PRIMARY CARE CASE MANAGEMENT FOR DUAL ELIGIBLES

SESSION LAW 2014-100, SECTION 12H.20

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

March 1, 2015

BACKGROUND

Session Law 2014-100, Section 12H.20 directs the Department of Health and Human Services, Division of Medical Assistance to:

> *"…draft one or more waivers that would expand primary care case management and that are designed to accomplish the following:*
> *(1) Medicare and Medicaid dual eligibles shall be required to enroll in primary care case management to the maximum extent allowed by the Centers for Medicare and Medicaid Services (CMS).*
> *(2) Primary care case management shall be provided for enrolled dual eligibles.*
> *(3) Primary care case management for dual eligibles with a primary diagnosis of mental illness or intellectual or developmental disability may be administered by the LME/MCOs.*
>
> *The Department may submit drafts of the waivers to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waivers for CMS approval until authorized by the General Assembly.*

The legislation also directs the Department to submit a report by March 1, 2015 to the House and Senate Health and Human Services Appropriations committees that includes the following:

(1) The anticipated increase in number of dual eligibles that will enroll in primary care case management.
(2) The costs associated with serving the increased number of enrolled dual eligibles.
(3) The anticipated savings to the Medicaid program.
(4) A detailed fiscal analysis supporting any calculation of anticipated savings.

PRIMARY CARE CASE MANAGEMENT

As defined by the federal Social Security Act, Primary Care Case Management (PCCM) is a Medicaid health delivery system considered managed care by the Centers for Medicare and Medicaid Services.[1] Although payment for services is billed on a fee-for-service basis, states contract with primary care case managers – physicians, physician group practices or entities, or at state-option, nurse practitioners, certified nurse midwives, and physician assistants – who are paid a monthly case management fee to manage the care of Medicaid beneficiaries. PCCM contractors provide:

- Location, coordination, and monitoring of covered primary care services;
- 24-hour information and referral for treatment for medical emergencies; and
- Arrangements with, or referrals to appropriate primary care.[2]

North Carolina Community Care Networks, Inc. (N3CN) is North Carolina Medicaid's PCCM contractor. Through 14 regional Community Care of North Carolina (CCNC) networks, N3CN

[1] See Medicaid.gov, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html and 42 C.F.R. 438.2, 42 C.F.R. 438.52.
[2] See Social Security Act, Title XIX, Section 1905(d) http://www.socialsecurity.gov/OP_Home/ssact/title19/1905.htm

brings together physicians, nurses, pharmacists, hospitals, health departments, social services agencies and other community organizations that provide coordinated care through the Primary Care Medical Home (PCMH) model. PCMHs link each beneficiary with a primary care physician who leads a health care team to address the beneficiary's health needs.[3]

N3CN coordinates care through the PCMHs and a number of specific initiatives, including but not limited to behavioral health integration, disease specific initiatives, pharmacy adherence and medication reconciliation, transitional support between institutional and community-based settings, and a call center.

DUALLY-ELIGIBLE MEDICAID BENEFICIARIES

"Dually-eligible" beneficiaries refer to individuals who are enrolled in both the Medicare and Medicaid health insurance programs. Duals include individuals who receive full Medicaid benefits as well as individuals who only receive Medicaid assistance with Medicare premiums or cost sharing. Duals must meet certain income and resource requirements and be entitled to Medicare Part A and/or Part B and one of the following Medicaid Programs:

