Nothing Compares
NORTH CAROLINA

NC Medicaid Reform and Long-term Services & Supports
Webinar Series: Summer 2016

Managed Care & Long-Term Services and Supports: A Tutorial

July 15, 2016

NC Medicaid Reform and Long-Term Services & Supports

Webinar Series

The Webinar Series

Last Week: Overview of NC Medicaid Transformation Act (SL 2015-245)

Today: Managed Care & Long-Term Services and Supports: A Tutorial

Next Week: North Carolina's Proposed Direction: An Overview of NC's 1115 waiver application

Overview of Today

Long-term services and supports (LTSS)

Why move to managed care?

Key differences between fee-for-service and capitation

Managed care cycle

Scenarios

Long Term Services and Supports

Potentially cover many people who rely on supports related to their activities of daily living

Often applied to long-term services for people with physical disabilities, intellectual and developmental disabilities, mental illness, traumatic brain injury, medical complexities

Broader than just Medicaid; other organizations and funding streams also provide LTSS

Long Term Services and Supports

For today, “LTSS” is Medicaid-funded, long-term supports NOT covered or coordinated by a behavioral health managed care organization (NC LME-MCOs)

Examples: Beneficiaries using Community Alternatives Programs (CAP/C; CAP/DA); Personal Care Services (PCS); or in nursing facilities

Medicaid Managed Care

Delivers Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and contracted organizations set per member per month payment for these services

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

Image: Thinkstock by Getty Images

Capitation: One of Several Managed Care Tools

A system of reimbursement where the contracted organization is paid a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care

Aggregate fees are intended to reimburse all provided services

Managed Care Entities

Federal regulations and CMS identify various types

MCO	PCCM	PIHP	PAHP
Managed Care Organizations	Primary Care Case Management	Prepaid Inpatient Health Plan	Prepaid Ambulatory Health Plan
Comprehensive benefit package Payment is risk-based/capitation	Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services Generally, paid FFS for medical services rendered plus a monthly case management fee	Limited benefit package that includes inpatient hospital or institutional services (example: mental health) Payment may be risk or non-risk	Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation) Payment may be risk or non-risk

Source: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

Managed Long Term Services and Supports (MLTSS)

Delivery of long term services and supports, such as nursing facility care and home- and community-based services, through capitated Medicaid managed care programs

MLTSS programs can either:

- Provide LTSS in addition to medical care through comprehensive MCOs, or
- Provide only LTSS benefits through PIHPs or PAHPs, referred to as MLTSS-only programs

NC's approach will include MLTSS as part of a more comprehensive managed care model.

Source: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf

Questions

CMS Managed Care Final Rule - MLTSS

- Rule released by CMS earlier this year
- Codifies 10 elements first introduced in 2013 as part of MLTSS
- All MLTSS programs must operate according to:
  - Adequate planning
  - Stakeholder engagement
  - Provision of home- and community-based services (consistent with Olmstead decision)
  - Support for beneficiaries
  - Person centered process
  - Comprehensive, integrated service package
  - Qualified providers
  - Participation protections
  - Quality
- Requires states to create a stakeholder group of LTSS beneficiaries, providers and others to ensure their opinions are solicited and addressed during design, implementation and oversight of MLTSS program
- Medicaid must establish and maintain a member advisory committee that includes a reasonably representative sample of LTSS population

Why States go to Medicaid Managed Care

Cost management is only part of the reason

IMPROVED CARE COORDINATION

- Coordination across service delivery sectors
- Coordination across lifespan

CLEARER POINT OF ACCOUNTABILITY

- Increase ownership of cost and outcomes by plans and providers
- Clearer responsibility for coordination

IMPROVE POPULATION HEALTH

- Advance policy directions through payment, contract requirements and quality measures
- Increase preventive service
- Population-specific measures and outcomes

EXPAND INNOVATION

- Flexibility in how and where services are provided
- Enable ways to better address needs (e.g., social determinants) that are not easily/effectively addressed in FFS (housing, employment, etc.)
- Improve investment in preventive approaches

