Coordinating care for dual-eligible beneficiaries

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Chapter summary

Beneficiaries who qualify for Medicare and Medicaid often have complex care needs that result in high program spending, yet the care furnished to them is typically uncoordinated. In June 2010, the Commission reported that combined program spending on dual-eligible beneficiaries varied considerably by number of chronic conditions, whether the beneficiary had dementia, and whether the beneficiary received care in a nursing home. It noted that improving the care for dual-eligible beneficiaries ideally would require integration of the financing and service delivery and described a handful of integrated programs. Although some integrated programs coordinate the Medicare and Medicaid services furnished to dual-eligible beneficiaries, those programs are small in number and enrollment.

As part of our ongoing work considering how to improve the coordination of services furnished to dual-eligible beneficiaries, this year we report on programs with the potential to integrate and coordinate services provided to their enrollees. In integrated programs, either a managed care organization or a provider receives capitated payments from the Medicare and Medicaid programs and assumes risk for the full spectrum of the dual-eligible beneficiaries' care. Some states implement care coordination programs that retain the fee-for-service system (and are paid a small monthly amount). While these programs do not align the financial and care management incentives as the capitated programs do, they represent a step toward integration of

In this chapter

- Integrated programs vary in approach and scope

- Integrated programs had similar key care coordination elements and challenges

- Key information is often missing from D–SNP model-of-care descriptions but is available from other data sources

- Conclusions and next steps

Medicare and Medicaid benefits. Commission staff conducted interviews and site visits to understand how integrated programs coordinate care and what lessons can be learned for states and entities seeking to develop integrated programs. Another avenue for coordinating care is through dual-eligible special needs plans (D–SNPs). D–SNPs are Medicare Advantage (MA) plans that target their enrollment to dual-eligible beneficiaries and thus have the potential to integrate and coordinate the services covered by both Medicare and Medicaid. Staff also examined D–SNPs' model-of-care descriptions submitted to CMS to evaluate whether D–SNPs were adequately coordinating beneficiaries' care and were integrating beneficiaries' Medicaid benefits.

We found that integrated programs vary considerably in their design and in the scope of services they manage. No single approach seemed likely to fit in every state, and the lack of comparable outcomes research on most approaches leaves open the question of which models are more effective. Nevertheless, we found two constants. First, administrators of integrated programs told us that the flexibility of capitated payments allowed them to deliver the mix of medical and social services each patient needed. Second, all the programs were similar in a number of key care coordination activities, including care transitions, medication reconciliation, patient education, and patient assessment with respect to risk for hospitalization or nursing home placement.

Expanding enrollment was a challenge for many of the programs. Program officials had ideas about how to grow enrollment but acknowledged that these ideas were likely to result in only incremental expansion. Many interviewees told us that the requirement to recruit on a person-by-person basis was a key limitation to expansion. State officials also consistently commented on the lack of financial incentives for states to pursue integrated programs, most notably that states cannot share in Medicare savings.

CMS may want to modify its model-of-care requirements for two reasons. First, the information that SNPs have submitted was too general to evaluate the plans' care coordination activities, whether the D–SNPs integrate Medicare and Medicaid services, or whether the D–SNPs tailored care coordination activities to the enrolled population. Some key care coordination elements and the plan's integration with Medicaid are not required elements in the model of care, and, with a few exceptions, plans did not describe them. To meet the requirements of the Patient Protection and Affordable Care Act of 2010 that all SNPs be approved by the National Committee for Quality Assurance, CMS recently announced an approval process based on evaluation of the plans' models of care. While this

approval process may improve the specificity of the model-of-care descriptions, it will not eliminate the gaps in the model of care requirements. Second, SNPs already report care coordination and integration activities in other reporting requirements, including quality measures to the National Committee for Quality Assurance and a detailed set of questions as part of the plan's MA application to CMS. CMS should target and streamline its model-of-care requirements to those key elements that are not otherwise available.

It is also not possible to evaluate the quality of care furnished by most D–SNPs. The star rating information for most SNPs is included in the overall reporting under a larger MA contract, which includes non-SNP plans. In addition, CMS has not routinely made available other quality information submitted by SNPs, including SNP-specific Healthcare Effectiveness Data and Information Set measures and structure and process measures developed by the National Committee for Quality Assurance. The Commission encourages CMS to shift its quality focus to outcome measures such as patient satisfaction, quality of life, and rates of emergency room use; institutionalization for long-term care; hospital admission and readmission rates; and medication errors. Many of these measures would allow for comparisons across the programs, MA plans, SNPs, and fee-for-service Medicare. D–SNPs could also be required to report the degree of integration with Medicaid.

Over the coming year, the Commission plans to continue its work identifying key elements of care coordination that should be components of any integrated care program and exploring program designs that improve care for dual-eligible beneficiaries. ■

Many dual-eligible beneficiaries are frail, have disabilities, or have multiple chronic conditions, including some form of cognitive impairment. Their conditions often result in high program spending and many of these beneficiaries need coordinated care. Because dual-eligible beneficiaries qualify for benefits under Medicare and Medicaid, their care in particular needs to be coordinated so that their providers are aware of their acute and chronic medical, behavioral health, long-term care, and social service needs and the care they receive. Last year, the Commission reported that the combined program spending on dual-eligible beneficiaries varied considerably according to the number of a beneficiary's chronic conditions, whether the beneficiary had dementia, and whether the beneficiary received care in a nursing home. The Commission noted that improving care for dual-eligible beneficiaries would require the integration of Medicare and Medicaid financing and care delivery. In addition, the Commission reviewed the literature on integrated programs—programs that coordinate Medicare and Medicaid benefits for dual-eligible beneficiaries (Medicare Payment Advisory Commission 2010).

This year we report on our examination of the care coordination activities of integrated programs and dual-eligible special needs plans (D–SNPs). Staff conducted interviews and site visits to understand how integrated programs coordinate care and what lessons can be learned for states and entities seeking to develop integrated programs. We also examined D–SNPs' model-of-care descriptions submitted to CMS to evaluate whether D–SNPs were adequately coordinating beneficiaries' care and were integrating beneficiaries' Medicaid benefits. With both efforts, we wanted to identify core activities that programs use to coordinate care and whether the activities improved the care beneficiaries received.

Background

Dual-eligible beneficiaries make up 16 percent of Medicare enrollment but account for one-quarter of its spending. Compared with other beneficiaries, dual-eligible beneficiaries are sicker, frailer, less educated, and more likely to be a minority, live alone, and be mentally impaired. However, within the dual-eligible population, care needs vary considerably. While more than one-quarter have three or more limitations in the ability to perform activities of daily living, almost half of dual-eligible beneficiaries have no limitations. Eleven percent of dual-eligible beneficiaries have five or more chronic conditions

and dementia, while 38 percent have one or no chronic conditions (Medicare Payment Advisory Commission 2010). Given these wide differences, the amount of care coordination individuals need varies considerably.

As a reflection of this range in care needs across the dual-eligible population, there is considerable variation in per capita spending based on a beneficiary's condition and whether the beneficiary is a long-term care resident. In 2005, average per capita Medicare and Medicaid spending was $26,185 for dual-eligible beneficiaries but averaged $50,278 for those with five or more chronic conditions; spending for beneficiaries with dementia was 30 percent to 90 percent higher than for those without it, depending on other comorbidities. Spending varied almost fourfold for beneficiaries with no nursing home spending compared with those with the highest nursing home spending (Medicare Payment Advisory Commission 2010). Given the range of spending, care coordination should vary in intensity, depending on the care needs of the individual.

Integrated programs

Few programs coordinate all Medicare and Medicaid benefits for dual-eligible beneficiaries. Under these programs, either a managed care organization or a provider receives capitated payments from Medicare and Medicaid and assumes risk for the full spectrum of the dual-eligible beneficiaries' benefits. Examples of these programs are the managed-care-based Senior Care Options program in Massachusetts and the provider-based Program of All-Inclusive Care for the Elderly (PACE).[1] Under the managed-care-based programs, the managed care plan is typically both a Medicaid managed care plan and a SNP. Some of the managed-care-based programs place limits on the amount of long-term care services covered, such as the number of nursing home days. The PACE program, in contrast, is a provider-based program. Under capitation with Medicare and Medicaid, the PACE organization is responsible, and at full risk, for providing all medically necessary care and services, including all nursing home days.

