Managed Long Term Care: Coordinated Care for a Vulnerable Population

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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

1985
- PHSP authorizing legislation enacted
- NYS legislature sets goal of enrolling 50% of Medicaid by 2000
- Child Health Plus created
- RFP issued for MMC providers
- Legislation passed imposing 9% surcharge on HMOs with too few Medicaid enrollees
- Eligibility streamlining and simplification provisions enacted
- Family Health Plus created
- Facilitated enrollment program launched

1990
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- Mandatory MMC enrollment begins
- Plan reserve requirements increased
- Legislature intervened to raise plan rates
- Mandatory MMC enrollment expanded to SSI populations
- MMC reimbursement reforms implemented
- Further population and benefit (personal care, pharmacy) expansions

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2000
- DOH Interim Report on MLTC recommends increasing MLTC enrollment
- DOH Final Report on MLTC recommends further increasing MLTC enrollment
- Mandatory MMC expanded to HIV/AIDS individuals
- Mandatory MLTC enrollment to begin

2005
- Mandatory MMC expanded to HIV/AIDS individuals
- DOH Final Report on MLTC recommends further increasing MLTC enrollment

2010
- OPWDD People First Waiver (DISCOs)

Federal Children's Health Insurance Program, modeled after NYS CHPlus
- General MLTC authorizing legislation enacted
- General MLTC authorizing legislation enacted for various specific PACE and MLTC demonstration projects

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OPWDD People First Waiver (DISCOs)
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 organizations.¹

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
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.