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

Webinar 2: Managed Care and LTSS | July 15, 2016

PowerPoint Presentation

Slide 1: Title slide

Slide 2: NC Medicaid Reform and Long-Term Services and Supports

An overview of this webinar series and today's webinar agenda.

Slide 3: Long Term Services and Supports

- To set a foundation for today's presentation, LTSS and managed care terms used are Centers for Medicare & Medicaid Services (CMS) and/or broadly accepted definitions.
- "LTSS" stands for long-term services and supports, and encompasses a wide group of individuals and services.
- LTSS covers individuals with physical disabilities, intellectual and developmental disabilities, mental illness, traumatic brain injury and medical complexities.
- LTSS is broader than just Medicaid. It includes other funding streams and social determinants.

Slide 4: Long Term Services and Supports

- Also for purposes of today's presentation, "LTSS" refers to Medicaid-funded, long-term supports that are not covered or coordinated by LME-MCOs – North Carolina's behavioral health managed care organizations.
- Behavioral health services will remain under the LME-MCOs. We will explain more when we discuss the Section 1115 waiver in the third webinar.
- When we talk today about the LTSS community, dual eligibles also are not included. The dual eligibles population is very complex and the recently formed Dual Eligibles Advisory Committee will advise the Department as it develops a strategy to transition those individuals into managed care.

Slide 5: Medicaid Managed Care

- In general, "Medicaid managed care" is delivering health benefits and additional services through contracted arrangements through state agencies and other organizations.
- Rates are set per member per month. Those rates can exist in fee-for-service and capitation models. Rates are often risk-adjusted by population, by geography, by acuity. A "set" rate is not one rate; it is a variety of rates set for different populations and geographies.

Slide 6: Capitation: One of Several Managed Care Tools

- "Capitation" and "managed care" are not interchangeable terms. Capitation is a tool of managed care. It is an amount established for each enrolled person for a period of time, whether or not the person seeks care.
- Capitation is basically paying someone to manage an individual's care. The better the care is managed, the more costs are saved and better outcomes are achieved.
- Capitation includes all fees intended to reimburse all providers.

Slide 7: Managed Care Entities

- Federal regulations and CMS identify various types of managed care entities. The information on this slide is from CMS and represent its terminology.
- MCO, managed care organization, includes inpatient and outpatient services, and a comprehensive benefits package. MCOs are where Medicaid reform is going.
- PCCM, primary care case management, exists today in North Carolina through CCNC. PCCM can exist in a capitated environment. It also can exist in a fee-for-service environment, where a per member per month fee is paid to provide case management in addition to the fees paid for services.
- PIHP, prepaid inpatient health plan, are LME-MCOs. There are also PAHPs, which are prepaid ambulatory health plans.
- MCO, PCCM, PIHP and PAHP are four different segments, but they are not exclusive. For example, MCOs can include pieces of the three other segments. The takeaway is that these are all tools for managed care.

Slide 8: Managed Long Term Services and Supports (MLTSS)

Within managed care is managed long term services and supports, known as MLTSS. MLTSS can be provided through comprehensive LME-MCOs. It also can be a separate PIHP or PAHP, referred to as MLTSS-only programs. North Carolina is looking at it as more of a comprehensive managed care model.

Slide 9: Questions

Questions and answers will be added to the Medicaid Reform Questions and Answers document.

Slide 10: CMS Managed Care Final Rule - MLTSS

- The Managed Care Final Rule, released this spring, outlines CMS requirements and expectations of states as they roll out managed care options and supports.
- For today, highlights of the final rule are being shared that are specific to the long term services and supports community. These are only highlights. Interestingly, the rule includes items that the LTSS community has advocated or advised for years.
- States must:
  - Plan adequately when integrating LTSS into managed care. CMS recognizes this population has specific needs and complexities that deserve extra attention.

- Include a robust stakeholder engagement process.
- Align with the Americans with Disabilities Act and the Olmstead decision.
- Include specific supports for beneficiaries engaged in the long-term care system and managed care environment.
- Use a person-centered process when working with beneficiaries.
- Explore how to best provide a comprehensive and integrated service package, so that service sector siloes often experienced by the long-term services and supports community are addressed.
- Follow LTSS-specific qualified providers and qualifications.
- Include participation and beneficiary protections related to enrollment and due process.
- Set quality assurance and quality measures, and ensure that these measure are specific to the LTSS community.