Programs that integrate some, but not all, of the Medicare and Medicaid benefits for dual-eligible beneficiaries are more common. For example, New Mexico and Texas have programs operated by managed care organizations that integrate some of the Medicare and Medicaid benefits. Programs that integrate some or all Medicare and Medicaid services vary considerably in the population and the size of the area they serve and in the services they manage. Enrollment in integrated programs is generally low. Most beneficiaries who enroll in the Medicaid

managed care plan side of the integrated program enroll in Medicare fee-for-service or a Medicare Advantage (MA) plan with a different company. Enrollment in PACE programs is also typically low, with individual PACE centers serving between 11 and 2,500 participants at each center (National PACE Association 2010). Fewer than 2 percent of all dual-eligible beneficiaries are enrolled in some type of integrated care program that coordinates some or all services (Center for Health Care Strategies 2010).

Some states pursue care coordination programs that are fee-for-service overlays—that is, providers continue to be paid under fee-for-service and receive an additional, small monthly payment to coordinate services for beneficiaries—rather than capitated, at-risk programs through managed care organizations or providers. These programs are not fully integrated because they do not cover all beneficiaries' Medicare and Medicaid benefits. An example of a fee-for-service overlay program is the North Carolina Community Care Networks. Under this program, networks of physicians receive per member per month payments from the state to coordinate dual-eligible beneficiaries' Medicare benefits. One reason states may pursue a fee-for-service overlay program is that few states manage Medicaid long-term care benefits through managed care. Although it is becoming increasingly more common, currently only 13 states enroll or intend to enroll dual-eligible beneficiaries in Medicaid managed care organizations to manage their long-term care (Smith et al. 2010). More commonly, many Medicaid managed care programs exclude dual-eligible beneficiaries or, if they do include them, carve out long-term care and behavioral health from their programs.

Dual-eligible special needs plans

D–SNPs are MA plans that focus enrollment on beneficiaries who are eligible for both Medicare and Medicaid (see text box, pp. 128–129, on SNPs). Although D–SNPs by themselves are not integrated programs, they can be if a plan also has a contract with a state to provide Medicaid benefits. In these instances, dual-eligible beneficiaries can be enrolled in the same health plan (or plans offered by the same company) for their Medicare and Medicaid benefits and the plan coordinates services covered by both programs. D–SNPs that manage beneficiaries' Medicaid benefits, including long-term care, are referred to as fully integrated D–SNPs.[2]

Most D–SNPs are not integrated programs because they do not also receive a Medicaid payment to manage

Medicaid benefits. Although D–SNPs are required to have contracts with states, they are not required to contract with states to manage the dual-eligible beneficiaries' Medicaid benefits, and most do not. The requirement for D–SNPs to have state contracts by 2013 is a step in the direction of more D–SNPs becoming integrated. A D–SNP that is not an integrated program may offer some degree of coordination with beneficiaries' Medicaid benefits, such as furnishing lists of providers that participate in the Medicaid program.

The SNP models of care can be one tool to evaluate whether D–SNPs are coordinating beneficiaries' Medicare benefits and whether the D–SNPs are moving toward becoming integrated programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires SNPs to submit evidence-based models of care. Only SNPs that were new or expanding plans in 2010 were required to submit their models of care to CMS as part of the MA application process; however, beginning in 2012, all SNPs must submit their model-of-care descriptions to CMS. The descriptions must contain information on 11 elements, including the SNP's target population, the interdisciplinary care team, beneficiaries' individualized care plans, and care management for vulnerable populations (Table 5-1, pp. 126–127). In addition, SNPs are required to complete an attestation covering their model of care as part of the MA application (Centers for Medicare & Medicaid Services 2011a). The attestation requires yes or no responses to more than 250 questions about the model of care, such as the members of the SNP's interdisciplinary care team and the specific care coordination activities the plan conducts.

Methods for gathering information on integrated programs for dual-eligible beneficiaries

We completed two analyses of integrated programs for dual-eligible beneficiaries. For the first, our goal was to learn about the characteristics of integrated programs that have been implemented, are in the planning phase, or failed to be implemented; the results of integrated programs on utilization and costs; and whether the programs could be readily expanded or replicated. We contracted with Mathematica Policy Research to conduct a series of interviews with nine state programs and site visits to three of the programs. In addition, Commission staff conducted site visits to two PACE providers and interviewed a third PACE provider and representatives from the Medicaid managed care and SNP industries,

advocacy groups, and foundations (see text box, p. 130, on site visits and interviews).

The goal of our second analysis was to assess whether D–SNPs provide care coordination activities for dual-eligible beneficiaries consistent with those offered by the integrated programs (state programs and PACE) we researched. We developed an analytic framework based on the key care coordination elements provided by these integrated programs and then used this framework to assess the D–SNP model-of-care descriptions submitted to CMS. Our framework consisted of the following elements: description of the enrolled population, the risk assessment process, care during transitions, medication reconciliation, patient education, utilization management, and coordination with Medicaid benefits. An incomplete description of care coordination or Medicaid integration efforts could reflect that a D–SNP was not offering these activities or was offering them but did not describe them in the model of care.

Models of care were not submitted by every D–SNP because existing SNPs that were not expanding were not required to submit them. In addition, many SNPs with the same parent company (such as a parent company having SNPs in multiple states) submitted the same model-of-care description for all their D–SNPs, and some submitted the same description for all their SNPs (chronic, dual eligible, and institutional). We received about 140 models of care from CMS. After we removed those that described models of care for chronic or institutional SNPs as well as the duplicate models of care, there were approximately 40 distinct D–SNP models of care.

In addition to the D–SNP model-of-care analysis, we explored whether a relationship existed between the quality of the model-of-care descriptions and D–SNPs' performance on quality measures. We were interested to know whether D–SNPs with stronger descriptions performed better on outcome measures than the other D–SNPs. For this analysis, we identified stronger and weaker model-of-care descriptions based on our framework and reviewed the publicly available quality measures for those D–SNPs.

Integrated programs vary in approach and scope

Many states have become interested in integrated programs, in part as a way to control their spending on dual-eligible beneficiaries. Existing and planned programs vary considerably. For administration, some states use managed care organizations while others employ provider-based approaches; for financing, some states implement capitated, risk-based structures while others prefer fee-for-service overlays. No single approach seems likely to fit in every state and the lack of comparable outcomes research on most approaches leaves open the question of which models are more effective.

Program characteristics reflect states' circumstances

Integrated programs take a variety of forms, reflecting the state's support for and experience with managed care, their approach to their Medicaid-only population (which they adapt to the dual-eligible population), and the level of support from providers and advocates. Interviewees told us that some states, such as Colorado, will not consider a managed care approach and some states are exploring or developing medical homes for the dual-eligible population.[3] Other states that have experience with managed care entities (such as Massachusetts) expand their managed care models to other populations. One state, Vermont, is exploring a design in which the state assumes the role of a managed care entity and manages the Medicare funds for dual-eligible beneficiaries. This model-of-care delivery is one of multiple approaches that the Center for Medicare and Medicaid Innovation may test (see text box, p. 131). Other states have expressed interest in this model in part because the state can retain any savings from reduced expenditures on Medicare services. Not all states pursue a single strategy. Massachusetts, for example, has managed care plans that operate both the state's Senior Care Options integrated care program and PACE programs.

