Managed Care: The Current Landscape

Introductory NYAHSA Managed Care Teleconference

May 26, 2011

NYAHSA
Policy Staff

Session Goals

- To learn the types of managed care programs serving Medicaid eligible New Yorkers
- To understand how different programs may impact your agency or facility
- To become familiar with resources and the terminology of managed care
- To understand the Medicaid Redesign Team (MRT) managed care initiatives
- To begin to consider possible strategies in response to the MRT

Key Concepts

- Individuals in government funded health programs are being increasingly served using managed care models
- More managed care options for disabled and elderly populations
- MRT initiative towards mandating managed care enrollment

What Just Happened?

- State enacted a framework for huge expansion of managed care, especially for LTC population
- Intent is to mandate enrollment for those who need community-based LTC for more then 120 days starting in April 2012
- Greatly reduces current exclusions and exemptions from mandatory enrollment
- Facilitates plan expansion and streamlines enrollment
- Will starts in NYC, then go county by county

Home Care

- **CHHA Payments and EPS**

- Imposes Certified Home Health Agency (CHHA) per patient payment limits effective 4/1/11 through 3/31/12 and CHHA Episodic Payment System (EPS) on and after 4/1/12 through 3/31/15.

Nursing Home Bed Hold

- At least 50 percent of residents must be enrolled in Medicare managed care to qualify for bed hold payments, effective 1/1/12.

Home Care Living Wage

- Provisions requiring CHHAs, LTHHCPs and managed care plans throughout the state to compensate aides with a "living wage." Requirements will apply to NYC providers beginning 3/1/12, with a three-year phase-in to providers in Nassau, Suffolk and Westchester Counties beginning 3/1/13.

LTHHCP and ADHC

- Options for other coordinated care models
- Expanded role for Medicaid managed care, including mandatory enrollment in MLTC or other care coordination for anyone receiving community based services for over 120 days. Expands the role of Medicaid managed care, including mandatory enrollment in MLTC or other care coordination models for anyone receiving community based services for more than 120 days. DOH must develop coordination and integration of care guidelines. LTHHCPs can be considered care coordination programs if they meet specific guidelines.

Anti-Trust

- Anti-trust oversight by DOH to allow for expanded coordination of services between health care providers and payers. Requires the involvement of the Public Health and Health Planning Council and sunsets the authority as of 12/31/16.

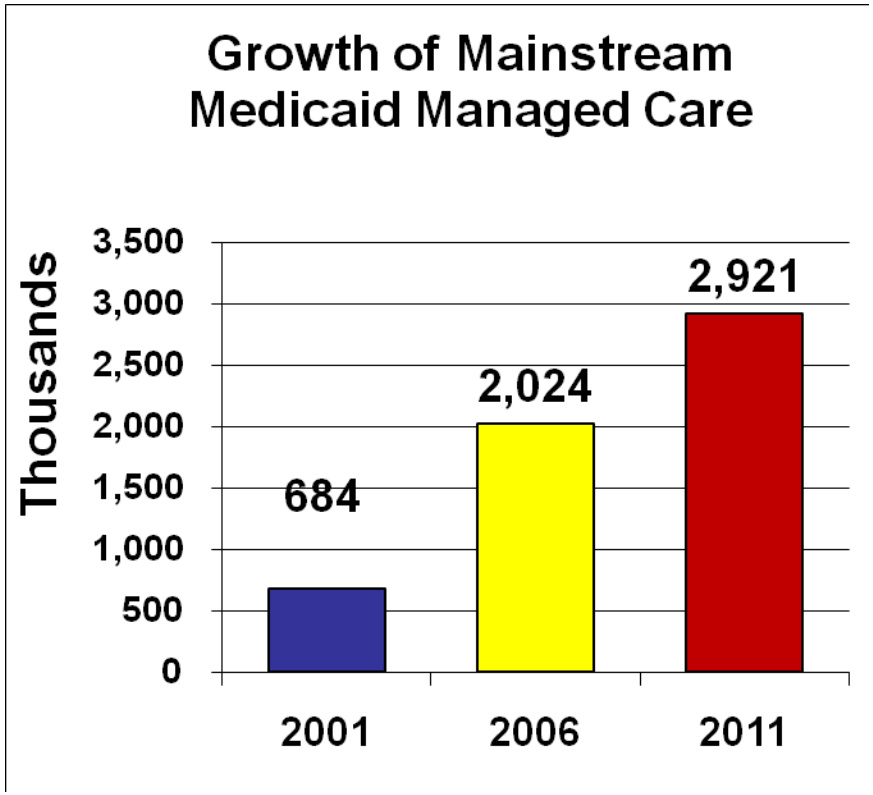
Initial Steps to Consider

- Providers should:
  - Become familiar with managed care models (esp. Medicaid)
  - Track developments closely
  - Be aware of the timing of these initiatives
  - Pay close attention to billing issues
  - Be prepared to navigate new regs and requirements
  - Understand state's policy agenda and priorities
  - Look for opportunities
  - Foster relationships (MCOs and other providers)
  - Learn about managed care contracting
  - Be aware of information resources

MRT Policy Priorities

- Reduce cost of Medicaid
- More predictable state expenses
- Contract with, and pay, fewer entities
- Improve care coordination
- Integrate Medicaid with Medicare
- Access federal funding

Growth of Managed Care



- Disabled individuals (SSI) in Medicaid managed care:
  - 2006 = 104,000
  - 2011 = 303,000
- Nursing home eligible individuals in Managed Long Term Care:
  - 2006 = 15,000
  - 2011 = 34,000
- Dual Eligibles in Medicaid managed care:
  - 2006 = 3,800
  - 2011 = 5,900

Why the Trend?

- Demographic & economic imperative
- Increased focus on care coordination
- Migration of care out of nursing home into community
- Payer desire to control health care costs, cost predictability

Why Relevant?