COST MANAGEMENT

- Medicaid health care costs are growing faster than state GDP
- Reduce inappropriate use of services
- Increase competition

Moving Beyond Traditional Cost Savings Measures

COST SAVING MEASURE	POSSIBLE CONSEQUENCE
Cut eligibility	Increase uninsured population
Cut provider rates	• Hurt providers • Reduce access as providers exit
Cut optional benefits	Save some $ but much care shifts to alternate services
Limit units of care per patient	Prevent abuse but may harm high-need patients
Enhance program integrity	Favorable but marginal impact

Medicaid "Managed Care Entities" Already Exists in NC; Reform Moves State Toward a More Comprehensive Model

What North Carolina Has Now

PRIMARY CARE CASE MANAGEMENT (CCNC)

- Primary care provider-based
- State pays additional fee to provide care management

PACE

- Comprehensive, capitated
- 55 years old and older
- Available in certain areas, not currently statewide

BEHAVIORAL HEALTH PREPAID HEALTH PLAN (LME-MCOs)

- Cover specific populations and specific services
- Provides care coordination for identified and priority groups

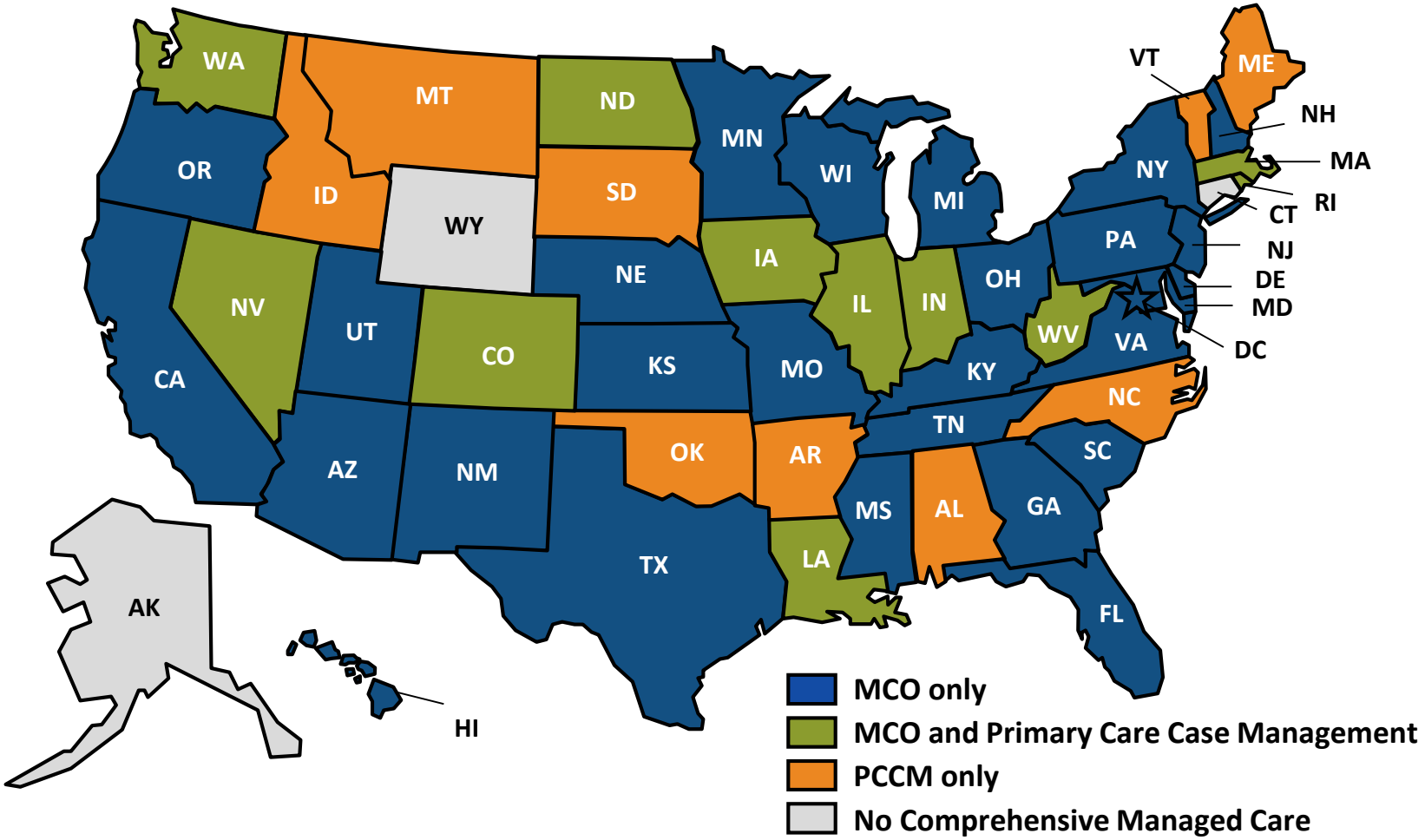
What Medicaid Reform Will Bring

MCOs will take two forms:

- Commercial Plans
- Provider-Led Entities

Participating plans will be responsible for coordinating all services (except services carved out) and will receive a capitated payment for each enrolled beneficiary

39 States Use Comprehensive MCOs

