## NC Medicaid Reform and Long-Term Services & Supports

### 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

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*

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

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

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<thead>
<tr>
<th>COST SAVING MEASURE</th>
<th>POSSIBLE CONSEQUENCE</th>
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<tbody>
<tr>
<td>Cut eligibility</td>
<td>Increase uninsured population</td>
</tr>
<tr>
<td>Cut provider rates</td>
<td>• Hurt providers</td>
</tr>
<tr>
<td></td>
<td>• Reduce access as providers exit</td>
</tr>
<tr>
<td>Cut optional benefits</td>
<td>Save some $ but much care shifts to alternate services</td>
</tr>
<tr>
<td>Limit units of care per patient</td>
<td>Prevent abuse but may harm high-need patients</td>
</tr>
<tr>
<td>Enhance program integrity</td>
<td>Favorable but marginal impact</td>
</tr>
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</table>
Medicaid “Managed Care Entities” Already Exists in NC; Reform Moves State Toward a More Comprehensive Model

<table>
<thead>
<tr>
<th>What North Carolina Has Now</th>
<th>What Medicaid Reform Will Bring</th>
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<tbody>
<tr>
<td>PRIMARY CARE CASE MANAGEMENT (CCNC)</td>
<td></td>
</tr>
<tr>
<td>• Primary care provider-based</td>
<td></td>
</tr>
<tr>
<td>• State pays additional fee to provide care management</td>
<td></td>
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<tr>
<td>PACE</td>
<td></td>
</tr>
<tr>
<td>• Comprehensive, capitated</td>
<td></td>
</tr>
<tr>
<td>• 55 years old and older</td>
<td></td>
</tr>
<tr>
<td>• Available in certain areas, not currently statewide</td>
<td></td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH PREPAID HEALTH PLAN (LME-MCOs)</td>
<td></td>
</tr>
<tr>
<td>• Cover specific populations and specific services</td>
<td></td>
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<tr>
<td>• Provides care coordination for identified and priority groups</td>
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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
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)

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

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

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

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
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</thead>
<tbody>
<tr>
<td>I</td>
<td>165k</td>
</tr>
<tr>
<td>II</td>
<td>280k</td>
</tr>
<tr>
<td>III</td>
<td>410k</td>
</tr>
<tr>
<td>IV</td>
<td>299k</td>
</tr>
<tr>
<td>V</td>
<td>291k</td>
</tr>
<tr>
<td>VI</td>
<td>230k</td>
</tr>
<tr>
<td>II &amp; IV</td>
<td>29k</td>
</tr>
</tbody>
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Populations estimated from June 2015 enrollment data
Cycle of Managed Care – Provider Perspective

1. **DHHS agrees to a contract with CP/PLE, which outlines benefits and limitations of services.**

2. **CP/PLE seeks providers for a network based on the needs outlined in the CP/PLE contract.**

3. **Providers agree to a contract that sets the fees.**

4. **Beneficiaries/families select providers within the network.**

5. **Some services require authorization before access, based on contract.**

6. **Providers submit claim for the services using the federal codes and modifiers agreed to for the services.**

7. **CP/PLE/DHHS payment systems review claims.**

8. **Payment Made.**

9. **MCO/PLE conducts quality and compliance audits.**
Managed Care Rules provides additional enrollment/disenrollment protections for LTSS beneficiaries.
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.
• 30 years old
• Receives Medicaid, but not Medicare
• Receives behavioral health services through LME-MCO

PROFILE

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

CHOICES

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

DELIVERY

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**
- 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

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.
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

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