- Trend in LTC
- Important for your clients/residents
- Familiarity will allow providers to help clients/residents
- Familiarity will help providers identify opportunities and threats as they arise

Key Concepts

A. Medicaid Managed Care

- ✓ For General Medicaid Population

B. Medicaid Managed Long Term Care

- ✓ For those Needing Nursing Home Level of Care *(NH level of care requirement changing)*

Key Concepts - Common Acronyms

- FFS – Fee for Service
- MC – Managed Care
- MCO – Managed Care Organization (a.k.a. Health Plan)
- HMO – Health Maintenance Organization
- PHSP – Prepaid Health Service Plan
- MMC – Medicaid Managed Care
- MLTC – Managed Long Term Care

Defining Features of Managed Care

- Care Coordination & Management
- Capitation
- Single point of contact- PCP, referrals
- Provider Network
- Potential for Lower Out-of-Pocket Costs

Key Concepts: Fee For Service vs. Managed Care

	FFS	**MC**
Consumer	Provider Choice	Gatekeeper/ Coordinator/ Network
Provider	State Set Reimbursement	Negotiated Rate
	Bill Medicaid	Bill Health Plan
Payor	Cost directly tied to utilization	Capitation

Types Managed Care Plans

1. Commercial Managed Care (wide variety)
2. ***Medicaid Managed Care***
   - Mainstream Medicaid Managed Care
   - Family Health Plus/Child Health Plus
   - Healthy New York
   - HIV Special Needs Plans (HIV-SNP)
   - ***Medicaid Managed Long Term Care (MMLTC or "Partial Cap")***
3. Medicare Managed Care
   - Medicare Advantage
   - Medicare Special Needs Plans (SNP) (& Evercare)
4. Medicaid & Medicare
   - Medicaid Advantage
   - Medicaid Advantage Plus
   - Programs of All-Inclusive Care for the Elderly (PACE)

Mainstream Medicaid Managed Care

- MMC
- NY Medicaid CHOICE
- Partnership Plan
- 1115 Waiver
- Medicaid HMO

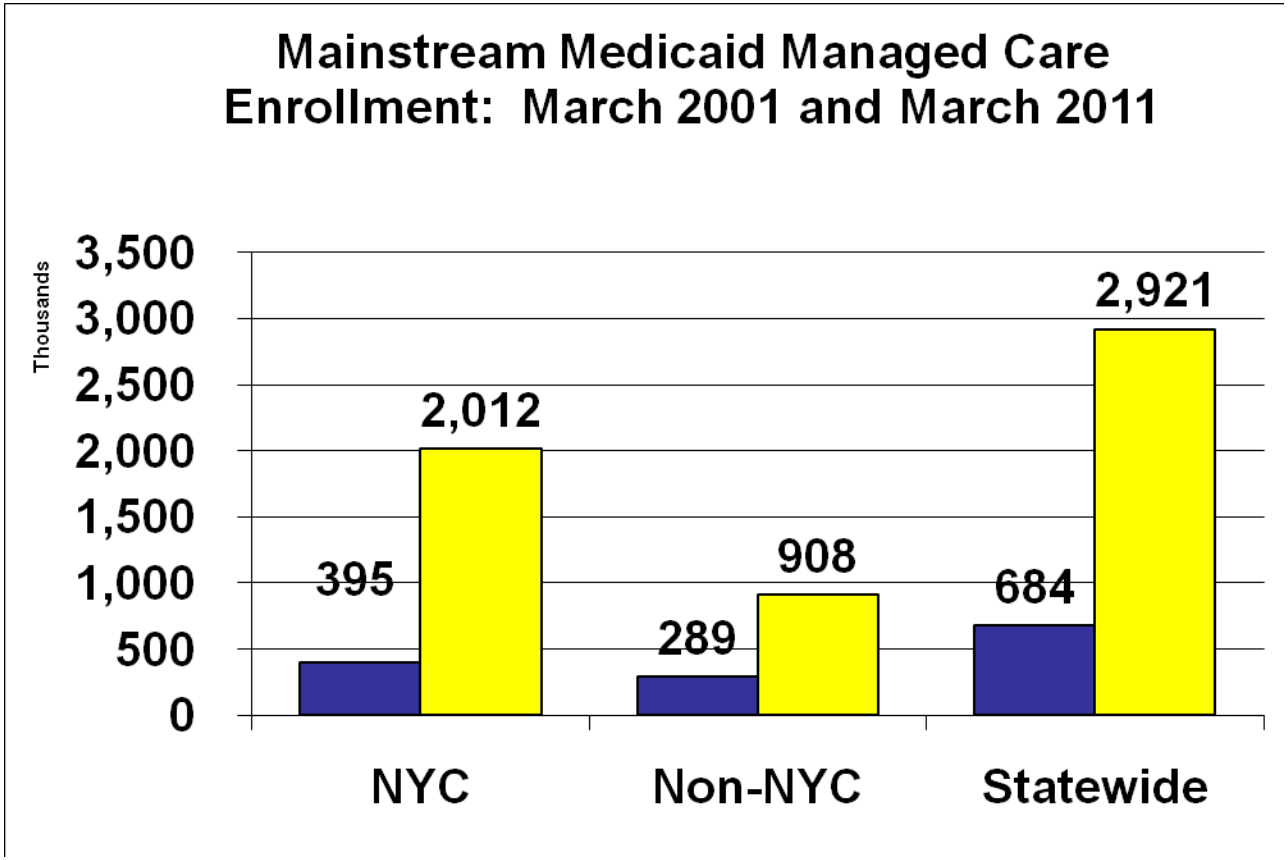
Medicaid Managed Care

- State contracts with managed care organization (MCO)
- State pays MCO fixed amount per enrollee
- MCO structures provider network, contracts with providers
- MCO determines medical necessity
- MCO coordinates enrollee's care
- MCO pays provider

