



Advising the Congress on Medicare issues

Coordinating the care of dual eligible beneficiaries

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Roadmap

- Poor incentives to coordinate care
- Characteristics and spending associated with duals
- Current approaches
- Challenges
- Concluding observations

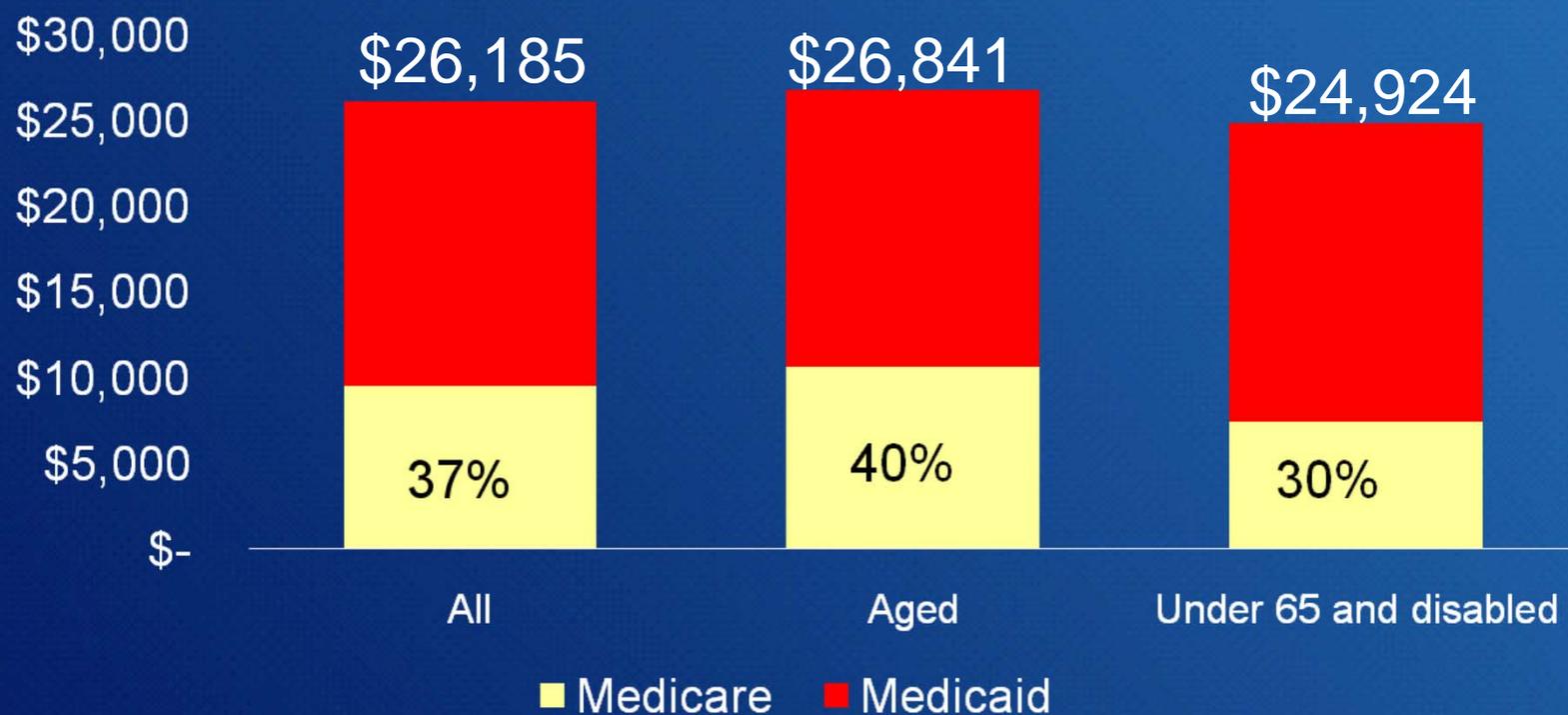
Poor incentives to coordinate care for dual eligible beneficiaries

- No incentive for Medicare or Medicaid to coordinate care
- Conflicting incentives between programs undermine care coordination
- No incentive under FFS payments to coordinate care
- Lack of coordination may raise costs and lower quality of care