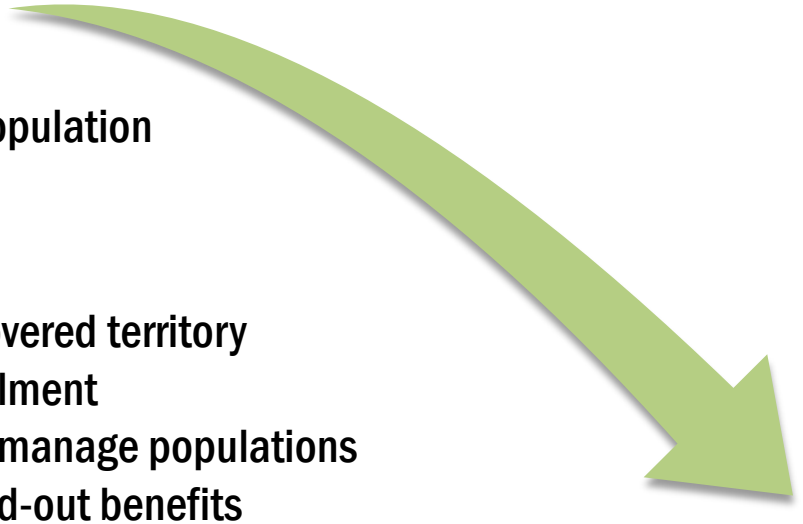


Source: Adapted from findings of Health Management Associates survey conducted for Kaiser Family Foundation, Oct. 2014

Most States Reform Incrementally

Progression over 20-25 years not uncommon

- Coordination agreements layered onto FFS
- Full-risk MCOs in limited areas
- Voluntary enrollment in MCO
- Confined to “moms and kids” Medicaid population
- Carve-outs from MCO services: Behavioral/Rx/LTSS/Dental



- Widen MCO-covered territory
- Mandate enrollment
- Add harder-to-manage populations
- Capitate carved-out benefits

- FFS/PCCM mostly eliminated
- Full-risk MCOs everywhere
- Mandatory enrollment in MCO
- All Medicaid aid categories in MCO
- MCO contracts span all services

TANF = Temporary Assistance for Needy Families

Questions

Key Differences: Current (FFS) vs. Potential (Managed Care)

	CURRENT	POTENTIAL
Financial Risk	State government (with federal match)	Insurance Plan (MCO/PLE)
Medical Management	Currently focused on and/or around primary care	Comprehensive
Care Coordination for LTSS	Reliant on more services but remain the least coordinated group	Expanded coordination of care across services and/or delivery systems
Innovation	Limited flexibility because FFS can only pay for services provided	Encourages flexibility of reimbursement to providers
Access	Unlimited network of providers but limited access	Limited network with unlimited access