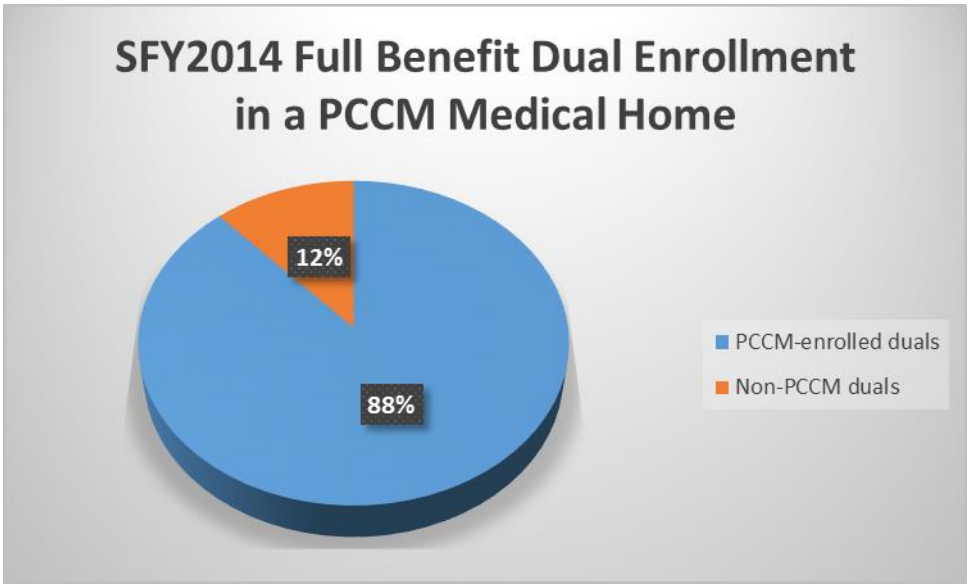
- Full Medicaid; or
- Medicare Savings Programs, which include the following four programs:
    - Qualified Medicare Beneficiary (QMB) Program;
    - Specified Low-Income Medicare Beneficiary (SLMB) Program;
    - Qualifying Individual (QI) Program; and
    - Qualified Disabled Working Individual (QDWI) Program.[4]

Medicare is the primary payer for physical health services of the dual eligible population. Medicaid pays co-payments, coinsurance, deductibles, and required premiums.

[3] See https://www.communitycarenc.org/population-management/medical-home/
[4] See http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

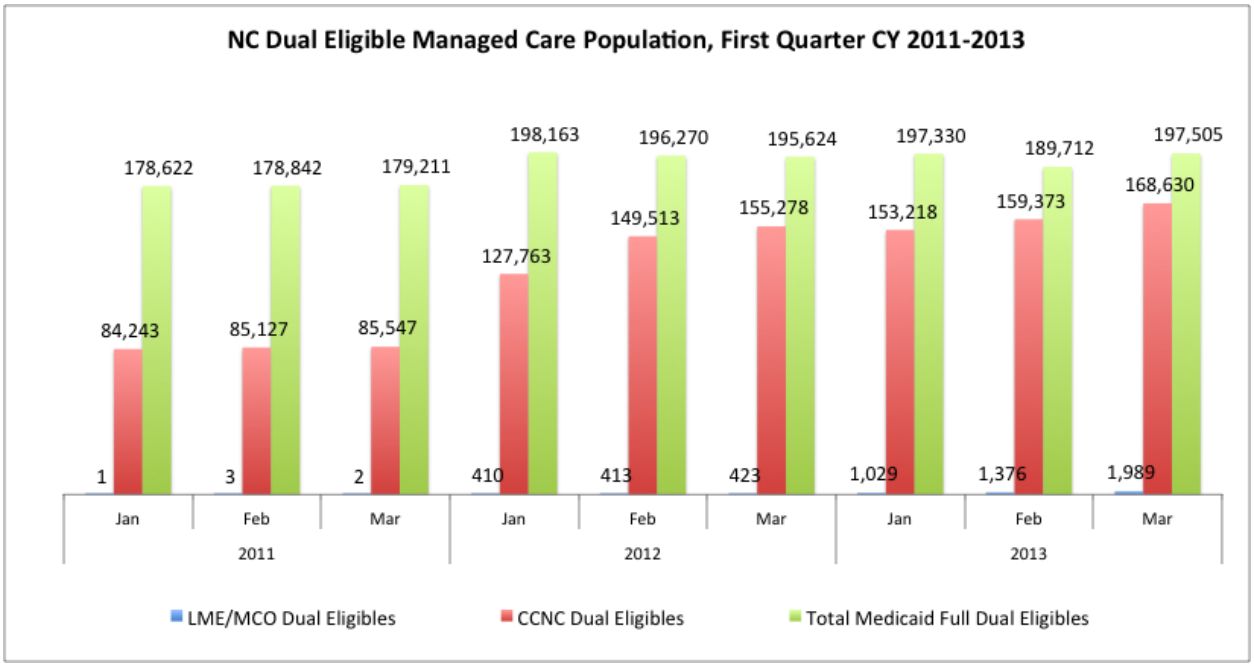
DUALLY-ELIGBLE MEDICAID BENEFICIARIES IN PCCM