Characteristics of dual eligible beneficiaries should shape care coordination

- Disability
- Physical impairments
- Cognitive impairment
- Live in an institution or alone
- Education level

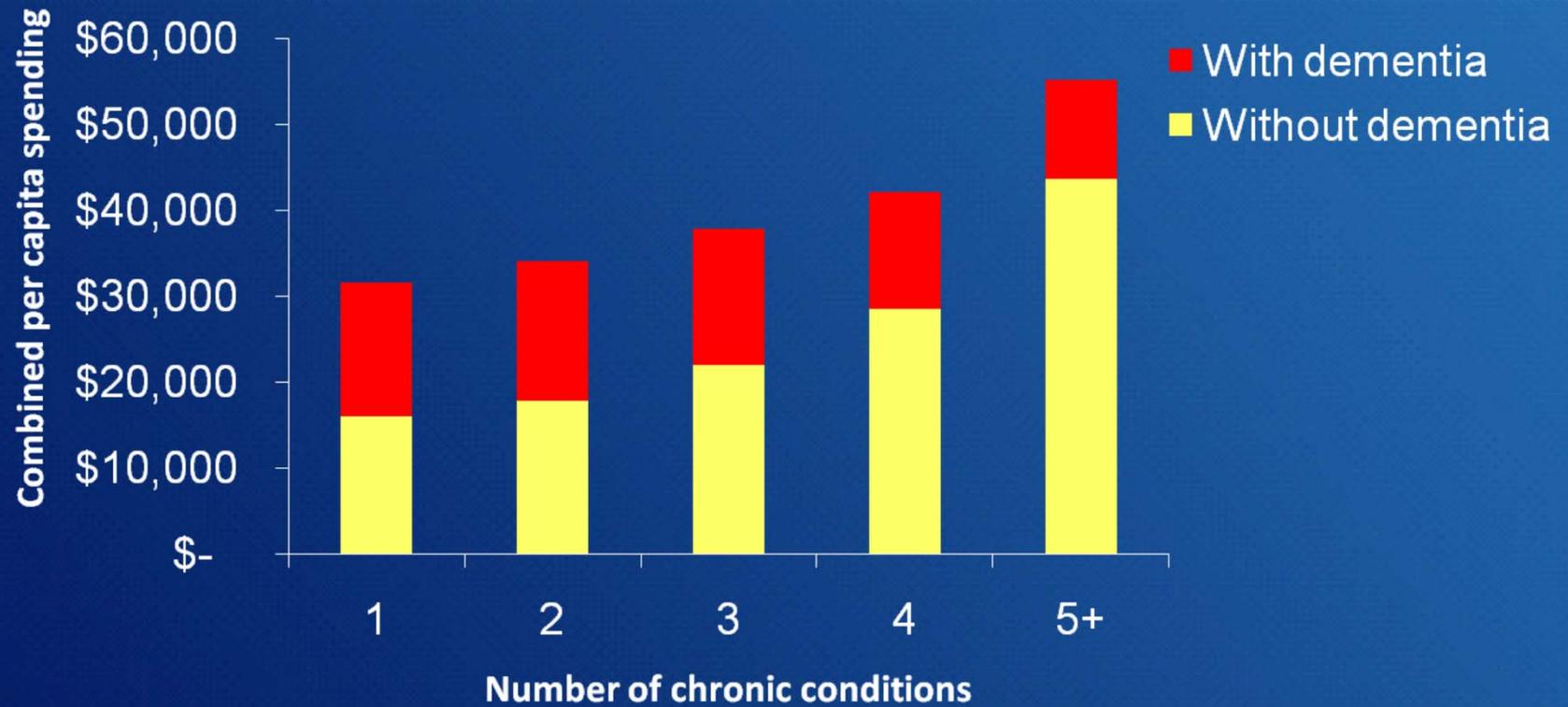
Per capita spending in 2005 by dual eligible group



Data are preliminary and subject to change. Percents are Medicare share of combined spending.

Source: Mathematica Policy Research tables prepared for MedPAC using CMS merged Medicaid MAX and Medicare summary BASF files.