One commonality among states that successfully implemented integrated programs is that each state had a champion—that is, an influential and effective leader—who steered the program through numerous administrative and financial barriers from development through implementation. The states also had stability in their leadership at the gubernatorial and agency levels to steer the programs' development through the design phase, engagement with providers and advocates, and implementation. Some states tried and failed to implement an integrated program or the program they implemented was narrower in scope than originally intended because of opposition from providers. In some states, advocates opposed integrated programs out of concern that restrictive provider networks would require beneficiaries to switch providers or that beneficiaries would lose their

**TABLE
5–1**   **Reporting requirements for special needs plans**

Instrument	Measure or domain
HEDIS® measures	• Colorectal cancer screening • Glaucoma screening in older adults • Use of spirometry testing in the assessment and diagnosis of COPD • Pharmacotherapy management of COPD exacerbation • Controlling high blood pressure • Persistence of beta-blocker treatment after a heart attack • Osteoporosis management in older women who had a fracture • Antidepressant medication management • Follow-up after hospitalization for mental illness • Annual monitoring for patients on persistent medications • Potentially harmful drug–disease interactions in the elderly • Use of high-risk medication in the elderly • Board certified physicians • Care for older adults • Medication reconciliation postdischarge
Structure and process measures	• *Identifying members for complex case management:* the number of different data sources used to identify enrollees for case management, how frequently identification is done, the ways members are referred for case management, the scope of the initial patient assessment, and whether the plan considers the members' cultural and linguistic needs and caregiver resources. • *Care transitions:* how SNPs manage transitions, identify unplanned transitions, and attempt to reduce them. • *Medication management:* does the plan document medication use by a member. • *Patient education:* whether the goals and preferences of members are considered in the development of the care plan, communication of self-management plans to a member, and patient notification of changes to the plan of care resulting from a care transition. • *Real-time utilization management:* the share of admissions to hospital and long-term care facilities reported within one business day of admission. • *Coordination with Medicaid benefits:* inform members about maintaining their Medicaid eligibility and the benefits they are eligible to receive under Medicare and Medicaid; help members understand their claims and correspondence from both programs and coordinate any adjudication of claims; and assist with accessing network providers including an assessment of the adequacy of the network.

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), COPD (chronic obstructive pulmonary disease), SNP (special needs plan), MA (Medicare Advantage).

Source: Centers for Medicare & Medicaid Services 2010, CMS model of care attestations, National Committee for Quality Assurance structure and process measures.

independence. The latter concern was more common among advocates for individuals with disabilities.

States that were planning programs agreed that they were motivated by a desire to control spending on dual-eligible beneficiaries. Although every state has a financial incentive to invest in care coordination that averts nursing home use, some states plan to start with managing only a portion of the dual-eligible beneficiaries' care, such as Medicare-covered primary care. In North

Carolina, even this narrow scope reflects the state's belief that coordinating services it is not responsible for will eventually lower the state's spending on long-term care services. For example, the state pays its network of primary care practices a per member per month payment to coordinate Medicare services, provides the network with data on hospitalization rates from nursing homes, and works with the provider network to develop strategies to lower readmission rates. State officials recognize that

TABLE
5–1
Reporting requirements for special needs plans (continued)

Instrument	Measure or domain
Models of care	• Target population • Measurable goals • Interdisciplinary care team • Staff structure and care management roles • Model of care training for personnel and provider network health risk assessment • Individualized care plan • Communication network • Provider network having specialized expertise • Clinical practice guidelines and protocols • Care management for vulnerable subpopulations • Performance and health outcome measurement
MA application attestation	• Interdisciplinary care team members • Medication reviews • Telemedicine services • Home safety assessments • Tracking and analysis of transitions of care • Identification and facilitation of access to community resources and social services • Conducting risk assessment • Facilitation of the implementation of the individualized care plan • Coordination of care across settings and providers • Monitoring provision of services to ensure care is seamlessly transitioned across settings and providers • Conducting care coordination meetings annually

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), COPD (chronic obstructive pulmonary disease), SNP (special needs plan), MA (Medicare Advantage).

Source: Centers for Medicare & Medicaid Services 2010, CMS model of care attestations, National Committee for Quality Assurance structure and process measures.

changing practice patterns takes time. Officials in New Mexico told us that they hoped the state's managed long-term care program would lower the growth in long-term care spending over three to five years.

Programs vary in the scope of services they manage

Administrators of fully integrated, risk-based programs emphasized the flexibility capitated payments gave them to decide which clinical and nonclinical services to furnish. It was particularly true among administrators of the PACE program because PACE providers have more flexibility in how they spend Medicare funds than SNPs, which are not permitted to spend Medicare dollars on non-health-care-related services. Administrators of programs that are not fully integrated appreciated that to control their spending they needed to include a full range of long-term care and behavioral health services, but the administrators told us that providers blocked their efforts

to include these services in the integrated program. Long-term care services are often left out of Medicaid managed care plans, leaving states with little experience managing these services. Behavioral health services are even more frequently carved out of programs. This omission leaves states and programs relatively inexperienced at managing services that shape total spending for dual-eligible beneficiaries.

Flexibility to furnish necessary clinical and nonclinical services

Administrators of integrated programs told us that they needed the flexibility to deliver the services they thought mattered. Capitation, rather than fee-for-service payments for covered services, gave them this latitude. Examples of this flexibility from PACE providers include sending meals home and installing grab bars in a beneficiary's home when the care team believed the services would prevent more costly spending on medical services. In addition,

What are special needs plans?

Special needs plans (SNPs) were authorized by the Medicare Modernization Act of 2003. SNPs must meet Medicare Advantage (MA) requirements and are paid the same as any other MA plan. However, unlike other MA plans, they must limit enrollment to their targeted populations (dual-eligible beneficiaries, beneficiaries residing in institutions, and beneficiaries with chronic or disabling conditions). Dual-eligible beneficiaries can enroll each month, whereas other MA plans can enroll beneficiaries only during annual open enrollment and during defined special election periods. Like any MA plan, SNPs are required to go through an approval process with CMS. Plans must submit materials such as proof of state licensure, names of key management staff, evidence of fiscal soundness, provider participation contracts, and a quality improvement program description.

Between July 2006 and January 2011, the number of SNPs grew rapidly (from 276 to 455), with beneficiary enrollment in these plans more than doubling during this period to almost 1.3 million (Table 5-2). Dual-eligible SNPs (D–SNPs) account for 71 percent of SNPs and enroll 81 percent of the Medicare beneficiaries enrolled in SNPs (data not shown). Currently, 11.4 percent of dual-eligible beneficiaries have enrolled in D–SNPs (data not shown). Most D–SNPs (80 percent) are parts of chains that enroll about three-quarters of all beneficiaries enrolled in D–SNPs. Among these chains, 1 company has 49 plans, while 3 run about 20 plans. Together, these four companies manage more than one-third of all SNPs.

There are 45 plans that are stand-alone D–SNPs. These plans are not part of larger parent organizations.

With the rapid growth in SNPs came concerns that Medicare's requirements did not ensure that SNPs were targeting populations with special care needs and tailoring their benefit plans to them. The Medicare, Medicaid, and SCHIP Extension Act of 2007 placed a moratorium on the approval of new SNPs and the expansion of existing ones. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) converted the moratorium to a one-year freeze, allowing plans to begin submitting applications for new plans or expansions in 2009 for the 2010 SNP contract year. In 2010, CMS tightened the definitions for chronic or disabling condition SNPs.

In response to the concern that SNPs were not providing specialized care, the Commission recommended in 2008 that the Secretary establish performance measures tailored for SNPs, evaluate SNP performance on the measures, and make the information available to beneficiaries and their counselors. This recommendation has been partially addressed—SNPs are required to report two sets of information: Healthcare Effectiveness Data and Information Set (HEDIS®) measures and structure and process measures developed by the National Committee for Quality Assurance (NCQA). The 15 required HEDIS measures are a combination of a subset of the HEDIS measures that all MA plans must report and some SNP-specific measures (Table 5-1, pp. 126–127). Although

TABLE
5–2

Enrollment by type of SNP as of February 2011

Type of SNP	Number of plans	Enrollment	Percent of all SNP enrollment
Chronic or disabling condition	92	162,207	13%
Institutional	65	80,508	6
Dual eligible	298	1,050,864	81
Total	455	1,293,579	100

Note: SNP (special needs plan).