- As noted earlier, the rule underscores that stakeholders are to be fully engaged in the design and planning process

Slide 11: Why States Go to Medicaid Managed Care

- There are multiple reasons why states go to managed care. While cost is often mentioned as a key driver, it is important to recognize that there are other reasons that can benefit the LTSS community.
- A crucial reason is to strive for improved care coordination; to explore opportunities to coordinate delivery across service delivery sectors and, importantly, across a person's life span. Stakeholders have repeatedly said that when service providers, case managers and service dynamics change, it creates a very disjointed care experience for individuals and their families.
- States pursue managed care because it establishes clear points of accountability. It creates opportunity for plans to increase ownership of cost and outcomes, with clear responsibility for who coordinates supports for an individual.
- There are also more opportunities under managed care to improve population health; advance policy directions through payment, contractual requirements and quality measures; to incent the increased use of preventive services; and to establish population-specific measures and outcomes.
- Specific measures relevant to the long-term services and supports community often can be more effectively be advanced in a managed care dynamic.
- Managed care also expands innovation, including allowed for flexibility in how and where services are provided and finding ways to address needs more effectively than possible in a fee-for-service model.
- Social determinants, those elements that are not clinical or medical in nature, are more recognized as making a significant impact on health outcomes. This includes housing, employment, transportation. Managed care provides flexible vehicles for addressing social determinants.
- Cost management, naturally, is a factor in why states explore managed care. But, as this slide outlines, it is not the only factor. It is important to emphasize this point.

Slide 12: Moving Beyond Traditional Cost Savings Measures

- It is helpful to recognize that traditional cost management strategies are not always effective or have significant unintended outcomes. This is a sample of those strategies and potential consequences.
    - Cutting eligibility may expand the uninsured population.
    - Cutting provider rates may compromise the provider network, which is particularly important in the long-term services and supports community.
    - Cutting optional benefits the state provides under Medicaid may save some resources, but care may unintentionally shift to other services.
    - Limiting units of care per beneficiary to prevent abuse may restrict the flexibility often needed to better support high-need individuals.
- The goal is to determine how to manage cost in ways that also result in improved care coordination and beneficiary outcomes.

Slide 13: Medicaid "Managed Care Entities" Already Exists in NC; Reform Moves State toward a More Comprehensive Model

- This is a refresher of some details presented in the last webinar to reinforce that the managed care entities concept is broad and already exists in North Carolina.
- Types of managed care entities North Carolina already has in place are:
    - Primary care case management, the CCNC model
    - Program of all-inclusive care for the elderly, the PACE model
    - Behavioral health prepaid health plans, known as the LME-MCOs
- Medicaid and the department are moving toward a more comprehensive approach to managed care. MCOs will take two forms: commercial plans and provider-led entities. Participating plans will be responsible for coordinating all services, except those services noted as being carved out or delayed, and will receive a capitated payment for each enrolled beneficiary.
- Of the 4 different types of managed care entities noted earlier, PCCM is CCNC; PACE is an MCO, complete, comprehensive capitation; behavioral health is a PIHP. PACE will remain independent and as a comprehensive benefit for the duals and LTSS population.

Slide 14: 39 States Use Comprehensive MCOs

- To underscore the information shared so far today, it is an increasing trend that more states are using a comprehensive managed care model. That trend is anticipated to continue.
- The data on this slide is from October 2014. Alabama has subsequently become an MCO-only state and its waiver was approved October 1. Alabama has moved from orange to blue.

Slide 15: Most States Reform Incrementally

States usually reform their systems over time, and many states have come before us. We benefit from the opportunity to learn from those experiences, including challenges and lessons learned, as we develop our own comprehensive approach.

Slide 16: Questions

Questions and answers will be added to the Medicaid Reform Questions and Answers document.

Slide 17: Key Differences: Current (FFS) vs. Potential (Managed Care)

- The next two slides list key attributes of health care delivery systems, and compares what exists today in fee-for-service with the potential that can be achieved in a managed care model.
- The word "potential" is used purposefully. The department will use lessons from other states' efforts and work closely with stakeholders to identify and take advantage of the potential that capitation offers.
- Medical management refers to the current focus on coordination of primary care. With capitation, more services – such as specialty services – are included in coordination efforts, providing a comprehensive approach.
- The LTSS population relies on more services, but today are the least coordinated group. Under capitation, care coordination occurs across services and across delivery systems. For example, a physical therapist providing services to a disabled child at home may recognize household changes that also would benefit the health of the child. Under fee-for-service, the therapist may not be able to address those changes. However, capitation has the potential for the flexibility needed to innovative solutions and improve health outcomes.
- Currently, beneficiaries can visit any Medicaid provider throughout the state; however, access is limited, for example, by available Medicaid slots. Under capitation, the provider network is limited, but access is unlimited. There will be network adequacy requirements, such as appointments available within a certain time period. Plans will be held accountable to follow these requirements.

