Care coordination for dual-eligible beneficiaries

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November 4, 2010

MEDPAC

Review: June 2010 chapter

- Poor incentives to coordinate care
- Duals are more likely to be disabled and have poorer health status
- Combined program per capita spending is highly variable
- Managing the care of this population will require integration of financial and care coordination

Site visits and interviews on care coordination

- Interviewed officials from 9 state programs and 3 PACE providers (a total of 5 site visits—NM, MA, NC, Philadelphia and Hampton VA)
- Selected a mix of approaches, age of program, varying success, and location
- Spoke with many other stakeholders

States' care coordination programs vary considerably

- Approach—managed care, FFS with care coordination overlay
- Readiness to integrate the financing and care coordination
- Willingness to assume risk
- Scope of programs—only acute services, all services

Ideal care coordination: Full risk for full array of services

- Financial integration gives programs flexibility to furnish mix of services to match patients' care needs
- Program administrators acknowledged that to fully coordinate care and control spending, all services needed to be managed
- There can be strong provider resistance to integration
  - Concern about reduced volume or payments
  - Some behavioral health providers prefer own system

What the care coordination programs have in common

- State circumstances and stakeholder support
- Programs have a long-standing champion to lead design and implementation
- Programs define their populations broadly
- Similar core care coordination activities

Care coordination is key to integrated programs

Core activities

- Assess patient risk
- Individual care plan
- Reconcile medications
- Transition care
- Medical advice 24/7
- Regular patient contact
- Centralized EHR

Activities vary by patient

- Frequency of contact
- Mix of providers
- Medical, social, behavioral health, and community-based services
- Ratio of patients to coordinator

Stakeholders' suggestions to increase enrollment

- Ideas to expand enrollment
  - Materials need to spell out care coordination activities
  - Program descriptions that accurately detail benefits for dual-eligible beneficiaries
  - Expand dissemination of program information
  - Technical and financial assistance for programs
- Opt-out enrollment to substantially increase participation

Financial incentives to gain interest in integrated programs

- Stakeholders want to benefit financially from lower Medicare service use
- States hope that better care coordination will lower their long-term care spending
- Nursing home industry example of incentives
  - Incentive payment if lower nursing home days
  - Enhanced nurse staffing

Summary

- Programs vary in the approach, scale, and scope
- Limited results
- Questionable replicability
- Lack of plan, state, and federal expertise in managing full range of services
- Expanded enrollment unlikely without opt-out enrollment

Broad approaches to care coordination

- Integrated financing and care coordination programs
  - Integration through a managed care organization
  - Integration through a provider (PACE)
  - Jointly financed by Medicare and states through capitation
  - Entity at-risk for acute and long-term care services
- Fee-for-service with care coordination
  - Medical homes
  - Care coordination demonstration programs
  - Do not integrate program finances
  - Maintain fee-for-service incentives

Integrated financing and care coordination programs

- Fully integrated managed care plans and PACE
  - Capitation and risk gives the incentive and flexibility to intervene with covered and non-covered medical, long-term care, and social services
  - Interventions help avoid hospitalizations, emergency room visits, and nursing home stays
- Challenges with expanding models:
  - Overcoming administrative barriers
  - Lack of managed care plans that cover long-term care
  - Small enrollment in these programs

Fee-for-service with care coordination

- Entity paid a PMPM to coordinate care
- Medical home program (NC) and Medicare care coordination demonstrations focus on acute care
- Likely to be less effective in coordinating Medicare and Medicaid benefits and controlling costs
  - Do not integrate financing
  - No ability to intervene with non-covered services
  - Continue fee-for-service spending incentives

Future Work

- Explore modifications of PACE to reach other dual-eligible populations
- Explore ways to scale-up managed care plans to become fully integrated
- Explore strategies for enrollment

Questions for Commissioners

- Are there priorities for the next phase of work?
- Are there additional programs or directions we should focus on?