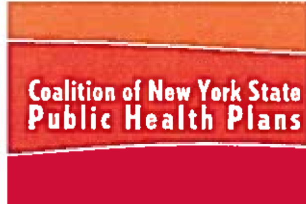

NYS Coalition of
MLTC and
PACE Plans

TESTIMONY OF

THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS AND

THE NEW YORK STATE COALITION OF MANAGED LONG TERM CARE AND PACE PLANS

ON THE GOVERNOR'S PROPOSED SFY 2017-2018 HEALTH AND MEDICAID BUDGET

SUBMITTED TO THE

JOINT LEGISLATIVE FISCAL COMMITTEES

HEALTH AND MEDICAID

FEBRUARY 16, 2017

Introduction

Members of the Joint Legislative Budget Committee: Thank you very much for the opportunity to testify on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition") and the New York State Coalition of Managed Long Term Care and Programs of All-Inclusive Care for the Elderly Plans ("MLTC/PACE Coalition").

Background on the PHP Coalition

Established in 1995, the PHP Coalition is an important voice for New York's non-profit, publicly-focused health plans and their members. The PHP Coalition currently represents eight health plans serving more than 3.6 million individuals in New York's Medicaid Managed Care, HIV Special Needs Plan (HIV SNP), Child Health Plus, Health and Recovery Plan (HARP), Essential Plan and Qualified Health Plan programs—approximately two-thirds of all of adults and children enrolled in these programs across the State. All PHP Coalition plans are sponsored by or affiliated with public and not-for-profit hospitals, community health centers and physicians. PHP Coalition plans have decades of experience delivering high-quality services to populations that have traditionally faced significant barriers to health care, and they consistently receive high marks in quality of care and member satisfaction.

Background on the MLTC/PACE Coalition

The MLTC/PACE Coalition represents 22 provider-sponsored, not-for-profit managed care plans that provide long-term care services to elderly or disabled Medicaid beneficiaries. MLTC and PACE plans coordinate an array of medical and social services for elderly or disabled Medicaid beneficiaries who require more than 120 days of community-based long-term care services. These plans provide access to quality long-term care at a fraction of the cost of institutional care, while also achieving high rates of patient and family satisfaction.

MLTC plans provide the full array of long-term care services—ranging from personal care to nursing home care—for a fixed per-member-per-month payment through a variety of different products. While the plans are not responsible for providing coverage of physician, hospital or other services, which patients typically access through their Medicare coverage, for the vast majority of MLTC enrollees, they oversee and coordinate all aspects of members' care through intensive care management, regardless of payer. PACE enrollees receive comprehensive health care services and coordination through their plan, which integrates coverage under both Medicaid and Medicare, including all physician, hospital and pharmacy services.

Managed long term care has proven to reduce enrollees' long-term care costs, and has done so by *improving* the coordination and quality of care. Understandably, enrollment in these programs has soared as the Department of Health (DOH) has transitioned to mandatory enrollment in managed care: since 2004, the number of New Yorkers enrolled in MLTC and PACE plans has increased from around 10,000 to nearly 190,000—approximately 70% of whom are enrolled in the not-for-profit plans in the MLTC/PACE Coalition. Plans are gratified that the program continues to receive very high marks for quality—not only from the DOH but, more importantly, from the tens of thousands of frail and elderly New Yorkers that they serve.

The Coalitions would like to comment on plans' partnership with the State to achieve the Medicaid Redesign Team's goals and further the success achieved thus far by New York State of Health, the State's Health Insurance Marketplace.[1] In addition, there are a number of provisions in the Executive Budget that we wish to discuss with you today. In sum, we respectfully request that the Executive and the Legislature consider strategies that will enable Coalition plans to achieve the aims of the Medicaid Redesign Team and continue to deliver high-quality health care to their members.

Plan Partnership with the State

The foundation of plans' partnership with the State is made up of shared and deeply rooted values and goals. Coalition plans serve some of the neediest New Yorkers—the poorest, sickest and hardest to reach—and in doing so, they, like the State, face myriad challenges. To effectively address these challenges, plans have worked closely with the State to improve the way care is delivered and to do so for an increasing number of residents.