Source: MedPAC analysis of February 2011 SNP Comprehensive Report, CMS (http://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage).

(continued next page)

MedPAC

SNPs have been required to report the 15 HEDIS measures since 2008, the results of these measures were published once (in 2008) and have not been published since then. The NCQA structure and process measures consist of six domains specific to SNPs: complex case management, improving member satisfaction, clinical quality improvements, care transitions, institutional SNPs' relationship with their facilities, and coordination of Medicare and Medicaid benefits (see http://www.ncq.org for a detailed list). Each measure consists of multiple elements that are individually scored. Plans began submitting these measures in 2009; however, the results are not publicly available. In addition, as part of their MA applications to CMS, plans describe 11 elements of the models of care used to coordinate the care for their enrollees.

The Patient Protection and Affordable Care Act of 2010 (PPACA) requires all SNPs to be approved by NCQA by 2012. In April 2011, CMS provided guidance to plans about the NCQA scoring and approval process it will use (Centers for Medicare & Medicaid Services 2011b). NCQA will review and score the models of care based on the completeness, detail, and depth of the discussion of each of the 11 elements, with scores ranging from zero to four for each element. For each element, a plan that includes multiple specific examples or a case study may receive full points (four), while a plan's description that includes incomplete details or incorrect information may receive no points. Plans with higher total scores will receive approval for two or three years (depending on the total score); those with lower total scores will be approved for one year. As part of its approval, NCQA will not review a SNP's responses to the attestation questions or the plan's performance on the structure and process measures.

The Commission has raised concerns that, although D–SNPs manage the Medicare services for patients who qualify for Medicaid, the plans were not necessarily providing or coordinating the services covered by the states' Medicaid programs. To that end, the Commission recommended that the Congress require D–SNPs to contract with states in their service areas to coordinate Medicaid benefits (Medicare Payment Advisory Commission 2008). MIPPA required new D–SNPs and expansions of existing SNPs to have a contract with the state Medicaid agency by 2010. The contracts must explain details such as which (if any) Medicaid benefits the SNP will cover, the SNP's service area, the process for verifying Medicaid eligibility, and the process for the state to share information on Medicaid provider participation with the SNP. Existing SNPs that were not expanding were required to submit a signed state Medicaid contract to CMS by 2011. PPACA extended the deadline for state contracts for Medicaid services from December 31, 2010, to December 31, 2012. States are not required to contract with SNPs and plans could have difficulty establishing contracts with some states.

MIPPA also required that CMS provide technical assistance to states to encourage Medicare and Medicaid benefit integration for dual-eligible beneficiaries. CMS has implemented a resource center that helps states negotiate contracts with SNPs and has developed best practices for model contracts with states. The resource center has also led training sessions and established a website to provide information on coordination issues (Centers for Medicare & Medicaid Services 2010). ∎

PACE transportation van drivers were able to detect subtle changes in a participant's behavior or to notice uneaten meals when they picked up participants at the beginning of the day. The drivers alerted the care team for follow-up once the beneficiary checked in at the day care center. Further, one PACE program supplied some participants with air conditioners to prevent dehydration.

States vary in including long-term care and behavioral health in integrated programs

States and programs vary in whether they would consider including long-term care services in their integrated program. In some states, the nursing home and home health care industries opposed the development of integrated programs because they worried about the loss of volume and negotiating power for higher payments.

To learn about a range of programs that coordinate the care for dual-eligible beneficiaries, we contracted with Mathematica Policy Research to conduct a series of interviews and site visits using structured interviews (Verdier et al. 2010). We selected programs to interview that represented a mix of well-established programs (Minnesota, Massachusetts, and Arizona), new approaches (Vermont, North Carolina, and New Mexico), and one state that currently excludes dual-eligible beneficiaries from Medicaid enhanced primary care case management but may include them in the future (Oklahoma). We also spoke with two states (Maryland and Virginia) that tried to establish programs but were not successful, hoping to learn from their experiences. In selecting our site visits to Massachusetts, New Mexico, and North Carolina, we considered a mix of approaches to integrated programs and geographic diversity. During each site visit, we interviewed representatives from state agencies, health plans, providers, and beneficiary counselors.

We also spoke with representatives from the Association for Community Affiliated Plans, the SNP (Special Needs Plan) Alliance, the National Governors Association, the SCAN (Senior Care Action Network) Foundation, the Center for Medicare Advocacy, the Medicare Rights Center, CareOregon, the Office on Disability within the Department of Health and Human Services, the Kaiser Family Foundation, AARP (formerly, the American Association of Retired Persons), the National PACE (Program of All-Inclusive Care for the Elderly) Association, and the Independent Care System (a nonprofit managed long-term care plan in New York for adults with disabilities). In addition, we spoke with a PACE provider in Boston and visited two others (in Philadelphia, Pennsylvania, and Hampton, Virginia). Commission staff also participated in a roundtable discussion with Medicaid officials from 11 states at the Transforming the Care for Dual Eligibles conference hosted by the Center for Health Care Strategies. ∎

In other states, provider support was won over with augmented payment rates or incentive payments to shorten stays. States also differ in their interest in and progress toward rebalancing their institutional and community-based long-term care services, which influences whether a state includes long-term care services in its integrated care approach.

Even fewer states and programs consider including behavioral health services in their integrated programs. In New Mexico and Arizona, where behavioral health services are excluded from their integrated programs, health plan representatives said these exclusions resulted in poorly coordinated care. In some states, behavioral services were excluded from the integrated programs as a concession to mental health providers. In these states, behavioral health providers thought stand-alone behavioral health programs could offer better care.

In adapting a Medicaid program to the dual-eligible population, some states expanded their network of providers to include specialists and social and behavioral health services. For example, North Carolina's primary care network initially excluded pharmacists and behavioral health services but integrated these services after it had difficulty controlling expenditures and coordinating beneficiary care. When the mentally ill are included in the enrolled population, program administrators told us that a broad range of behavioral health providers are needed. They also said that primary care providers are often unaware of the range of behavioral health providers in their areas and do not coordinate services with them.

Integrated programs had similar key care coordination elements and challenges

Programs that coordinate the care for dual-eligible beneficiaries have many common care coordination elements. They typically enroll broadly defined populations, use similar care coordination activities, and are challenged to expand enrollment.

States as the entity to manage Medicare funds

At least five states (Vermont, Massachusetts, Tennessee, Texas, and California) expressed interest in directly receiving Medicare funding for their dual-eligible beneficiaries. Under this approach, a state would receive Medicare payments and either assume the financial risk for Medicare benefits itself or make a combined Medicare–Medicaid payment to an entity (e.g., a managed care organization or an accountable care organization) to manage the beneficiaries' acute and long-term care benefits. Savings achieved by lowering the use of all services (including those financed by Medicare) would accrue to the state, if the state is receiving Medicare and Medicaid payments. The Patient Protection and Affordable Care Act of 2010 gave the Center for Medicare and Medicaid Innovation in CMS the authority to test this model and permits the Secretary to waive any Medicare requirements during the testing

of this model. Under CMS's State Demonstrations to Integrate Care for Dual Eligible Individuals initiative, 15 states received planning grants to design integrated programs for dual-eligible beneficiaries, and some of those states are designing programs in which the state would manage the Medicare funds.

This approach raises concerns about how Medicare funds would be used. States would have a financial incentive to use Medicare funds to reduce their own spending and Medicare would not receive any savings. There is a long history of states using financial strategies such as intergovernmental transfers to maximize federal support while minimizing the state's Medicaid contributions and increasing federal spending. If these types of programs are implemented, there will have to be carefully designed transparent accountability mechanisms to ensure program integrity. ■

Programs enroll broadly defined populations

None of the integrated program officials we spoke with targeted their programs at clinically defined groups of dual-eligible beneficiaries, such as those with specific chronic conditions. Program and state representatives we spoke with thought that selecting specific diseases tended to focus care on a narrow set of care needs, too often ignoring other care needs of the beneficiaries. Interviewees told us that while beneficiaries with different diseases require different mixes of services, the basic model of care coordination—regular risk assessment and development of a patient-specific care plan by a multidisciplinary team, tailored to each beneficiary's care needs and living situation—would be the same.

