members</a></td>
</tr>
<tr>
<td>Centerlight</td>
<td>Centerlight</td>
<td>Closed (Nassau, NYC, Rockland, Suffolk, Westchester)</td>
<td>Closed eff. Jan. 31, 2017 - members transferred to Centers Plan for Healthy Living unless chose different plan</td>
</tr>
<tr>
<td>Centers Plan for Healthy Living</td>
<td>Centers</td>
<td>NYC (All boroughs), Erie, Nassau, Suffolk, Niagara, Rockland, Westchester</td>
<td><a href="https://centershealthcare.com/centersplan/about/what-is-new">https://centershealthcare.com/centersplan/about/what-is-new</a></td>
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<tr>
<td>Elderwood Health Plan</td>
<td>Elderwood</td>
<td>Erie, Genesee, Monroe, Niagara, Orleans, Wyoming</td>
<td><a href="https://www.elderwoodhealthplan.com/about-us/">https://www.elderwoodhealthplan.com/about-us/</a></td>
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<tr>
<td>ElderPlan</td>
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<td>See HomeFirst</td>
<td>See HomeFirst</td>
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<tr>
<td>Empire BlueCross BlueShield HealthPlus</td>
<td>Healthplus</td>
<td>New York city (All boroughs)</td>
<td>Oct. 2015 - HealthPlus Amerigroup is renamed Empire BlueCross BlueShield Healthplus. May 2022 - Anthem acquired all BlueCross BlueShield plans and is changing its name to Elevance. <a href="https://mss.empireblue.com/ny/contact-us.html">https://mss.empireblue.com/ny/contact-us.html</a></td>
</tr>
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</tr>
<tr>
<td>Extended MLTC, LLC</td>
<td>Extended</td>
<td>NYC (All boroughs), Nassau, Suffolk</td>
<td><a href="http://www.extendedmltc.org/MLTC_About">http://www.extendedmltc.org/MLTC_About</a></td>
</tr>
<tr>
<td>Name of Plan</td>
<td>Name or Abbreviation used in Visualizations</td>
<td>Service Area by County (2022)</td>
<td>Ownership &amp; control / Plan Closings &amp; Changes</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Fidelis Care at Home</td>
<td>Fidelis</td>
<td>NYC (All boroughs), all Upstate counties</td>
<td>July 1, 2018 - Fidelis was bought by Centene Corp. With transition, several reports were filed for this plan in 2018- Fidelis, Fidelis Care, &amp; Fidelis Legacy Plan <a href="https://www.fideliscare.org/About-Us">https://www.fideliscare.org/About-Us</a></td>
</tr>
<tr>
<td>Guildnet</td>
<td>Guildnet</td>
<td>Closed (Nassau, NYC, Suffolk, Westchester)</td>
<td>Closed all plans eff. 1/1/2019 and stopped operating some plans in some counties earlier</td>
</tr>
<tr>
<td>Hamaspik Choice</td>
<td>Hamaspik</td>
<td>Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster</td>
<td><a href="https://www.hamaspik.com/team">https://www.hamaspik.com/team</a></td>
</tr>
<tr>
<td>HomeFirst, a product of Elderplan, Inc.</td>
<td>ElderPlan</td>
<td>NYC (All boroughs) Albany, Dutchess, Erie, Nassau, Niagara, Monroe, Onondaga, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Suffolk, Sullivan, Ulster, Westchester</td>
<td>Stopped operating in Suffolk County mid-2017, and in 8 upstate counties shown in adjacent cell in 9/2015 <a href="https://www.elderplan.org/elderplan/disclaimers/">https://www.elderplan.org/elderplan/disclaimers/</a></td>