For decades, plans have been effecting positive change in New York's health care delivery system. Both before and since Governor Cuomo's 2011 formation of the Medicaid Redesign Team (MRT), plans have played a critical role in efforts to improve the quality of care and reduce per capita costs in the State's public programs. This is exemplified by the MRT's embrace of Medicaid managed care as the vehicle to achieving the Governor's stated goals: "measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."[2] It is further demonstrated by the Special Terms and Conditions of New York's Delivery System Reform Incentive Payment (DSRIP) Program, which recognize the integral role of plans in the long-term sustainability of DSRIP. In fact, the savings associated with expanding managed care allowed the State to negotiate over $8 billion in new investment in its delivery system. **It is clear that in the midst of such redesign and reform, managed care plans are a critical partner in the delivery of health care in New York.**

Over the last several years, plans have enrolled new, more complex populations, offered a more comprehensive array of services and developed original products to implement new State programs. For example, over the past year, PHP Coalition plans have implemented the State's new program for individuals with significant behavioral health needs, HARP, and now cover nearly 70% of the State's HARP enrollees. Looking ahead, plans in both Coalitions will continue to work with the State to "carve in" additional services and populations. The continued shift of more complex populations and services into managed care is testament to plans' collective success in providing high-quality care to members at lower costs.

In addition to their significant Medicaid redesign efforts, PHP Coalition plans have worked closely with multiple State agencies to support the continued success of New York State of Health. On the Marketplace, six PHP Coalition plans offer Essential Plan (EP) coverage and five offer Qualified Health Plan (QHP) coverage, collectively accounting for 62% and 50% of the

[1] As of January 31, 2017, more than 3.6 million people were enrolled in coverage through the Marketplace, three-fourths of them enrolled in Medicaid or Child Health Plus. See https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-enrollment-surges.
[2] State of New York, Executive Order #5 (January 2011). See http://www.governor.ny.gov/executiveorder/5.

Statewide markets, respectively. PHP Coalition plans bring to the Marketplace a unique perspective that stems from a longstanding mission and operational focus on public programs for the neediest, lowest income residents. Beyond serving the majority of the State's Medicaid and Child Health Plus enrollees, Coalition plans are committed to providing New Yorkers with a *continuum of coverage*, to minimize disruption in care when income or other circumstances change.

Similarly, MLTC/PACE Coalition plans work closely with the State to implement Medicaid redesign and to work toward the goal of providing *fully integrated care* to New Yorkers in need of long-term care, a vast majority of whom are dually eligible for Medicaid and Medicare. Plans have continued to offer existing fully integrated products to enrollees—including PACE and Medicaid Advantage Plus (MAP)—and, over the past two years, several MLTC/PACE Coalition plans have partnered with DOH to offer enrollment in the Fully Integrated Duals Advantage (FIDA) program, a joint Medicare and Medicaid demonstration designed to integrate care for individuals eligible for both Medicare and Medicaid. The MLTC/PACE Coalition is committed to partnering with DOH on the future of integrated care beyond the duration of the FIDA demonstration to continue efforts to fully integrate care for dual eligible enrollees.

Plans' work on these transitions and programs presents tremendous opportunity to improve health outcomes and quality of life for hundreds of thousands of New Yorkers across the State. However, the success of these new initiatives require thoughtful policy implementation, well-designed state infrastructure and adequate premium support. Indeed, past experiences have shed light on areas where policy refinements can allow future initiatives—and improved implementation of existing ones—to better meet New Yorkers' health needs.

Quality Incentives

DOH has identified the delivery of high-quality and high-value care as one of its top priorities for the Medicaid program, rightfully so. At the same time, it has proposed reductions—totaling $70 million—in the quality incentive funding available to both "mainstream" Medicaid and MLTC plans. This proposal undercuts any efforts aimed at improving quality in the managed care program. In a true value-based program, the State should be *reinforcing* quality, not cutting it. *We therefore request that the State restore funding to the managed care quality programs to ensure that plans delivering high-quality care are rewarded for doing so.*

Health Plans Rates

With over half of the Medicaid budget now allocated to health plans, the Coalitions urge the Joint Legislative Budget Committee to be attentive to the overarching issue of rate adequacy. Sufficient rates are a critical prerequisite to effective, appropriate delivery and management of care. Plans in both Coalitions have urged DOH to work with them to monitor expenses and ensure that rates accurately reflect the true costs of the populations and benefits covered.