Interviewees thought the services to coordinate care for the dual-eligible population of individuals under age 65 with disabilities would need to be broader than those coordinated for the population age 65 or older but that the care model would be similar. Care coordination would still center on risk assessment, a patient-specific plan of care, regular monitoring, and transition care, but the mix of the services and providers would differ. Services for individuals with disabilities would emphasize supporting independence and would include behavioral health, social,

fitness, and other community-based services—such as assisting with meal preparation, finding accessible transportation and housing, and repairing wheelchairs.

Core care coordination activities were similar

According to officials of coordinated care programs for dual-eligible beneficiaries, all the programs use multidisciplinary teams and conduct similar activities:

- assess and assign each patient to a risk group,

- design and periodically update an individualized care plan,

- assist the beneficiary in negotiating the health care and community service system,

- manage service use (including averting hospitalizations, nursing home stays, and emergency room visits),

- reconcile medications prescribed and check they have been taken, and

- coordinate behavioral and primary care.

TABLE
5–3

Integrated programs had common care coordination activities but intensity varies by patient

Common core activities	Activities vary by enrollee's care needs
• Assess patient risk • Individualize care plan • Reconcile medications • Transition care • Medical advice available 24/7 • Regular contact with enrollee • Centralized electronic health record	• Frequency of contact • Mix of providers • Mix of medical and social services • Coordinator-to-patient ratios vary by services that require coordination

Note: SNP (special needs plan).

Source: MedPAC review of SNP models of care submitted to CMS.

When we asked care teams at integrated programs what core elements of their care coordination activities would be essential to replicate in any integrated care program, they replied that having medical advice available 24/7, the financial flexibility to furnish any needed service, and a centralized medical record accessible to all caregivers were key features.

All the coordinated care programs in our study assess all patients for their relative risk for costly services—including hospitalization, emergency room use, and institutionalization—and use this assessment to assign the enrollee to a level of care coordination. Programs vary, though, in how they assess each patient's care needs and risk for high-cost services. The intensity of the core care coordination activities varies based on the risk each patient poses for hospitalization, nursing home institutionalization, and medical complexity requiring coordination of many services (Table 5-3). For those patients with the least risk, care coordination includes periodic risk assessment, regular but less frequent communication with the beneficiary, reminders to keep medical appointments, documentation of changes to the patient's care regimen in the patient's medical chart, and medication reconciliation. These activities are intended to prevent beneficiaries' health status from deteriorating.

For beneficiaries at greater risk for hospitalization or institutionalization, programs focus on averting hospitalizations and making smooth transitions between care settings and the beneficiaries' living situation. Some programs place nurses in the nursing homes where dual-eligible beneficiaries are residents or make additional payments to the homes as a way to raise the facilities'

level of nurse staffing. Community-dwelling beneficiaries otherwise certifiable for nursing home care have frequent contact with the care manager, medication management, and coordination of multiple medical and social service needs to avert hospitalizations and institutionalization. Even subtle changes in a patient's general orientation—such as dehydration, lack of eating, and increased need for supportive services at home—are followed up to avert hospitalizations.

Some programs use nurses to monitor and manage their enrollees' care in hospitals and have nurses visit beneficiaries during the hospital stay to begin care coordination before discharge. Nurses inform the hospital of a beneficiary's care before hospitalization (such as medication use), ensure that the beneficiary understands and follows care instructions after discharge, and inform the beneficiary's primary care team of any information from the hospitalization that would change the beneficiary's care regimen. Medication reconciliation, home visits to high-risk beneficiaries, and reassessment of the beneficiary are key components of transitional care. Care managers often coordinate a beneficiary's medical appointments, follow up to make sure the appointments are kept, and identify social services in the community if needed.

Program officials commented that when their enrollees are a small share of a nursing facility's or hospital's volume, it is often difficult to focus attention on averting hospitalizations or managing care transitions. Some programs use a limited number of institutional providers to give them leverage to change provider behavior.

MedPAC

Lack of real-time data hinders care coordination

Lack of real-time data on dual-eligible beneficiaries' Medicare utilization was a challenge for many of the integrated care programs. Many of the entities we interviewed did not receive utilization data on Medicare-funded services—most importantly, on their use of prescription drugs, hospitalizations, and physician services. This lack of information makes it very difficult for them to manage beneficiaries' care and to realize the savings from better coordinated care.

To work around this lack of information, some entities have developed their own mechanisms to obtain patient data on hospitalizations but often receive this information after the patient is discharged. For example, one managed care entity in New Mexico estimated that it does not learn about one-quarter of hospitalizations until it reviews claims for payment. In contrast, PACE providers learn about hospitalizations immediately given their almost daily contact with participants and their families. The CMS physician group practice demonstration illustrated that Medicare data are unlikely to flow to providers on a real-time basis and that successful entities will develop their own systems for gathering the information they need to manage their populations, including phone calls from hospitals when patients are admitted or an accessible common electronic health record. The North Carolina network recently launched a web-based portal to facilitate providers' access to the health records for program enrollees.

Increasing enrollment is a challenge for many state programs

Increasing the number of dual-eligible beneficiaries served by fully integrated plans that include long-term care will be a challenge for many states and plans. Except for PACE, few programs integrate acute care, long-term care, and behavioral health services. Only 13 states include or plan to include long-term care services in managed care (Smith et al. 2010). Most Medicaid managed care plans and MA plans exclude the dual-eligible population and, if they do include them, they do not cover long-term care services. Despite the success of the PACE program (evaluations show the program's lower hospitalizations and emergency room visits (Chatterji et al. 1998)), fewer than 1 percent of beneficiaries enroll in this provider-based program. Though existing programs may grow incrementally, large expansions in enrollment are unlikely without major changes in policy.

Interviewees' ideas to expand growth incrementally

Given the small scale of most existing programs and the limited results, increasing the number and size of programs is likely to happen incrementally. Interviewees in our study discussed ways for states and Medicare to increase voluntary enrollment. Some thought that information about integrated programs sent by the state or Medicare would be more likely to be read than materials sent directly from a program.

Interviewees also thought the MA marketing and membership materials (whose format and content are developed by CMS) could better explain the Medicare and Medicaid benefits enrollees receive through the integrated program (such as help managing their prescription drugs; furnishing transition care between settings; and covering podiatry, vision, dental, and personal care assistants at home) to make it easier for beneficiaries to appreciate the value of integrated programs.

Some SNP representatives thought the requirements for the SNP descriptions were not tailored to integrated programs and resulted in informational materials that were inaccurate and confusing. For example, fully integrated SNPs must describe Medicaid benefits in a section separate from the explanation of Medicare benefits, even though the beneficiary would receive both sets of benefits through the plan. Interviewees also noted that the materials need to be made easier to understand for dual-eligible beneficiaries whose education levels tend to be low or for whom the materials are not available in their primary language. CMS could approve a template for fully integrated SNPs that is tailored to the benefits dual-eligible beneficiaries would receive through the program.

Some interviewees perceived voluntary enrollment as limiting the number of eligible beneficiaries enrolled in integrated programs

Many interviewees in our study told us that Medicare's requirement for voluntary enrollment in coordinated care programs was a key limitation to expansion. Some thought an opt-out approach, in which beneficiaries are assigned to an integrated program with the option to switch to another integrated program or to fee-for-service, was needed to substantially increase enrollment in integrated programs. Supporters thought an opt-out policy could be designed to allow beneficiaries to switch integrated programs or select fee-for-service with an easy disenrollment process. Others opposed an opt-out policy for three reasons. First, they disagreed with a policy that would interfere with

beneficiary choice of provider or require beneficiaries to change providers. Second, they contended that the opt-out policy does not consider the importance of beneficiary "buy in" to the program's approach, and the adherence needed for the program to be successful. Third, opponents maintained that the programs could limit the independence of individuals with disabilities and their access to needed social and community services.