</tr>
<tr>
<td>iCircle Care</td>
<td>iCircle</td>
<td>Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Cortland, Delaware, Erie, Genesee, Herkimer, Livingston, Madison, Monroe, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates</td>
<td><a href="https://www.icirclecny.org/for-members/">https://www.icirclecny.org/for-members/</a></td>
</tr>
<tr>
<td>Independence Care Systems</td>
<td>Independence</td>
<td>Closed (NYC except Staten Island)</td>
<td>closed 12/31/19 - members transferred to VNS Choice unless opted for other plan</td>
</tr>
<tr>
<td>Integra</td>
<td>Integra</td>
<td>NYC (All boroughs), Nassau, Suffolk, Westchester</td>
<td>April 2022- acquired by Anthem, which owns Empire-BlCr Bl Shield-Health Plus -- Members not notified about any plan transfer as of Aug. 2022 <a href="https://www.integraplan.org/">https://www.integraplan.org/</a></td>
</tr>
<tr>
<td>Name of Plan</td>
<td>Name or Abbreviation used in Visualizations</td>
<td>Service Area by County (2022)</td>
<td>Ownership &amp; control / Plan Closings &amp; Changes</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MetroPlus</td>
<td>MetroPlus</td>
<td>NYC (All boroughs)</td>
<td>Subsidiary of NYC Health + Hospitals</td>
</tr>
<tr>
<td>Montefiore Diamond Care</td>
<td>Montefiore</td>
<td>Bronx and Westchester</td>
<td><a href="https://www.montefiore.org/diamond-care">https://www.montefiore.org/diamond-care</a></td>
</tr>
<tr>
<td>North Shore-LIJ MLTC</td>
<td>North Shore</td>
<td><strong>CLOSED</strong> (NYC, Nassau, Suffolk)</td>
<td>Effective Jan. 2018 members were transferred to Centers Plan for Healthy Living, unless they selected another plan.</td>
</tr>
<tr>
<td>RiverSpring at Home</td>
<td>Elderserve or Riverspring</td>
<td>NYC (All boroughs), Nassau, Suffolk, Westchester</td>
<td><a href="https://riverspringathome.org/leadership/">https://riverspringathome.org/leadership/</a></td>
</tr>
<tr>
<td>Senior Health Partners</td>
<td>Healthfirst/Sr. Health Partners or Healthfirst</td>
<td>NYC (All boroughs) and Nassau, Westchester</td>
<td>Senior Health Partners is the name of Healthfirst’s MLTC product. <a href="https://healthfirst.org/about-us/">https://healthfirst.org/about-us/</a></td>
</tr>
<tr>
<td>Name of Plan</td>
<td>Name or Abbreviation used in Visualizations</td>
<td>Service Area by County (2022)</td>
<td>Ownership &amp; control / Plan Closings &amp; Changes</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Senior Network Health, LLC</td>
<td>Senior Network Health</td>
<td>Herkimer and Oneida</td>
<td>Operated by Mohawk Valley Health System</td>
</tr>
<tr>
<td>Senior Whole Health of New York MLTC</td>
<td>Senior Whole Health</td>
<td>NYC except Staten Island, Westchester</td>
<td>Acquired by Molina Dec. 2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><a href="https://investors.molinahealthcare.com">https://investors.molinahealthcare.com</a></td>
</tr>
<tr>
<td>United HealthCare</td>
<td>United HealthCare</td>
<td>Closed</td>