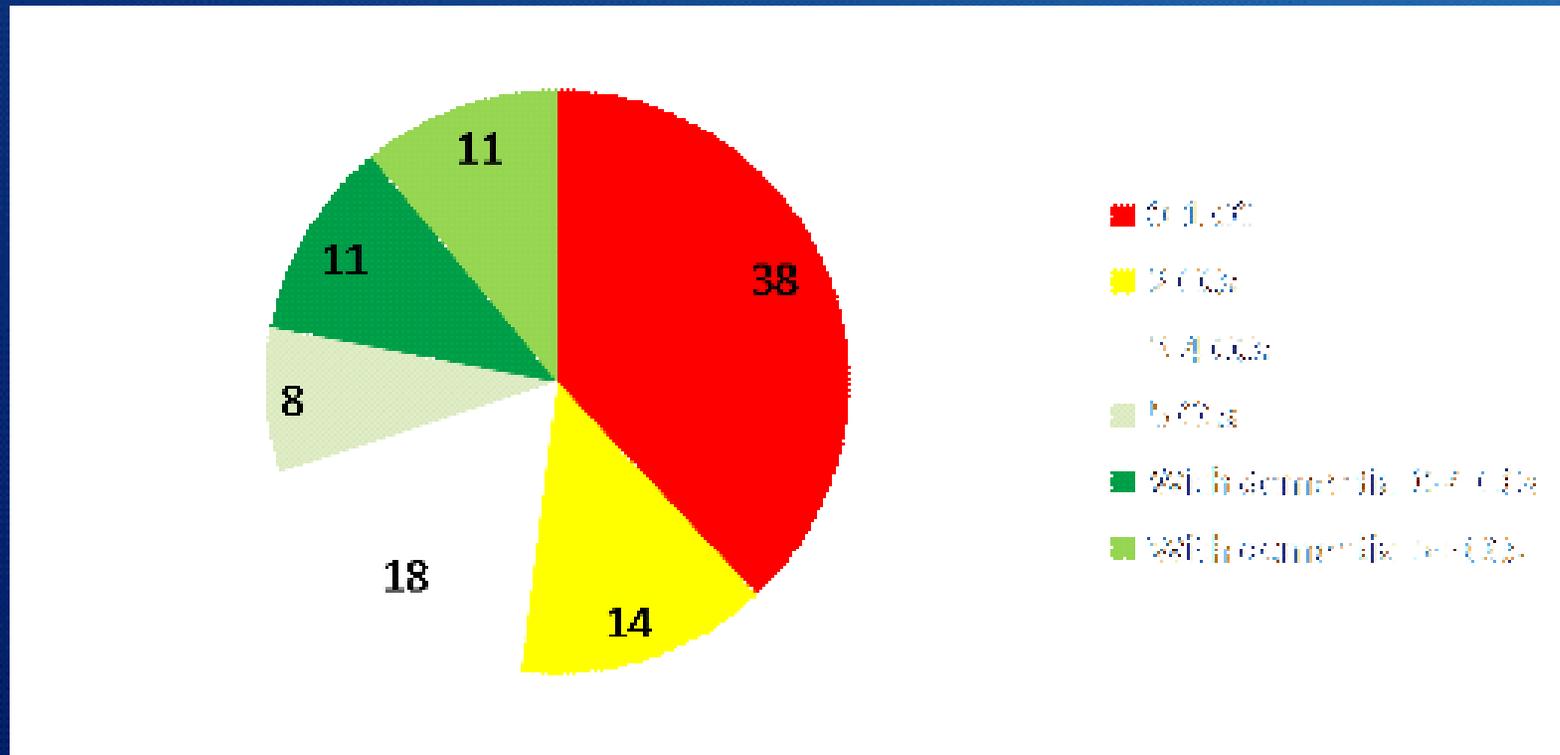
Combined per capita spending increases with dementia and number of chronic conditions



Data are preliminary and subject to change.

Source: Mathematica Policy Research prepared for MedPAC, using CMS merged MAX and Medicare summary spending files, 2005.