Key Differences: Current (FFS) vs. Potential (Managed Care)

	CURRENT	POTENTIAL
Network of care	Providers fragmented	Providers contract with CP or PLE
Provider Reimbursement	Provider paid per visit or procedure; rewards volume & intensity	Provider paid per enrollee with VBP to providers
Enrollment	Beneficiary enrolls in Medicaid; uses providers who accept Medicaid	Beneficiary enrolls in Medicaid; selects or is assigned to MCO or PLE Medicaid Health Plan

How Capitation Works

Fixed fee (per member per month)

- Payment amounts based on average expected health care utilization of that patient, with greater payment for patients with significant medical history

Specific period of time (generally a month)

- Per member per month

Defined set of services (benefits)

Assigned population of members

Provider accepts “risk” for delivering services

A Note about Capitation and LTSS

Capitation payments are set through a rate-setting process

- Groups divided by Medicaid aid category, age, certain chronic illnesses
- "Risk adjusted" based on acuity, geography, Medicaid aid category
- Prior FFS acuity

Managed care does not mean a one size fits all PMPM

- An MCO may get paid X for all services provided to a pregnant woman
- An MCO gets paid Y for a healthy child
- An MCO may get Z for a person with long-term support needs

Set rates that encourage quality, prevention and healthy outcomes

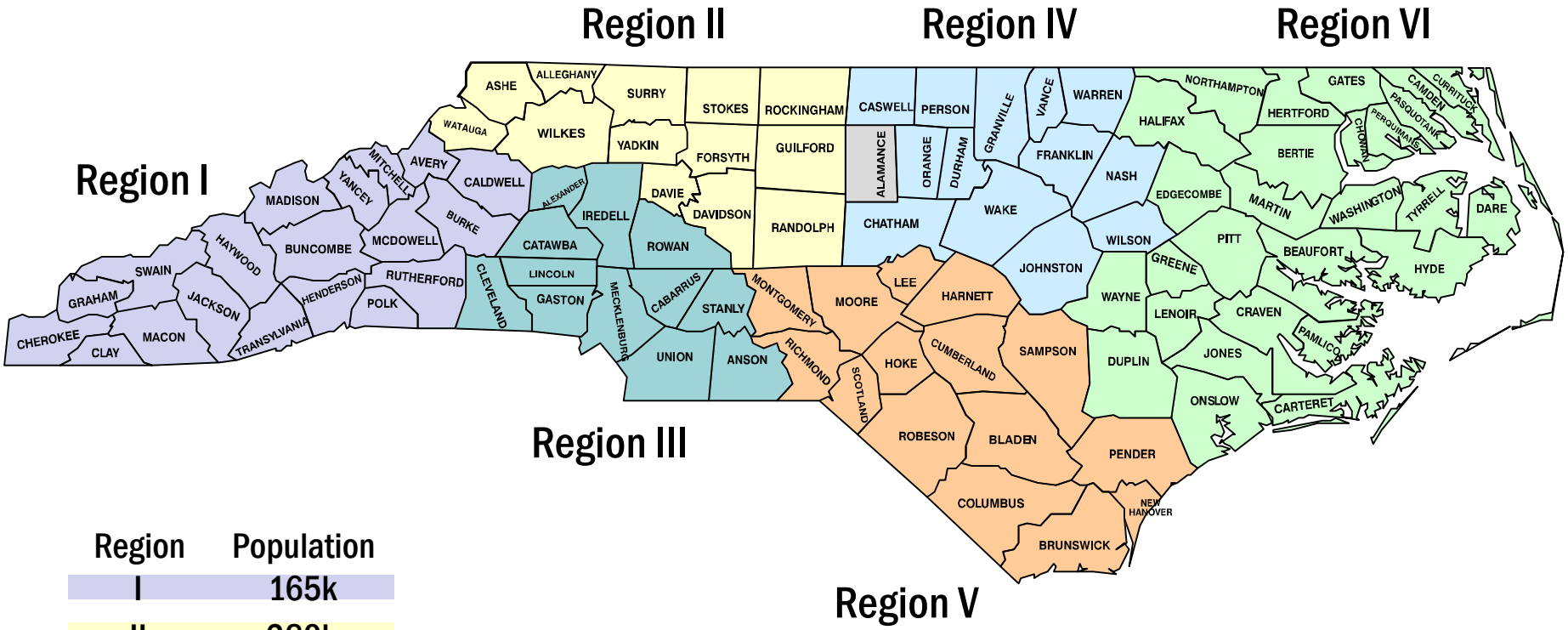
How that is defined sometimes depends on the population

