
Managed Long Term Care: Options for New York and Examples From Other States

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Introduction and Overview

- **Potential goals and challenges**
- **Building blocks for Medicaid managed long term care (LTC) in New York**
 - Partial Capitation Managed LTC, Medicaid Advantage Plus, PACE
- **Options for combining Medicaid acute and LTC services for Medicaid-only beneficiaries**
 - Add Medicaid acute care services to Managed LTC
 - Add LTC services to mainstream Medicaid Managed Care
- **Options for including Medicare services for dual-eligible beneficiaries**
 - Medicare Advantage Special Needs Plans (SNPs), Medicaid Advantage Plus, PACE
- **Examples and lessons from other states**

Potential Goals

- **Improve coordination and cost-effectiveness of acute and LTC services for Medicaid-only beneficiaries**
 - Acute care services include physicians, hospitals, Rx drugs, clinics
 - LTC services include personal care assistance, home health, HCBS waivers, other community services, nursing facility services, services for people with developmental disabilities

- **Improve coordination and integration of Medicare and Medicaid acute and LTC services for dual eligible beneficiaries**
 - NYSDOH has a \$1 million contract with CMS to design a dual eligible demonstration program or programs to be implemented in 2012

Challenges for New York

- **Expanding coverage of Medicaid managed LTC plans beyond New York City area**
 - Adding management of Medicaid acute care benefits to managed LTC plans
- **Adding management of LTC benefits to acute care services in mainstream Medicaid Managed Care plans**
- **Coordinating and integrating care for dual eligibles**
 - **Enrollment growth obstacles**
 - Medicare enrollment in managed care cannot be mandatory
 - Initial assignment with easy opt-out may be feasible
 - **Financing obstacles**
 - Medicaid initiatives to reduce inpatient hospital and ER use save money for Medicare, but cost money for Medicaid
 - CMS is considering options for states to share in Medicare savings
 - **Administrative obstacles**
 - Conflicting Medicare and Medicaid rules and procedures
 - CMS is working on reducing these obstacles

Challenges for New York (Cont.)

- **Designing programs for dual eligibles**
 - **Major differences between duals age 65 and over and those under age 65**
 - One-third of duals in NY are under age 65
 - Under-65 duals are very diverse, with widely differing needs for physical and behavioral health care, social and community supports, and care coordination
 - Over-65 duals are similar to other Medicare enrollees in that age group, except that their incomes are lower
 - **Medicaid-only SSI population in mainstream Medicaid managed care plans has demographic characteristics and care needs that are similar to those of under-65 duals**
 - NY can build on that managed care experience
 - Adding management of LTC for this population is still a major challenge
 - **Coordinating physical and behavioral health services is critical for dual eligibles, especially those under age 65**
 - **Extensive consultation with stakeholders is essential for program success**

Examples From Other States

- **Medicaid managed long-term care**
 - AZ, CA, MA, MN, NM, TN, TX, WI

- **Mandatory enrollment of Medicaid SSI/disabled beneficiaries in capitated Medicaid managed care programs**
 - AZ, CA, MN, NM, TN, TX

- **FFS-based care management programs for SSI/disabled beneficiaries and/or dual eligibles**
 - NC, OK, VT

- **SNP-based programs for dual eligibles**
 - AZ, CA, MA, MN, NM, TX, WI

- **PACE programs for dual eligibles**
 - CA, MD, MA, NM, NC, OK, TN, TX, VA, WI

Lessons From Other States

- **Focus on high-cost, high-need Medicaid populations**
 - SSI/disabled, ABD, dual eligibles
 - **Better coordination of care has both clinical and cost benefits**
 - Neither will occur right away
 - Requires development of health plan staff, information systems, provider networks, performance and quality measurement
 - FFS beneficiaries often have accumulated unmet needs

- **Starting with Medicaid-only managed care may be easier**
 - Build health plan capacity, provider networks, stakeholder relationships, financing arrangements, track record
 - Enrollment can be mandatory for Medicaid services
 - Most financing and administrative requirements are within state control

- **Integrating Medicare services for dual eligibles is the gold standard, but challenges are substantial**
 - Build on existing state managed care experience and models
 - Work with and learn from other states