<td>Closed April 2019 after withdrawing in upstate counties Feb. 2019</td>
</tr>
<tr>
<td>VillageCareMAX</td>
<td>Village Senior Services</td>
<td>NYC except Staten Island</td>
<td><a href="https://www.villagecaremax.org/about-us/">https://www.villagecaremax.org/about-us/</a></td>
</tr>
<tr>
<td>VNA HomeCare Options</td>
<td>Nascentia or VNA Homecare Options</td>
<td>see Nascentia</td>
<td>see Nascentia</td>
</tr>
<tr>
<td>Wellcare Advocate</td>
<td>Wellcare Advocate</td>
<td>Closed (Albany, Erie, NYC, Nassau, Orange, Rockland, Suffolk)</td>
<td>June 1, 2020 --Wellcare acquired by Centene; members were transferred to Fidelis MLTC</td>
</tr>
</tbody>
</table>

List compiled by NYLAG 8/22/2022


Service area of plans that are no longer operating is from [https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/)
## APPENDIX D
### SFY 2017-18 and SFY 2018-19 Medical Loss Ratio (MLR) Report Summary
#### Managed Long-Term Care (MLTC)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Premium Total (Denominator)</th>
<th>Remittance (Millions)</th>
<th>Member Years DOH</th>
<th>MLR MMCOR</th>
<th>Member Years MMCOR 2018</th>
<th>Order MMCOR 2018</th>
<th>MLR AFTER Credibility Adjust</th>
<th>Order 18-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Health Choice</td>
<td>$8,037,113</td>
<td>$12,076,785</td>
<td>Partially</td>
<td>307</td>
<td>65.57%</td>
<td>370</td>
<td>78.00%</td>
<td>29</td>
</tr>
<tr>
<td>Integra</td>
<td>$310,443,491</td>
<td>$397,069,993</td>
<td>Fully</td>
<td>7,624</td>
<td>73.61%</td>
<td>11,800</td>
<td>80.75%</td>
<td>28</td>
</tr>
<tr>
<td>Montefiore</td>
<td>$63,867,265</td>
<td>$78,782,057</td>
<td>Partially</td>
<td>1,395</td>
<td>77.76%</td>
<td>1,500</td>
<td>89.61%</td>
<td>27</td>
</tr>
<tr>
<td>Senior Network Health</td>
<td>$15,282,020</td>
<td>$18,078,140</td>
<td>Fully</td>
<td>527</td>
<td>81.57%</td>
<td>545</td>
<td>88.84%</td>
<td>26</td>
</tr>
<tr>
<td>Centers Plan for Healthy</td>
<td>$1,029,480,093</td>
<td>$1,172,087,142</td>
<td>Fully</td>
<td>20,386</td>
<td>82.62%</td>
<td>28,562</td>
<td>87.81%</td>
<td>25</td>
</tr>
<tr>
<td>Extended</td>
<td>$118,275,312</td>
<td>$135,842,279</td>
<td>Partially</td>
<td>3,049</td>
<td>79.12%</td>
<td>4,615</td>
<td>89.74%</td>
<td>24</td>
</tr>
<tr>
<td>Homefirst - Elderplan</td>
<td>$628,601,559</td>
<td>$710,528,161</td>
<td>Fully</td>
<td>12,453</td>
<td>87.08%</td>
<td>12,929</td>
<td>89.56%</td>
<td>23</td>
</tr>
<tr>
<td>MetroPlus</td>
<td>$82,303,289</td>
<td>$94,068,574</td>
<td>Partially</td>
<td>1,662</td>
<td>85.69%</td>
<td>1,838</td>
<td>94.70%</td>
<td>22</td>
</tr>
<tr>
<td>Hamaspik</td>
<td>$87,320,253</td>
<td>$99,386,802</td>
<td>Partially</td>
<td>2,069</td>
<td>79.76%</td>
<td>2,179</td>
<td>87.87%</td>
<td>21</td>
</tr>
<tr>
<td>Senior Health</td>
<td>$716,252,744</td>
<td>$801,930,224</td>
<td>Fully</td>
<td>14,084</td>
<td>85.46%</td>
<td>14,474</td>
<td>94.82%</td>
<td>20</td>
</tr>
<tr>
<td>VNSNY Choice</td>
<td>$711,287,362</td>
<td>$794,481,093</td>
<td>Fully</td>
<td>12,736</td>
<td>89.40%</td>
<td>12,709</td>
<td>88.10%</td>
<td>19</td>