- ***Funding Care for High-Needs, High-Cost Members.*** The rate setting methodology utilized by DOH has failed to adequately reimburse plans for the costs associated with high-needs members, including individuals with serious mental illness and substance use disorder

enrolled in mainstream Medicaid, and individuals in nursing homes and those with high needs in the community enrolled in MLTC and PACE plans.

- Mainstream Medicaid members with behavioral health needs. In 2015, the State began enrolling individuals with serious mental illness and substance use disorder into HARP plans. Many individuals eligible for HARP have remained in mainstream Medicaid plans, however—in part due to a State systems issue that prohibits HARP enrollment on the State's Marketplace. The result is a more than $100 million shortfall in the most recent Medicaid managed care rates for the HARP-eligible population.
- MLTC and PACE members in nursing homes and those with high needs in the community. The nursing home benefit has been underfunded ever since it was carved into MLTC. Plans are required to pay nursing home providers a rate specified by DOH; however, plans' premiums are insufficient to cover this level of reimbursement. Further, the calculation of plans' premium does not accurately capture the number of members utilizing this benefit.[3] In addition, DOH's methodology fails to capture the costs of serving community-based members with high needs (e.g., individuals with substantial hours of personal care and home care).

Establishing a separate rate cell for these populations would help ensure that plans receive more adequate reimbursement enabling them to provide high quality care to their enrollees. *We request that the Legislature consider our proposed legislation establishing separate rate cells for high-need, high-cost New Yorkers.*

- ***Pharmacy Costs.*** Higher cost drugs, both brand and generic, are driving costs up, faster than medical inflation. Unfortunately, the adjustments made by DOH to plans' rates to reflect these costs fall short of covering the added expense. Analyses completed by the PHP Coalition have found that pharmacy cost trends have *far* exceeded State calculations, contributing to a $563 million deficiency in mainstream Medicaid plans' rates. While the Budget proposes some important cost containment initiatives for the pharmacy program that the PHP Coalition strongly endorses—including restricting the "provider prevails" policy, setting "benchmark prices" for high-cost drugs and subjecting more generic drugs to penalty rebates—even these changes, if enacted, will not obviate the need to update plan rates to keep pace with the extraordinary increases in pharmacy costs. *Therefore, we support the proposals in the Executive Budget aimed at curbing unjustified escalations in the costs of prescription drugs, but also urge the State to take greater action to fund plan's pharmacy costs adequately.*
- ***MLTC Rates.*** As additional services and populations are carved into MLTC and PACE and new programmatic and financial mandates are placed on the plans, premiums are being squeezed in ways that threaten the overall sustainability of these programs. MLTC and PACE plan rates have a complex structure, which include adjustments for minimum wage and the Fair Labor Standards Act (FLSA), risk scores, administrative loads, care management, high-cost/high-need pools, quality withholds, managed care savings assumptions, and a "blend" for nursing home certifiable and non-nursing home certifiable

[3] This is in part caused by the Department's use of a "blended rate," which includes both those members in nursing homes and those members receiving care in the community.

populations. Not only has this complicated structure caused the issuance of rates to be delayed, it has also contributed to inadequate reimbursement for plans. *We encourage the Legislature to become more engaged in rate setting and examine funding for managed care closely, particularly as the proportion of the Medicaid budget allocated to MLTC grows.*

- ***Funding Home Care Wages.*** While we support State efforts to increase the minimum wage, this increase, paired with adjustments to the FLSA requirements, have added to MLTC and PACE plans' financial pressures. DOH has not provided plans with funding that is sufficient to cover the amount that providers need to meet these requirements, resulting in the underpayment of home care workers. Further, DOH has not yet provided plans or providers with a clear explanation of the methodology for distributing the minimum wage funding that was included in last year's budget, resulting in industry-wide confusion related to plans' obligation to make additional payments. *We urge the Legislature to ensure that plans' rates are sufficient to support the impact of both the State's minimum wage increase and the FLSA requirements.*

Eligibility for and Enrollment in Coverage and Access to Care

The State's Marketplace, New York State of Health ("NYSOH"), has enrolled millions of New Yorkers in coverage since its establishment; however, there remain a number of issues related to eligibility and enrollment ("E&E") that create burdens for consumers and negatively impact access to care. PHP Coalition plans urge the State to make the investments needed to ensure E&E systems—particularly those for the public insurance programs—work effectively.