Majority of duals have 0-2 chronic conditions without dementia



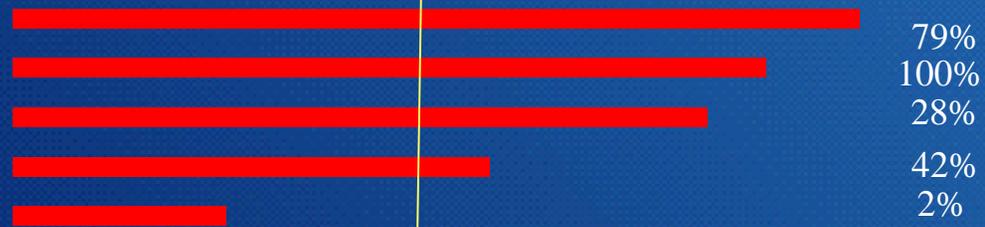
Percents are shares of all full year dual eligible beneficiaries who qualify for full Medicaid benefits. Data are preliminary and subject to change.
Source: Mathematica Policy Research prepared for MedPAC, using CMS merged MAX and Medicare summary spending files, 2005.

Per capita spending varied by type of impairment for disabled and aged

Disabled



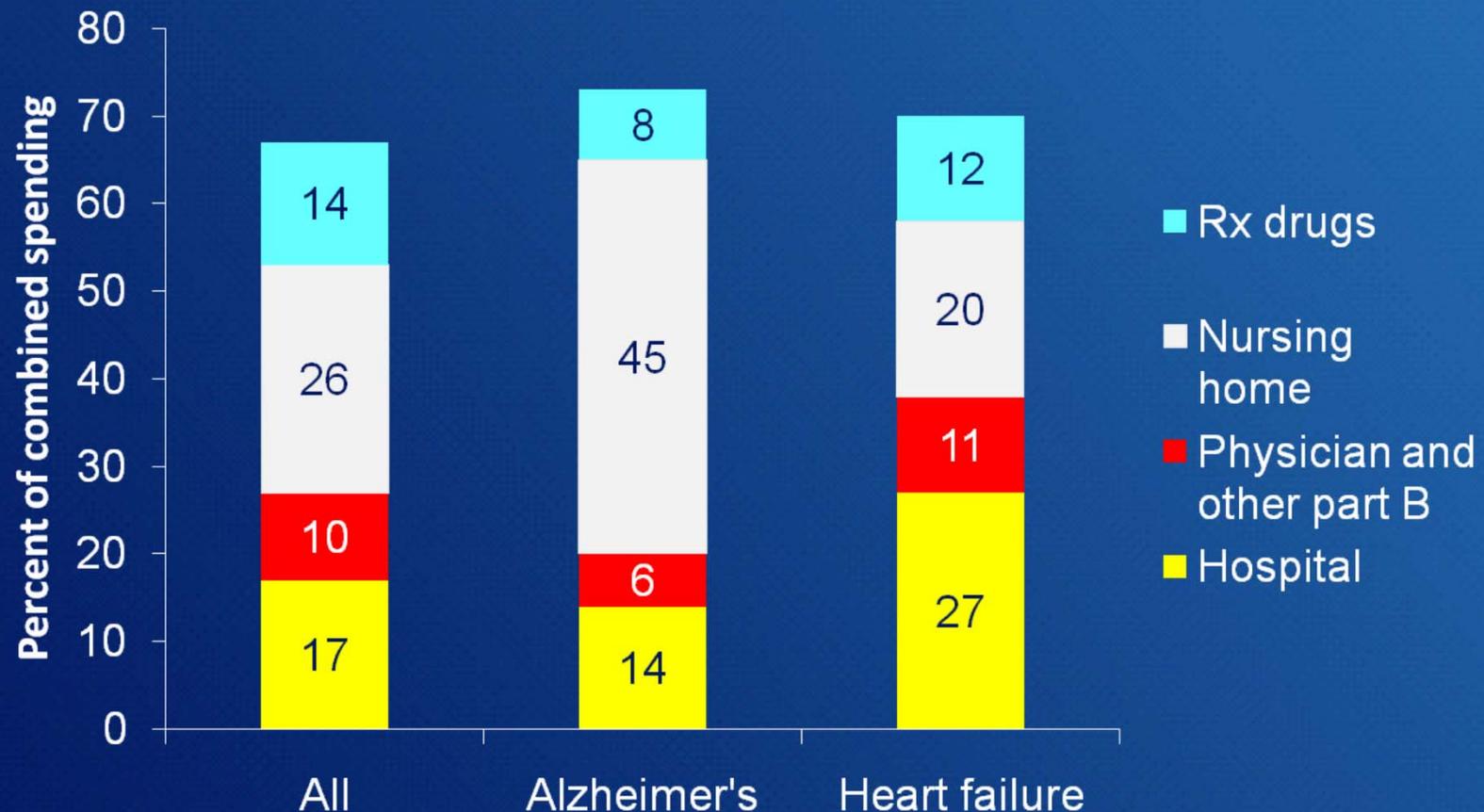
Aged



Per capita spending relative to average

Data are preliminary and subject to change.
 Source: MedPAC analysis of MCBS Cost and Use 2004-2006 files.