</tr>
<tr>
<td>Fidelis - NYS Quality Health</td>
<td>$1,007,184,461</td>
<td>$1,121,519,863</td>
<td>Fully</td>
<td>19,541</td>
<td>92.45%</td>
<td>10,428</td>
<td>95.34%</td>
<td>18</td>
</tr>
<tr>
<td>VillageCare Max</td>
<td>$305,984,166</td>
<td>$436,896,920</td>
<td>Fully</td>
<td>8,838</td>
<td>86.52%</td>
<td>10,546</td>
<td>89.74%</td>
<td>17</td>
</tr>
<tr>
<td>ArchCare -Catholic MLTC</td>
<td>$164,331,107</td>
<td>$183,400,447</td>
<td>Partially</td>
<td>2,972</td>
<td>89.16%</td>
<td>3,853</td>
<td>95.38%</td>
<td>16</td>
</tr>
<tr>
<td>Niagara</td>
<td>$3,032,564</td>
<td>$9,320,598</td>
<td>Partially</td>
<td>161</td>
<td>82.53%</td>
<td>303</td>
<td>89.48%</td>
<td>15</td>
</tr>
<tr>
<td>AgeWell NY</td>
<td>$461,071,993</td>
<td>$504,854,826</td>
<td>Fully</td>
<td>8,811</td>
<td>88.98%</td>
<td>9,655</td>
<td>90.11%</td>
<td>14</td>
</tr>
<tr>
<td>VNA Homecare (Nascentia)</td>
<td>$317,568,518</td>
<td>$346,170,657</td>
<td>Fully</td>
<td>5,330</td>
<td>91.36%</td>
<td>6,596</td>
<td>99.58%</td>
<td>13</td>
</tr>
<tr>
<td>Elderserve</td>
<td>$614,187,019</td>
<td>$662,293,969</td>
<td>Fully</td>
<td>11,314</td>
<td>95.63%</td>
<td>12,273</td>
<td>97.18%</td>
<td>12</td>
</tr>
<tr>
<td>iCircle</td>
<td>$89,360,166</td>
<td>$97,360,792</td>
<td>Fully</td>
<td>2,047</td>
<td>85.20%</td>
<td>2,626</td>
<td>95.09%</td>
<td>11</td>
</tr>
<tr>
<td>Kalos -Erie Niagara</td>
<td>$59,125,157</td>
<td>$63,855,922</td>
<td>Partially</td>
<td>1,169</td>
<td>93.39%</td>
<td>1,273</td>
<td>95.77%</td>
<td>10</td>
</tr>
<tr>
<td>Senior Whole Health</td>
<td>$559,345,183</td>
<td>$591,323,857</td>
<td>Fully</td>
<td>13,247</td>
<td>92.75%</td>
<td>13,932</td>
<td>92.78%</td>
<td>9</td>
</tr>
<tr>
<td>WellCare</td>
<td>$287,169,537</td>
<td>$299,685,444</td>
<td>Fully</td>
<td>5,710</td>
<td>86.50%</td>
<td>5,539</td>
<td>92.87%</td>
<td>8</td>
</tr>
<tr>
<td>Aetna Better Health, Inc.</td>
<td>$248,380,912</td>
<td>$259,067,326</td>
<td>Fully</td>
<td>4,706</td>
<td>89.23%</td>
<td>6,088</td>
<td>96.64%</td>
<td>7</td>
</tr>
<tr>
<td>HealthPlus</td>
<td>$251,663,849</td>
<td>$261,967,026</td>
<td>Fully</td>
<td>4,604</td>
<td>92.48%</td>
<td>5,100</td>
<td>98.29%</td>
<td>6</td>
</tr>
<tr>
<td>Fallon Health Weinberg.</td>
<td>$21,567,348</td>
<td>$22,508,773</td>
<td>Partially</td>
<td>591</td>
<td>80.09%</td>
<td>729</td>
<td>89.78%</td>
<td>5</td>
</tr>
<tr>
<td>Independence Care System</td>
<td>$454,187,862</td>
<td>$450,325,452</td>
<td>Fully</td>
<td>6,552</td>
<td>106.50%</td>
<td>6,240</td>
<td>109.13%</td>
<td>4</td>
</tr>
<tr>
<td>EverCare</td>
<td>$40,132,317</td>
<td>$40,233,695</td>
<td>Partially</td>
<td>874</td>
<td>89.15%</td>
<td>951</td>
<td>95.72%</td>
<td>3</td>
</tr>
<tr>
<td>United Healthcare of NY</td>
<td>$219,133,324</td>
<td>$212,955,403</td>
<td>Partially</td>
<td>3,412</td>
<td>102.34%</td>
<td>4,088</td>
<td>110.79%</td>
<td>2</td>
</tr>
<tr>
<td>GuildNet, Inc.</td>
<td>$622,486,696</td>
<td>$597,110,805</td>
<td>Fully</td>
<td>9,942</td>
<td>102.52%</td>
<td>6,883</td>
<td>114.61%</td>
<td>1</td>
</tr>
</tbody>
</table>