- ***PCP Selection Functionality.*** For the past several years, the PHP Coalition has urged the State to ensure the availability of reliable primary care provider (PCP) selection functionality on the Marketplace. Unfortunately, DOH has done little to date to address this technical shortcoming. Today, consumers shopping on the Marketplace are unable to select a PCP when they enroll in a plan, requiring them to call their plan, separately log into their plan's member portal, or mail a paper form after their coverage has been effectuated. The lack of PCP selection functionality at the point of enrollment places significant burden on both consumers and plans, represents a step *backwards* from prior Medicaid processes, and has implications on continuity of care. Plans must devote substantial resources to tasks like issuing multiple member ID cards per member (due to requirements that Medicaid member ID cards be reissued when a PCP is assigned and then selected) and handling members' calls and complaints related to PCP assignment. These resources can and should be devoted to serving members on a variety of other, important issues.

  In addition, the State has begun the process of moving consumers who enrolled in Medicaid through their local district of social services ("local district") over to NYSOH at the time of consumers' renewal of coverage. It is critical that NYSOH delay this process until PCP selection functionality is up and running on the Marketplace. If PCP selection is not functional and fully tested prior to these consumers' enrollment through NYSOH, *millions* of Medicaid members face the prospect of having their PCPs stripped from their enrollment records. No plan will be able to restore these through manual means. *We renew our longstanding request for the State to prioritize the development and deployment of PCP selection functionality on NYSOH this calendar year.*

- ***HARP Enrollment on the Marketplace.*** Currently, there is no way for consumers to enroll in a HARP through the Marketplace. As a result, eligible consumers who are currently enrolled in Medicaid through NYSOH must go through a confusing and arduous process that involves disenrolling from Marketplace coverage and manually enrolling through their local district. Not only is this in direct opposition to the State's effort to drive more enrollment through the Marketplace, it is burdensome for consumers and, most importantly, results in thousands of individuals with serious mental illness and substance use disorder not being enrolled in health care coverage that best fits their needs. *We ask the Legislature to take steps to ensure that HARP enrollment is added to NYSOH as quickly as possible.*

- ***Facilitated Enroller (FE) Program.*** DOH intends to reduce administrative funding for mainstream Medicaid plans by an aggregate amount of $20 million. This reduction, according to DOH officials, reflects a changing reliance on facilitated enrollment in light of lower uninsured rates. However, plan FEs are needed now more than ever, with the growing number of coverage programs and complexity of eligibility and enrollment processes. FEs are critical to member education and do more than just enroll consumers into new coverage—they ensure consumers *stay covered.* FEs played an integral role in the success of New York's most recent open enrollment period, during which hundreds of thousands of people enrolled in coverage. *We urge the Legislature to restore funding for the FE program.*

- ***Consumer Transitions Between Eligibility and Enrollment Systems.*** As mentioned above, DOH has begun requiring consumers who enrolled in coverage through their local district to enroll through NYSOH, in an effort to make NYSOH the eligibility and enrollment platform for all New Yorkers enrolled in insurance affordability programs. To date, rollout of this transition has been flawed and Medicaid managed care enrollment in the initial transition counties has dropped. These drops are not customary, cannot be accounted for by the transition of some Medicaid members to the Essential Plan, and are being experienced by all plans in the area—leading to concerns that there is a broader issue with State systems and that Medicaid-eligible consumers are losing coverage. *We encourage the Legislature to become more engaged in ensuring consumers do not lose coverage as a result of DOH initiatives to "move" enrollment to the Marketplace.*

Long Term Care-Specific Provisions

This year's Executive Budget includes several provisions aimed specifically at MLTC and PACE plans.