For Further Information

- **New Mathematica report for MedPAC summarizes dual eligible care coordination efforts in nine states (AZ, MD, MA, MN, NM, NC, OK, VT, and VA) and site visits to MA, NM, and NC**
 - Available at:
http://medpac.gov/documents/Jun11_ManagingDualEligibles_CONTRACTOR.pdf

- **MedPAC June 2011 Report to the Congress**
 - Chapter 5 discusses dual eligibles and state efforts to coordinate their care
 - Available at: http://medpac.gov/documents/Jun11_EntireReport.pdf

- **MedPAC June 2010 Report to the Congress also has an excellent chapter on duals, with data on their care needs and costs**

- **Mathematica report for NYS Health Foundation and NYSDOH will outline dual eligible options for New York and experiences and lessons from other states**
 - Due to the Foundation in August

Additional Background Information

Medicaid Per Capita Spending* in New York State, FFY 2009

Type of Service	New York State	U.S. Average	NY National Rank
All	\$2,511	\$1,176	1
All LTC	1,036	372	1
Nursing Facility	390	163	1
ICF-MR	159	42	1
Personal Care	139	38	1
Home Health	91	15	1
HCBS Waivers – DD	241	80	3
HCBS Waivers – A/D	2	27	48

•Per capita spending = Medicaid spending divided by total state population

SOURCE: Steve Eiken, et al. “Medicaid Long-Term Care Expenditures in FY 2009.”

August 17, 2010. Available at hcbs.org

Dual Eligible Enrollment in Medicaid Managed Care Plans in New York (6/30/2009)

- **Out of 643,000 total duals (full and partial) in New York, fewer than 5% were enrolled in Medicaid managed care**
 - **Medicaid Advantage – 5,291**
 - Largest enrollment
 - HIP, GHI, Liberty Health Advantage, Senior Whole Health, and Touchstone
 - **Medicaid Advantage Plus – 20,917**
 - Largest enrollment
 - VNS Choice, Guildnet , HomeFirst, Senior Health Partners, Independent Care Systems, and AMERIGROUP
 - **PACE – 2,626**
 - Largest enrollment
 - Comprehensive Care Management, PACE CNY, and Independent Living for Seniors

SOURCE: CMS. “2009 Medicaid Managed Care Enrollment Report: Summary Statistics as of June 30, 2009.”

Total Enrollment in Medicare Special Needs Plans (SNPs) in New York (6/2011)

- **Dual Eligible SNPs – 98,848**
 - Largest enrollment
 - HealthFirst, EmblemHealth, United/Evercare, WellCare, VNS, MetroPlus, Affinity, Fidelis, Health Plus

- **Chronic Condition SNPs – 395**
 - Largest enrollment
 - MetroPlus (HIV/AIDS)

- **Institutional SNPs – 7,876**
 - Largest enrollment
 - Evercare/United, Independent Health, ArchCare, Elderplan, Comprehensive Care Management

SOURCE: CMS. “Special Needs Plan Comprehensive Report.” June 2011

National Enrollment of Dual Eligibles in Medicaid and Medicare Managed Care Plans

- **Approximately 12 percent of duals were enrolled in comprehensive capitated *Medicaid* managed care plans in 2009**
 - **Largest numbers were in CA (196,000), TN (187,000), AZ (94,000), TX (86,000), MN (50,000), NM (31,000), and OR (31,000)**
 - Source: statehealthfacts.org, “Total Dual Eligible Enrollment in Medicaid Managed Care, as of June 30, 2009.” Includes only enrollees in HIO and MCO plans.

- **About 15 percent of full duals are enrolled in Medicare Advantage (MA) managed care plans, mostly in Special Needs Plans (SNPs)**
 - CMS has not published data on enrollment by full duals in MA plans, so this is a rough estimate

States with Integrated Medicare and Medicaid Managed Care Programs

- **AZ, CA, MA, MN, NM, NY, TX, WA, and WI**
 - **Services covered, extent of integration, and geographic areas covered vary substantially**
 - **Medicaid enrollment is voluntary except in AZ, CA, NM, and TX**
 - Medicare enrollment is always voluntary
 - **Most, but not all, have relied on SNPs to provide coverage**
 - PACE enrollment is concentrated in NY, CA, MA, PA, and CO (only states with more than 1,000 enrollees in 2009)
 - **See Center for Health Care Strategies (CHCS) “Dashboard” for details on program features**
 - http://www.chcs.org/usr_doc/ICP_State-by-State_Dashboard.pdf

