Care coordination for dual-eligible beneficiaries: evaluating special needs plans' models of care

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MEDPAC

Context of the analysis of D-SNP models of care

- Past research
  - November presentation on integrated care programs
  - Found similar key care coordination activities and Medicaid integration
- Current analysis
  - Compared D-SNP models of care to fully integrated care programs
  - Can D-SNP MOCs be used to evaluate care coordination and Medicaid integration?
  - Relationship between MOC descriptions and quality?

Background: Special Needs Plans

- Types of SNPs: Dual-eligible, chronic condition, institutional

- Differences from MA plans
  - Can limit enrollment to target populations
  - Dual eligible SNPs can enroll members each month, not just during enrollment periods

Concerns about SNPs

- SNPs may not be providing specialized care to their target populations
- SNPs may not be coordinating Medicaid benefits

Concern: SNPs may not be providing specialized care

- In 2008, MedPAC recommended that CMS establish performance measures tailored to SNPs
- SNPs now required to report quality data

Plans are required to report:

SNP-specific data	15 HEDIS Measures	Structure & Process Measures	Models of Care
To Whom?	Collected by NCQA, then sent to CMS	Collected by NCQA, then sent to CMS	Collected by CMS, then sent to NCQA
Published?	2008	No	No- NCQA approval begins 2012

NCQA model of care approval

- PPACA requires all SNPs to be NCQA approved
- CMS has outlined a potential approval process using the Models of Care (MOC)

Concern: SNPs may not be coordinating Medicaid benefits

- Commission recommended the Congress require D-SNPs to contract with states to coordinate Medicaid benefits

- PPACA extends deadline for D-SNPs to contract with states to December 31st, 2012

Analysis of care coordination activities

- CMS shared with us the MOC submitted by SNPs
- Did not receive a MOCs for every SNP
  - Only new and expanding SNPs were required to submit one
  - Many SNPs with distinct contract numbers have the same parent company
  - Some plans submitted the same MOC for all SNPs (chronic, institutional, dual)

Evaluated MOC for key care coordination activities of fully-integrated programs

- SNP target population
- Risk assessment process
- Care during transitions
- Medication reconciliation
- Patient education
- Utilization management
- Coordination with Medicaid benefits

Linking MOC to SNP quality measures

- Identified strong and weak model of care descriptions and tried to link them to publicly available quality measures
- Star ratings at contract level
- SNP- specific HEDIS
- Structure and process measures

Overall, key information is missing from the D-SNP models of care

- Information missing from D-SNP MOC questions on:
  - Key care coordination elements
  - Coordination with Medicaid services

- D-SNP MOC descriptions often general or vague

Enrolled populations are often not described

- Characteristics of dual-eligible enrollees often missing
- More often described care coordination for chronically ill or those who elected care management
- Some plans submitted same MOC for more than one type of SNP

A number of core care coordination activities are not typically described

Key care coordination elements described:

- Risk assessment process

Key care coordination elements not often described:

- Care transitions
- Medication reconciliation
- Patient education
- Real-time utilization management

Example of a better D-SNP MOC description of core care coordination activities

Transition care	Case manager is responsible for: • assuring that information is sent to receiving institution • ensuring that members understand discharge orders • investigating adverse events • providing feedback to providers and institutions
Patient education	High risk members receive: • review of the current treatment plan • calls from a health coach to discuss the member's goals Low risk members receive: • ongoing health education • opportunity to contact a health coach

Coordination with Medicaid services are often not described

- D-SNPs are not required to report on Medicaid coordination
- Majority of MOCs do not describe coordination with Medicaid benefits
- Descriptions that are available are often vague
- Most MOCs do not state whether D-SNP has a state contract

Example of a D-SNP description of Medicaid coordination

- SNP maintains a registry of social services organizations
- SNP directs members to housing assistance, legal and financial counseling, and community support groups
- Care managers are aware of members' Medicaid eligibility and assist members in the coordination of benefits
- Members are provided with a directory of providers who accept both Medicare and Medicaid

Lack of publicly available quality data for SNPs

- Not possible to compare MOCs and quality data
- MA star ratings often calculated at plan level, not individual SNP level
- HEDIS subset measures not reported since 2008
- NCQA structure and process measures not reported

Improving and streamlining D-SNP data

- D-SNPs should be evaluated on the complete set of care coordination activities, including Medicaid integration
- Data collection should be streamlined
- Benefits to public reporting of SNP measures
  - Helps beneficiaries make informed choices
  - Can evaluate and compare SNP quality

Next steps of this analysis

- Questions for today's discussion:
  - Should D-SNPs be evaluated on the care coordination elements in our framework, including Medicaid coordination?
  - Are there key elements missing that should be added?

- April presentation will address:
  - Improving the D-SNP data collection tool to include all key elements and reduce reporting and review burden
  - Streamlining D-SNPs' evaluation and approval processes

Next steps of this analysis (continued)

- June report chapter:
  - Site visit and interview findings on integrated care programs
  - Findings from evaluation of D-SNPs' models of care

Advising the Congress on Medicare issues

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