Sharing Medicare savings would raise interest in integrated programs

Officials we spoke with thought the lack of ability for states to share the Medicare savings and the slower rate of realizing state savings inhibited the development of new programs. State officials and program administrators told us they were reluctant to develop integrated programs that save Medicare money mostly by reducing hospitalizations and emergency room visits. They said the savings that result from lower nursing home use require costly state investments and take a longer time to realize, making it difficult for states to commit the necessary resources to start integrated programs in the current budget environment. Officials from states with integrated programs said they hope to realize Medicaid savings from better managed Medicare-covered services that may, in turn, lower spending on long-term care.

Key information is often missing from D–SNP model-of-care descriptions but is available from other data sources

The model-of-care descriptions submitted by D–SNPs to CMS vary considerably in content, with most lacking the detail needed to assess whether the plan offered coordinated and integrated services tailored to their enrolled populations. This finding is not surprising, as D–SNPs are not required to report on many of these elements. The lack of reporting does not necessarily indicate that D–SNPs are not conducting these key care coordination activities, only that the activities were not described. Other data were not available to determine whether the quality of the SNPs' model-of-care descriptions was related to the quality of care the plans delivered or whether the plans coordinated or integrated the care they furnished. Given the multiple requirements for SNPs to report their care coordination and integration activities, CMS may want to consider targeting and streamlining its model-of-care requirements.

Models of care generally do not describe their enrolled population

Most D–SNP models of care note "all duals" or "full duals" as their enrolled population, but they do not describe additional population characteristics—such as the percentage of the population that have disabilities, are under age 65, have dementia, are frail, are nursing home certifiable, or have multiple chronic conditions. In addition, most models of care did not specify whether the D–SNP limited enrollment to a group of dual-eligible beneficiaries. Two plans stated that they enrolled nursing home certifiable individuals, while another plan excluded individuals who were not full dual eligibles (individuals eligible for Medicare and all Medicaid benefits). Because the description of the enrolled population was not included in most of the models of care, in most cases, it is not possible to assess whether a model of care is appropriately tailored to the enrolled population. The descriptions of the populations may improve because the scoring method NCQA will use to rate a D–SNP's model of care considers information about characteristics of the Medicare and Medicaid populations served by the plan.

More frequently, plans described limiting their integrated programs to specific enrollees, such as beneficiaries with certain chronic conditions, or to those who elected to participate in care management. Participation in care coordination was voluntary in almost one-fifth of models of care we reviewed. One D–SNP required beneficiaries to mail back a survey or call member services or their primary care physician to participate. In D–SNPs with voluntary participation, some continued to monitor the utilization of beneficiaries who opted out and, if spending was high, they asked beneficiaries midyear to reconsider their decision.

A few D–SNPs submitted the same model of care for more than one type of SNP. For example, in some cases, the D–SNP's model-of-care description was the same as for the chronic care SNP, the institutional SNP, or both. In one instance, the model of care did not differentiate between the D–SNP and the chronic care SNP on any elements. While some care coordination activities and benefits could be expected to be the same across all SNP populations, the lack of differentiation in some of the models of care brings into question whether the care management activities were in fact tailored to meet the distinct needs of the different special needs populations.

TABLE	
5–4	**Excerpt from a strong dual SNP's model-of-care description on transition care and patient education activities**

	Description
Transition care	• During care transitions, SNP staff will make postdischarge calls to review discharge plans and medications, to make sure that members understand the discharge instructions, and to make sure that follow-up care is scheduled and appropriate. • The case manager is responsible for ensuring that all relevant clinical information is sent to the institution the member is transitioning to, performing postdischarge calls to ensure members understand discharge orders and have access to medications and services, and investigating adverse events such as medication errors and inappropriate discharges and providing feedback to providers and institutions regarding transitions.
Patient education	• High-risk members receive a complete condition-specific assessment, review of the current treatment plan, health education, and calls from a nurse health coach to discuss the member's goals. • Low-risk members receive ongoing health education related to their chronic condition and they can contact a nurse health coach.

Note: SNP (special needs plan).

Source: MedPAC review of SNP models of care submitted to CMS.

Models of care do not discuss key elements of care coordination

The majority of the D–SNP models of care included very little discussion of the key elements of care coordination. Specifically, activities to ensure good transitions between sites of care, medication reconciliation, patient education, and real-time utilization management were typically not mentioned or only vaguely described. In contrast, most D–SNPs discussed how they assess patient risk. Plans are not required to include the key elements in their submissions and only a handful of plans clearly stated their specific care coordination activities (Table 5-4). The NCQA scoring of plans may improve some of these descriptions (see specifics below).

Transition care

About half of the D–SNPs did not mention how they managed beneficiaries' transitions between settings. Of the plans that discussed this element, the transitional care activities most frequently noted were coordinating with hospital discharge planners and ensuring that beneficiaries made the follow-up medical appointments listed in the discharge plan. The majority of plans that reported on care transitions began their discharge planning process once the patient was home. A handful of plans mentioned that transitional care included movement between multiple settings, not just between the hospital and home. This aspect of models of care may improve because NCQA

will score each plan's narratives of how the plan will know whether it has achieved its goals to improve seamless transitions across settings.

Medication reconciliation

Fewer than half of the D–SNP models of care described activities of medication reconciliation. For a majority of plans, we could not determine whether the plans reconciled medications at initial enrollment, after hospital stays, or on a regular basis. In contrast, one D–SNP described its efforts in detail. The plan described reviewing the lists of enrollees' medications, opening medication containers, and ensuring that beneficiaries understood how to store the medication. Only a handful of plans mentioned conducting a medication review in the beneficiary's home, which some integrated programs told us is the most effective way to see which medications a beneficiary takes.

Patient education

Another area lacking in detail was how D–SNPs educate patients about their medical conditions and about how to seek care before a condition becomes acute. Although the majority of plans had a 24-hour nurse advice line, most plans did not describe whether patients were taught how to recognize signs of a worsening condition, who to call, and when to go to the emergency room. The models of care may become more specific in this aspect of care coordination. NCQA's scoring will evaluate

Description

- The SNP has a team that assists with the coordination of Medicare and Medicaid benefits and assists with directing members to community resources when needed. The SNPs' customer service department representatives are trained in coordination of benefits so that they can provide accurate information to members.
- SNP staff maintain a registry of service organizations and governmental agencies in the SNPs' service areas and direct members to housing assistance, legal and financial counseling, and community support groups.
- The members are provided with a provider directory that indicates which providers accept both Medicare and Medicaid. Also, the SNP's service representatives discuss Medicare and Medicaid benefit coordination with providers during in-person meetings and educational material.
- Care managers are able to view changes in members' Medicaid eligibility, access coverage, and contact information and assist members in the coordination of benefits.

Note: D–SNP (dual-eligible special needs plan).

Source: MedPAC review of D–SNP models of care submitted to CMS.

a plan's description of the efforts the plan makes to educate beneficiaries and beneficiaries' access to the interdisciplinary care team.

Real-time utilization management

Most D–SNP models of care did not discuss real-time utilization management. While many plans tracked emergency room use, many models did not discuss how plans tracked other resource use, such as an admission, in real time so that care could be coordinated. Some plans noted that a requirement for prior authorization triggered care management. A handful of models of care focused less on care management than on describing prior authorization, bringing out-of-network use within the network, and identifying when services were no longer needed. NCQA will score each plan's narratives of how the plan will know whether it has achieved its goals to ensure appropriate service use.