Current National SNP Marketplace

- **SNPs in June 2011**
 - 298 dual eligible SNPs with 1,090,774 enrollees
 - 92 chronic condition SNPs with 178,136 enrollees
 - 65 institutional SNPs with 79,172 enrollees
 - 455 total SNPs and 1,348,082 total enrollees

- **80 percent of enrollment was concentrated in 10 states and Puerto Rico in May 2011**
 - PR, CA, FL, NY, PA, TX, AZ, GA/SC, MN, and TN
 - 70 percent of enrollment was in 13 companies
 - Largest enrollment outside of PR was in United, Care Improvement Plus, HealthSpring, Kaiser, Humana, SCAN, and Healthfirst

- **55 percent of SNPs had fewer than 500 enrollees in May 2011**

SOURCE: SNP Comprehensive Reports on CMS web site at:
<http://www.cms.gov/MCRAdvPartDENrolData/SNP/list.asp#TopOfPage>

Current National SNP Marketplace (Cont.)

- **SNP trends**
 - **Total SNP plans and enrollees**
 - 2007: 477 plans, 1.1 million enrollees
 - 2008: 762 plans, 1.3 million enrollees
 - 2009: 699 plans, 1.4 million enrollees
 - 2010: 562 plans, 1.3 million enrollees
 - 2011: 455 plans, 1.3 million enrollees
 - **Plans are consolidating and enrollment growth is flattening**

- **SNPs are paid in the same way as other Medicare Advantage plans, but have more care management and performance reporting requirements**
 - For details, see: <https://www.cms.gov/SpecialNeedsPlans/>
 - MA reimbursement is scheduled to be reduced starting in 2012

- **Total SNP enrollment (1.3 million) is 11 percent of total MA enrollment of 12.2 million**
 - MA covers 25 percent of 48 million Medicare enrollees

Impact of Health Care Reform on SNPs

- **SNP authority extended through 2013**
 - P.L. 111-148, Section 3205
- **Dual eligible SNPs must have a contract with states by January 1, 2013 “to provide [Medicaid] benefits, or arrange for benefits to be provided” (MIPPA 2008, Sec. 164)**
 - May include long-term care services
 - But states are not required to contract with SNPs
- **Dual SNPs that are fully integrated, including capitated contracts for Medicaid LTC and other services, are eligible for a special “frailty adjustment” to their rates, beginning in 2011 (similar to PACE frailty adjustment)**
 - CMS is also required to consider additional payment adjustments in 2011 for chronic condition SNPs and others serving high-risk beneficiaries

Impact of Health Care Reform on SNPs (Cont.)

- **Federal Coordinated Health Care Office established in CMS to improve coordination of care for dual eligibles**
 - P.L. 114, Section 2602
 - Goals are to more effectively integrate Medicare and Medicaid benefits for duals and improve coordination between the federal government and states
 - Specific responsibilities include “Supporting state efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program”

- **Center for Medicare and Medicaid Innovation (Sec. 3021)**
 - Models to be tested include “Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals”
 - May be option for states with no or low managed care penetration

Impact of Health Care Reform on Coordinated Care Options for Duals

- **The Federal Coordinated Health Care Office (renamed the Medicare-Medicaid Coordination Office) and the Center for Medicare and Medicaid Innovation are partnering to help states develop integrated care programs for dual eligibles**
- **CMS selected 15 states on April 14, 2011 to receive contracts of up to \$1 million each to help them plan dual eligible demonstration projects**
 - **States selected were CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, and WI**
 - **Planning contracts will be for 18 months, and demonstrations will start in 2012**
- **SNPs are one option for coordinating care for duals; states will be considering others**

Dual Eligible Demo States Considering SNPs

- **Based on a review of January 2011 proposals from 15 states selected in April 2011 to receive contracts**
 - State plans may have become more focused since January
- **States currently contracting with SNPs for Medicaid services**
 - CA, CO, MA, MN, NY, OR, TN, WA, WI
- **States considering contracting with SNPs for dual eligible demonstration**
 - CA, MA, MN, NY, OR, TN, WA, WI
- **State is requesting to receive Medicare payments for duals directly from CMS**
 - MA, MI, OK, OR, TN, WI, VT

