

Managed Long Term Care: Coordinated Care for a Vulnerable Population



March 8, 2013
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MLTC and its implications

- Introduction to MLTC
- Evolution of MLTC
- Implications for services to persons with developmental disabilities



Recession and Human Services

Many states are cutting reimbursement rates as a result of the recession and diminished federal support

- ↓ Tax Revenue and ↑ Medicaid enrollment leads to increased budget pressure
- Medicaid is the 1st or 2nd largest item in every state budget
- Because of Maintenance of Effort requirements in ACA, states cannot cut eligibility
- Thirty-three states froze or reduced Medicaid payments to providers
- Michigan cut provider rates by 8 percent in 2010
- California attempted to cut most provider rates in the state's Medicaid program, by 10 percent

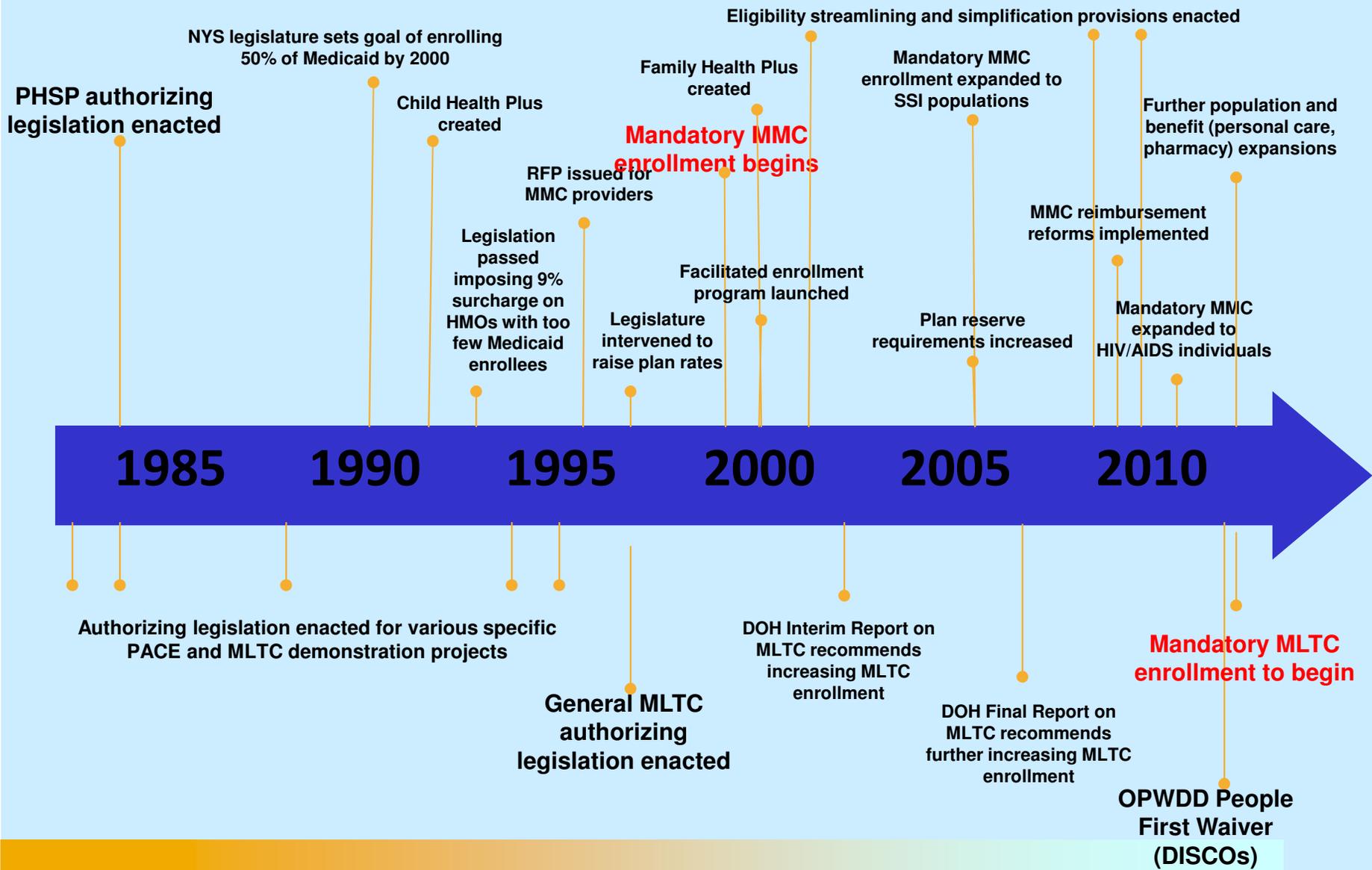
Another popular answer:

EXPAND MANAGED CARE

Managed Care/Care Coordination is Not New in New York Medicaid

- Medicaid experimentation in late 70s/early 80s
- “Ethical” cost containment
- Medicaid managed care baby steps
- The early managed long term care pioneers

The NYS Timeline of Care Coordination



Mandatory Medicaid Managed Care

- Managed care has been the backbone of NYS public health insurance coverage for over a quarter of a century
- **Nearly 4.2 million** of NYS public insurance enrollees are covered through mainframe managed care organizations¹
- Family Health Plus and Child Health Plus benefits are solely delivered through managed care plans
- The managed care model as the State's primary public coverage vehicle has had bi-partisan support through five administrations

¹ As of February 1, 2013, 3,437,000 in Medicaid Managed Care; 435,000 in FHP; 323,000 in Child Health Plus.