Slide 18: Key Differences: Current (FFS) vs. Potential (Managed Care)

- As discussed earlier, today Medicaid providers are fragmented. Under capitation, providers will contract with a commercial plan or provider-led entity.
- Providers are paid today by visit or procedure; they are rewarded for the volume and intensity of the services they deliver. Under capitation, providers will be paid per enrollee with a value-based payment. More about value-based payments will be shared during the third webinar. Remember, there will be a fee-for-service component under capitation. But capitation provides the opportunity to measure and pay for value and quality.
- Enrollment in the Medicaid program will remain. Under capitation, beneficiaries also will select a plan, either a commercial plan or provider-led entity.

Slide 19: How Capitation Works

- Under capitation, plans are paid a fixed fee, per member per month, based on an expected average utilization of that patient. Payments are greater for patients with significant medical history, which is called a risk adjustment.
- Payments are risk adjusted for different factors, including acuity and geography. Payments are for a defined set of purposes, benefits and population.
- In return, the plan accepts the risk for delivering those services. The payment covers the entire bucket of services the person will use.

Slide 20: A Note about Capitation and LTSS

- Capitation payments are set through a very structured rate setting process that heavily involves CMS. Groups are divided by aid category, age, illness and, as mentioned earlier, risk adjusted based on acuity, geography and Medicaid aid category. Payments are also based on a historical look back; for example, the prior fee for service acuity.
- It does not mean that one-size fits all. Some MCOs will get paid for a certain amount for services provided to pregnant women, a different amount for a healthy child and a third amount for people with long-term support needs. The payment may also get adjusted higher or lower for specific long-term needs.
- Rates also encourage quality, prevention and health outcomes. Depending on the level of outcome desired for a specific population, rates may be adjusted accordingly.

Slide 21: Questions

Questions and answers will be added to the Medicaid Reform Questions and Answers document.

Slide 22: Just a Reminder: NC Medicaid Reform Basics

- For those who did not attend last week's webinar, these are a few North Carolina Medicaid reform basics.
- What will change is outlined in the left-hand column:
  - Medicaid beneficiaries will enroll in their choice of health plans.
  - Plans will receive capitated payments and incentive payments for quality care goals.
- Over the course of this shift to a transformed Medicaid system:
  - Services provided by CCNC will be transitioned to the plans.
  - A dual eligibles enrollment strategy will be developed to transition this population into managed care.
- The right-hand column lists what is currently planned to stay the same.
  - Dental services, local education agency services, child development services and short-term eligibility groups will remain fee for service.
  - PACE will remain outside the scope of Medicaid reform.

Slide 23: Proposed Regions

The department is aiming for five plans per region; three statewide commercial plans and at least two regional provider-led entities. This may change depending on the number of participants.

Five options provides beneficiaries with choices that can be differentiated among plans. Too many plans, and it becomes more difficult to differentiate among them. Too few plans, and beneficiaries will not be offered enough choice.

Slide 24: Cycle of Managed Care – Provider Perspective

- This slide represents the provider perspective on how managed care would work.
- Over the next couple of years, the Department will develop a contract for the commercial plans and provider-led entities. Once a contract is established, the bid process begins and, eventually, a plan is accepted.
- The plan will build its network based on the requirements outlined in the contract, and negotiate rates with those providers.
- Beneficiaries will select a plan and providers within that network.
- Based on the contract, some services may require authorization. That will depend on the objectives set for improving outcomes. Providers will then submit a claim for those services.
- Claims are reviewed by the commercial plan, the provider-led entity or the department, depending on the type of service. For example, dental services do not fall under capitation and will be reviewed by the department.
- After approval, the payment will be made.
- Quality and compliance audits will take place. Those will be covered in the third webinar.

