

MEDICAID AND MMA ADMINISTRATIVE CHALLENGES: SPECIAL NEEDS PLANS

**James M. Verdier
Mathematica Policy Research, Inc.**

**The Second National Medicare
Prescription Drug Congress
Washington, DC
November 2, 2005**

MATHEMATICA
Policy Research, Inc.

Introduction and Overview

- **Special Needs Plans (SNPs) represent a major opportunity to better integrate Medicare and Medicaid acute and long-term care for dual eligibles**
- **Dual eligible characteristics**
- **Medicaid Rx drug use by dual eligibles and nursing facility residents**
- **Administrative and implementation challenges for SNPs, states, and CMS**
- **Medicare takeover of Medicaid Rx drug coverage for duals may further impede coordination of care unless Medicare and Medicaid MCOs and states can partner**
 - **SNPs need support from states and CMS**

MMA Opportunities and Risks

- Medicare Part D takes over responsibility for Rx drugs for dual eligibles on January 1, 2006
 - Medicaid will no longer provide Rx coverage for duals (with very limited exceptions)
- Huge beneficiary outreach and education challenge for CMS, SSA, advocates, states, health plans, and others
- Duals will be auto-enrolled in stand-alone prescription drug plans (PDPs) in October-December 2005, unless they are enrolled in or choose an MA-PD plan or SNP
 - Duals will constitute a very large portion of initial enrollment in PDPs, especially those with low premiums

MMA Opportunities and Risks *(Cont.)*

- PDPs have no responsibility to coordinate or manage non-Rx care for duals, or provide Rx data to those who do
 - A major potential challenge for Medicaid MCOs, disease management (DM) programs, and nursing facilities that serve duals
 - ◆ Dual eligible enrollment in Medicaid managed care and DM programs is currently quite limited

MMA Opportunities and Risks *(Cont.)*

- **Risks for MCOs and PDPs in serving dual eligibles**
 - Dual eligible Rx drug costs are very high, especially for under-65 disabled duals
 - CMS risk adjustment may not adequately account for Rx drug cost variation (limited historical data)
 - ◆ May be a bigger problem for PDPs than MA-PDs, since PDPs can't offset Rx losses with savings from other services
 - CMS risk sharing and risk corridors will prevent major PDP and MA-PD losses (and gains) in 2006 and 2007

MA Special Needs Plans

- MA SNPs can specialize in serving nursing facility residents, dual eligibles, and others with severe or disabling chronic conditions (SSA, Sec. 1859(b)(6))
 - Can contract with Medicaid to cover Medicaid services for duals (42 CFR sec. 422.106)
 - Opportunity to coordinate/integrate all Medicare and Medicaid services
- Authority for MA plans to restrict enrollment to those with special needs expires on 1/1/2009 (SSA Sec. 1859(f))
- DHHS report to Congress assessing impact of SNPs on cost, quality of services, and savings to Medicare due by 12/31/2007 (MMA Sec. 231(e))

Risk Adjustment for SNPs

- Risk adjustment for SNPs will be the same as for other Part D plans
 - 75% risk adjustment in 2006, 100% in 2007
- Payments for Rx drugs and other services will be adjusted for health status - higher payments for those with costly health conditions
- CMS Rx risk adjustment formula will also pay additional amounts for:
 - Dual eligibles: 8% more
 - Long-term institutionalized aged: 8% more
 - Long-term institutionalized disabled: 21% more
- Possibility of a “frailty adjuster” in 2006 or 2007

SOURCE: <http://www.cms.hhs.gov/pdps/PmntNtcNRskAdjMdl.asp>

Characteristics of Dual Eligibles

- Over 6 million “full” dual eligibles
 - 15-20% of both Medicare and Medicaid enrollees
- Over one-third are under age 65 and disabled
- Over 20 percent say their health is poor
- One-third have 3+ ADL limits
- Over half live alone (31%) or in a nursing facility (23%)
- 62% have incomes below poverty
- 62% never graduated from high school

SOURCE: MedPAC Report to the Congress, June 2004, p. 76

Dual Eligible Rx Drug Use

- Medicaid reimbursement for Rx drugs for dual eligibles in 1999 accounted for over half of total Medicaid Rx drug costs
- Average annual Medicaid Rx reimbursement in 1999
 - All duals: \$1629
 - Under-65 disabled duals: \$2,143
 - Non-disabled adults: \$182
 - Children: \$83
- 12% of under-65 duals had annual Medicaid Rx reimbursement of over \$5,000 in 1999
 - Less than 4% of 65+ duals had costs this high

SOURCES: CMS-MPR data at:

http://www.cms.hhs.gov/researchers/projects/Medicaid_rx/
MPR Issue Brief, "Medicaid Drug Use Data Show High Costs and Wide Variation for Dual Eligibles," August 2005

Dual Eligible Rx Drug Use in Nursing Facilities

- Annual Medicaid Rx reimbursement for all-year dual eligible nursing facility (NF) residents in 1999
 - All \$2,172
 - 0-64 3,360
 - 65-74 2,796
 - 75-84 2,292
 - 85+ 1,752
- Dual eligibles in NFs (all-year and part-year) accounted for 14 percent of total Medicaid Rx reimbursement in 1999

SOURCE: CMS-MPR data at:
http://www.cms.hhs.gov/researchers/projects/Medicaid_rx/

Administrative and Implementation Challenges

- **Serving NF and long-term (LT) care beneficiaries**
 - **Rx drugs in NFs are provided by specialized institutional pharmacies**
 - ◆ **Usually one per NF**
 - ◆ **How will NFs and pharmacies coordinate with multiple Part D plans?**
 - **Medicaid in the past has done relatively little to scrutinize Rx drug use in NFs**
 - ◆ **Medicaid pays separately for NF drugs; not in NF per diem rate as in Medicare**
 - ◆ **NF consulting pharmacists who review drug use are usually employed by institutional pharmacies**
 - **Major opportunities for institutional SNPs to improve Rx drug use and overall NF and LT care**
 - ◆ **But must partner with states, who fund most NF and LT care**

Administrative and Implementation Challenges (Cont.)

- **Conflicting Medicare and Medicaid managed care rules**
 - Rate setting and financing
 - Marketing and enrollment
 - Complaints, grievances, and appeals
 - Monitoring and reporting
- **SNPs that contract with states to provide Medicaid services must maintain dual administrative structures unless current regulatory and statutory requirements are modified**
 - S. 1602 (Grassley, Bayh, and Clinton) would require CMS to work on removing barriers to integration (Title III)
 - See New York State Medicaid Advantage model contract for illustration of awkward work-arounds

State Interest in Integrated Care and SNPs

- **Center for Health Care Strategies (CHCS) Integrated Care Program**
 - Goal is to integrate financing, delivery, and administration of primary, acute, and long-term care, and social and behavioral health services for dual eligibles and other Medicaid beneficiaries
- **CHCS will provide Innovation Awards to states of up to \$100,000, technical assistance and training, support for contracting with SNPs, evaluation support, and dissemination of best practices**
- **Up to five states will be chosen, with winners announced in December**
 - Check www.chcs.org for details

Conclusion

- **MA SNPs provide a major opportunity for Medicare and Medicaid MCOs and states to partner, with support from CMS**
 - **Potential to substantially improve care for duals and other Medicare and Medicaid beneficiaries**
- **MMA and Part D experience may lead to further rethinking about how to better structure and coordinate care for dual eligibles and others**
 - **Including LT care and home- and community-based services**
- **Differing Medicare and Medicaid managed care administrative requirements are an unnecessary obstacle**