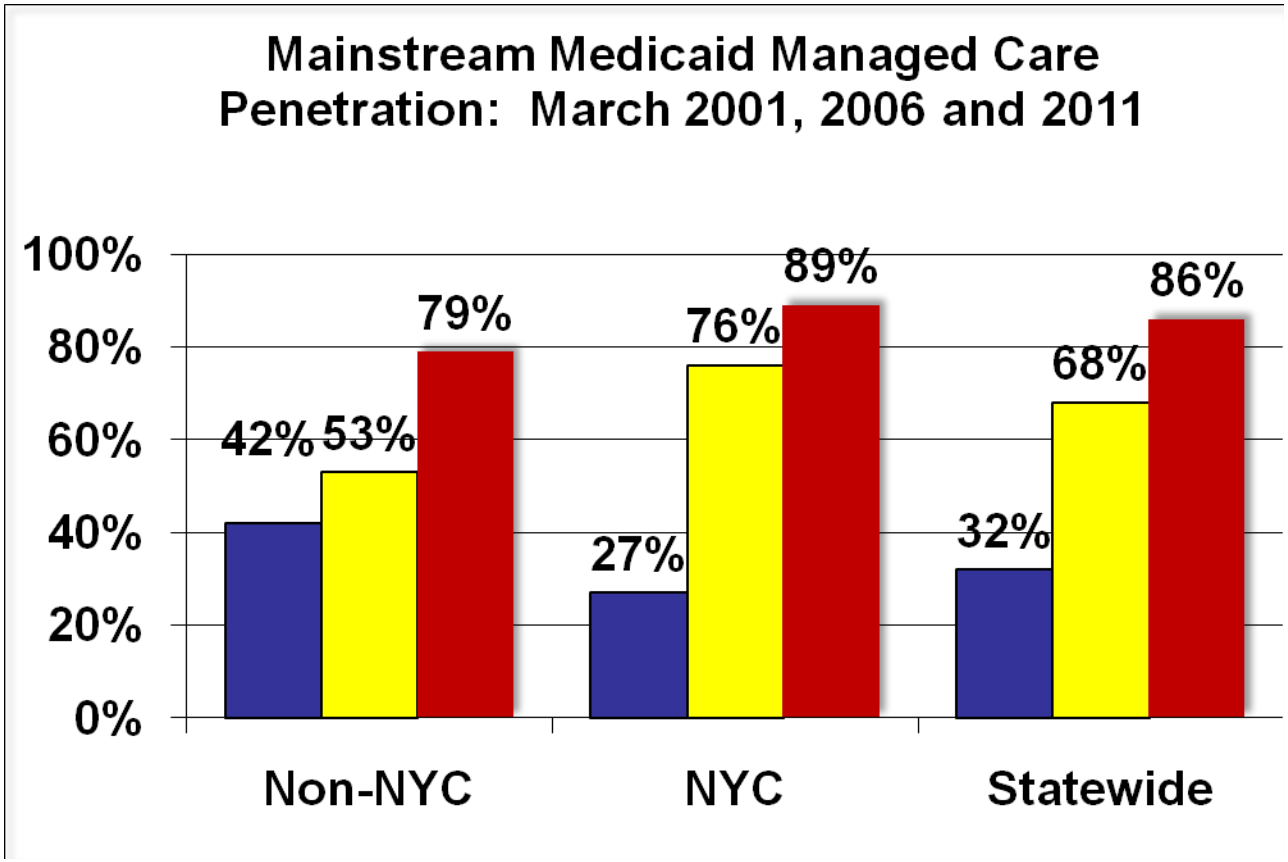
Mainstream Medicaid Managed Care

- Federal 1115 Waiver received 1997
- Mandatory enrollments began in some upstate counties in 1997
- NYC 5-phase process 1999 – 2002
- Rest of state- minimum of 2 plans unless rural
- All but 9 counties mandatory in 2011

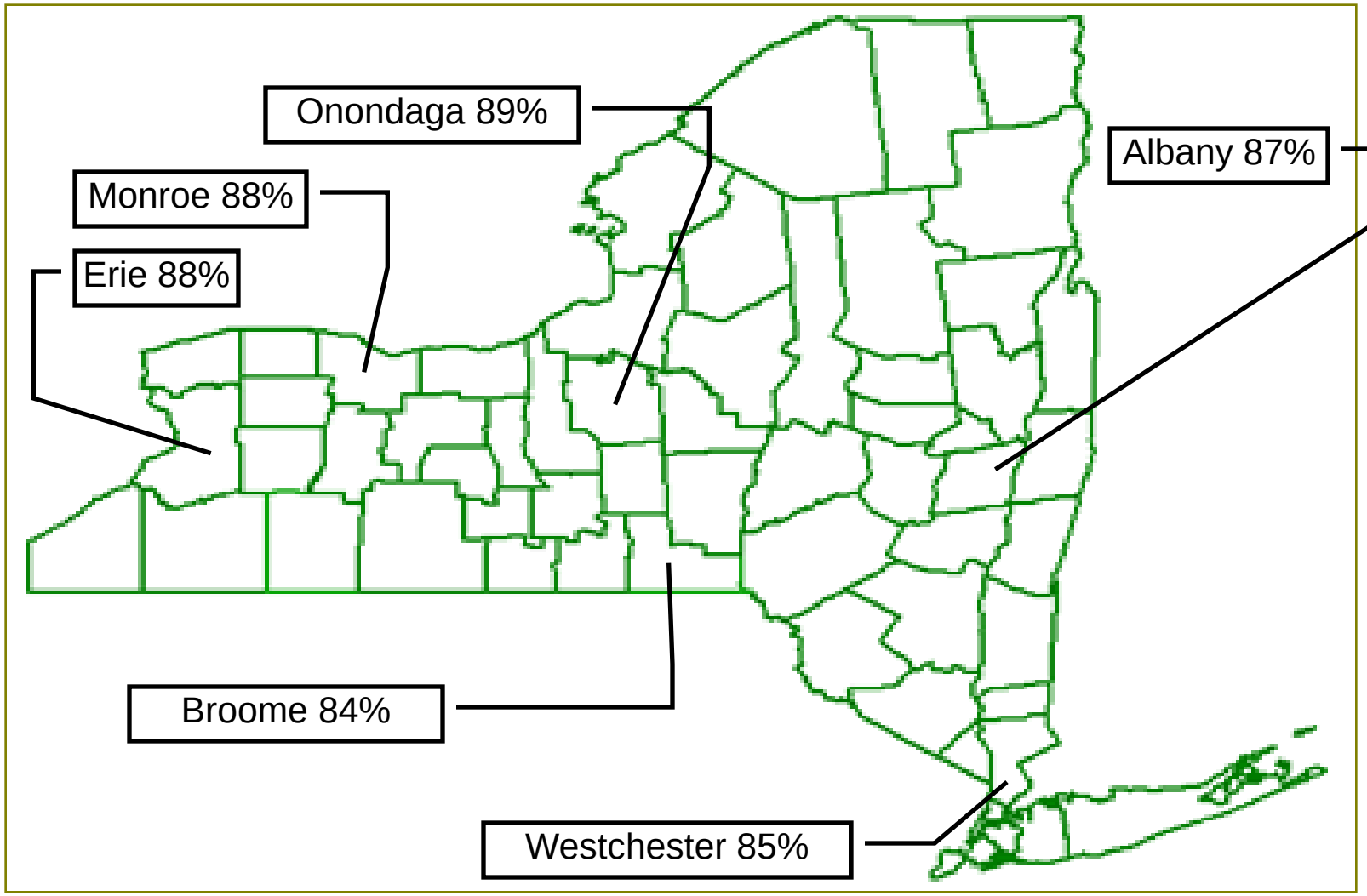
Medicaid Managed Care: Enrollment



Medicaid Managed Care: Penetration



Mainstream Medicaid Managed Care: Penetration



Most non-mandatory county penetration rates below 10%

Medicaid Managed Care: Benefits

- Covered
- “Carved-out”
- Not Covered
- Optional

Carved Out or Included?