Pursuant to 42 CFR 438.50(d), enrollment in a Primary Care Case Management (PCCM) medical home is optional for the dually eligible population. Beneficiaries can be assigned to a medical home, but they retain the option to opt out should it be desired. The pie chart below shows the State fiscal year 2014 distribution of North Carolina's 764,227 duals enrolled in Medicaid. There were 674,787 duals enrolled in a PCCM medical home, and 89,440 who were exempt from enrollment in a PCCM medical home.



Working in partnership with N3CN, DMA increased enrollment in PCCMs starting in 2011 in an effort to achieve legislated N3CN budget savings of $90,000,000 in State appropriations (S.L. 2011-145). DMA contracted with Public Consulting Group (PCG) to auto-enroll dually eligible beneficiaries and enrollment increased significantly from 2011 to 2013. Currently, medical home enrollment is executed manually for individual beneficiaries by local county divisions of social services at enrollment and recertification. However, auto-assignment of dually eligible beneficiaries into a PCCM medical home is scheduled for implementation in NCTracks.

The bar chart below shows PCCM enrollment for the first quarter of calendar years 2011 through 2013. These particular dates were selected because DMA has supporting data through May of 2013 for all three comparison categories: the number of full dual eligibles enrolled with N3CN; dual eligibles enrolled in LME/MCOs with a primary diagnosis of mental illness or intellectual or developmental disabilities; and the total number of Medicaid beneficiaries for the selected months.



Source: NC Division of Medical Assistance. See also http://www.ncdhhs.gov/dma/ca/dualstatus/index.htm

Note: Cardinal Innovations began providing Medicaid Managed Care Behavioral Health Waiver services in July 2005 as an LME. The waiver expanded in 2012 and 2013 to include the remaining MCOs. The only MCO in 2011 was Cardinal Innovations (formerly Piedmont Behavioral Healthcare). In January 2012, Western Highlands was added and merged with Smoky Mountain Center in 2013. In addition, East Carolina Behavioral Healthcare and Sandhills were added in 2012. Alliance, CenterPoint, CoastalCare, EastPointe, Partners Behavioral Health and Mecklink were added in 2014.

North Carolina's Local Management Entity Managed Care Organizations (LME/MCOs) do not currently provide primary care case management for beneficiaries with a primary behavioral health diagnosis or intellectual or developmental disabilities (IDD). N3CN provides primary care management, while MCO staff coordinates behavioral health and IDD services. N3CN and MCO staff meet on a monthly basis, utilizing the four-quadrant model, to have case conferences and ensure coordinated case management for beneficiaries with high behavioral health and high medical needs.

DUAL ELIGIBLE COST PROJECTION

Enrollment of dually eligible beneficiaries in PCCM remains high, reaching 88 percent of all full duals based on the most current data. Additional enrollment efforts will increase PMPM payments made on behalf of duals once NCTracks auto-enrollment functionality goes live. However, DMA does not anticipate a significant additional cost to the State because there is not a statistically significant increase in enrolled dual eligibles with a PCCM on a month-to-month basis.

DMA does not currently provide PCCM services to dually eligible beneficiaries in skilled nursing facilities. To enroll these duals in PCCM would require a State Plan Amendment and additional funding for per member per month payments. The anticipated savings are unknown, as it is a currently non-covered population. Past analyses to increase PCCM coverage have focused on better coordination of emergency department visits, hospital readmissions, falls prevention, and medication reconciliation.

CONCLUSION

DMA continues looking for opportunities to align care coordination where applicable with both Medicare and Medicaid in the form of demonstration projects or other available grants. The newly formed federal Medicare-Medicaid Coordination Office will be a resource for the purpose of decreasing duplicative services and payment. Aligning and coordinating benefits between Medicaid and Medicare are imperative for efficiency and cost-effectiveness to ensure access and high quality care.