Relationships with Medicaid Managed Care: Bane or Opportunity?

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Welcome & Introductions

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Overview

• National Overview of Medicaid Managed Care
  o Recent Federal Changes
  o National Trends
  o Opportunities for Providers

• State Focus: Virginia
  o Commonwealth Coordinated Care Plus
  o Specific Provisions for Long-Term Care Providers

• Questions and Discussion
National Overview
Factors and Trends Influencing the Medicaid Managed Care Landscape

Nancy Archibald
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About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans
Managed Care Models with a Medicaid Component

Medicare Benefits

- Original Medicare
- Medicare Advantage
  - MA-PDs
  - SNPs

Medicaid Benefits

- MMPs
- FIDE SNPs
- PACE
- FFS

Managed Acute Care
- MLTSS
- BH Managed Care

Note: Shaded boxes represent models that integrate all or some Medicare and Medicaid benefits for dually eligible beneficiaries.

Key: BH = Behavioral Health; C-SNPs = Chronic Conditions Special Needs Plans; D-SNPs = Dual Eligible Special Needs Plans; FFS = Fee-for-service; FIDE SNPs = Fully Integrated Dual Eligible Special Needs Plans; I-SNPs = Institutional Special Needs Plans; MA-PDs = Medicare Advantage Prescription Drug Plans; MLTSS = Managed Long-Term Services and Supports; MMPs = Medicare-Medicaid Plans; PACE = Program of All-Inclusive Care for the Elderly
Factor: New D-SNP Integration Standards

- For CY2021, all Dual Eligible Special Needs Plans (D-SNPs) must either:
  - Contract with states to cover Medicaid behavioral health services and/or LTSS
  - Notify state and/or its designee(s) of Medicare hospital and **skilled nursing facility (SNF) admissions** for group of high-risk enrollees to improve coordination during transitions of care
- States determine the mechanism for information-sharing
- HIEs will likely play a large role over time

**Implications:** D-SNPs will require contracted SNFs to report timely admissions data, and states may require SNFs to join and report admissions data via HIEs.

**What to Watch:** D-SNPs must submit their CY2021 contracts with states to CMS by early July 2020. Contracts must specify the process by which D-SNPs will share information on members’ hospital and SNF admissions.

Trend: Continued Interest in Medicaid MLTSS Programs

- New D-SNP integration standards and new state demonstration opportunities to integrate Medicare and Medicaid may spur renewed state interest in MLTSS
- Who’s included (populations) and what’s included (nursing facility care and/or HCBS) vary by state
- 23 states
- 1.8M people enrolled in MLTSS programs

**Implications:** MLTSS programs likely to develop in new states and cover more populations.

**What to Watch:** Stakeholder engagement activities and corresponding opportunity to influence program design; state contracting with Medicaid plans and/or D-SNPs that are aligned; and expansion of MLTSS in some states to new areas (e.g., IL, CA).
States with Medicaid MLTSS Programs

MLTSS for some or all populations
Trend: I-SNP Growth

- Rapid rise in I-SNPs
  - December 2015: 57 plans
  - December 2019: 125 plans
- Growth led by nursing facility/senior housing providers
- Move from RUG-IV to PDPM may accelerate I-SNP growth
- States with integrated care programs are concerned that I-SNPs could affect enrollment

Implications: States are interested in exploring new ways to integrate Medicaid benefits through I-SNPs, particularly HCBS for individuals transitioning out of nursing facilities.

What to Watch: State uptake of new opportunities to create demonstrations under the Financial Alignment Initiative or their own state-specific demonstration models.
Opportunities for Providers

- Emphasis on care coordination and team-based care builds capacity for participation in integrated models of care
- More robust IT systems and data reporting and monitoring support participation in value-based payment arrangements
- Increased experience with managed care systems and processes prepares providers to take on risk-based contracting
Virginia
COMMONWEALTH COORDINATED CARE PLUS

- Virginia’s Financial Alignment Demonstration (CCC) served 30,000 dually eligible adults
- Began March 2014; ended December 2017
- Voluntary participation program with limited geographic implementation
- No required ratios for Care Coordinators

- CCC produced great results and offered valuable experience and lessons learned
- CCC Plus was designed to build upon the successes
- CCC Plus established ratios for Care Coordinators
- CCC Plus established mandatory enrollment providing greater program stability and mitigating coverage gaps

- CCC Plus extends the benefits of care coordination, serves over 243,000 individuals statewide through required participation
- With Medicaid Expansion, CCC Plus includes former Governor’s Access Program (GAP) members with serious mental illness and medically complex individuals

CCC Plus builds on the success of CCC and expands care coordination strategies statewide
CCC PLUS PROGRAM DESIGN

High-quality care in the least restrictive and most integrated treatment setting, through a fully-integrated delivery system, with care coordination, person-centered care and an interdisciplinary team approach.

Primary goal is to improve health outcomes
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<th>DD</th>
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CONTRACTING

• For initial contract and each subsequent amendment, sought input and comments from the Virginia Health Care Association
  o Definitions
  o Patient Pay
  o Medicaid

• 14-day, clean claim timely processing

• Hospice room and board paid at 100% directly to Nursing Centers
INITIAL ASSIGNMENT

• DMAS deployed an intelligent assignment process when determining how to initially assign members to one of the six Health Plans

• Existing Nursing Center placement and in-network status are criteria for Health Plan initial assignment

• Members currently living in a Nursing Center will not be moved. If the Nursing Center chooses not to participate with the health plan, they will be paid out of network
• Work group began prior to CCC Plus implementation to determine streamlined processes across Health Plans to create a “Doing Business With Health Plans” for Nursing Centers

• Notification vs authorization (Friday afternoon admissions) and timeframes

• Forms and processes for new members vs member transitions from hospitals
• In close collaboration with VHCA, the State, Health Plans and Nursing Center providers convened reoccurring meetings to test claims prior to implementation

• On-going meetings and conference calls have continued to identify, discuss and resolve issues
  o Accuracy and timeliness of custodial claims
  o Accuracy of crossover claims
  o Bad debt documentation
CARE COORDINATION

• Communication
  o Health Plans assign one Care Coordinator per facility when feasible
  o Nursing Centers notify health plans regarding admissions, discharges and changes in level of care

• Collaboration
  o Nursing Centers share the Care Plan Meeting schedule with the assigned Care Coordinators
  o Nursing Centers notify Health Plans regarding critical incidents and significant changes in health care status

• Problem Solving
  o DMAS conducts site visits and mediates between Nursing Centers and Health Plans when necessary
BEST PRACTICES

• Collaboration with Association and Nursing Center Providers
• Mechanisms for open communications between the State, Health Plans and Nursing Centers
• Dedicated state staff to address claims processing issues through technical assistance
• Strong compliance program that allows for appropriate escalation of issues with corresponding penalties, e.g. restricting new enrollments
Additional Questions?
Potential Opportunities for Providers
Working with States and Managed Care

• Areas of Influence
  o Program Design
  o Contract Provisions
  o Implementation Process

• Payment Models
  o Institutional Special Needs Plans (I-SNPs)
  o Alternative Payment Methodologies
    ▪ Share in savings for avoided hospitalizations
    ▪ Share in savings for a period of time if residents transition back to the community
Thank you!

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