Managed Long Term Care: Current and Emerging Options for Dual Eligibles

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Introduction and Overview

- Background on long-term supports and services (LTSS) in Medicaid
  - Types of services, costs, and populations served
  - Medicare-Medicaid dual eligibles are heaviest users

- Options for containing costs and improving care
  - Shift service use from institutions to the community
  - Improve cost-effectiveness of institutional and community care
  - Improve performance and quality measurement in both settings

- Tools available to achieve these goals
  - In the fee-for-service (FFS) system
    - HCBS waivers, Money Follows the Person, new PPACA options, reimbursement reform, pay for performance (P4P)
  - Using managed care
    - Medicaid-only managed long-term care programs
    - Integrated Medicare-Medicaid programs

- Presentation today focuses on managed care and dual eligibles
Background on LTSS in Medicaid

- LTSS in Medicaid includes nursing facility and other institutional services, home health, hospice, home- and community based services (HCBS) waivers, and other community-based services.

- Medicaid paid for 43 percent of all long-term care services in 2009.
  - Medicare paid for 24 percent, and private sources paid for most of the rest.

- LTSS accounted for 33 percent of total Medicaid spending in FY 2009.
  - Nursing facilities, home health, and personal care accounted for 85 percent of Medicaid long-term care spending, and ICFs/MR and mental health facilities accounted for the rest.

Sources: Kaiser Commission on Medicaid and the Uninsured, “Medicaid and Long-Term Care Services and Supports,” March 2011; statehealthfacts.org.
Background on Dual Eligibles

- Nine million dual eligibles in 2006-2007 accounted for 39% of Medicaid and 36% of Medicare expenditures
  - Enrollment shares were 15% (Medicaid) and 21% (Medicare)
  - About 77 percent are “full duals” receiving full benefits from both programs
    - Medicaid pays only Medicare premiums and cost sharing for “partial duals”
  - About 60 percent are over age 65, and about 40 percent are under 65 and disabled or chronically ill
    - High levels of physical and cognitive impairments
    - High nursing facility use, especially among over-65 duals
    - Substantial behavioral health problems, low levels of education, and limited family and community ties, especially among under-65 duals

- For more details on duals, see Ch. 5 in MedPAC June 2010 Report to the Congress
  - “Coordinating the care of dual-eligible beneficiaries”
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
  - See also sources cited in “References” slide at the end for more state-by-state and background information
States with Programs in Development

- CO, MD, MI, PA, TN, and VA have considered using SNPs and related managed care approaches to integrate care for duals, but have no firm plans at this point (see CHCS “Dashboard” for additional details)

- NC is implementing an integrated care program for duals that will be operated by local provider networks
  - Builds on long-standing Medicaid enhanced primary care case management program (Community Care of North Carolina)

- VT has been working on a program in which the state would function as the managed care entity and receive Medicare funding
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
Current SNP Marketplace

- **SNPs in March 2011**
  - 298 dual eligible SNPs with 1,058,386 enrollees
  - 92 chronic condition SNPs with 165,141 enrollees
  - 65 institutional SNPs with 80,426 enrollees
  - 455 total SNPs and 1,303,953 total enrollees

- **Nearly 80 percent of enrollment was concentrated in 10 states and Puerto Rico in 2010**
  - PR, CA, FL, NY, TX, PA, AZ, GA/SC, MN, and AL
  - Over 70 percent of enrollment was in 13 companies

- **Over 90 percent of SNPs had fewer than 500 enrollees in 2010**

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 12 percent of total MA enrollment of 11.1 million
- MA covers 24 percent of 47 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. 148, 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 SNPs (Cont.)

- Federal Coordinated Health Care Office ("Duals Office") and the Center for Medicare and Medicaid Innovation ("Innovation Center") are partnering to help states develop integrated care programs for dual eligibles.

- CMS will award contracts of up to $1 million each to up to 15 states in April 2011 to help them plan dual eligible demonstration projects:
  - Planning contracts will be for 18 months, and demonstrations will start in 2012.
  - Check this link in April to see which states are awarded contracts: [http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/](http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/)

- SNPs are one option for integrated care for duals; states will be considering others.
Contracting With SNPs – Considerations for States

- States that want to improve integration of care for duals should consider dual eligible SNPs if:
  - SNPs or parent companies have experience with Medicaid and/or an established presence in the state (Medicaid managed care or Medicare Advantage)
  - SNPs are prepared to take into account special needs and characteristics of the Medicaid program in that specific state
  - SNPs have experience or strong interest in managing Medicaid long-term care supports and services
    - States now cover few acute care services for duals in Medicaid (vision, dental, transportation, very limited Rx drugs, and Medicare premiums and cost sharing)
    - As a result, states have little incentive to contract with SNPs just to cover Medicaid acute care services
  - States have staff and other resources needed to negotiate contracts with SNPs and conduct procurements if necessary
    - States will have a few other things on their plates in the next few years
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 on coordinating care for dual eligibles in nursing facilities listed in “References” slide
Conclusions

- Dual eligibles in general have greater care needs and less ability to navigate the health care system than other Medicare and Medicaid beneficiaries
  - The “system” they must navigate is highly complex and poorly coordinated

- Capitated managed care plans that include all Medicare and Medicaid benefits for dual eligibles can improve their care and reduce overall expenditures

- Substantial obstacles to expansion of managed care for duals currently exist
  - Most legal and regulatory obstacles are on the Medicare side, but there are political obstacles on the Medicaid side in many states
  - Voluntary enrollment in Medicare managed care limits enrollment
  - Inability to share in Medicare savings limits state interest

- The new federal Duals Office is actively working to help reduce these obstacles
References