Service mix varies by chronic condition



Spending implications: Care coordination strategies should vary by patient's care needs

- Institution vs community residence
- Multiple chronic conditions
- Physical impairment
- Cognitive impairment
- At risk for:
 - Hospitalization
 - Nursing home placement
 - High prescription drug spending

Considerations for integrated care programs

- Method of Medicare and Medicaid financial integration
 - Federal government assumes state funds for duals
 - States receive federal Medicare and Medicaid funds for duals through block grants
 - An entity receives both funding streams
- Impact of financial integration method on incentives for care coordination
- Covered services and risk-sharing arrangements
- Adequate performance measures

Two models for fully integrated care

- Integration entity is at full risk for all Medicare and Medicaid benefits, including long-term care
 - State-SNP managed care programs
 - Payments and services are integrated by an insurer – a Medicare managed care plan
 - PACE
 - Payments and services integrated by a PACE provider

State-SNP integrated managed care programs

- State-SNP programs are operating in 8 states (AZ, MA, MN, NM, NY, TX, WA, WI):
 - Programs are often initiated by states
 - SNPs or MA plans are the vehicle for the integration
- Approximately 120,000 duals (under 2% of all duals) are in fully integrated SNPs
- Three states – MN, MA, and WI – began as demonstration programs that later converted to SNP authority

Characteristics of state-SNP integrated managed care programs

- Aged and disabled often enrolled into same program
- Enrollment generally voluntary for Medicaid benefits. Voluntary enrollment for Medicare benefits due to Freedom of Choice
- All Medicare and Medicaid services covered, with some limits on long-term care coverage
- Care coordination is a central element

Outcomes of state-SNP integrated managed care programs

- Outcomes research is limited, but available results are generally positive
- Declines in institutionalization:
 - The Massachusetts program reduced nursing facility use compared to duals in fee-for-service
- Long-term care rebalancing:
 - Nursing facility utilization declined by 22 percent over five years in Minnesota's program and HCBS users increased by 48 percent

Program of All-Inclusive Care for the Elderly (PACE)

- Provider-based program for the frail nursing home-certifiable elderly
- Services provided at an adult day care center
- All services, including care transitions, coordinated by an interdisciplinary team
- PACE employs most of its providers and contracts for services such as hospital and nursing home care

Outcomes of PACE

- Positive outcomes
 - Higher rates of ambulatory service
 - Lower rates of hospitalization and nursing home utilization
- Limited enrollment
 - 72 PACE organizations in 30 states with almost 18,000 enrollees

Challenges to expanding enrollment in integrated care

- Lack of experience with managed long-term care
- Stakeholder resistance
- Require initial financial investments; Medicaid savings accrue later from avoided nursing home use
- Separate Medicare and Medicaid administrative rules and procedures

Additional expansion challenges

- State-SNP managed care model:
 - All states are not likely to adopt this model
 - Dual-eligible SNPs state contract requirement not likely to result in more fully integrated programs
- PACE:
 - Day care based model is not a match for all dual eligible subgroups

Concluding observations

- To improve care for duals, approaches would offer financial and clinical integration
- Range of services included will shape effectiveness at care coordination and cost control
- Tailor care coordination activities to individual patient's care needs
- Performance measures gauge efficiency and how well care is coordinated

Next steps

- Interview and visit fully integrated programs
- Understand features of “best practices”
- Consider how to facilitate enrollment in integrated care models

Questions for Commissioners

- Do you want us to prioritize our investigation of fully integrated care models?
 - Subgroups of duals
 - Range of services
 - Insurer model or provider model
- Are there other integration models staff should research further?