Questions

Just a Reminder: NC Medicaid Reform Basics

What Will Change	To be Transitioned	What Will Remain the Same
• Medicaid beneficiaries will enroll in their choice of health plans • Providers receive capitated payments and incentive payments for quality care goals	• Services provided by CCNC • Strategy to include dual eligibles (enrollees in both Medicare and Medicaid)	• Dental services (FFS) • Program of All-inclusive Care for the Elderly (PACE) services (carved out of PHP scope) • Local education agency services (FFS) • Child development service agencies (FFS) • Short-term eligibility groups; e.g., emergency-only services (FFS)

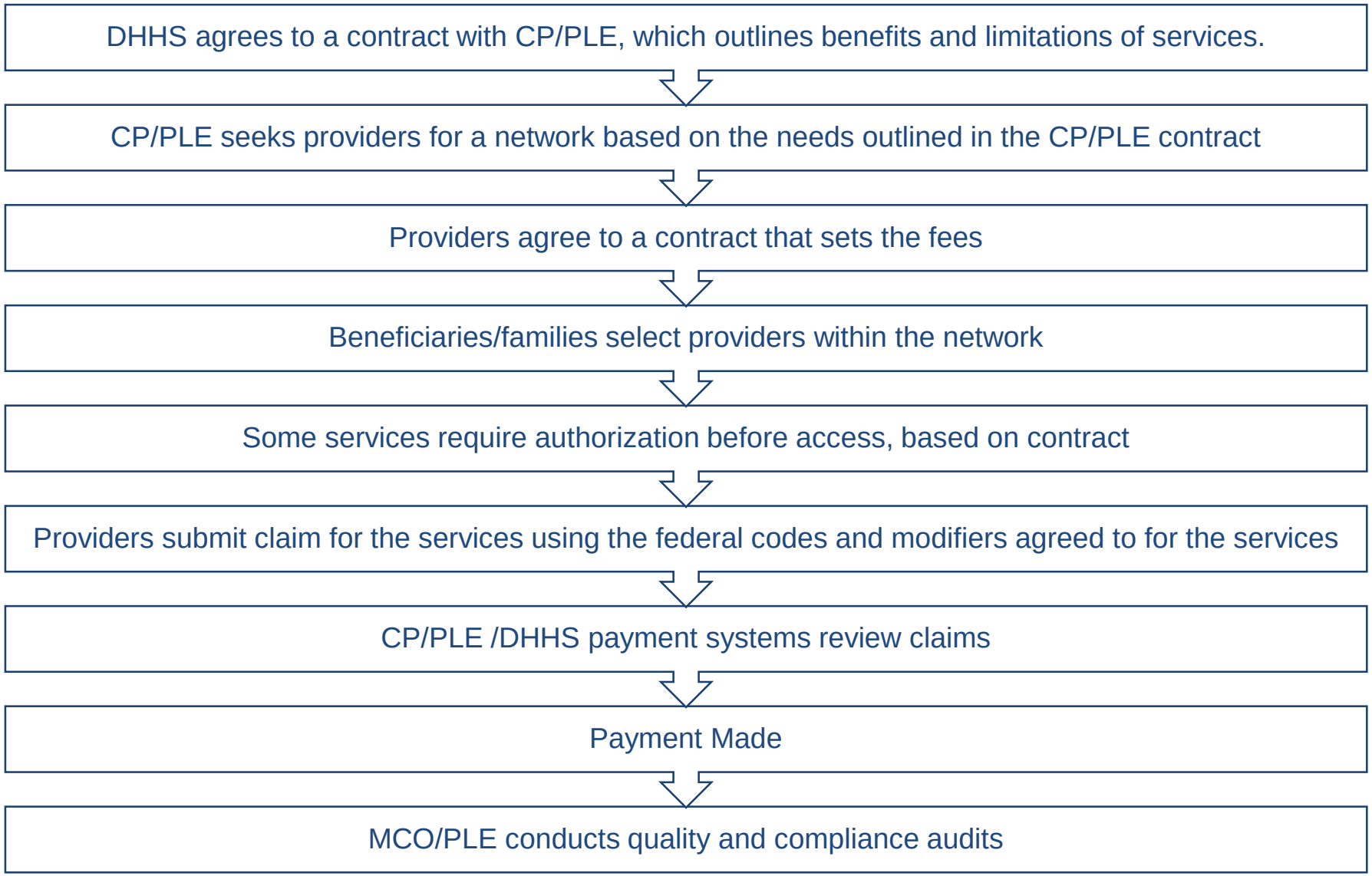
Proposed Regions



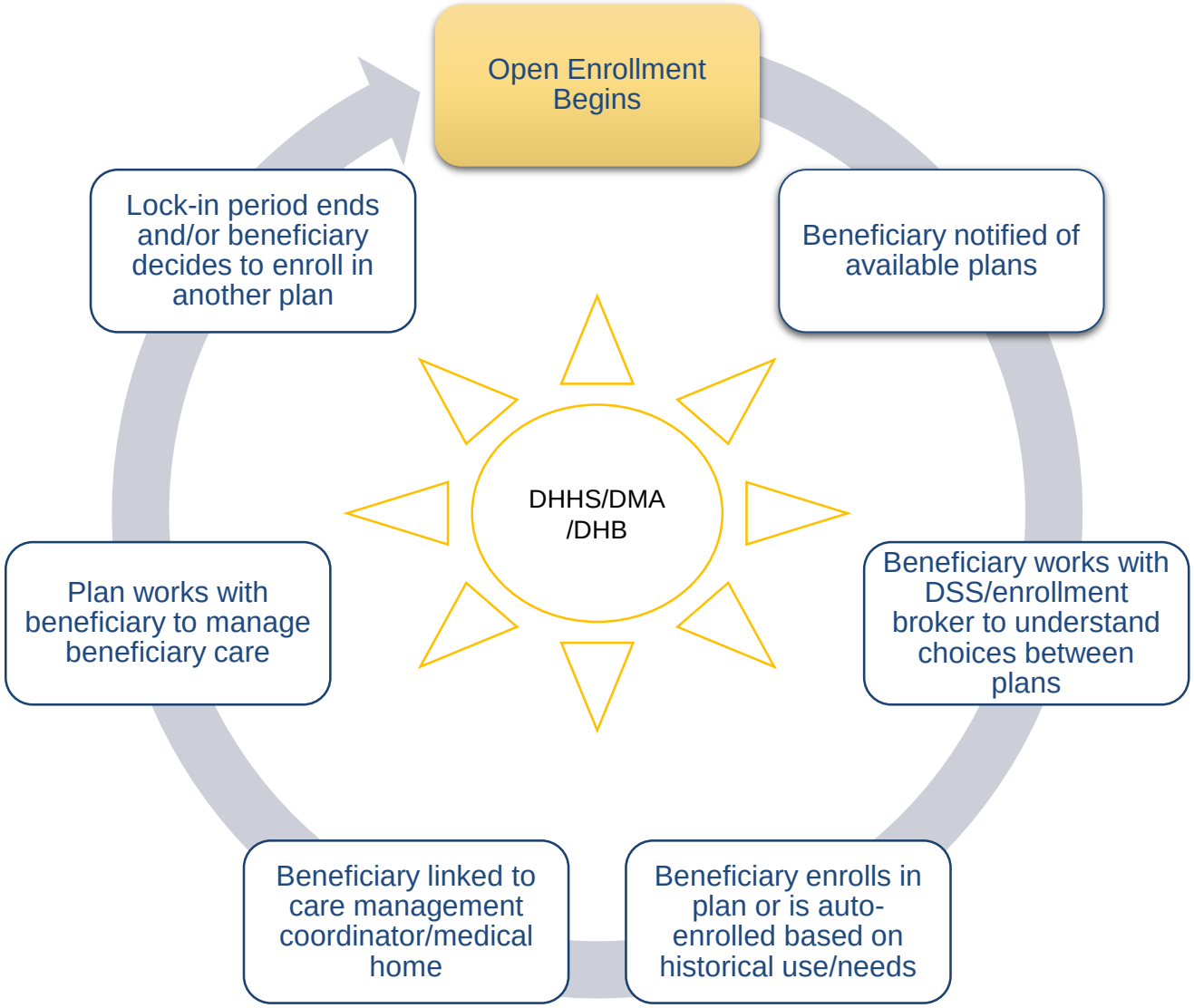
Region	Population
I	165k
II	280k
III	410k
IV	299k
V	291k
VI	230k
II & IV	29k