Massachusetts Experience With SNPs

- **Senior Care Options (SCO) program has provided integrated care for duals age 65 and over since 2004**
 - **Started as a CMS demo; participating health plans became SNPs in 2006**
 - Four SNPs (Commonwealth Care Alliance, Senior Whole Health, Evercare, and NaviCare [Fallon])
 - **SCO plans cover all Medicare and Medicaid services, including LTC**
 - **Both Medicaid and Medicare enrollment is voluntary, but SCO enrollees must get both Medicaid and Medicare services from the SCO plan**
 - 11 percent of 130,000 over-65 full duals in MA are enrolled in SCO plans
 - **Despite years of experience and positive results, enrollment remains low and coordination between Medicaid and Medicare remains difficult**

- **State is considering both SNPs and other options for under-65 disabled dual population**

New Mexico Experience With SNPs

- **New Mexico Coordination of Long-Term Services (CoLTS) program for dual eligibles is primarily a Medicaid managed long-term care program**
 - **Medicaid enrollment in CoLTS is mandatory for duals and for most Medicaid-only beneficiaries needing LTC services**
 - **Two SNPs (AMERIGROUP and Evercare) covered 38,000 CoLTS enrollees (including almost all full duals in NM) for Medicaid LTC services (as of mid-2010)**
 - But only 1,600 duals also receive their Medicare benefits from these SNPs
 - Others receive Medicare from other Medicare Advantage plans or fee-for-service
 - **Program planning began in late 2004, with implementation starting in August 2008**
 - A major goal was to control and coordinate Medicaid personal care option services, where costs were growing rapidly
 - Medicare-Medicaid integration has been limited because major MA plans in NM chose not to participate in CoLTS

Managed Long-Term Care Opportunities

- **More than half of all nursing facility residents are dual eligibles**
 - 77% of Medicaid spending on duals is for LTC
 - 51% institutional; 26% community
- **Care is highly fragmented and poorly coordinated**
 - Medicare pays for short-term post-hospital SNF stays, Rx drugs, and physician services
 - Medicaid pays for long-term NF care and alternative home- and community-based services (HCBS)
 - Medicaid has little or no information on Medicare-provided services
- **Incentives and resources for coordinated and cost-effective LTC for duals are not well aligned**
 - Costs of avoidable hospitalizations for dual eligibles fall on Medicare, so Medicaid has few incentives to invest in programs to reduce hospitalizations
 - Nursing facilities benefit financially if dual eligible Medicaid residents are hospitalized and return after three days at higher Medicare SNF rate
 - Medicaid has lost access to Rx drug information needed to manage and coordinate care, and is generally not informed about hospitalizations

Managed LTC Opportunities (Cont.)

- **Dual eligible and institutional SNPs that cover Medicaid long-term services and supports could:**
 - **Benefit financially from reduced Medicare-paid hospitalizations**
 - **Use part of those savings to fund improved care in nursing facilities and in the community that could further reduce avoidable hospitalizations**
 - **Manage Rx drugs in LTC settings more effectively and use information on Rx drug use to improve care management**
 - **Increase availability of community-based Medicaid services and reduce unnecessary use of Medicaid nursing facility services, if Medicaid capitated rates provided appropriate incentives for community care**
 - **Provide “one-stop shopping” for all Medicare and Medicaid acute and long-term care services for dual eligibles**

Managed LTC Challenges

- **Few SNPs and states have experience with managed LTC**
- **Medicaid LTC providers (nursing facilities and HCBS providers) generally oppose managed care**
- **Organized dual eligible beneficiaries may also be opposed**
 - **The most organized and vocal beneficiaries may be managing their own care more effectively than SNPs could manage it for them**
 - Not necessarily representative of all dual eligible beneficiaries
- **Return on investment for states is long-term and hard to measure and explain**
- **Institutional SNPs face special challenges**
 - **Hard to build enrollment (nursing facilities must agree to contract with SNP, and then residents must choose the SNP)**
 - **Enrollment is low and declining; heavily concentrated in Evercare SNPs**
- **For more details, see March 2010 Mathematica policy brief**
 - **James M. Verdier, “Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement.” Available at: http://mathematica-mpr.com/publications/PDFs/health/nursing_facility_dualeligibles.pdf**