- ***Elimination of MLTC Marketing.*** The Budget proposes to administratively ban marketing activities by MLTC plans. DOH has cited concerns over the rapid growth in MLTC enrollment and believes that eliminating marketing activities by MLTC plans will slow such growth. The MLTC/PACE Coalition questions whether the modest marketing undertaken by plans has been the cause of this enrollment growth and maintain that other factors may be the real drivers of enrollment. Plans are eager to work with DOH to better understand the enrollment growth and address any concerns or abuses in marketing activities, but they do not, however, believe that an across-the-board ban on marketing is the best solution. *We urge the Legislature to oppose this administrative action by DOH in its current form.*

- ***Transportation Carve-Out.*** The Executive Budget proposes "carving out" transportation expenses from the MLTC benefit package and relying on a State vendor to manage transportation services for MLTC members. This proposed change would have profound implications on the program models used—especially by MLTC plans serving upstate regions—that have successfully linked enrollees with needed medical services and that provide a host of other informal supports to enrollees in rural areas. As a result, most MLTC/PACE Coalition plans oppose the carve-out and, at a minimum, would strongly urge limiting any change in transportation services and funding to exempt upstate plans where these services can make a *significant* difference in enhancing access to care, reducing institutional care and increasing patient satisfaction. *A majority of the MLTC/PACE Coalition plans urges the Legislature to reject this proposal.*
- ***MLTC Eligibility.*** The Budget proposes to limit enrollment in MLTC plans to those enrollees who require a nursing home level of care. The MLTC/PACE Coalition recognizes the need for well-defined eligibility criteria to simplify eligibility determinations and strongly advocates that this criteria be defined more precisely—for example, as a score of five or higher on the Uniform Assessment System for New York (UAS), the tool used to determine eligibility for MLTC. Such a change, however, must be accompanied by rate adjustments that accurately reflect plans' new mix of members. This change should *not* justify a decrease in MLTC plan rates; to the contrary, rates should increase to reflect the fact that all new enrollees will require nursing home level of care. *We ask the Legislature to better define "nursing home level of care" (e.g., as a score of five or higher on the UAS assessment tool) and to help ensure that MLTC rates are appropriately adjusted to reflect this eligibility change.*

Carve-Out of the TBI/NHTD Waivers

As a result of the Medicaid Redesign Team recommendations, the State has proposed including individuals who receive services through the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) Medicaid waiver programs into managed care. The Coalitions have significant concerns about the carve-in of these populations, which presents no opportunity for savings to the State but would require substantial effort on the part of the plans and providers to accommodate a relatively small number of individuals spread out across the State. Further, many of the individuals currently enrolled in the waivers would not qualify for MLTC and would be at risk of losing access to the community-based services they utilize today. **Assembly Bill 2442 (Gottfried)/Senate Bill 1870 (Hannon)** would permanently exempt these individuals from enrollment in managed care. *The Coalitions request that the Legislature support this bill and include similar language in the 2017-18 Enacted Budget.*

Medicaid Program Funding

The Executive Budget includes a request for flexibility around Medicaid program funding moving forward, in light of the debates taking place in Washington, D.C. regarding the potential repeal, replace or repair of the Affordable Care Act and potentially dramatic Medicaid program reforms. It is critical—now more than ever—that New York State maintain its investments in the Medicaid program, which covers more than six million residents statewide. *Both Coalitions urge*

the Legislature to reject the Governor's ask for flexibility around Medicaid program funding and retain oversight of the Medicaid program.

Conclusion

We thank you again for the opportunity to provide testimony on these critical issues. The Coalitions welcome the Committee's interest in them. Coalition plans look forward to continued partnership with the Legislature to ensure that a strong and sustainable health care system is in place to not only serve the growing number of New Yorkers that rely on it but also to reflect and enrich the collective vitality of the State.