Coordination with Medicaid benefits

Despite the fact that dual-eligible beneficiaries, by definition, can receive benefits from both Medicare and Medicaid, D–SNP model-of-care descriptions are

not required to report on their efforts to coordinate beneficiaries' Medicaid benefits. Most of the D–SNP models of care we reviewed did not describe efforts to coordinate dual-eligible beneficiaries' Medicaid benefits and did not discuss which, if any, Medicaid benefits the plan covered. D–SNPs are not required to report on their coordination with Medicaid and the majority of D–SNPs did not. Of the few plans that mentioned coordinating with Medicaid, the descriptions were vague. For example, most of the D–SNPs did not state which of the following activities they provided: covering Medicaid services in their benefit packages, finding providers that accept Medicaid, coordinating services covered by Medicaid, explaining Medicaid benefits to dual-eligible beneficiaries, and assisting with claims and coverage decisions. Even if the plans did not cover Medicaid benefits, coordination activities would facilitate dual-eligible beneficiaries' access to Medicaid services. Only a handful of plans noted that they helped inform beneficiaries about their Medicaid benefits or helped identify Medicaid providers (see Table 5-5 for one D–SNP's description).

Fewer than one-quarter of the plans we reviewed specified whether the D–SNP had a contract with the state and, if so, what the contract covered. The lack of reporting on Medicaid coordination did not appear to be related to whether a D–SNP had a contract with a state or was fully integrated. For example, one D–SNP stated that it was also a Medicaid managed care plan, but the model of care described only the members' Medicare benefits and not how coordination with Medicaid benefits would occur. The plan's patient questionnaire implied that the health plan coordinated Medicare and Medicaid benefits, but it was not clear whether dual-eligible members had the same case manager for their Medicare and Medicaid benefits or separate case managers.

Enrollee risk assessment

Assessing enrollees' risk for high use of costly services was the one key care coordination element in our framework that most D–SNP models of care described, which is not surprising given that detailing a plan's health risk assessment is one of the required elements in the model-of-care description. In general, D–SNP enrollees are initially surveyed, usually by paper survey or telephone, about their health, their ability to perform daily activities, their mental state, and, less frequently, their use of prescription medications and recent hospitalizations. This information is often combined with existing Medicare data on utilization and the beneficiary's risk score (the CMS–hierarchical condition categories

TABLE
5–6

Publicly reported quality data on special needs plans are limited

	Star ratings	HEDIS® measures	NCQA structure and process measures
Year data made available	Every year	2008	Not made available
Limitations	• SNP data are included under a broader contract with non-SNP plans. • Many SNPs have small enrollments—ratings are missing for many plans.	• No composite measure • Many SNPs have small enrollments—many plans have missing data.	• No composite score to summarize a plan's performance across the measures.

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), NCQA (National Committee for Quality Assurance), SNP (special needs plan).

Source: MedPAC analysis of the public reporting of Medicare Advantage star ratings, HEDIS® measures, and NCQA structure and process measures.

(CMS–HCC) score) in assigning an enrollee to a risk group. For example, many plans use a predictive model that combines information on diagnoses (especially chronic conditions), severity, recent emergency room and hospital use, and CMS–HCC score. Less frequently, the stratification considers referrals from providers, the use of hospice/palliative care, an assessment of the enrollee's social isolation and risk for depression or falls, laboratory results indicating a worsening condition, pharmacy data indicating high-cost patients, diet and exercise, and whether the enrollee has received services from multiple specialists or lacks a primary care provider. A minority of plans mentioned conducting a home or in-person assessment for enrollees identified as high risk based on an initial assessment. Only one plan mentioned doing a cultural assessment. Enrollee risk groups are often disease specific, based on the enrollee's frailty and risk for hospitalization.

Most D–SNPs described reassessing the risk level assigned to enrollees at least annually. In these plans, certain service use—most often hospitalizations, emergency room or behavioral health service use, and specific patterns of prescription drug spending—prompts reevaluation. Without specific events that generally trigger a reassessment, plans' frequency of assessments varied by risk level and plan. For example, one plan reassessed its enrollees monthly, bimonthly, or every three months, depending on the risk group. Another plan offered case management to dual-eligible beneficiaries with specific chronic conditions and reassessed them every three months; all other enrollees were evaluated annually. A couple of plans contract out their periodic evaluations, with specific problems forwarded to them for follow-up.

Additional care coordination information is available from unpublished data sources

Our analysis of whether D–SNPs with stronger model-of-care descriptions performed better on outcome measures was limited by a lack of publicly available quality data for D–SNPs. There are three potential sources for D–SNP quality-of-care data: MA plan star ratings, SNP-specific HEDIS subset measures, and NCQA structure and process measures. Of these sources, only the SNP-specific HEDIS subset measures are publicly available, but this information has not been updated since 2008. CMS could publish SNP-specific data to facilitate the evaluation of plans and beneficiary choice among SNPs, MA plans, and fee-for-service. Making the SNP HEDIS and NCQA data publicly available and developing and reporting SNP star ratings could help the policy community compare the quality of care of D–SNPs and identify areas for improvement. In addition, publicly reporting SNP-specific quality data could help dual-eligible beneficiaries make informed decisions when choosing among a SNP, another MA plan, an integrated care program, or fee-for-service.

Star ratings are not separately calculated for most SNPs

It was not possible to discern whether the quality of the model-of-care descriptions was related to the D–SNPs' MA plan star rating, because most SNPs do not have their own star ratings (Table 5-6). Star rating information for most SNPs is included in the overall reporting under a larger MA contract, which includes non-SNP plans. As a result, the data used to calculate MA star ratings are not currently submitted at the SNP level. The exception

is a health plan that is exclusively a SNP and has an enrollment large enough to calculate a rating.

The Commission has discussed the need for SNPs to have their own star ratings so that CMS and beneficiaries can compare a SNP's performance with regular MA plans. To rate them under the star system, SNPs would need to submit data in addition to what is currently required. CMS may need to address the issue of small sample sizes for some of the individual measures—for example, by pooling a plan's data over multiple years.

Publicly reported SNP-specific HEDIS measures are not regularly available

CMS has not published the results for the 15 HEDIS measures that SNPs have been required to report since 2008. Because the models of care we reviewed were submitted only by new or expanding plans that were generally not in operation in 2008, we were missing measures for most of the plans for which we had models of care. In reviewing the SNP-specific HEDIS data that were publicly available, we found this information difficult to use, particularly from a beneficiary's perspective. For one thing, data are reported for individual HEDIS measures, but there is not a composite measure reflecting the overall performance across all measures. In addition, many of the HEDIS results are blank because SNPs' sample sizes were too small for measures to be calculated. A strategy such as pooling data over multiple years may be needed to obtain sufficient sample sizes for the smaller plans. CMS is planning to make public the more recent SNP-specific HEDIS results but has not set a timetable to do so.

NCQA structure and process measures are not publicly reported

A SNP's structure and process measures are not publicly available; therefore, we were not able to compare the model-of-care descriptions with these data. This information is collected by NCQA and forwarded to CMS. To date, NCQA has not developed a composite measure to aggregate a plan's performance across all six measures.

Information D–SNPs report needs to be targeted and streamlined

On the basis of our review of the D–SNP models of care, we have concluded that the model-of-care descriptions as currently submitted cannot be used to evaluate the care coordination for dual-eligible beneficiaries. However, CMS is undertaking several activities aimed at improving

the models of care submitted by SNPs. In 2011, CMS held a series of training sessions for plans to learn what CMS expects in the models of care. Plans have been told to give specific examples for each element in the model of care. CMS also audited a sample of models of care, including site visits to verify that the plan conducted its activities as reported. CMS will use this information to revise and improve the models of care. CMS also intends to provide feedback to those plans and share the results of this review as part of a "best practices" discussion with all plans. Last, CMS may develop template models of care for each type of SNP so that the submissions more closely match the target populations. While these efforts are aimed at the shortcomings associated with the currently required elements, they will not address the problem of missing key elements of care coordination that are not required as part of the MA approval process.