Populations estimated from June 2015 enrollment data

Cycle of Managed Care – Provider Perspective



Cycle of Managed Care – Beneficiary Perspective



Managed Care Rules provides additional enrollment/disenrollment protections for LTSS beneficiaries.

Image: Thinkstock by Getty Images

PROFILE

- Age 85
- Receives Medicaid and Medicare
- Receives services under CAP/DA

CHOICES

No new decisions initially required under Medicaid reform

DELIVERY

- Medicaid services remain available
- CAP/DA services remain available
- Neither is coordinated through PHP medical home

Illustrative purposes only; based on June 1, 2016, Section 1115 waiver application as submitted to CMS. Application is subject to modification by CMS prior to final approval.

PROFILE

- 30 years old
- Receives Medicaid, but not Medicare
- Receives behavioral health services through LME-MCO

CHOICES

- Health plan: 3 statewide and 2 regional
- Primary care physician/medical home
- Beneficiary has access to enrollment broker to assist in decision-making

DELIVERY

- Medical care received through his chosen PCP and medical home
- Medical services under health plan
- Behavioral health care under LME-MCO

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Image: Thinkstock by Getty Images

Image: Thinkstock by Getty Images

PROFILE

- 7 years old
- Medically complex
- Receives Medicaid only

CHOICES

- Health plan: 3 statewide and 2 regional
- Primary care physician/medical home
- Beneficiary has access to enrollment broker to assist in decision-making

DELIVERY

- All Medicaid services coordinated through selected plan
- Any school-based services remain outside of plan
- Improved coordination among all services used, including non-Medicaid

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Questions

Additional Information and Resources

CMS-Affiliated Links

For Managed Care Overview: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html

For Managed Care Final Rule: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-final-rule.html

For Summary of Key LTSS Provisions in Final Rule: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/strengthening-the-delivery-of-managed-long-term-services-and-supports-fact-sheet.pdf

Coming up

FRIDAY, JULY 22

North Carolina's Proposed Direction:
An Overview of NC's 1115 Waiver Application

Registration for session is required

Recognizing the importance of ongoing dialogue, the Department will seek and identify opportunities for additional discussion and engagement

www.ncdhhs.gov/dual-eligibles-advisory-committee

- Registration for upcoming webinars
- Dual Eligibles Advisory Committee information

www.ncdhhs.gov/nc-medicaid-reform

- Medicaid reform updates, presentations and materials
- Session law 2015-245
- June 1, 2016, waiver demonstration application