Carved Out of Benefit Package

✓ Individual may access the service through FFS Medicaid, but care coordinator's recommendation could have influence

Part of Benefit Package

✓ Individual likely to be required to receive services from network provider

MMC: Exclusions & Exemptions

Exempt

- ✓ Individual has the option to enroll but is not required

Excluded

- ✓ Individual may not enroll in Medicaid Managed Care

MAJOR CHANGES TO THESE ENACTED THIS YEAR

MMC: Agencies Involved

Changes coming:

- State is taking over some local DSS responsibilities
- Managed LTC enrollment being streamlined (pre-enrollment approval will be phased out)

MMC: What Enrollees Need to Know

- Whether they qualify for an exemption
- How to select a plan & PCP
- How to select network providers
- How to get necessary pre-authorization
- What is covered by the plan, what is carved out
- Process for resolving problems
- Whether transportation is covered
- How to access transportation benefit

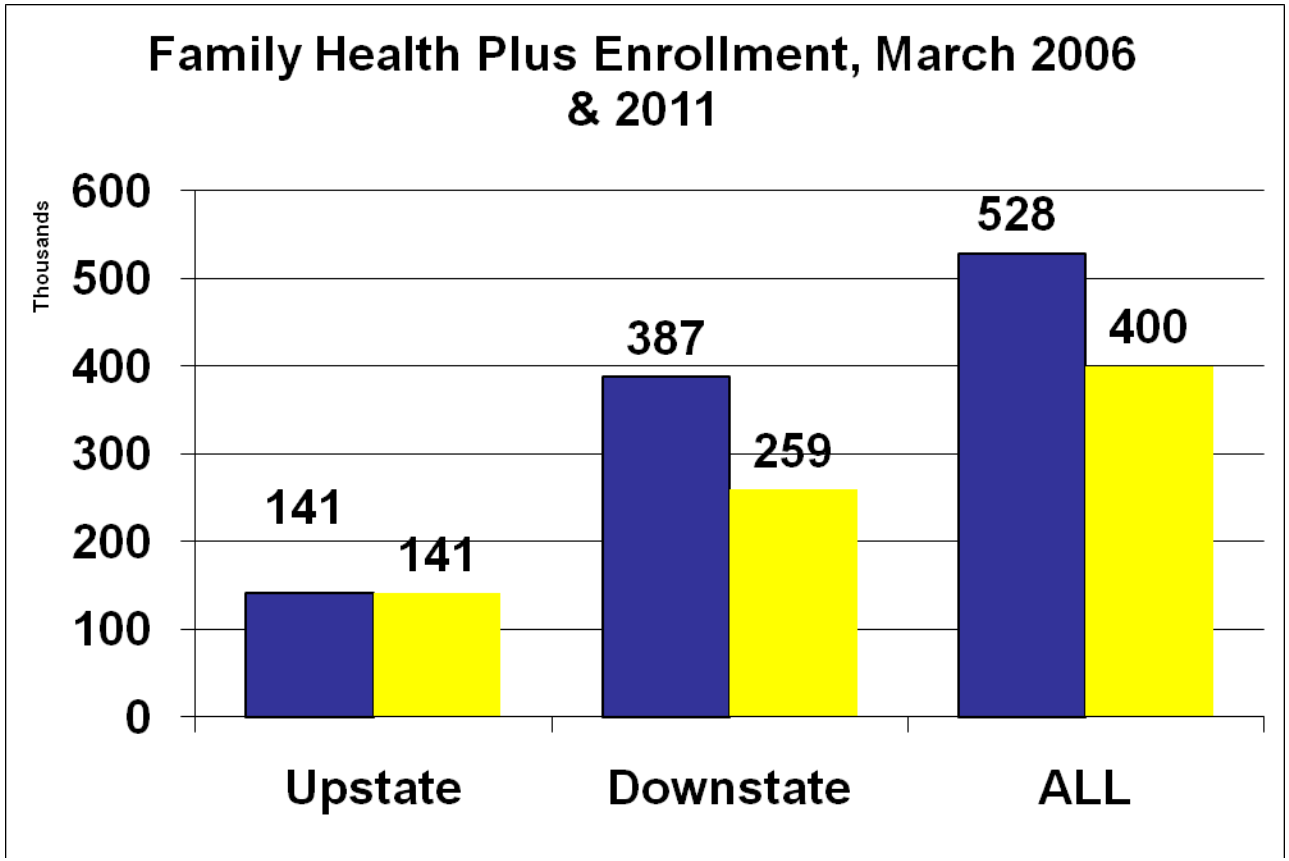
MMC: SSI Initiative

- Prior to Fall 2005, Supplementary Security Income (SSI) recipients and SSI-related individuals (disabled, blind, 65+) could join voluntarily
- DOH Initiative to encourage SSI recipients to join MMC (2003-04)
- Starting in October 2005, SSI recipients in NYC no longer exempt from mandatory enrollment

MMC: SSI Initiative

- Mainstream Medicaid Managed Care
- Impacts disabled populations
- Now mandatory in most counties with 303,000 SSI enrollees

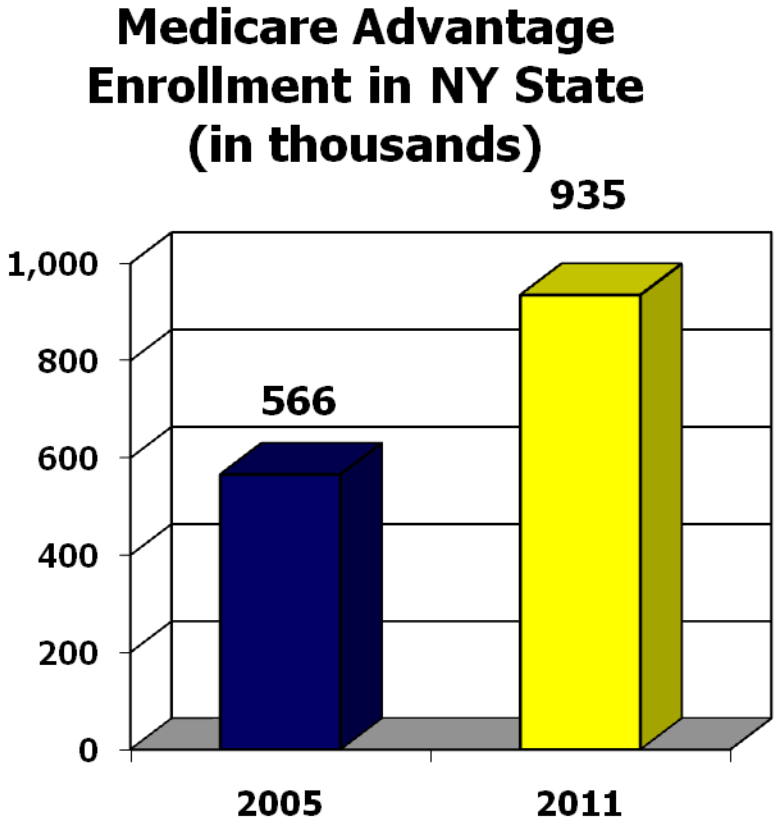
FHP: Enrollment



Also Child Health Plus enrollment of 400,000

Medicare Managed Care

- Formerly "Medicare+Choice", now Medicare Advantage Plans
- Some added benefits, lower out-of-pocket costs for enrollees
- Voluntary
- Medicare Modernization Act of 2003 increased payments to MCOs
- 31% penetration in NY (NJ= 12.7%, PA= 38.5%)



Medicare Special Needs Plans (SNPs)

- Medicare Advantage plans allowed to restrict enrollment to individuals with specific needs
  1. Nursing home residents or nursing home eligible residing in the community
  2. Individuals eligible for both Medicaid and Medicare (dual eligible)
  3. Persons with chronic conditions
- Majority serving dual eligible persons
- Benefits tailored to suit enrollees' needs
- Success unclear

Dual Eligible Initiative: Rationale

- Account for 35% of US Medicaid spending
- 40% suffer from cognitive/mental impairments
- More likely than other Medicare enrollees to suffer chronic conditions
- Likely to receive fragmented, uncoordinated care with gaps between Medicare & Medicaid benefits
- Thousands of MMC enrollees were “aging out” of MMC upon reaching Medicare eligibility

Dual Eligible Initiative: Concept

- Allow duals to enroll in Medicare and Medicaid managed care product offered by same MCO
- Make it “seamless” to client
- Provide a Medicare MC product with standardized benefits
- Combine with Medicaid product covering Medicare out-of-pocket costs and services not covered by Medicare

Dual Eligible Initiative: Eligibility

- Full Medicaid coverage
- Medicare Part A & B coverage
- At least 21 years old
- Not categorically excluded from Medicaid Managed Care
- Voluntary enrollment in same plan for Medicaid & Medicare services

Dual Eligible Initiative: Options

- Medicare FFS + Medicaid FFS
- Medicare Advantage (MC) + Medicaid FFS
- Medicare Advantage + Medicaid Advantage (through same plan)

- Nursing home eligible individuals have option of enrolling in Managed Long Term Care

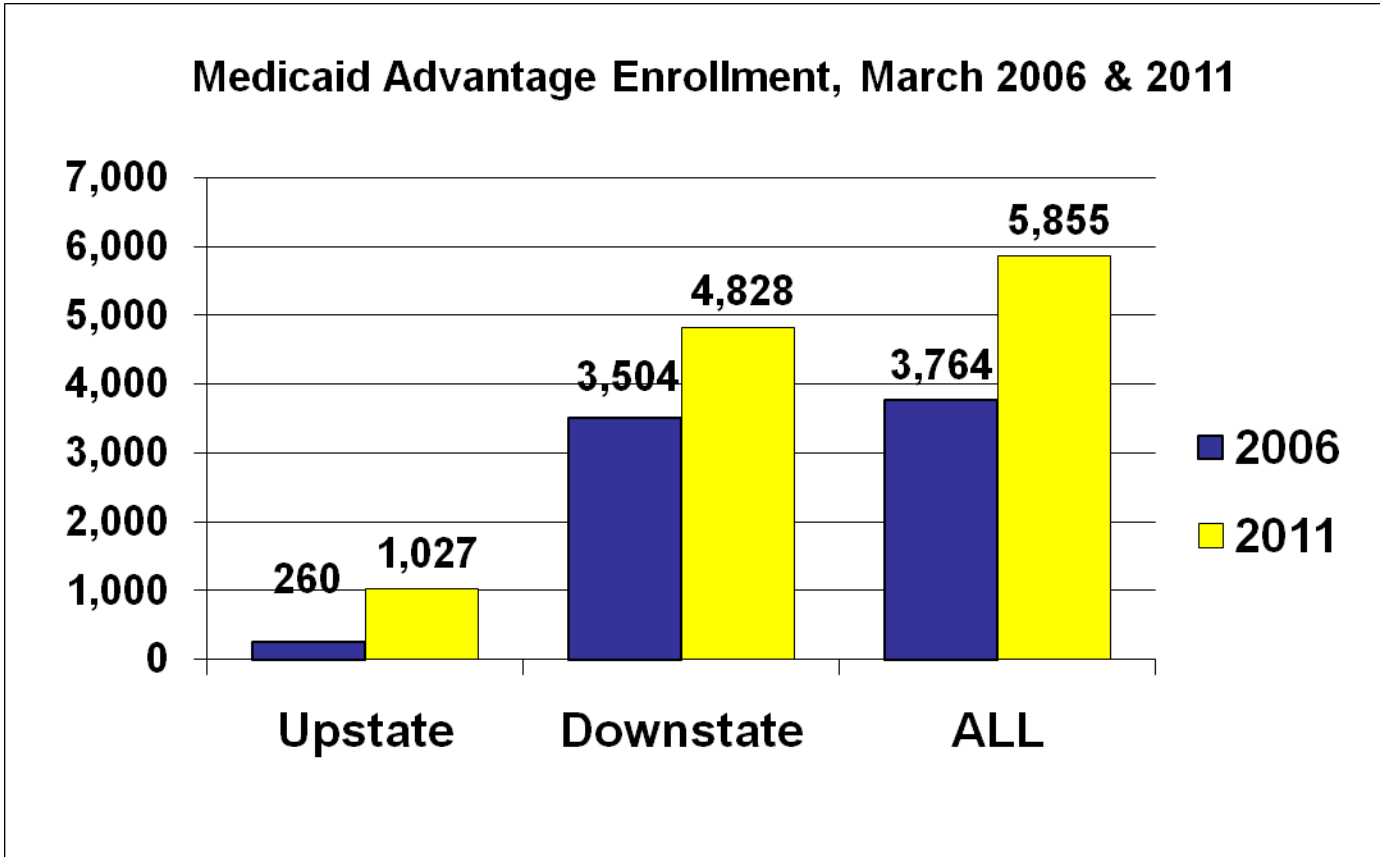
Dual Eligible Initiative: Impact

- Slow start with fewer than 6,000 enrolled statewide
- Called Medicaid Advantage
- Medicare is part of plan but Medicare does not allow mandatory enrollment
- Potential: 170,000 Dual Eligibles in NYC, 138,000 outside of NYC