The Commission questions whether the model-of-care descriptions are necessary to assess if plans coordinate care, given that SNPs already submit documents that are easier to review and include more of the key elements of care coordination of integrated programs (see Table 5-2, p. 128). One alternative to the model of care is the attestation submitted as part of the MA application. Currently, this information is not reviewed as part of the model-of-care evaluation even though it includes information relevant to care coordination activities, such as the plan's transition care activities and medication reconciliation. Compared with the models of care, the format of the attestation questions is much simpler for plans to submit and easier for CMS to review. The attestation does not include questions about the D–SNP's coordination with Medicaid services, however, and those questions would need to be added to the attestation to make that tool complete.

Other alternatives to the model-of-care descriptions are the NCQA structure and process measures that SNPs are required to report. CMS could use these measures as the basis for NCQA's approval of SNPs rather than the model-of-care descriptions. The structure and process measures include many of the key care coordination and Medicaid integration elements of the integrated programs we researched. SNPs are already required to report on these measures and the information is collected in a survey format. Additional elements would need to be added or existing elements expanded to gauge all key care coordination elements, such as patient education. Compared with the model-of-care descriptions, the structure and process measures would be less burdensome

for SNPs to report and for CMS to review. In addition, NCQA and CMS could develop a composite score of the measures to make them easier for beneficiaries to understand.

Another option is for CMS to focus on measuring the impact of care coordination through outcome measures (see discussion, p. 140) rather than on the model-of-care descriptions. Outcome measures would gauge whether care coordination has improved patient satisfaction, enhanced quality of life, and averted hospitalizations and emergency room use. The outcome measures could be collected in addition to data on structures and processes. Continuing to collect structure and process measures would facilitate our understanding of which care coordination activities result in good performance. CMS should decide which key elements of care coordination and outcomes programs should be required to report on and streamline its reporting requirements to that limited set.

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Conclusions and next steps
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Programs that integrate Medicare and Medicaid financing and are responsible for all services are more likely to have the flexibility to meet beneficiary care needs. The variation in programs across states reflects individual state circumstances and preferences toward integrated programs, availability of state resources to implement integrated programs, and the ability of states to overcome or accommodate providers' and advocates' concerns. Capitated, risk-based programs that integrate financing and care delivery offer the most promise for improving care coordination. However, not all states can or want to implement such programs. Also, fee-for-service overlays can begin to coordinate services for these beneficiaries. Low enrollment in integrated programs is a barrier and a large expansion in enrollment in these programs is unlikely without major policy changes.

Full integration of finances and services offers the best opportunity for care coordination

Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services. In these programs, an entity receives capitated payments from Medicare and Medicaid to offer and assume risk for all services to dual-eligible beneficiaries. Under one plan type, a managed care entity receives the

payments; under the other, a PACE provider does. Because either entity is at full risk, it has the financial incentive to furnish an efficient, effective mix of services that lower total costs while improving patient outcomes. The entities also have the flexibility to intervene with whichever medical and social services are covered by Medicare and Medicaid and are necessary to help beneficiaries avoid hospitalizations, nursing home placements, and deterioration. PACE providers also have the flexibility to intervene with noncovered, nonclinical services such as fixing the carpet in beneficiaries' homes to prevent falls or supplying bottled water to prevent dehydration. In contrast, fee-for-service payment systems lack such financial incentives and flexibility and instead encourage individual providers to deliver a high volume of care, regardless of its clinical value or connection to services furnished by the patient's other providers.

Care coordination within fee-for-service Medicare

Care coordination can operate within fee-for-service Medicare but this approach has less promise than capitated, risk-based integrated programs for effectively coordinating services. The range of services covered under the integrated program could vary from acute care services (as in the North Carolina primary care network) to long-term care and behavioral health services. Accountable care organizations (ACOs)—which combine a fee-for-service payment structure with some financial risk incentives— are also of interest with regard to care coordination for dual-eligible beneficiaries. Although more limited than capitated, full risk-based programs in the alignment of financial incentives, ACOs and other fee-for-service overlays represent a stepping stone to fuller integration in states unlikely to adopt managed care or full risk-based integrated arrangements.

A single program design is not likely to be adopted in every state

States develop integrated care program designs based on a state's unique characteristics, including its approach to managing the Medicaid-only population, experience with managed care, providers' and advocates' concerns, presence of provider networks and managed care organizations, and the support of a strong leader to champion integrated care. Given the variation across states, it would be unlikely for states to embrace the same program approach, scale, or scope. In addition, there is no clear evidence about which programs are most effective for every type of dual-eligible beneficiary.

Acknowledging that multiple designs might be needed to match the varying states' environments, the Federal Coordinated Health Care Office at CMS requested proposals from states to design and implement programs to coordinate the care for dual-eligible beneficiaries. CMS has funded 15 contracts to assist states in developing a range of integrated care program designs.

Increasing differentiation among D–SNPs

Recognizing that D–SNPs need to coordinate Medicaid-financed services, CMS has begun to distinguish between fully integrated SNPs and other D–SNPs. PPACA defines a fully integrated D–SNP as a D–SNP with a capitated contract with a state to provide Medicaid benefits, including long-term care. SNPs that meet this definition and enroll patients with similar average frailty levels as PACE providers will receive a frailty adjustment.

CMS is also considering an initiative to promote enrollment in high-quality, fully integrated SNPs beginning in 2013. The fully integrated SNPs that qualify for this initiative may be eligible for flexibilities that would encourage care coordination and simplify administrative procedures. CMS has not determined how high quality will be defined, how enrollment in these plans will be promoted, or what types of flexibilities the qualifying SNPs will be eligible for. In our research on integrated programs, we found that PACE providers had more flexibility in how they used Medicare payments than SNPs because SNPs are not permitted to use Medicare dollars to cover non-health-care services and may be able to offer nonclinical services only if they are covered under Medicaid.

Consistent set of outcome measures is needed to evaluate integrated programs

Common performance measures are critical to evaluating alternative designs for integrated programs. The evaluation should include cost, administration, and quality measures. Cost measures should consider the total annual cost of all services to both programs. It is important to know, for

example, if a program that is narrow in scope has lowered its own spending but has shifted costs to services and providers beyond its purview. Administrative measures could evaluate the efficiency of program administration (medical loss ratio), call waiting times for enrollees, and disenrollment rates. Outcome measures could include patient satisfaction, quality of life, hospital admission and readmission rates, rates of emergency room use, institutionalization for long-term care, and medication errors. In its 2012 call letter, CMS outlined plans to add several outcome measures to the MA plan star ratings, including all-cause admission rates, risk-adjusted mortality rates, preventable hospitalizations, and serious reportable adverse events including hospital-acquired conditions. The collection and public reporting of these measures for integrated programs, MA plans, SNPs, and fee-for-service Medicare would allow for comparisons across programs. Beginning in 2012, all MA plans, including SNPs, have to submit encounter data that will allow some of these outcome measures to be calculated, including hospital admissions and readmissions and emergency room use. In addition, MA plans will begin reporting all-cause readmission rates in 2011.

In addition to outcome measures, programs should report on a consistent set of measures focused on care coordination activities. This set would need to measure activities associated with care transitions, medication reconciliation, patient education, utilization management, and coordination with Medicaid benefits.

Next steps

In the coming year, the Commission plans to continue its work identifying key elements of care coordination that should be components of any form of integrated care program. In addition, it plans to explore the key elements of provider-based models of integrated care. Last, the Commission will examine an opt-out policy to increase enrollment in integrated programs and whether one could be designed to minimize the risks for providers and beneficiaries, while ensuring beneficiary protections. ∎

Endnotes

1   PACE coordinates all services for dual-eligible beneficiaries who require the level of care furnished in a nursing home, referred to as nursing-home certifiable. Currently, there are 75 PACE providers around the country, enrolling more than 18,000 dual-eligible beneficiaries (National PACE Association 2010).

2   The other two types of SNPs—institutional SNPs and chronic SNPs—may also enroll dual-eligible beneficiaries. Some individual institutional or chronic SNPs enroll mostly dual-eligible beneficiaries.

3   In the medical home model, primary care practitioners are typically paid an extra fee on a per member per month basis to coordinate care for patients between visits and across providers.

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