Slide 25: Cycle of Managed Care – Beneficiary Perspective

- This is a very high-level overview of managed care from the beneficiary's perspective.
- Once the plans have been awarded, there will be a designated time for open enrollment.
- Beneficiaries will be notified of the available plans in their regions. The goal is to have five plan options per region; at a minimum there will be three.
- Beneficiaries will work with DHHS, DSS and/or an enrollment broker. The enrollment broker is required by federal law to educate the beneficiary on the differences among the plan options in an unbiased manner. This can be an independent contractor or DHHS; it cannot be a plan.
- Beneficiaries will choose a plan. They can choose a plan based on their current provider or on the services they need. Please note that if services are not available in the chosen plan's region, then contracts will allow for those specific services to be provided outside of the region.
- Beneficiaries who do not personally choose a plan will be assigned one using an auto-assignment process. This process selects a plan based on markers, such as where care is currently provided, where they are living and who is the primary care provider.

- Beneficiaries will remain in the plan for a certain period; usually one year. The purpose is to allow plans the opportunity to improve outcomes over the course of a year. LTSS beneficiaries will have additional enrollment and disenrollment protections, as specified by CMS, included in the contracts. There will be instances where changing plans within the lock-in period is possible, but it will not be as simple as going to a different doctor under fee-for-service.
- Once enrolled, all beneficiaries will be assigned a medical home and a care management coordinator. The level of contact with the care management coordinator and medical home will depend on services needed. Some beneficiaries will need a more active care manager.
- After the year, the individual may switch plans and the cycle begins again.

Slide 26: Scenario 1

- The next two examples are a continuation from the first webinar, and a third one has been added as requested.
- The first example is a dual eligible individual who is 85 years old, and enrolled in Medicare and Medicaid. She also receives services under the Community Alternatives Program for Disabled Adults.
- Under current legislation, session law 2015-245, no decisions are required of this beneficiary because dual eligibles are carved out of managed care. The recently established Dual Eligibles Advisory Committee will advise the department as it builds a strategy to transition dual eligibles.
- Therefore, Medicaid and CAP/DA services will remain available and there is no change in how her care is delivered. This scenario will be different, of course, after the dual eligible population is transitioned into managed care.

Slide 27: Scenario 2

- This next individual is approximately 30 years old and receives Medicaid, but not Medicare; therefore, he is not a dual eligible. He also receives behavioral health services through the LME-MCO in his area.
- During the enrollment period, this individual will choose among the health plans offered, which will be three statewide commercial plans and at least two provider-led entities. He will choose his medical home and primary care physician. An enrollment broker will be available to help him make these decisions. Again, please note that the enrollment broker is not affiliated with any health plan option.
- Medical services and care will be received through his chosen plan, medical home and primary care physician. However, behavioral health care will continue to be coordinated by this LME-MCO.

Slide 28: Scenario 3

This last example is a child about 7 years old with medical complexities. He currently receives Medicaid, but not Medicare, so he is not a dual eligible.

His family will choose a health plan from the options available in their region, and a medical home and primary care physician. An enrollment broker is available to help with those decisions.

All Medicaid services, including LTSS, Community Alternatives Program for Children (CAP/C) services, and any additional support covered by Medicaid will coordinated through the plan.

School-based services are not part of managed care; however, there is an expectation that the plans will collaborate with different systems that support this child to achieve better health outcomes.

One note: Each family member on Medicaid selects a plan. For example, if a parent and child are enrolled in Medicaid, they do not need to be on the same plan.

Slide 29: Questions

Questions and answers will be added to the Medicaid Reform Questions and Answers document.

Slide 30: Additional Information and Resources

The links on this slide are connected to CMS information that may be helpful.

Slide 31: Coming Up

Next Friday is the third and final webinar in this series, and will be focused on North Carolina's 1115 waiver application and how it applies to the long-term services and supports community.

Note that this final webinar will certainly not be the last opportunity to ask questions. There will be additional opportunities for input, dialogue and exchange of ideas around Medicaid reform. Questions can be submitted any time on www.ncdhhs.gov/nc-medicaid-reform.

Websites to bookmark:

First link, www.ncdhhs.gov/dual-eligibles-advisory-committee, is a website dedicated to information related to the Dual Eligibles Advisory Committee, including these webinar presentations and registration information.

Second link, www.ncdhhs.gov/nc-medicaid-reform, is a website dedicated to North Carolina Medicaid reform, including updates, presentations, links to the session law and other materials.

We appreciate your time and attention, and look forward to seeing you at next week's webinar. Have a great rest of your afternoon.

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