Medicaid Advantage

- Mainstream Medicaid MC for those eligible for Medicare & Medicaid ("dual eligibles")
- Dually eligible individual can only participate if s/he enrolls in both Medicare and Medicaid MC
- Voluntary

Dual Eligible Initiative: Enrollment



Medicaid Advantage **Plus**

- MLTC plan designed for dually eligible individuals in need of nursing home level of care *(NH level of care requirement changing)*
- A combination of a Medicare Advantage Plan with a Medicaid MLTC plan

Managed Long Term Care

- PACE (Dual Capitation)
- MMLTC (Single Capitation)
- Medicaid Advantage Plus (MAP)
- NYC, LI, Rockland, Westchester, Orange, Schenectady, Albany, Herkimer, Oneida, Onondaga, Monroe, Erie, Cattaraugus, Allegany
- *MAP only: Columbia, Dutchess, Greene, Montgomery, Rensselaer, Saratoga, Ulster, Warren, Washington*
- For those needing nursing home level of care residing in the community *(NH level of care requirement changing)*
- Care coordination, comprehensive benefits package

MLTC: PACE vs MMLTC

PACE

1. Receives capitated Medicaid and Medicare payments
2. Provides or arranges and pays for all long term and acute health care services
3. Day center is core of many programs
4. Nationwide program
5. Enrollees 55+
6. Comprehesive interdisciplinary team

MMLTC

1. Receives capitated Medicaid payment
2. Provides or arranges all health care needs but pays only for long term care services
3. Less reliance on day center than in PACE, home care focus
4. New York State program
5. Enrollees 18+ *
6. Variety of care coordination models

MLTC: ADHC in MLTC

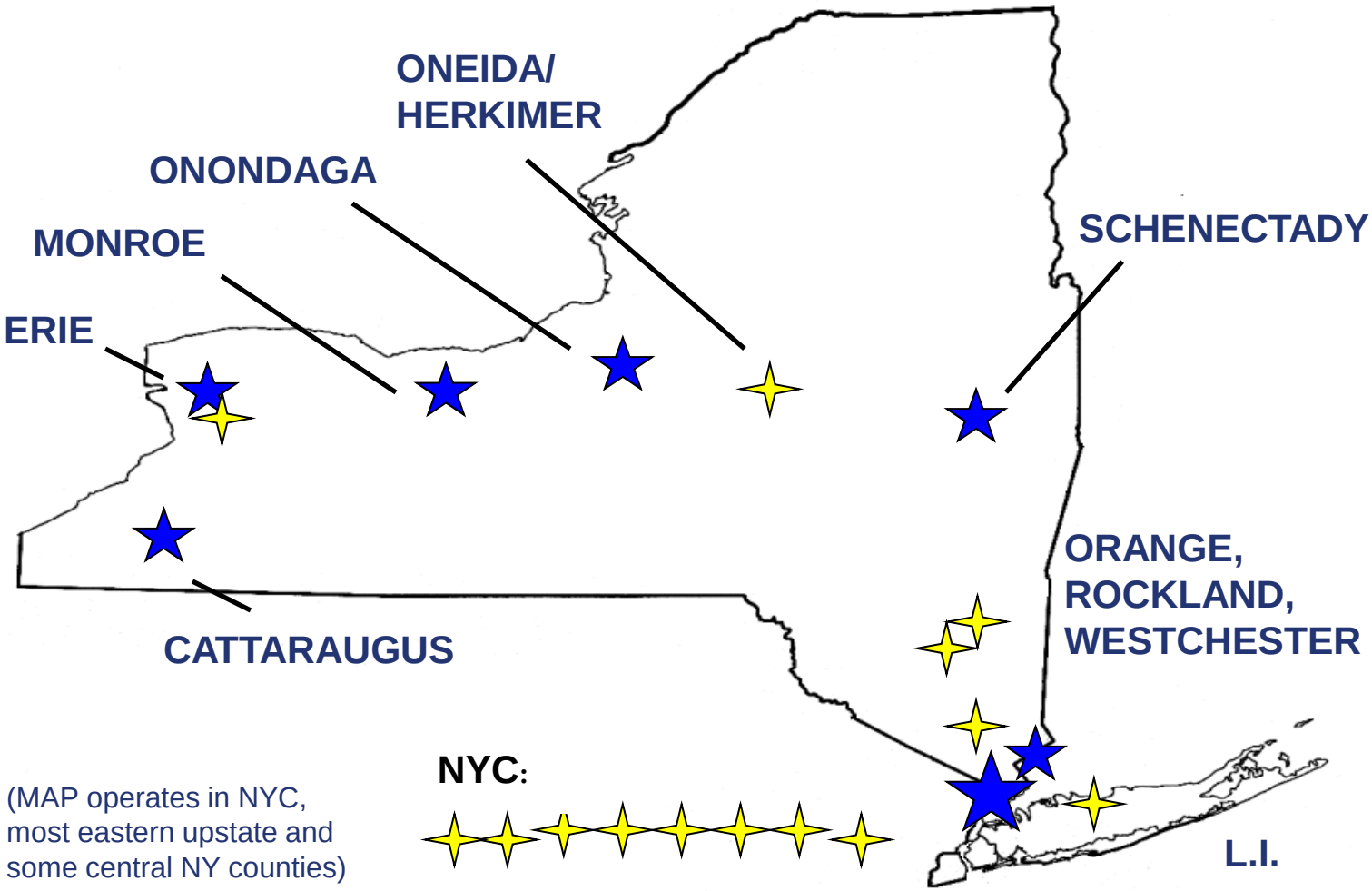
PACE

- Day center a central feature
- Full clinic

MMLTC

- ADHC a covered service
- Provided directly or through contracts with programs

MLTC: Location of PACE ★ /MMLTC ✦

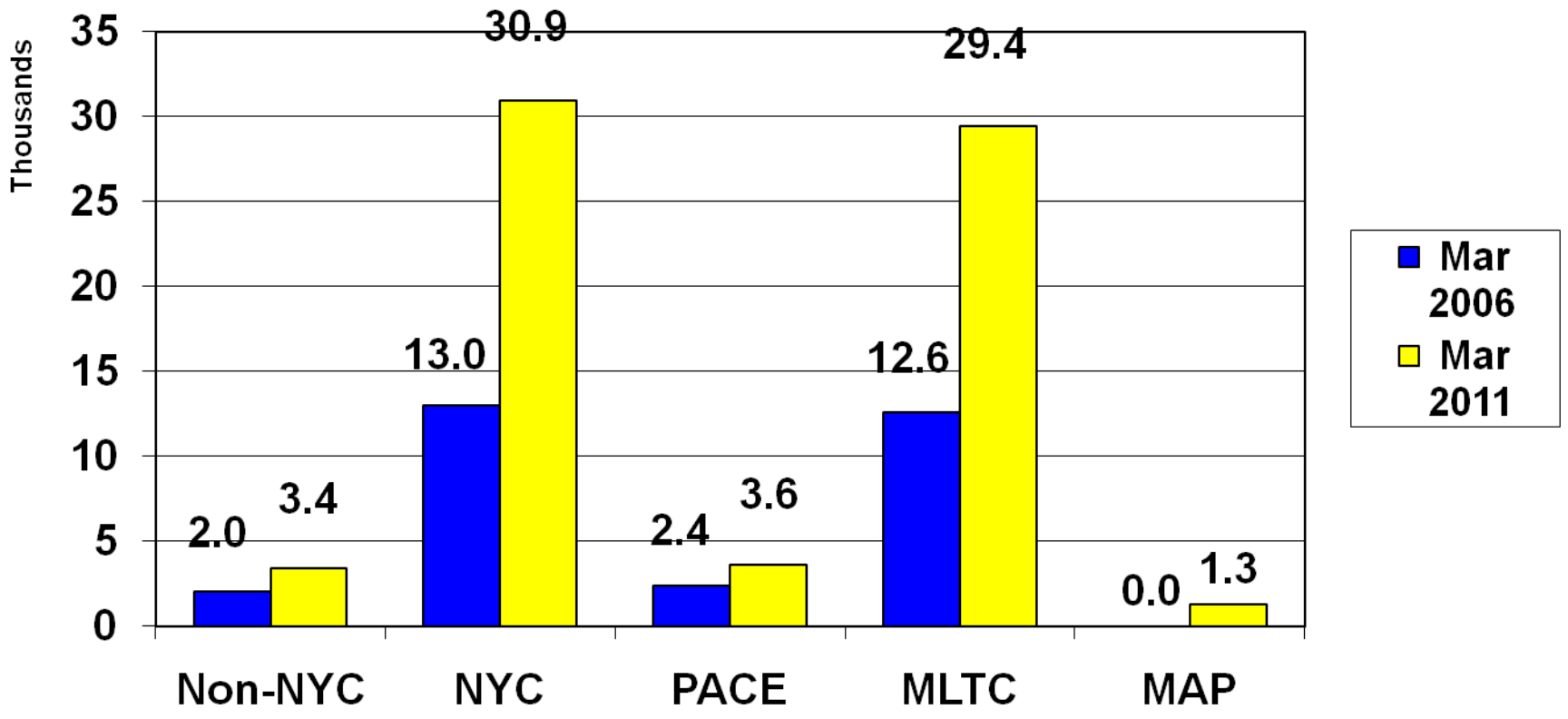


(MAP operates in NYC, most eastern upstate and some central NY counties)

MLTC: LTC Integration & Finance Act

- Consolidated all MLTC plans under one legislative authority
- Authorized legislature to designate additional plans
- Set max of 50 MLTC plans
- 2011 amendments expand max to 75
- MLTC provisions in 4403-f of Public Health Law

MLTC: PACE / MMLTC / MAP Enrollment

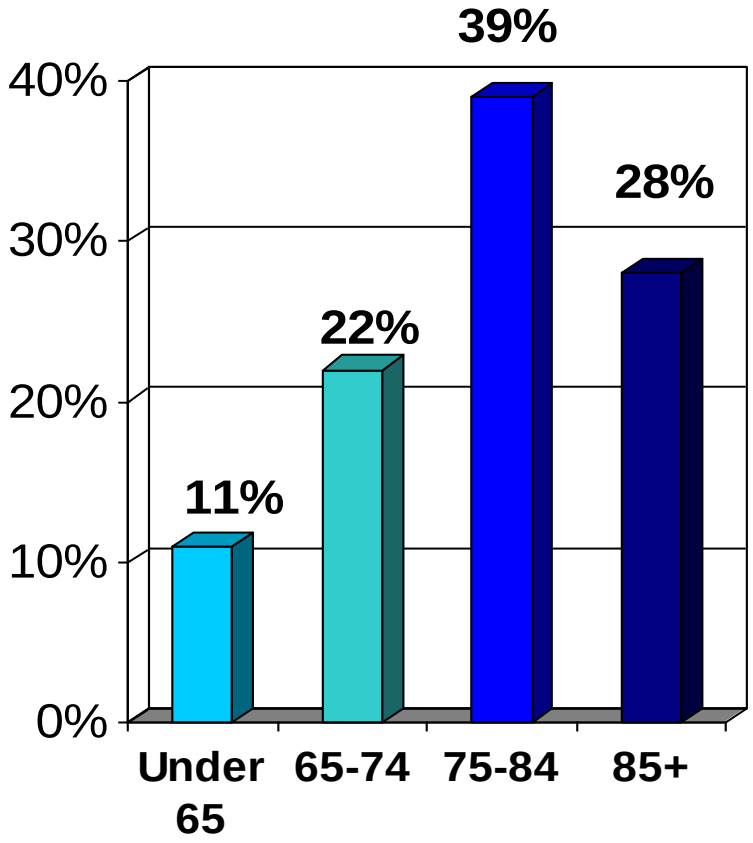


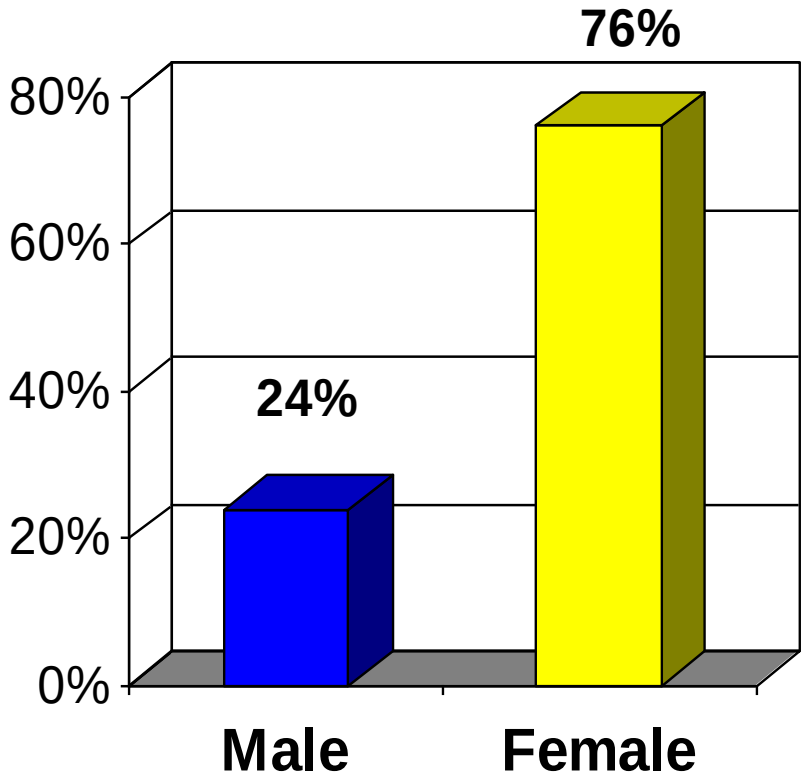
Organizations Currently Operating MLTC

One or combination of providers:

- Hospitals
- Nursing homes
- Certified or licensed home care agencies
- Managed care organizations (some for-profit)
- Not-for-profit organizations with a history of providing or coordinating health care & long term care services to the elderly and disabled

MLTC: Enrollees by Age & Gender (Jan 2006)





MLTC: Enrollee Characteristics

Percent needing assistance with:

- Grooming – 75%
- Dressing – 89%
- Bathing – 92%
- Toileting – 46%
- Transfering – 72%
- Walking – 95%
- Eating – 78%

MLTC: Most Common Enrollee Diagnoses & Conditions

1. Hypertension (82%)
2. Heart Disease (52%)
3. Visual Impairments (44%)
4. Osteoarthritis (42%)
5. Diabetes (40%)

MLTC: Enrollee Satisfaction

- 91% PACE / 86.5% MMLTC enrollees rate plan good to excellent
- Only 6% of dis-enrollments due to dissatisfaction with quality or quantity of services
- Quality of meals at day center a common complaint

MLTC: Largest Plans

MMLTC

- VNS Choice -- 8,748 enrollees
- GUILDNET -- 6,212
- Elderplan -- 3,619

PACE

- Comprehensive Care Management– 2,574

As of March 2011

Review

- Mainstream Medicaid MC: ADHC carved out
- MLTC (PACE, MAP, MMLTC: ADHC in benefit package
- Terminology: Medicaid Advantage, Medicare Advantage
- Check & document Medicaid managed care enrollment status (1st and 10th of the month at least)
- Develop relationships with MCOs / MLTC plans
- Links to plan directories, troubleshooting phone numbers, other MC info on following slides

Resources

NYAHSA Doc. ID # n00005005 Background on Health Homes
NYAHSA Doc. ID # n00005012 Overview on Medical Homes
NYAHSA Doc. ID # n00005013 NCQA Medical Home Accreditation
NYAHSA Doc. ID # n00005014 Additional Health Home Resources
NYAHSA Doc. ID # n00005055 DOH Briefing on Managed Care Initiatives
NYAHSA Doc. ID # n00005104 Federal Rule on ACOs

Resources

NYAHSA's general counsel, Cadwalader, Wickersham and Taft, has developed a preliminary legal analysis on ACOs, available at: http://www.cadwalader.com/assets/client_friend/113010_NationallHealthCareReform.pdf.

Resources

Medicaid Redesign Team

http://www.health.state.ny.us/health_care/medicaid/redesign/

Resources

DOH Medicaid Managed Care Web Page:
www.health.state.ny.us/health_care/managed_care/mamctext.htm

DOH MC info for providers:
www.nyhealth.gov/health_care/managed_care/providers/

Managed Care Organization Directory:
www.health.state.ny.us/health_care/managed_care/pdf/hmo_dir.pdf

List of Managed Long Term Care Plans:
http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

List of MC Plans with e-MedNY codes:
www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information_2011-2.pdf

MEVS Manual:
www.emedny.org/ProviderManuals/AllProviders/MEVS/MEVS_Provider_Manual/1_13/MEVS%20Provider%20Manual.htm

Resources

Typology of Managed Care Programs in NY State:
www.health.state.ny.us/professionals/patients/discharge_planning/docs/managed_care_program_comparison.pdf

Model Contracts for MAP, MMLTC:
www.health.state.ny.us/health_care/managed_care/providers/index.htm#model_contracts & www.health.ny.gov/health_care/managed_care/mltc/

NYC Medicaid Managed Care Web Page:
www.nyc.gov/html/doh/html/hca/hca1.shtml

List of Medicaid Plans and Programs in NYC (not LTC):
http://www.nyc.gov/html/doh/downloads/pdf/hca/hca-med.pdf

Medicaid Managed Care Regional Consumer Guides (Lists MCOs, Web sites, phone numbers and quality ratings):
http://www.health.ny.gov/health_care/managed_care/consumer_guides/

Resources

Statewide County DSS listing with Web links:
www.health.state.ny.us/health_care/medicaid/ldss.htm

List of DOH Managed Care Complaint contacts:
www.health.state.ny.us/health_care/managed_care/complaints/index.htm

For consumer MLTC complaints:
www.health.state.ny.us/health_care/managed_care/mltc/mltcomplaint.htm

DOH MC help lines for providers and patients:
http://www.health.state.ny.us/health_care/managed_care/contact/helplines.htm

Medicare HMO Reference Guide (for Consumers & Advocates):
http://www.medicarerights.org/

HIV SNP Information:
www.nyc.gov/html/doh/html/hca/hcaspec.shtml

Medicare Special Needs Plan Information:
www.cms.hhs.gov/SpecialNeedsPlans/Downloads/FinalSNPGuidance1-19-06R1.pdf

A New MC World: Considerations

Why is NY Doing This?

- Reduce cost of Medicaid
- More predictable state expenses
- Contract with and pay fewer entities
- Improve care coordination
- Integrate Medicaid with Medicare
- Access federal funding
- National trend

New MC World: Possible Developments

- Increase in number of MC enrollees
- Proliferation of MLTC plans
- Large commercial MCOs in MMC & MLTC
- Less DSS involvement, greater plan authority
- Increased confusion among Medicaid recipients
- New care coordination models
- Capacity issues

New MC World

- Large number of unanswered questions
- What will qualify as a “care coordination” model
- Wage Parity will affect MLTC in April 2012
- Workgroup “to evaluate and promote transition of persons in receipt of home and community based LTC into MLTC plans and other care coordination models”
- SSI mandatory enrollment as an indicator
- A likely focus on models that will fit ACA provisions and funding opportunities (health homes, ACOs, preventable hospitalizations, dual eligible initiative)
- Need to contract and/or align with other entities very likely

Questions?

Please contact Policy Staff at NYAHSA, (518) 867-8383, or pcucinelli@nyahsa.org at any time if you have questions or we can be of assistance.

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