Mandatory Managed Long Term Care

- When fully implemented, all Medicaid beneficiaries (1) **age 21 and older who (2) require community-based long term care services for longer than 120 days** must be enrolled in MLTC, PACE, MAP or another Care Coordination Model
- Mandatory enrollment began during the Summer of 2012 in New York City and is now expanding to suburban counties
- Proposed timeline for this process is three years
- Voluntary enrollment mushroomed from 32,602 to over 50,000 enrolled, even before mandatory enrollment commenced
- **Now enrollment exceeds 82,000**

MLTC 101



- MLTC vs. PACE Plans
- Provider-sponsored vs. commercial plans
- Moving to Medicare integration
- Key is benefit package
- And importance of care coordination

MLTC 101



Limited benefit package:

- Home Care, including Personal Care, CHHA, private duty nursing, CDPAP
- Adult Day Health Care (medical model and social adult day care)
- Personal Emergency Response System (PERS),
- Nutrition -- Home-delivered meals or congregate meals
- Home modifications
- Medical equipment (wheelchairs, medical supplies, prostheses, orthotics)
- Physical, speech, and occupational therapy outside the home
- Hearing Aids and Eyeglasses
- Podiatry, Audiology (hearing aids), Dental, and Optometry (eyeglasses)
- Non-emergency medical transportation to doctor offices, clinics
- Nursing home care

MLTC 101



What's not covered:

- Primary and specialized physician services;
- Hospital inpatient and outpatient care, outpatient clinics, emergency room care, mental health care
- Lab and radiology tests
- Prescription drugs
- Assisted living program

MLTC 101



Who is eligible:

- have a chronic illness or disability;
- are able to stay safely at home at the time you join the plan;
- are expected to need long-term care services for at least 120 days from the date you enroll;
- meet the age requirement of the plan (the age requirement for a PACE organization is 55 years old; for most other plans, the age requirement is 65 years old, some serve younger people with disabilities);
- live in the area served by the plan;
- have or are willing to change to a doctor who is willing to work with the plan; and
- have a way of paying that is accepted by the plan. All plans accept Medicaid. Some plans also accept Medicare and private pay.

MLTC 101



DOH report: ***“overall survey findings were very favorable”***

- 90 percent of enrollees’ overall functional ability had either stabilized or was improved after enrollment in the MLTC plan
- 87 percent of enrollees were stable or showed improvement in the ability to manage their own oral medication
- Only two percent were admitted to a nursing home (and two-thirds of those enrollees were discharged after that stay) and only eight percent to hospitals
- 72 percent had received their flu vaccine in the past year
- 85 percent rated their plan as good or excellent
- 91 percent would recommend their MLTC plan to others
- MLTC is the only long term care program in New York State that actually reduced per recipient expenditures over the last six years

New York State: Medicaid Redesign Team (MRT)

- Global Spending Cap
- Initiation of Health Homes
- Patient-Centered Medical Homes
- Expand electronic health records/HIT
- MRT Waiver Amendment
- Care Coordination Imperative: End of fee-for-service and managed care for all

Impact and Implications of MLTC/Coordinated Care Initiatives

- Regarded as most controversial and challenging proposal in 2011
- Even bitter opponents appear to have accepted as of 2013
- Implementation:
 - Continuity of care requirements
 - Contracting requirements
 - Premium pressure
 - Referral and Enrollment Issues
 - Ombudsman proposed
 - Quality pool

FIDA

Fully-Integrated Dual Advantage:

- Capitated managed care program that provides comprehensive array of Medicare, Medicaid, and supplemental services – including:
 - All physical healthcare
 - All services currently available through Medicaid Advantage Plus (MAP) program
 - Additional services currently only available through HCBS Waivers
 - Additional supplemental services not currently required in NYSDOH managed care plans
 - All behavioral healthcare
 - All Dual Eligibles in NYC plus Nassau, Suffolk, Westchester, commencing January, 2014

Latest budget developments

- \$1.1 billion “federal revenue problem”
- Significant cuts/deferrals
- Other response: escalate care coordination
 - Increase MLTC enrollment from 2000 to 4000 per month
 - Book savings from behavioral health initiatives
 - Realize savings from FIDA implementation
 - Restructuring OPWDD service system
- Decrease premiums through \$25 million “efficiency adjustment”



Implications for OPWDD Providers

What works in managed care world?

- Bigger is probably better
- Multiple services are better
- Care coordination is name of the game
- Reputation counts
- Quality matters
- Importance of strong advocacy

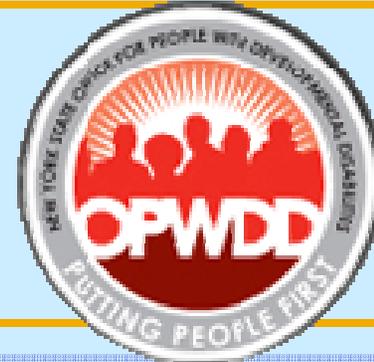


Transition to new system is challenging but achievable



Over the past 30 years, a broad array of providers have successfully made the difficult shift into a managed care environment, as each category has, in succession, been required to make that transition.

Good luck.



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