APPENDIX I: MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

Plan	Affiliated Organizations	Public Insurance Program Service Areas	NYSOH Service Areas
Affinity Health Plan	Primary care provider organizations with representation on the Board of Directors from Morris Heights Health Center, Charles B. Wang Health Center, Urban Health Plan, Cornerstone Family Healthcare and Institute for Family Health	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester counties	New York City and Nassau, Orange, Rockland, Suffolk and Westchester counties
Amida Care	HIV Special Needs Plan founded and sponsored by Bright Point Health, Community Healthcare Network, Harlem United, Housing Works, Acacia Network, St. Mary's Episcopal and VillageCare	New York City	*N/A*
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic health care providers	Every county in the State	New York City and 50 additional counties[4]
Healthfirst	Health systems in all counties in which the plan operates	New York City and Nassau and Suffolk counties	New York City and Nassau and Suffolk counties
MVP Health Care	Hudson Health Plan (*previously*)	Albany, Columbia, Dutchess, Genesee, Greene, Jefferson, Lewis, Livingston, Monroe, Oneida, Ontario, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, Washington and Westchester counties	48 counties[5]
MetroPlus Health Plan	New York City Health and Hospitals Corporation	New York City	New York City
YourCare Health Plan, Inc.	Monroe Plan for Medical Care (*previously*)	Allegany, Cattaraugus, Chautauqua, Erie, Monroe, Ontario and Wyoming counties	Allegany, Cattaraugus, Chautauqua, Erie, Monroe, Ontario and Wyoming counties
VNSNY CHOICE	Visiting Nurse Service of New York	New York City	*N/A*

[4] Albany, Allegan, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schuyler, Seneca, St. Lawrence, Steuben, Suffolk, Sullivan, Tioga, Warren, Washington, Wayne, Westchester, Wyoming, Yates

[5] Albany, Broome Cayuga, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Seneca, St, Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, Yates

APPENDIX II: MEMBERS OF THE NEW YORK STATE COALITION OF MLTC AND PACE PLANS

Plan	Product Lines Offered	Counties Served
ArchCare	Partial Capitation MLTC, PACE[6]	New York City, Putnam, Westchester
Catholic Health Living Independently for Elders	PACE	Erie
CenterLight Healthcare	PACE, MA I-SNP	New York City, Nassau, Suffolk, Westchester
Eddy SeniorCare	PACE	Albany, Schenectady
Elant Choice (Evercare)	Partial Capitation MLTC	Dutchess, Orange, Rockland
ElderONE	PACE	Monroe
ElderServe Health (RiverSpring Health Plans)	Partial Capitation MLTC, FIDA	New York City, Nassau, Suffolk, Westchester
Fallon Health Weinberg	Partial Capitation MLTC, PACE	Erie, Niagara
Fidelis Care at Home	Partial Capitation MLTC, MAP, FIDA	New York City and 57 additional counties[7]
GuildNet	Partial Capitation MLTC, MAP, FIDA	New York City, Nassau, Suffolk, Westchester
Hamaspik Choice	Partial Capitation MLTC	Dutchess, Putnam, Orange, Rockland, Sullivan, Ulster
HomeFirst/Elderplan	Partial Capitation MLTC, MAP, FIDA	New York City, Dutchess, Nassau, Niagara, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester
Independence Care System	Partial Capitation MLTC, FIDA	New York City
MetroPlus Health Plan	Partial Capitation MLTC, FIDA	New York City
Montefiore Diamond Care	Partial Capitation MLTC	New York City, Westchester
North Shore-LIJ Health Plan, Inc.	Partial Capitation MLTC, FIDA	New York City, Nassau, Suffolk
PACE-CNY	PACE	Onondaga
Senior Health Partners/Healthfirst	Partial Capitation MLTC, FIDA, MAP	New York City, Nassau, Westchester
Senior Network Health	Partial Capitation MLTC	Herkimer, Oneida
VillageCareMAX	Partial Capitation MLTC, FIDA	New York City

Continued on next page

[6] ArchCare only offers PACE in New York City.

[7] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesce, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, Yates.

VNA Homecare Options LLC	Partial Capitation MLTC	Albany and 46 additional counties[8]
VNSNY Choice	Partial Capitation MLTC, MAP, FIDA	New York City and 28 additional counties[9]

[8] Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates

[9] Albany, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Madison, Monroe, Montgomery, Nassau, Onondaga, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester