

C H A P T E R

3

Care coordination programs for dual-eligible beneficiaries

R E C O M M E N D A T I O N S

- 3-1** The Congress should direct the Secretary to improve the Medicare Advantage (MA) risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- 3-2** After the changes in Recommendation 3-1 take effect, the Congress should change the age eligibility criteria for the Program of All-Inclusive Care for the Elderly to allow nursing home-certifiable Medicare beneficiaries under the age of 55 to enroll.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- 3-3** After the changes in Recommendation 3-1 take effect, the Secretary should provide prorated Medicare capitation payments to Program of All-Inclusive Care for the Elderly providers for partial-month enrollees.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- 3-4** After the changes in Recommendation 3-1 take effect, the Secretary should establish an outlier protection policy for new Program of All-Inclusive Care for the Elderly sites to use during the first three years of their programs to help defray the exceptionally high acute care costs for Medicare beneficiaries.

The Secretary should establish the outlier payment caps so that the costs of all Chapter 3 recommendations do not exceed the savings achieved by the changes in Recommendation 3-1.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

- 3-5** The Congress should direct the Secretary to publish select quality measures on Program of All-Inclusive Care for the Elderly (PACE) providers and develop appropriate quality measures to enable PACE providers to participate in the Medicare Advantage quality bonus program by 2015.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

Care coordination programs for dual-eligible beneficiaries

Chapter summary

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits. In 2010, there were approximately 9.9 million dual-eligible beneficiaries. These individuals are, on average, a high-cost population for both Medicare and Medicaid and often require a mix of medical, long-term care, behavioral health, and social services. They also have fewer financial resources than the general Medicare population. While accounting for about 18 percent of Medicare fee-for-service (FFS) enrollment, they represent about 31 percent of total Medicare FFS spending (Medicare Payment Advisory Commission 2011a). They also account for about 15 percent of Medicaid enrollment and 40 percent of Medicaid spending (Kaiser Family Foundation 2011). Given the challenges this particular population faces in accessing services through two payer and delivery systems, care coordination programs have the potential to improve dual-eligible beneficiaries' access to services and the quality of care they receive. These programs also have the potential to reduce Medicare and Medicaid spending through better coordination of care.

In this chapter, the Commission assesses two approaches to care coordination for dual-eligible beneficiaries. We also discuss the forthcoming CMS demonstration projects that aim to improve care coordination for dual-eligible beneficiaries by partnering with states.

In this chapter

- Analyses of the Program of All-Inclusive Care for the Elderly
- Analyses of dual-eligible special needs plans
- CMS demonstrations on integrated care programs

- ***Program of All-Inclusive Care for the Elderly (PACE)***—PACE is a provider-based program that integrates Medicare and Medicaid benefits for the dual-eligible population who are 55 or older and nursing home certifiable. Through site visits to PACE providers, we analyzed the structure of the PACE program in urban and rural settings. We found that both urban and rural PACE providers retained the core PACE model, which structures service delivery and patient monitoring around the day care center. Enrollment in the PACE program is generally low, and the providers we visited generally enroll small numbers of beneficiaries each month. One barrier to enrollment is that eligibility for PACE is restricted to beneficiaries who are nursing home certifiable and age 55 or older. Most PACE providers we visited were able to achieve positive margins after a few years of operation by balancing costs with enrollees' needs. PACE staff also noted that having the flexibility to use Medicare funds to cover nonclinical services is an important component in being able to keep enrollees residing in the community rather than in an institution.

The literature on PACE suggests that the program reduces hospitalizations, nursing home utilization, and mortality. However, because quality data on individual PACE providers is not publicly available, we were not able to assess quality. We also found that Medicare spending on PACE enrollees exceeds what it would have been had these beneficiaries remained in traditional FFS.

The Commission's recommendations on improving the PACE program include paying PACE providers using rates established through the Medicare Advantage (MA) program and allowing these providers to participate in the MA quality bonus program, expanding Medicare eligibility for PACE to beneficiaries under the age of 55, prorating Medicare payments to PACE providers, providing PACE providers with outlier protection, and publishing select quality data on PACE providers.

- ***Dual-eligible special needs plans (D-SNPs)***—D-SNPs are MA plans that enroll dual-eligible beneficiaries. They can be integrated care programs if the plans contract with a state to cover Medicaid benefits, but most D-SNPs are not integrated care programs. Fully integrated dual-eligible special needs plans (FIDE-SNPs) are a subset of D-SNPs. They have state contracts to cover most or all of a state's Medicaid benefits, including long-term care. We analyzed quality of care and Medicare spending for D-SNPs and FIDE-SNPs. We were not able to conclude whether D-SNPs or FIDE-SNPs provide better quality of care than FFS or other MA plans because quality data were not available. Medicare payments to D-SNPs and FIDE-SNPs are higher than what Medicare would have spent had these beneficiaries remained in FFS; however, MA spending in general is higher than comparable FFS spending. The fact that the

bids submitted for Medicare Part A and Part B services by D–SNPs and FIDE–SNPs in 2012 exceeded FFS spending raises questions about the ability of these plans to provide Part A and Part B services at a cost equal to or below FFS.

Finally, we discuss D–SNPs and FIDE–SNPs having the flexibility that PACE providers have to use Medicare funds to cover nonclinical services.

- ***Discussion of CMS demonstrations on integrated care programs***—CMS is in the process of working with states to develop integrated care demonstration programs for dual-eligible beneficiaries. CMS will collaborate with individual states to test a capitated model and/or a managed FFS model for the states' dual-eligible populations. Under the capitated model, CMS will sign a three-way contract with a state and a health plan and will work with each state to develop the Medicare and Medicaid capitation rates for the plans in that state. States may also test passive enrollment with an opt-out provision during the demonstrations. CMS intends to ensure Medicare savings by setting the capitation rates at a level that provides for upfront savings. Under the managed FFS model, states will finance a care coordination program for dual-eligible beneficiaries. In that model, the beneficiaries will remain in Medicare FFS. Under both approaches, CMS intends to share a portion of Medicare savings with the states.

The Commission supports the goals of the demonstrations and believes they provide an opportunity to learn more about how to improve care management and quality of care for dual-eligible beneficiaries. As the Commission has previously reported, the current FFS Medicare and Medicaid systems for most dual-eligible beneficiaries have conflicting incentives, which can discourage care coordination and lead to poor quality of care and higher Medicare and Medicaid spending (Medicare Payment Advisory Commission 2010a). The demonstrations are an opportunity to test how to encourage care coordination, improve quality of care, and reduce spending by reducing some of the conflicting financial incentives between Medicare and Medicaid.

The demonstrations are also an opportunity to test how to tailor capitated and FFS overlay models to different subgroups of dual-eligible beneficiaries. The Commission has stated that these two models hold promise to improve care coordination for dual-eligible beneficiaries. In addition, through the three-way contracts, the capitated model demonstration can test how to overcome some of the barriers to the development of integrated care programs (Medicare Payment Advisory Commission 2010a).

However, there are a number of outstanding issues with the demonstrations. We want to ensure that the dual-eligible beneficiaries who participate in the demonstrations are matched with care delivery organizations that can meet their needs and improve the quality of the care they receive. The dual-eligible population is very heterogeneous with respect to health status, cognitive status, and physical or developmental disabilities. It is therefore important that the demonstrations be structured to test which care management models and financial incentives improve quality of care for subgroups of dual-eligible beneficiaries. It is also important that the demonstrations ensure that beneficiaries have alternative sources of care if the demonstration plans fail to meet their needs.

Most states pursuing the capitated model are proposing to enroll most or all dual-eligible beneficiaries in a state or entire subgroups of beneficiaries (such as disabled individuals under the age of 65) in a state into a health plan. However, the varied and complex needs of many of these individuals leads us to question whether care management models should be tested on large numbers of dual-eligible beneficiaries or entire subgroups within a state. In addition, the large scope also makes the demonstrations appear to be large-scale program changes rather than true demonstrations. Further, it can limit the evaluation of the demonstrations if there are not comparable beneficiaries in FFS for comparison.

It is unclear how CMS and the states are going to ensure that dual-eligible beneficiaries are matched with the best care management models to meet their needs given the participating plans' lack of experience with this population. Our work suggests that about 20 health plans have experience being capitated and at risk for all Medicare and Medicaid benefits. These plans do not operate in every state that has proposed a demonstration, most do not operate state wide, and none of these plans serves every subgroup of dual-eligible beneficiary. It therefore is not clear whether every plan that participates in the demonstration will be able to establish provider networks and provider payment rates that encourage high-quality care and care coordination for services with which they lack experience. When selecting plans for the demonstration, CMS and the states will have to balance having plans available to participate in the demonstration with selecting plans with enough experience for there to be a reasonable expectation that the plans will succeed in serving the dual-eligible beneficiaries.

CMS and states propose to use passive enrollment with an opt-out provision for the capitated model demonstrations. Under this enrollment strategy, states will assign beneficiaries to a health plan through passive enrollment with

“intelligent assignment” unless the beneficiaries opt out of the demonstration or select a demonstration plan. We have documented that low enrollment is a barrier to the expansion of integrated care programs (Medicare Payment Advisory Commission 2010a). Passive enrollment with intelligent assignment can be used to increase enrollment into integrated care programs with proven experience providing high-quality care; however, we are uncertain whether it can be appropriately executed during the demonstrations.

We do not know whether every state has the resources and information on dual-eligible beneficiaries to make intelligent assignments that best match beneficiaries’ needs to appropriate care management plans. We also do not know whether CMS and each state will require plans to meet certain quality or experience criteria to be eligible for passive enrollment. There are many aspects of this enrollment strategy that CMS and states will need to determine. The structure of passive enrollment with intelligent assignment is an important beneficiary protection.

Finally, CMS and some states are working toward an implementation date of January 1, 2013. This short period may not give CMS and these states adequate time to resolve all the outstanding issues. The Commission’s greatest concern is that all dual-eligible beneficiaries in a state will be enrolled in the demonstration, representing a program change rather than a demonstration. The Commission will continue to consider this and other concerns as we move forward. ■

Introduction

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits. In 2010, there were approximately 9.9 million dual-eligible beneficiaries.¹ Most dual-eligible beneficiaries qualify for full Medicaid benefits, including long-term care. They are referred to as full-benefit dual-eligible beneficiaries. Partial-benefit dual-eligible beneficiaries have higher incomes than full-benefit dual-eligible beneficiaries and receive assistance with Medicare premiums and cost sharing but do not receive other Medicaid benefits. The dual-eligible population is diverse and includes individuals with multiple chronic conditions; difficulties with activities of daily living; cognitive impairments such as dementia; individuals who are relatively healthy; and individuals with physical disabilities, developmental disabilities, and severe mental illness. Given the diversity of their needs, dual-eligible beneficiaries require a mix of medical, long-term care, behavioral health, and social services. Dual-eligible beneficiaries also have lower financial resources than the general Medicare population. In 2006, more than half of dual-eligible beneficiaries had incomes below the poverty line, compared with 8 percent of non-dual-eligible Medicare beneficiaries (MedPAC 2010a).

Dual-eligible beneficiaries are, on average, a high-cost population to both Medicare and Medicaid. They account for approximately 18 percent of Medicare fee-for-service (FFS) enrollment but about 31 percent of total FFS spending (Medicare Payment Advisory Commission 2011a). They also account for about 15 percent of Medicaid enrollment and 40 percent of Medicaid spending (Kaiser Family Foundation 2011). Medicaid is a jointly financed federal and state program; therefore, total federal spending on dual-eligible beneficiaries is higher than Medicare spending alone. One study estimated that federal spending accounted for 80 percent of total spending on dual-eligible beneficiaries (Coughlin et al. forthcoming). The 80 percent is a combination of Medicare spending and the federal portion of the Medicaid payments, known as the federal medical assistance percentage (FMAP). FMAP rates vary by state and range from 50 percent to 73 percent for fiscal year 2013 (Kaiser Family Foundation 2012). The average FMAP rate for 2013 is 59 percent.

Given the challenges this particular population faces in accessing services through two payer and delivery systems, care coordination programs have the potential to improve dual-eligible beneficiaries' access to services and

the quality of care they receive. A program that integrates Medicare and Medicaid services and financing could improve beneficiaries' quality of care and reduce Medicare and Medicaid spending through better care coordination. To that end, the Commission has been analyzing existing programs that integrate and coordinate care for dual-eligible beneficiaries to assess whether, relative to FFS, the programs improve quality of care and reduce spending (see text box on Commission reports on dual-eligible beneficiaries, p. 68).

Two main integrated care programs cover all Medicare and Medicaid benefits for dual-eligible beneficiaries: the Program of All-Inclusive Care for the Elderly (PACE) and dual-eligible special needs plans (D-SNPs). PACE is a provider-based program and one of the few programs that completely integrates Medicare and Medicaid benefits, including long-term care and behavioral health services as well as medical care. D-SNPs are Medicare Advantage (MA) special needs plans (SNPs) that target enrollment to dual-eligible beneficiaries. These plans can be integrated care programs if they contract with a state to cover all or most Medicaid benefits. PACE and D-SNPs involve one entity (a provider in PACE or a managed care plan under D-SNPs) receiving separate capitation payments from Medicare and Medicaid and assuming full risk for the Medicare and Medicaid benefits that the entities cover. CMS plans to test additional integrated care programs through demonstrations that are under development. Under these demonstrations, states will be able to implement capitated integrated care programs and managed FFS programs.

Our findings on the PACE program stem from site visits to urban and rural PACE providers to assess how the PACE model operates in those settings, literature on the PACE programs' quality of care, and analyses of publicly available quality data on PACE providers and Medicare's payments to PACE providers. To develop findings on D-SNPs and a subset of D-SNPs known as fully integrated dual-eligible special needs plans (FIDE-SNPs), which have state contracts to cover most or all Medicaid services including long-term care, we analyzed the available data on quality of care and Medicare spending on these plans. The Commission also held a panel meeting on opt-out enrollment strategies for dual-eligible beneficiaries. The results from that panel are summarized in the text box (pp. 70–71). Finally, we also discuss our current understanding of the structure of the CMS demonstrations and identify issues to consider with the design and evaluation of the demonstrations.

Commission reports on dual-eligible beneficiaries

The Commission has reported on dual-eligible beneficiaries in the June 2010 and 2011 reports (Medicare Payment Advisory Commission 2010a, Medicare Payment Advisory Commission 2011b). In the June 2010 report, the Commission noted that dual-eligible beneficiaries account for disproportionate shares of Medicare and Medicaid spending relative to their enrollment. We also found that fewer than 2 percent of dual-eligible beneficiaries were enrolled in a program that integrated their Medicare and Medicaid benefits. Barriers to the development of integrated care programs included lack of experience with managed care for long-term care services, resistance from providers and other stakeholders, states wanting to share in savings that accrue to the Medicare program, separate Medicare and Medicaid

administrative procedures, and low program enrollment (Medicare Payment Advisory Commission 2010a).

In the June 2011 report, after site visits to managed care-based integrated care programs, provider-based integrated care programs, and fee-for-service care coordination programs, we found that these structurally different programs had key care management characteristics in common: assessing patient risk, developing an individualized care plan, managing service use, conducting medication reconciliation, guiding enrollees through transitions in care, establishing medical advice that is available 24 hours a day/7 days a week, maintaining regular contact with enrollees, and maintaining a centralized electronic health record (Medicare Payment Advisory Commission 2011b). ■

Analyses of the Program of All-Inclusive Care for the Elderly

PACE is a provider-based program that serves frail, elderly Medicare and Medicaid beneficiaries. It is a benefit under the Medicare program and an optional benefit under Medicaid. PACE providers receive separate capitation payments from Medicare and Medicaid and blend those funds to cover all primary, acute, and long-term care; behavioral health services; prescription drugs; and end-of-life care planning. PACE is one of the few programs that completely integrates Medicare and Medicaid benefits. The goal of PACE is to keep enrollees living in the community rather than in long-term care institutions. Beneficiaries are eligible to enroll in PACE if they are age 55 or older and are certified by their state as being eligible for a nursing home level of care. The requirements for determining whether beneficiaries are eligible for a nursing home level of care vary by state, though generally they are defined as needing assistance with two or more activities of daily living or having a cognitive impairment.

Background on the PACE program

CMS and states are jointly responsible for oversight of PACE providers. The providers are required to be nonprofit organizations; for-profit organizations can sponsor PACE programs through a demonstration program

operated by CMS. Currently, five for-profit PACE sites are operating through a demonstration program and all are located in Pennsylvania. A total of 84 PACE sites in 29 states serve about 21,000 enrollees nationwide (National PACE Association 2012).² Enrollment in individual PACE programs ranges from about 20 to almost 2,600, with about two-thirds of sites enrolling fewer than 300 beneficiaries.

The core of the PACE model is the day care center, where enrollees receive therapy and medical services from members of an interdisciplinary team (IDT). The IDT utilizes attendance at the day care center to monitor enrollees' health status and manage their clinical care and supportive service needs. The IDT is required to consist of a primary care physician, registered nurse, master's level social worker, physical therapist, occupational therapist, activity coordinator, dietitian, PACE center manager, home care coordinator, personal care attendant, and driver. The day care center and IDT requirements make PACE a capital-intensive model with high start-up costs. PACE providers can open "satellite" alternative care settings in addition to the day care center, where enrollees receive a limited number of PACE services provided by a subset of the IDT. There is also a conceptual variation of PACE referred to as "PACE without walls." This model would not include a day care center but would include other PACE principles such as the IDT, full financial risk for

services, and full integration of services provided under the Medicare and Medicaid benefits. Interest in this model stems from the desire to expand the PACE model to serve more beneficiaries by eliminating the capital costs and enrollment capacity limitations associated with the day care center.

Most PACE sites employ a primary care physician and enrollees must change from their current primary care physician to the PACE physician when they join the program. However, PACE providers may apply to CMS for a waiver to contract with primary care physicians in the community. If CMS grants the waiver, enrollees can stay with their existing physician and can also be treated by the PACE physician while in the day care center.

Characteristics of PACE enrollees

Most PACE enrollees are dual-eligible beneficiaries; however, Medicare-only beneficiaries can enroll and pay the Medicaid capitated rate out of pocket. States can also permit Medicaid-only beneficiaries to enroll and states pay a higher capitated rate for them.

Medicare PACE enrollees tend to be older than 75, female, and White.³ Of the almost 21,000 beneficiaries enrolled in PACE in 2009, almost two-thirds (65.8 percent) were over the age of 75. Another 26 percent were between the ages of 65 and 75 and only 8 percent were between the ages of 55 and 64. In addition, more females were enrolled in PACE than males (72.3 percent and 27.7 percent, respectively). More than half of the beneficiaries enrolled in PACE in 2009 were White (56.9 percent), while almost one-quarter (24.8 percent) were African American, almost 8 percent were Hispanic, and 7.4 percent were Asian American.⁴ In 2009, 9.8 percent of PACE enrollees died during the year.

Disenrollment from PACE is low. Excluding beneficiaries who died during the year, 5 percent of Medicare beneficiaries disenrolled from PACE in 2009. In addition, a very small number of Medicare PACE enrollees (0.2 percent) disenrolled from PACE in 2009 but reenrolled at the same or another PACE site the same year.

Medicare payments to PACE providers

Medicare payments to PACE providers are based on the MA risk-adjustment system, which develops risk scores using the CMS-hierarchical condition category (HCC) model. Under this system, a county benchmark rate (the base payment rate) is multiplied by the individual participant risk score to determine the risk-adjusted

payment for each enrollee. PACE payments differ from payments to MA plans in a number of ways:

- Unlike MA plans, PACE providers do not submit bids to CMS. MA plans use rebates (which occur when a plan's bid is below its applicable benchmark) to offer beneficiaries supplemental services, such as dental and vision care; however, these services are already included in PACE. PACE providers receive the full risk-adjusted benchmark as their Medicare payment.
- CMS began using a revised HCC model in 2012 to risk-adjust payments to PACE providers, whereas MA plans will continue to be paid based on the nonrevised HCC model. The revised risk-adjustment model adds dementia as a condition, which may affect payments to PACE providers as many PACE enrollees have dementia.
- Payments to PACE providers are adjusted for frailty. The frailty adjuster is calculated from the Health Outcomes Survey—Modified data that are collected on PACE enrollees and includes questions about activities of daily living and physical and mental health. The responses are used to produce a frailty factor for each PACE provider, which is added to each PACE enrollee's HCC score. As such, a PACE provider's total risk-adjustment factor consists of the HCC score and the provider's frailty score. For example, the frailty factor is 0.147 for a provider whose enrollees have an average of three or four activities of daily living. This factor is added to the HCC score for every Medicare beneficiary enrolled in that PACE provider's program. An enrollee with an HCC score of 2.4 would have a total risk-adjustment factor of 2.547 (2.4 + 0.147).
- Unlike integrated care programs that are operated by SNPs, PACE providers have statutory waivers that expand the scope of services they can provide to their enrollees. SNPs, like other MA plans, may use Medicare funds only to provide Medicare-covered services and may use rebate dollars only to provide items and services that can be classified as health care services. However, PACE providers can furnish any service or item authorized by the IDT in an enrollee's plan of care, regardless of whether those services are covered under traditional Medicare or Medicaid benefit packages.
- The Patient Protection and Affordable Care Act of 2010 (PPACA) made changes to the MA payment

Results from panel on opt-out enrollment strategy for dual-eligible beneficiaries

In July 2011, the Commission convened a panel of stakeholders who had experience with or expertise in dual-eligible issues to discuss an opt-out enrollment strategy for integrated care programs. Under opt-out enrollment an individual is automatically enrolled in a particular program unless the individual opts out of the program by choosing another plan or choosing to stay in fee-for-service (FFS). Panelists included representatives from managed care organizations, state integrated care programs, beneficiary advocates, and existing managed care and provider-based integrated care programs. They were asked to consider opt-out enrollment for integrated care programs that currently exist or that may be developed in the future. Panelists were asked to discuss any concerns they might have with opt-out enrollment and whether policies could be designed to address these concerns.

Participants gave their perspectives on the types of standards necessary for integrated care programs to be considered candidates for opt-out enrollment. Those requirements included:

- **Care coordination**—Panelists stated that integrated care programs should change the delivery system to achieve real care coordination. They noted that many health plans have networks of providers but do not operate as a true network. One panelist stated that integrated care programs should go beyond care coordination through multidisciplinary care teams and focus on redesigning primary care systems. Panelists also stated that care coordination should involve reviewing beneficiaries' medications, assisting beneficiaries through transitions of care, coordinating with beneficiaries' behavioral health providers, having systems that notify the program within 24 hours of a beneficiary's hospital admission, coordinating with social services, and developing plans for end-of-life care. Some panelists noted that receiving information on beneficiaries' service use before they joined the program would help with care coordination.
 - **Member-centered programs**—Many panelists stated that the integrated care programs should be
- member centered and value the outcomes that the beneficiaries want. Characteristics of member-centered programs include comprehensively assessing beneficiaries, involving beneficiaries or their families in developing their plan of care, ensuring that the care plan is driving the care management, measuring consumer satisfaction, and tracking outcomes related to a beneficiary's condition. One panelist noted that integrated medical records could help facilitate member-centered care.
- **Benefit packages that meet beneficiaries' needs**—Panelists discussed the importance of integrated care programs establishing benefit packages that meet beneficiaries' needs. Some panelists noted the importance of including home- and community-based services and durable medical equipment in the benefit package. Other panelists stated that integrated care programs should meet beneficiaries' needs across a continuum of care. For example, one panelist noted that some beneficiaries might need less-intensive care coordination while beneficiaries with five conditions might need an intensive program.
 - **Consumer representation**—Many panelists strongly advised having integrated care programs involve beneficiaries in plan operations. This goal could be achieved by having beneficiary representation on governing or advisory boards. Panelists also stated that beneficiary involvement must be meaningful.
 - **High quality**—Many participants were comfortable with only high-quality plans being eligible for opt-out enrollment. Panelists suggested the following quality indicators to measure integrated care programs: time spent on care coordination, beneficiaries' access to a provider of choice, member satisfaction, provider satisfaction, number of appeals and grievances and the nature of those complaints, disenrollment rates, Healthcare Effectiveness Data and Information Set scores, access to a person at a call center, emergency department admission rates, 30-day hospital

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Results from panel on opt-out enrollment strategy for dual-eligible beneficiaries

readmission rates, and number of hospital days and nursing facility days.

Panelists also discussed their concerns about an opt-out enrollment policy and issues that would need to be considered in designing this policy.

- **Beneficiary choice**—One concern among panelists was the need for an opt-out policy to respect individual choice and the need to make special efforts on behalf of beneficiaries and their families who are unable to navigate the Medicare and Medicaid systems on their own. The panelists also discussed whether the opt-out policy would be applied only to beneficiaries in fee-for-service, to those enrolled in Medicare Advantage plans, or to beneficiaries already enrolled in another integrated care program.
- **Plan assignment**—Panelists questioned how plan assignment would be done under an opt-out enrollment policy if there were multiple plan options. Many panelists discussed the entity that would assign the beneficiary into an integrated care program. While there was not consensus on which entity should make plan assignments, a number of participants noted the importance of the assignments being made by an independent, unbiased entity. One participant noted that an independent entity could make assignments to match beneficiaries' needs with a program designed to meet those needs rather than enrolling beneficiaries in a plan at random. Multiple panelists also discussed the need for the unbiased entity to provide beneficiaries with information about their choices and to help them decide whether to opt out.

- **Access to providers and services**—Panelists were largely concerned about beneficiaries losing access to their current providers and services when they transitioned to an integrated care program. They discussed the importance of integrated care programs including beneficiaries' current providers in their networks. However, if beneficiaries had to change providers, a few panelists suggested a transition period of 90 days when enrollees could still access their former providers and make plans to transition to the new ones. Another panelist noted the importance of programs' networks including providers that are close to where beneficiaries live.
- **Monitoring and oversight**—Panelists emphasized the importance of monitoring integrated care programs, particularly under an opt-out enrollment policy. Some panelists stated that it is unclear whether the federal government or states would be responsible for monitoring existing integrated care programs. Other panelists noted that budget constraints have reduced some states' capacity to monitor programs. One panelist suggested that ombudsmen may be able to help with monitoring appeals and grievances.

There was no consensus among panelists on the need for an opt-out enrollment policy. Participants expressed more comfort with an opt-out enrollment policy if the integrated care program met the standards described above and the outstanding issues and concerns were addressed. Some panelists were skeptical that integrated care programs could meet all the standards. Other panelists suggested that voluntary enrollment could be improved, eliminating the need for an opt-out enrollment policy. ■

system that do not apply to PACE providers. PPACA established new county benchmarks to better approximate a county's FFS spending; however, PACE providers are still paid on pre-PPACA benchmarks. In addition, PPACA introduced a quality bonus system and a phase-out of indirect medical education payments from MA capitation rates; these changes did not apply to PACE.

For the PACE sites that we visited, average Medicaid monthly payments were higher than Medicare monthly payments. These sites were in states that partially based their payments to PACE providers on the payment rates to nursing homes for long-term care services. For the PACE sites we visited, the average Medicaid per member per month payments ranged from \$3,300 to \$4,000 (this payment includes the federal and state components of

Medicaid's financing) and the average Medicare per member per month payments ranged from \$1,700 to \$2,600. This information was given to us anecdotally by the PACE sites and we were not able to independently verify the average Medicare and Medicaid payments. Further, the Medicare and Medicaid payments of these providers may not be representative of payments across all PACE providers.

Quality measures

PACE providers are required to report a number of quality measures to CMS. These measures include the rate of routine immunizations, grievances and appeals, disenrollment, hospital readmissions, emergency care, unusual incidents, deaths, falls or traumatic injuries resulting in death or that require a hospitalization of five days or more, infectious disease outbreaks, and acquisition of a pressure ulcer. CMS uses these data to monitor the quality of care at PACE sites, and certain outcomes trigger an internal investigation by the PACE plan and a root cause analysis of factors that contributed to the event. However, CMS does not publicly report the PACE quality measures.

Rural PACE grant program

To encourage the expansion of PACE into rural communities, the Congress authorized a rural PACE provider grant program in the Deficit Reduction Act of 2005 (DRA). The grant program allocated \$7.5 million in fiscal year 2006 to be awarded to up to 15 prospective PACE sites. CMS provided 14 sites with grants of \$535,000 each. The grant monies were disbursed after a site entered into a signed agreement with the state and CMS. The rural PACE sites also had access to an outlier pool for the first three years of operation to defray exceptional costs of hospitalizations and related ancillary services. Under the outlier protection, providers could receive 80 percent of costs that exceeded \$50,000 per enrollee. The money for the grants and the outlier pool was appropriated by the Congress as part of the DRA.

Methodology of analyses of the PACE program

The analyses of the PACE program consisted of three parts: site visits to urban and rural PACE providers, a review of quality-of-care data on the PACE program, and analyses of the Medicare payment system for PACE. Our site visits included two urban PACE providers in 2010 and four rural PACE providers in 2011. We also interviewed a fifth rural provider in 2011. The PACE

sites included in our analysis were Senior CommUnity Care, with day care centers in Montrose and Eckert, CO; Riverside PACE in Hampton, VA; LIFE in Philadelphia, PA; LIFE Geisinger in Kulpmont, PA; Northland PACE, with centers in Dickinson and Bismarck, ND; Piedmont Health SeniorCare in Burlington, NC; and Siouxland PACE in Sioux City, IA. We did not intend for the site visits to be representative of the experiences of all PACE providers. We selected the sites based on geographic variability and variety of sponsoring organizations, including health systems, hospitals, and organizations that provide health care and social services for the elderly. All the rural PACE sites in our study participated in the rural PACE demonstration. Enrollment in the PACE sites ranged from about 50 to over 400. We interviewed PACE center management staff, members of the IDT, and staff from the organization that sponsors the PACE site. Our questions centered on: care management best practices, changes to the core PACE model for rural providers, the necessity of the day care center to the PACE model, barriers to enrollment, PACE providers' experience with nonelderly beneficiaries, and financial operations of the PACE center.

In addition to site visits, we analyzed the literature on PACE providers' quality of care and public availability of quality data on PACE providers. We also analyzed the structure of the Medicare payment system for PACE and Medicare spending on PACE.

Key findings from site visits

PACE providers use care management techniques similar to the other integrated care programs we studied for the June 2011 report (Medicare Payment Advisory Commission 2011b). We also found that rural PACE sites maintained the key characteristics of the PACE model, with few modifications, which heavily emphasized the day care center. Monthly enrollment in PACE sites is low and barriers to enrollment include the inability to enroll beneficiaries on days other than on the first day of the month in this capitated program, beneficiaries not wanting to change physicians, and the 55-or-older age restriction. Many sites have positive margins achieved partly through balancing enrollees' needs with the cost of services.

Care management key principles consistent with other integrated care programs

The PACE sites we visited incorporated many of the same care management key principles as other integrated care programs in our previous analysis (Medicare Payment Advisory Commission 2011b). These principles include

an emphasis on care transitions, conducting medication reconciliation, and patient education. Some PACE sites also focused on end-of-life care. This focus was not one that we heard during our previous study of integrated care programs and appears to depend on the average age of participants, as younger participants may have different goals. One PACE site worked with enrollees to develop a pathway for end-of-life care that specifies enrollees' goals and preferences for aggressive medical treatment and palliative care. The IDT at that site reviewed enrollees' pathways with them every six months and referred to the pathways when deciding on a course of treatment or other services.

Rural providers retain core PACE model

The structures of the rural PACE sites we studied were largely consistent with the core PACE model. The model of care was structured around a day care center where IDT members closely monitored enrollees, frequently communicated with other team members, and intervened with medical and social services. For enrollees who did not want to attend the day care center, extra home visits, rather than telehealth services, were most often substituted. PACE staff strongly stated that the PACE model could not function as well as it does without the day care center. Because of the importance each PACE site placed on the day care center, we did not find support for the PACE without walls concept among rural PACE staff.

Some rural sites we studied made two adjustments to the PACE model—they contracted with primary care physicians in the community and established alternative care sites. Contracting with community-based primary care physicians permits enrollees to keep their primary care physician, while maintaining access to the PACE physician and clinic. The use of alternative care sites allowed PACE staff to monitor beneficiaries and provide some clinic services without having to transport beneficiaries long distances to reach the day care center.

Strong reliance on the day care center Staff at each rural PACE provider we visited emphasized the importance of the day care center in preventing medical and functional declines among PACE enrollees. Staff described their observation of enrollees at the day care center as "constant eyeballing" and noted that all staff members—including transportation drivers and personal care aides—monitor enrollees. For example, drivers have noticed changes in an enrollee's gait or when an enrollee is disheveled. PACE staff have an avenue to discuss their concerns during daily morning meetings or weekly IDT meetings at the day

care center. In addition to monitoring and communication, PACE staff were able to utilize the day care center's clinic and therapy services to treat conditions early to help avoid hospitalizations.

Most enrollees at rural PACE sites attended the day care center three days a week. PACE staff reported that many enrollees want to attend because they enjoy the socialization the day care centers offer. Enrollees who do not want to attend generally receive more home care hours or home visits by IDT staff. The day care centers still serve an important role for these enrollees, as they come to the centers at least once a month for clinic visits and IDT staff discuss the enrollees at the day care centers during morning and IDT meetings. The rural PACE sites generally do not use telehealth services to substitute for attendance at the day care centers. One PACE site used telehealth technology with some enrollees to complement IDT monitoring at the day care center. That site placed sensors in the homes of enrollees who lived alone to monitor falls, determine whether the enrollee got out of bed in the morning, and determine whether the stove was left on.

The rural PACE sites we visited did not operate a modified PACE model that could be considered a PACE without walls. IDT members we interviewed generally did not support a PACE model that does not include a day care center. Staff stated that they would not be able to closely monitor and intervene early without a day care center. One exception was staff at an urban site who expressed interest in developing a PACE without walls model.

Although there were conflicting opinions on the possibility of a PACE without walls, it may be possible to incorporate some core elements of the PACE model into a program that is not constrained by a day care center. While needing further development, this concept could be a way to build on the existing PACE model and expand elements of that model to more dual-eligible beneficiaries.

Slight alterations to the PACE model in rural sites Rural PACE sites deviated from the basic PACE model in two ways: contracting with community-based physicians and operating alternative care sites. Two of the rural PACE sites decided to pursue contracts with physicians in the community after finding that changing physicians was a barrier to beneficiaries enrolling in PACE. Another rural site was contracting with many physicians in the community and had been doing so since the beginning of the program. Management staff at this site stated that beneficiaries' ties to their physicians were strong in their rural area and that contracting with those physicians

was necessary to increase enrollment. This site had higher monthly enrollment since the beginning of the program than the other rural PACE sites in our study. The community physicians at this site were required to participate by phone in monthly IDT meetings and at the six-month and annual reevaluations of their patients. Physicians were paid a fee equal to the amount of an office visit for participating. Enrollees were also seen by PACE medical staff in the day care center clinic for services such as urgent care, lab work, and wound care. However, other sites reported that the office visit payments did not encourage physicians in the community to participate in calls with the IDT.

Two of the rural PACE providers established alternative care sites and a third provider was considering opening one. The providers used the alternative care sites as a way to serve beneficiaries in rural areas who live far from a day care center. For example, one rural PACE provider's alternative care site was located across mountains in the same county as the day care center. The alternative care site opened twice a week and enrollees participated in activities and received meals. The site was not a full day care center and did not have a full clinic or therapy staff; however, staff at the site were able to take basic vitals, provide wound care, and administer medications. The PACE provider established the site after achieving enough enrollment that it was financially able to operate an alternative care site.

Reaching enrollment goals helps PACE sites become profitable, but enrollment is generally slow

Operating close to or at their enrollment targets can help PACE sites operate with a positive margin and build up financial reserves. Most PACE sites in our study were not operating at full capacity, although some were near capacity. Monthly enrollment at PACE sites was low, with some sites enrolling between two and five beneficiaries each month on average. While some staff expressed frustration at the slow nature of PACE enrollment, staff were generally consistent in the perception that PACE enrollment needed to occur on a one-at-a-time basis. Staff stated that it is necessary for beneficiaries and their families to understand and buy into the PACE model and that this buy-in is best achieved on an individual enrollment basis. Referral sources varied across the sites; however, common sources were word of mouth and referrals from health care providers.

Enrollment barriers PACE staff identified Medicare regulations, state processes, and characteristics of the PACE model that they perceived as enrollment barriers. For one, CMS does not allow PACE sites to begin marketing the program until the center opens. This restriction was a problem for one PACE site because the provider was unable to achieve a large enough enrollment before the program opened to financially support the day care center and all IDT members. The other PACE sites did not state this issue as a main barrier, and it seems that they factored the costs of the day care center and IDT staff into their initial program start-up costs.

Another barrier to enrollment is that PACE sites can enroll beneficiaries only on the first day of each month because PACE providers receive a prospective per enrollee payment from Medicare and Medicaid at the beginning of each month. PACE providers that enrolled beneficiaries after the first of the month would not receive capitation payments for those beneficiaries until the first of the following month. CMS will not make a retrospective payment for those beneficiaries, though Medicare-covered services would be paid for on a FFS basis. As a result, PACE sites are losing eligible beneficiaries, particularly those who are referred from hospitals and are in immediate need of post-acute care or long-term care after they are discharged.

Another barrier to enrollment identified by a few PACE sites was states' methods for certifying beneficiaries as eligible for a nursing home level of care. This concern occurred specifically in states where the local state agency that makes the certification also operates a Medicaid home- and community-based services (HCBS) program. In these instances, the PACE providers stated that the local state agency competes with the PACE site for beneficiaries and was reluctant to refer potential enrollees to the PACE site.

PACE staff also stated that two characteristics of the PACE model deter some beneficiaries from enrolling: beneficiaries having to change from their existing primary care physician to the PACE physician and the need to attend the day care center. One PACE site tried to ease enrollees' transition from their physician to the PACE physician by allowing enrollees to have a few social visits with their physicians. Other eligible PACE enrollees chose not to enroll because they did not want to attend a day care center and preferred home-based services. A few participants at one PACE site voluntarily disenrolled from the program for this reason.

Increasing enrollment by permitting beneficiaries younger than 55 to enroll

One strategy to increase PACE enrollment is to open the program to nursing home–certifiable beneficiaries who are younger than age 55. Interviewees reported on their experiences with the nonelderly population that is currently eligible for PACE (beneficiaries aged 55 to 64 years) and whether the PACE model could serve nursing home–certifiable beneficiaries under the age of 55. In general, staff stated that PACE providers could serve nursing home–certifiable beneficiaries under the age of 55, although the providers might have to make some adjustments to their current practices. The PACE staff we discussed this issue with were largely supportive of PACE providers serving these younger nursing home–certifiable beneficiaries.

The current PACE enrollees between the ages of 55 and 64 tend to have different clinical conditions from the population age 65 or older. At one PACE site, these enrollees were more physically impaired, with diagnoses including severe heart disease, stroke, and neurologic degenerative disease. At other PACE sites, enrollees age 55 to 64 were more likely to have a severe mental illness—such as schizophrenia, bipolar disorder, depression, or severe anxiety—and to have multiple comorbidities as well. One PACE site found that increasing the frequency of day care center attendance for nonelderly enrollees helped control their utilization of emergency department services.

The rural PACE providers largely supported the ability of the PACE model to serve the under 55 population of nursing home–certifiable adult beneficiaries. Staff stated that these beneficiaries could gain from the PACE model and that PACE services were needed among this population. A number of staff noted instances when they had to deny enrollment to a beneficiary who was a few years younger than 55 but otherwise would have qualified for PACE.

Most PACE staff stated that they might have to make some adjustments to the way they operate if they enrolled beneficiaries under the age of 55. Interviewees said they could serve these beneficiaries in the same day care center they use for the existing population; however, the ability to integrate with the existing PACE population might depend on the younger enrollees' conditions and behavior. If the younger enrollees could not integrate well, staff said they could schedule days of attendance at the day care center by age groups or by enrollees' conditions. Staff also said that PACE providers could adjust their services to

younger beneficiaries by adding staff with competencies appropriate for working with that population, offering separate activities for those enrollees, providing more individual or group behavioral health therapy, or contracting with local organizations that provide services for those beneficiaries.

Financial operations of the PACE sites

Most urban and rural PACE providers secured the start-up funds from their sponsoring organizations or through grants. While the CMS grant that was part of the rural PACE demonstration was an incentive to many of the sponsors to open the sites, it did not cover all the start-up costs. Most of the urban and rural PACE sites we visited operated with a positive margin. Close management of costs and utilization were key factors to maintaining positive margins.

Starting up a PACE site The most common reason the sponsoring organizations gave for deciding to open a PACE site was to meet a need in the community. Sponsors also considered the PACE program as a part of their organization's continuum of care, as a way to diversify their organization, or as an opportunity to strategically position the organization. For example, one sponsor described the PACE site as an opportunity to market its organization and establish a presence in an area where it intended to expand additional health care services later. Sponsors were also financially able to accept the full risk of providing Medicare and Medicaid benefits to PACE enrollees and to finance some or all of the start-up costs.

The costs of opening up a fully equipped day care center, hiring IDT staff, and arranging for transportation vans were between \$2 million and \$3 million per site. PACE sites secured the start-up funds from their sponsoring organizations or grants from other institutions. The rural PACE demonstration included a grant from CMS; however, rural providers did not receive the grants until they were operational. The sponsor staff of the rural PACE sites all stated that their organization would have opened the PACE site without the CMS grant but that it helped them to open the site more quickly. For example, one site used the CMS grant for equipment and renovating a building to turn it into a day care center. Sites also varied in the time it took to reach the break-even point. One site broke even after 13 months of operation; another, after 22 months.

PACE programs also said the outlier pool, part of the rural grant demonstration, was an incentive to open a site

but did not consider it a reason to start a program. All the plans we spoke with purchased reinsurance at the start of operation, though CMS does not require them to do so. The plans cited high deductibles and monthly premiums as drawbacks to their private reinsurance plans.

Medicare payments and flexibility in use of Medicare funds

Average monthly Medicare payments ranged from \$1,700 to \$2,600 per member per month across PACE sites. In addition to the Medicare capitated rates, only the rural PACE sites were eligible for outlier protection under the demonstration. The outlier protection was temporary and applied only during the start-up of the PACE site. Staff at the rural sites noted the importance of the outlier protection. Although most rural sites did not have any high-cost outliers when the outlier protection was available, staff stated that having the outlier protection available was an incentive to their sponsoring organization to open the PACE site.

Staff from all PACE providers stated that the flexibility they have to use Medicare funds to cover medical or nonmedical services is central to their ability to intervene with any necessary services to avoid an enrollee's deterioration or hospitalization. With this flexibility, PACE providers are able to pay for all services by blending Medicare and Medicaid funds. PACE staff also noted that this flexibility enables PACE providers to offer enrollees more benefits than they would have received under Medicare or Medicaid FFS. For example, PACE providers are able to cover maintenance therapy rather than only the restorative therapy that Medicare covers. The maintenance therapy, such as range-of-motion exercises, helps enrollees maintain their physical function and prevent further deterioration.

Many sites successfully balance enrollees' needs and costs and have positive margins As under any capitated payment system, management of enrollees' costs and utilization is key to operating a PACE site at or above a break-even level. Five of the PACE sites we visited reported to us that they were operating above the break-even point. They reported margins of 3 percent to 11 percent. Management and IDT staff at these sites were very focused on cost management and on meeting enrollees' needs with cost-effective solutions. For example, staff at one PACE site closely monitored their hospital and nursing home utilization and other costs, such as durable medical equipment and home health services. At this site, IDT staff were trained to consider the costs of the services they recommend and try to find less

expensive but effective options when possible. We were told anecdotally that some PACE sites use funds from the positive margins to improve the day care center facility, to hire additional staff, or to build up their financial reserves. However, we did not consistently ask staff at all the PACE sites how they spent funds from the positive margins.

We were told anecdotally that two sites not operating at a positive margin had not been closely managing every enrollee's costs and were beginning to introduce cost management measures at the time of our interviews. One of these sites has begun to receive pressure from its sponsoring organization to operate with a positive margin because the sponsor has been subsidizing the PACE centers' expenses. Management staff plan to introduce cost management measures with a focus on considering lower cost alternatives into the IDT care planning process.

PACE programs' quality of care

In the literature on the quality of care of PACE, evaluations found that the program performed better on measures of hospitalizations, nursing home use, and mortality relative to comparable beneficiaries in FFS Medicare. We were not able to conduct an independent analysis of PACE providers' quality of care. Although CMS collects quality data from PACE providers, these data are not publicly available.

Evidence from the literature that PACE results in improved quality of care

A number of research studies show that beneficiaries enrolled in PACE had fewer hospitalizations and nursing home admissions and lower mortality than similar beneficiaries who were not enrolled in PACE. In one CMS-sponsored evaluation, the study group consisted of beneficiaries who enrolled in 1 of 11 PACE sites and the comparison group consisted of beneficiaries who expressed interest in joining 1 of these PACE sites, had a home visit conducted by PACE staff, and decided not to enroll in the program (Chatterji et al. 1998). PACE enrollees were less likely to be high school graduates, own a home, or live with a spouse or sibling. They were also more likely to be female, widowed, in receipt of paid supportive care, and attending a senior day center. The authors tried to control for selection bias by adjusting for patient demographics at baseline (race, age over 85, less than 12 years of education, homeowner status, living alone), care arrangements (number of home visits in the past six months, receiving paid or informal care, and attending a senior day center), utilization of health services

(number of hospital days, ambulatory visits, and nursing home days), and health status (self-reported status, number of limitations with activities of daily living). However, the authors noted that the study results could still reflect some selection bias and not solely be attributable to the effect of PACE.

PACE enrollees in this study were 50 percent less likely than comparison group members to have had one or more hospital admissions at the six-month follow-up and 40 percent less likely at the 12-month follow-up. They also had fewer hospital days than the comparison group. At the six-month follow-up, the mean number of hospital days for PACE enrollees was 1.9 days, compared with 6.1 days for the comparison group. At 12 months, PACE enrollees had an average of 3 fewer days in the hospital than comparison group members had. Nursing home use was also lower for PACE enrollees 6 months and 12 months after baseline. At the six-month follow-up, 30 percent of comparison group members had one or more admissions to a nursing home compared with 10 percent for PACE enrollees. At the 12-month follow-up, PACE enrollees were 52 percent less likely than comparison group members to have a nursing home stay. Differences in number of hospital days and nursing home use between PACE enrollees and the comparison group decreased at the 18-month and 24-month follow-up.

PACE enrollees also had better self-reported health status and quality of life and lower mortality than the comparison group. At six months after baseline, 43 percent of PACE enrollees reported being in good or excellent health, compared with 37 percent of the comparison group, and 72 percent of the PACE enrollees reported their lives were “pretty satisfying,” compared with 55 percent of the comparison group. Mortality was also lower among the PACE enrollees. Over the 2.5-year observation period, 19 percent of PACE enrollees died, compared with 25 percent of the comparison group. Regression results estimated a median life expectancy of 5.2 years for PACE enrollees and 3.9 years for comparison group members.

Other studies have also demonstrated positive outcomes of the PACE program. One study compared hospital and emergency room utilization between beneficiaries enrolled in PACE and the Wisconsin Partnership Program (WPP), a managed care–based integrated care program (Kane et al. 2006). WPP also integrates Medicare and Medicaid funding and is at financial risk for acute and long-term care benefits. WPP differs from PACE in that the program does not include a day care center and enrollees can keep

their own physician. The interdisciplinary team (registered nurse, nurse practitioner, social worker or social services coordinator) includes fewer staff disciplines than the PACE IDT and the nurse practitioner liaises with the enrollee’s physician, who does not participate in IDT meetings. The authors found that WPP enrollees had unadjusted mean monthly hospital admission rates of 52.8 per 1,000 enrollees compared with 35.7 for PACE enrollees. Preventable mean monthly hospital admission rates were also higher for WPP enrollees (13.3 per 1,000 enrollees compared with 8.6 for PACE enrollees) as were the mean number of monthly emergency room visits (82.3 per 1,000 enrollees compared with 62.2 for PACE enrollees).

Another evaluation found that PACE enrollees in one state had a lower risk of dying and greater stability in physical functioning than Medicaid beneficiaries receiving HCBS services in that state. However, the state spent more on PACE enrollees than on HCBS enrollees. This difference may have been because the PACE enrollees had similar acuity to the HCBS population but the state payment rates for PACE were higher than for the HCBS program (Mancuso et al. 2005). Another study compared five-year survival rates for enrollees in PACE with enrollees in a HCBS program and beneficiaries residing in nursing homes (Wieland et al. 2010). The study found that the median survival rate was longest for PACE enrollees at 4.2 years, compared with 3.5 years for enrollees in the waiver program and 2.3 years for beneficiaries in nursing homes.

One study analyzed mortality rates for African American and White beneficiaries enrolled in PACE between 1990 and 1996. Compared with White patients, African American patients were younger and had worse functional status, worse cognitive status, and higher dementia rates at baseline. The authors found that after controlling for medical, functional, and demographic characteristics, African American patients had lower mortality rates than White patients after the first year of enrollment in PACE (Tan et al. 2003).

Lack of available data on quality for PACE providers

CMS monitors PACE providers’ quality of care. Outcome and performance measures that PACE sites track include hospitalizations, readmissions, emergency department visits, falls, mortality rates, and appeals and grievances. Some sites also collect rates of depression, satisfaction among enrollees’ families, medication errors, and attendance at IDT meetings. However, because CMS does

not publicly report PACE outcome measures, we are not able to use these data to assess quality of care in PACE.

Medicare spending on PACE

We also analyzed the Medicare payment method for PACE sites. PPACA revised the county benchmarks for the MA payment system to try to ensure that Medicare payments are more closely aligned with FFS spending. However, PACE providers are still paid on the pre-PPACA benchmarks. The PACE benchmarks are on average 17 percent higher than FFS in the counties where PACE providers operate.

As we discuss in Chapter 4 of this report, the risk-adjustment system can be refined to improve its accuracy even though, on average across large populations, it is generally accurate on an aggregate basis. PACE providers enroll small numbers of complex patients; for some of those patients, the current system underpredicts costs while for other complex patients it overpredicts costs. If the risk-adjustment system underpredicts the costs of PACE enrollees in aggregate, then spending on PACE would exceed FFS by less than 17 percent. If the risk-adjustment system overpredicts the cost of PACE enrollees in aggregate, then spending on PACE would exceed FFS by more than 17 percent.

Two features of the PACE payment system help improve the accuracy of payments for PACE enrollees. First, payments to PACE providers are risk-adjusted using an HCC model that includes dementia as a factor. This model improves the prediction of costs for PACE enrollees. Second, PACE providers receive a frailty adjuster. For complex patients whose costs may be underpredicted, the frailty adjuster compensates for some of the underprediction. For complex patients whose costs are overpredicted, the frailty adjuster increases the amount of the overprediction.

Our analysis has found that for certain patients who are the types of patients PACE providers enroll, the HCC model that includes dementia overpredicts and the frailty adjuster increases the level of overprediction. Therefore, for certain PACE enrollees, the difference between PACE payments and spending for comparable beneficiaries in FFS would be greater than 17 percent. At the same time, the HCC model that includes dementia underpredicts for some types of patients who enroll in PACE, but the frailty adjuster compensates for some of this underprediction. Therefore, for other PACE enrollees, the difference between PACE

payments and spending for comparable beneficiaries in FFS would be slightly less than 17 percent.

Considering all the factors that determine Medicare payments to PACE providers, 17 percent is a reasonable estimate for the amount by which Medicare spending on PACE enrollees in aggregate exceeds spending on comparable beneficiaries in FFS.

Improving PACE

Overall, evaluations of PACE demonstrate that relative to FFS, the PACE model performs better on hospitalization and mortality rates and on keeping beneficiaries in the community rather than in nursing homes. In addition, the PACE model includes the components most likely to improve care coordination for dual-eligible beneficiaries: full integration of Medicare and Medicaid benefits, capitated Medicare and Medicaid payments, and full financial risk assumed by providers (Medicare Payment Advisory Commission 2011b). PACE providers also have the advantage of furnishing services to enrollees who are not covered under traditional Medicare (such as physical therapy for functional maintenance) because the providers are permitted to use Medicare funds on any necessary medical, social, and nonclinical services, even if these services are not Medicare-covered services. Our research shows that the PACE model is able to function in urban and rural areas and that PACE providers are able to serve beneficiaries with a range of conditions, including those with multiple chronic conditions, multiple limitations in activities of daily living, severe mental illness, dementia, and neurologic conditions.

There remain areas for improvement in the PACE program—namely, Medicare’s payment methodology, program enrollment, and data on quality. In light of these areas needing improvement, we are making recommendations to pay PACE providers and MA plans more accurately for the beneficiaries they enroll, support program growth, and more closely align the payment systems for PACE and integrated care programs operated by SNPs.

RECOMMENDATION 3-1

The Congress should direct the Secretary to improve the Medicare Advantage (MA) risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay Program of All-Inclusive Care for the Elderly providers based on the MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015.

RATIONALE 3-1

This recommendation corrects the MA risk-adjustment system's underprediction and overprediction of some complex patients' costs. When revising the risk-adjustment system, the Secretary could consider using factors such as multiple conditions and functional status. In addition, the amount of the frailty adjuster should be revised because improvements to the risk-adjustment system may reduce or eliminate the need for the frailty adjuster.

Second, by paying PACE providers based on the PPACA-revised county benchmarks, payments would be better aligned with FFS spending levels, which would reduce spending. In addition, PACE providers would be permitted to earn bonus payments through the quality bonus program. These changes would also promote equity among programs that coordinate care for dual-eligible beneficiaries by making the payment system for PACE more consistent with the payment systems of integrated care programs operated by SNPs.

IMPLICATIONS 3-1

Spending

- This recommendation would have no effect on federal spending on PACE relative to current law in the first year and would decrease spending by less than \$1 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse impacts on Medicare beneficiaries with respect to access to care. Although payments based on the PPACA-revised benchmarks would lower payments to PACE, this reduction would be offset by the improvements to the risk-adjustment system and participation in the quality bonus program, which could result in a net increase in payments to PACE providers. We do not expect these changes to reduce PACE providers' willingness and ability to care for Medicare beneficiaries.

Our second area for improvement relates to program enrollment and expansion. PACE serves a small segment of the dual-eligible population that is eligible for a nursing home level of care. Although nursing home-certifiable beneficiaries under the age of 55 could benefit from PACE services, they are not eligible because of the age limit. In addition, PACE providers lose potential enrollees because Medicare policies do not allow for prorated capitation payments for beneficiaries who are enrolled after the first of the month.

CMS and the Congress could take steps to encourage enrollment of more nursing home-certifiable beneficiaries in this program. Increasing monthly enrollment and reaching enrollment projections could help PACE providers achieve economies of scale. However, even if these steps were taken, PACE is likely to remain a small program and is not likely to serve large numbers of dual-eligible beneficiaries for various reasons. Reliance on a day care center constrains the capacity of PACE providers, beneficiaries will continue to be enrolled on an individual basis, and the PACE model may not appeal to beneficiaries who do not want to change their physician or attend a program focused on a day care center.

RECOMMENDATION 3-2

After the changes in Recommendation 3-1 take effect, the Congress should change the age eligibility criteria for the Program of All-Inclusive Care for the Elderly to allow nursing home-certifiable Medicare beneficiaries under the age of 55 to enroll.

RATIONALE 3-2

This recommendation would allow, but not require, PACE providers to enroll beneficiaries who are not currently eligible for PACE. This change would help PACE providers increase their enrollment, which could help them achieve economies of scale faster. The newly eligible population of under-55 dual-eligible beneficiaries tends to be severely mentally ill, developmentally disabled, or physically disabled. In our judgment, these beneficiaries would benefit from the services available through PACE providers. PACE providers might have to make some changes to their program to accommodate the newly eligible younger population, such as developing targeted activities for them or hiring staff with experience and competencies to serve this population.

Revising the age eligibility criteria in the PACE Medicare statute would permit PACE providers to begin enrolling and receiving Medicare payments for nursing home-certifiable beneficiaries under the age of 55. However, PACE is an optional Medicaid benefit, and states would retain discretion over whether to contract with PACE providers to enroll beneficiaries younger than age 55. Given that Medicare currently spends more on PACE services relative to FFS, this recommendation should take effect after the changes in our first recommendation are implemented. This timing would ensure that expanding access to PACE services to beneficiaries under the age of 55 would not increase Medicare spending.

IMPLICATIONS 3-2

Spending

- Any enrollment expansion in PACE under current law would increase Medicare spending because payments to PACE are higher than FFS spending levels. However, implementing this recommendation after the changes to the county benchmarks take effect would offset most of the increase in Medicare spending from expanding eligibility to the under-55 nursing home-certifiable Medicare beneficiaries. Assuming this recommendation is implemented after the recommended changes are made to use the PPACA-revised county benchmarks, it would have no impact on federal spending on PACE relative to current law in the first year and would increase spending by less than \$1 billion over five years.

Beneficiary and provider

- We expect this recommendation to increase access to PACE services for nursing home-certifiable Medicare beneficiaries under the age of 55. This recommendation could also help PACE providers to increase their program enrollment.

RECOMMENDATION 3-3

After the changes in Recommendation 3-1 take effect, the Secretary should provide prorated Medicare capitation payments to Program of All-Inclusive Care for the Elderly providers for partial-month enrollees.

RATIONALE 3-3

PACE providers state that they have lost some potential enrollees because providers cannot receive prorated Medicare and Medicaid capitation payments for beneficiaries who enroll after the first of the month. This issue with partial-month enrollees applies to PACE providers and not MA plans in general for two reasons. First, MA plans can enroll beneficiaries after the first of the month and the beneficiaries still receive Medicare services through FFS until the MA plan receives the capitated payment on the first of the following month. However, PACE providers furnish certain services that are not covered in Medicare FFS, such as day care center services, therapy for maintenance purposes, and nonclinical services. Thus, enrollees in PACE plans after the first of the month would not be covered for the rest of the month for those services. Moreover, the types of beneficiaries PACE enrolls, particularly those being discharged from a hospital, are often in immediate need

of services. If PACE cannot enroll these beneficiaries because of the timing problem, the beneficiaries would instead likely be admitted to nursing facilities or HCBS programs.

Prorating Medicare capitation payments for beneficiaries enrolled for a partial month would enable PACE providers to receive Medicare payments for partial-month new enrollees. It would also give some beneficiaries another care option to select when they are discharged from the hospital. Given that Medicare currently spends more on PACE services than it does for the same or comparable beneficiaries under FFS, this recommendation should take effect after the recommended changes to use the PPACA-revised county benchmarks are implemented. This timing would ensure that expanding access to PACE services to beneficiaries under the age of 55 did not increase Medicare spending.

IMPLICATIONS 3-3

Spending

- Any enrollment expansion in PACE under current law would increase Medicare spending because Medicare currently spends more on PACE services than it does for comparable beneficiaries under FFS. However, implementing this recommendation after the changes to the county benchmarks take effect would offset most of the increase in Medicare spending. Assuming this recommendation is implemented after the recommended changes to the PPACA-revised county benchmarks, it would have no impact on federal spending on PACE relative to current law in the first year and would increase spending by less than \$1 billion over five years.

Beneficiary and provider

- We expect this recommendation to increase access to PACE services for some nursing home-certifiable Medicare beneficiaries. The recommendation could also help PACE providers to increase their program enrollment.

We are also concerned that new PACE providers—both urban and rural—could need outlier protection during the start-up of their program. New rural PACE sites participating in the demonstration had an outlier pool, and although most of the sites did not use the outlier protection, its availability helped persuade some of the sponsors to start PACE programs.

RECOMMENDATION 3 - 4

After the changes in Recommendation 3-1 take effect, the Secretary should establish an outlier protection policy for new Program of All-Inclusive Care for the Elderly sites to use during the first three years of their programs to help defray the exceptionally high acute care costs for Medicare beneficiaries.

The Secretary should establish the outlier payment caps so that the costs of all Chapter 3 recommendations do not exceed the savings achieved by the changes in Recommendation 3-1.

RATIONALE 3 - 4

Because of the very small scale of most PACE programs, even a few dually eligible beneficiaries who incur exceptional costs during the initial period of operation can jeopardize a program's fiscal solvency. This risk may be significant enough to dissuade sponsors from opening a PACE. An outlier protection could help PACE maintain a financially stable operation and prevent the insolvency that could occur from enrolling a few exceptionally high-cost beneficiaries. A mechanism that helps providers reach a break-even point over time would help ensure financial stability during the start-up period, providing an incentive for sponsors to open PACE programs.

To avoid increasing total Medicare spending, the outlier protection should be financed through the spending reductions that would result from basing PACE payments on the PPACA-revised county benchmarks (Recommendation 3-1). As under the rural PACE demonstration, the outlier protection would be available for the first three years of the program and could be used only to offset high acute care expenditures for Medicare beneficiaries. CMS could structure the outlier protection similar to the one available to the rural PACE sites, which included the following components: (1) outlier protection equaled 80 percent of costs that exceeded \$50,000 for a PACE enrollee, (2) total outlier expenses for a given enrollee could not exceed \$100,000 over a 12-month period, (3) PACE providers could not receive more than \$500,000 in total outlier payments over a 12-month period, and (4) providers had to exhaust any risk reserves before receiving payment from the outlier fund. To avoid increasing total Medicare spending, the Secretary should determine the size and structure of the outlier pool so that the outlier protection, the expansion to enroll beneficiaries under the age of 55, and prorating capitation payments for partial-month enrollees can be completely financed from the changes to the PACE county benchmarks.

IMPLICATIONS 3 - 4

Spending

- This recommendation would not increase federal spending on PACE relative to current law because the outlier protection would be funded by the reduction in Medicare spending on PACE that occurs from basing PACE payments on the PPACA-revised county benchmarks.

Beneficiary and provider

- We do not expect this recommendation to have adverse impacts on Medicare beneficiaries with respect to access to care. This recommendation may be an incentive for sponsors to open new PACE sites.

Our third area of concern is the availability of quality data. The Commission recognizes the importance of collecting consistent outcomes and other quality data across integrated care programs to monitor the quality of the dual-eligible beneficiaries' care. In general, the Commission supports the collection of a small number of outcome measures in addition to patient satisfaction measures. While CMS closely monitors PACE providers through the collection of outcome data, this information is not available to the public.

RECOMMENDATION 3 - 5

The Congress should direct the Secretary to publish select quality measures on Program of All-Inclusive Care for the Elderly (PACE) providers and develop appropriate quality measures to enable PACE providers to participate in the Medicare Advantage quality bonus program by 2015.

RATIONALE 3 - 5

Publishing select quality measures would permit the policy community to evaluate PACE and would help beneficiaries and their families make more informed choices when deciding to join PACE. Before CMS could publish any quality data, the agency would need to determine how to accurately report measures given the small sample sizes of PACE providers (see Chapter 6 of our March 2010 report for a discussion of the issue of small sample sizes for quality reporting in general) (Medicare Payment Advisory Commission 2010b). For example, CMS could combine data from multiple years to achieve a large enough sample size to report the data. In addition, CMS would need to identify the measures to be used that would enable PACE providers to participate in the quality bonus program. The measures could be the same ones that MA plans report or CMS could develop PACE-specific measures.

Spending

- This recommendation would not affect federal spending on PACE relative to current law.

Beneficiary and provider

- We do not expect this recommendation to adversely affect Medicare beneficiaries' access to PACE services and it could enhance beneficiaries' ability to choose a program that meets their needs. This recommendation should have no adverse impacts on PACE providers.

Analyses of dual-eligible special needs plans

Our analysis of D-SNPs and FIDE-SNPs focused on quality-of-care measures and Medicare spending. With regard to quality, we were not able to determine whether D-SNPs or FIDE-SNPs improved quality of care relative to FFS or other MA plans because of limited available data. With regard to spending, we found that Medicare spending on D-SNPs and FIDE-SNPs exceeded FFS spending and that these plans' bids for Medicare Part A and Part B services were higher than FFS costs to cover these services. This raises the question of whether these plans can provide Part A and Part B services and care coordination to dual-eligible beneficiaries at a cost that is below FFS. We also explored options for extending to FIDE-SNPs the flexibility that PACE providers have to use Medicare funds to cover nonclinical services.

Background on SNPs

SNPs are MA plans that target enrollment to specific groups of beneficiaries. There are three types of SNPs: D-SNPs, chronic condition SNPs (C-SNPs), and institutional SNPs (I-SNPs). D-SNPs enroll only dual-eligible beneficiaries; C-SNPs enroll beneficiaries with 1 of 15 chronic conditions;⁵ and I-SNPs enroll beneficiaries who reside in nursing facilities, intermediate care facilities, and inpatient psychiatric facilities and beneficiaries living in the community who have an institutional level of need. About 500 SNPs enroll 1.4 million Medicare beneficiaries (Centers for Medicare & Medicaid Services 2012). Most SNPs are D-SNPs. Slightly more than 320 D-SNPs enroll 1.16 million dual-eligible beneficiaries, or about 83 percent of all beneficiaries enrolled in SNPs. C-SNPs enroll almost 14 percent of beneficiaries enrolled in SNPs and I-SNPs enroll about 3 percent. SNPs are currently authorized through December 31, 2013.

Our analysis focuses on D-SNPs and a subset of those plans known as FIDE-SNPs. Dual-eligible beneficiaries can enroll in C-SNPs and I-SNPs, and those plans may be coordinating the Medicare benefits for them. However, we focus on D-SNPs because they are the current pathway under the Medicare program for dual-eligible beneficiaries to enroll in a managed care-based integrated care program.

Not all D-SNPs are integrated care programs; however, they can be if a D-SNP contracts with a state to cover Medicaid benefits. D-SNPs are required to have a state contract by 2013, but states are not required to enter into contracts with D-SNPs. Merely having a state contract does not guarantee that a D-SNP integrates Medicare and Medicaid benefits. To meet the 2013 requirements, the state contracts have to cover some (but not all) Medicaid services. Contracts can cover a range of Medicaid services for dual-eligible beneficiaries, from beneficiary cost-sharing and wrap-around services, such as vision and dental care, to some or all long-term care and behavioral health services.

D-SNPs with contracts to cover most or all Medicaid services are called FIDE-SNPs. CMS previously used a more restrictive definition of FIDE-SNPs in which plans had to cover all primary, acute, and long-term care services on a capitated basis. Our analysis of FIDE-SNPs included only the plans that met this definition in 2012. There were fewer than 20 of those plans with a total enrollment of 23,000 beneficiaries as of February 2012, or about 2 percent of all dual-eligible beneficiaries enrolled in SNPs.⁶ CMS revised the definition of a FIDE-SNP in the April 2012 call letter to include plans that are at risk for substantially all services and are at risk for nursing facility services for a minimum of six months.

Characteristics of SNP enrollees

D-SNPs and I-SNPs have higher percentages of women (62 percent and 66 percent, respectively) than C-SNPs (55 percent). I-SNPs have the highest proportion of White enrollees (76 percent). More than two-thirds of enrollees in C-SNPs are White (67 percent) and one-quarter are African American. D-SNPs have the smallest proportion of White enrollees (57 percent). About 21 percent of beneficiaries enrolled in D-SNPs are African American and almost 14 percent are Hispanic.⁷

The average age of enrollees also varies across SNP type. I-SNPs' enrollees tend to be older—an average age of 79 compared with 71 for C-SNPs and 66 for D-SNPs. This

age difference is not surprising, given that I–SNPs generally enroll beneficiaries who reside in nursing facilities, while D–SNPs enroll dual-eligible beneficiaries, some of whom are younger than age 65. About 35 percent of beneficiaries in D–SNPs are younger than age 65, compared with 18 percent in C–SNPs and 4 percent in I–SNPs. About 31 percent and 28 percent of enrollees in C–SNPs and D–SNPs, respectively, are age 76 or older compared with 63 percent of beneficiaries enrolled in I–SNPs.

Quality measures

We used three sets of quality data to evaluate MA plans, but not all of the data were available at the SNP level. Some of the data are reported at the contract level, which combines data for an organization’s MA plans and SNPs.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS®) measures plan performance on clinical processes and intermediate clinical outcomes. The measures are based on administrative data, such as claims and encounter data, supplemented with clinical data extracted from medical records for certain measures. There are 45 effectiveness-of-care HEDIS measures that all MA plans report to CMS. Separately from the reporting required of all MA plans, SNPs are required to report on 12 of the 45 effectiveness-of-care measures reported by all MA plans and an additional 5 measures that only SNPs report: advanced care planning, functional status assessment, medication review, pain screening, and medication reconciliation postdischarge. Some MA contracts consist only of SNP plans, in which case the MA plan reports the 45 measures for its enrollees as well as complying with the SNP-specific reporting requirement (meaning that potentially 12 measures are redundantly reported if an MA plan consists exclusively of a single SNP benefit package) (Centers for Medicare & Medicaid Services 2009).

Consumer Assessment of Healthcare Providers and Systems

Systems The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a set of patient experience surveys administered to Medicare beneficiaries in MA and FFS. CAHPS provides information on respondents’ personal experiences interacting with their health plan and health care providers. CAHPS results are used to measure quality from the patient’s perspective across six domains: quick access to care of any type, access to needed care without delays, effectiveness of physician communication, health plan information and customer service, overall rating of health care quality,

and overall rating of health plan quality. It is possible to identify from the CAHPS data whether a beneficiary is enrolled in a SNP.

Health Outcomes Survey The Health Outcomes Survey (HOS) is a longitudinal survey of self-reported health status for MA plan enrollees. It measures changes in beneficiaries’ self-reported physical and mental health status over two years. For each MA plan, randomly selected enrollees are surveyed in a given year and resurveyed two years later about perceived changes in their physical and mental health. The beneficiaries’ physical and mental health status is categorized as better, the same, or worse than expected, based on a predictive model that takes into account risk-adjustment factors to determine expected results. When results are reported, a plan is deemed to have better or poorer outcomes if the plan’s results on physical or mental health measures differ significantly from the national average across all plans. The HOS data are reported at the MA contract level.

D–SNPs’ and FIDE–SNPs’ quality of care

We sought to determine whether D–SNPs and FIDE–SNPs offer better quality of care than beneficiaries can receive through alternative options—other MA plans that are not specialized or FFS Medicare—but our ability to make this assessment was limited (see Chapter 6 of our March 2010 report for a discussion of the limitations of comparing SNPs with FFS) (Medicare Payment Advisory Commission 2010b). MA plans report only a few measures at the SNP level, and we could not compare SNPs’ performance with FFS for most of them. In general, in comparison with non-SNP MA plans, we found that D–SNPs’ quality of care is mixed, while FIDE–SNPs perform better than other SNPs on the one HEDIS intermediate outcome measure that CMS publicly reports. We were not able to determine whether D–SNPs or FIDE–SNPs improve quality of care relative to FFS.

D–SNPs’ quality of care is mixed

We analyzed HEDIS and CAHPS quality-of-care measures for D–SNPs (for more detailed analysis of SNP quality of care, see the online appendix to this chapter (<http://www.medpac.gov>)). The full set of 45 effectiveness-of-care HEDIS measures are not reported at the SNP level. Therefore, to analyze the broader set of HEDIS measures for D–SNPs, we used a proxy method. We identified contracts in which 75 percent or more of the enrollment was in D–SNP plans and compared those results with the results for contracts with D–SNP

enrollment of 10 percent or less. We found that D-SNPs' performance on HEDIS measures was mixed. They performed better than non-SNPs on five HEDIS measures: two measures related to fall risks (discussing and managing fall risks), advising patients on physical activity, managing urinary incontinence, and bronchodilator pharmacotherapy management of exacerbation of chronic obstructive pulmonary disease.

For 11 of the 45 HEDIS measures that we tracked, there were no statistically significant differences between D-SNPs and non-SNPs. These measures included blood pressure control among diabetics, four of five measures for monitoring persistently used drugs, recording body mass index in the medical record, the two measures of antidepressant medication management, and the treatment of urinary incontinence.

In contrast, D-SNPs performed worse than non-SNP MA plans on 29 measures. Measures with statistically significant differences included the intermediate outcomes of blood pressure control among enrollees with hypertension, blood glucose control among diabetics, and cholesterol control among diabetics and among those with cardiovascular conditions; breast cancer, colorectal cancer, and glaucoma screening; eye exams, lipid profiles, blood glucose measurement and monitoring nephropathy among diabetics; six measures of potentially harmful drug interactions or the use of high-risk drugs; and osteoporosis management among women with fractures. Although as a group, D-SNPs' quality performance was mixed, some D-SNPs performed better than non-SNPs on the HEDIS measures and had high star ratings in CMS's system for rating MA plans.

We also analyzed CAHPS data on influenza vaccination rates. We found that beneficiaries in D-SNPs received the influenza vaccination at lower rates than beneficiaries in non-SNP MA plans. When we limited the comparison to dual-eligible beneficiaries, we found that these beneficiaries in D-SNPs, FFS, and non-SNP MA plans received the influenza vaccination at the same rates. (Because of sampling issues, we are unable to calculate a similar person-level analysis to compare HEDIS results for dual-eligible beneficiaries enrolled in MA plans with dual-eligible beneficiaries in FFS.)

FIDE-SNPs perform better than other SNPs on a limited number of quality measures

To assess FIDE-SNPs' quality of care, we analyzed the small subset of HEDIS measures that SNPs report. We

found that FIDE-SNPs perform very well on the SNP-level measures, to the extent that we can generalize from the small number of plans reporting. Eight FIDE-SNPs are HMOs that reported the blood pressure control measure for 2011, with rates ranging from 39 percent to 84 percent, with an average of 64 percent (compared with an average of 57 percent among other HMO D-SNPs). Four of the eight FIDE-SNPs have blood pressure control rates that placed them above the 90th percentile of rates for all reporting MA plans (which is 73 percent). FIDE-SNPs also perform very well on measures that only SNPs report: medication review, functional status assessment, pain screening, medication reconciliation postdischarge, and advanced care planning. The FIDE-SNP average rates for these measures are well above the average for all D-SNPs and above the average for non-D-SNPs.

Medicare spending on D-SNPs and FIDE-SNPs

Generally, Medicare spends more on beneficiaries who enroll in MA plans than it would have spent had they remained in FFS (although MA spending in some markets is below FFS spending). Consistent with higher MA spending in general, we found that in aggregate Medicare spending on beneficiaries in D-SNPs and FIDE-SNPs exceeds spending on comparable beneficiaries in FFS. On the basis of 2012 bid data, we estimate that, compared with FFS spending in 2012, Medicare payments to D-SNPs and FIDE-SNPs are expected to average 12 percent and 10 percent higher, respectively. The estimates are risk-adjusted weighted plan averages and are compared with risk-adjusted FFS.

To determine whether D-SNPs and FIDE-SNPs have the potential to reduce FFS spending, we analyzed 2012 D-SNP and FIDE-SNP bids containing plans' estimates of the cost of providing Part A and Part B services to their enrollees. A bid below FFS indicates that a plan is able to provide Medicare Part A and Part B services below what spending would have been for these beneficiaries if they remained in FFS. On a risk-adjusted basis, the Part A and Part B bids across all D-SNPs were an average of 4 percent higher than risk-adjusted FFS and the bids across all FIDE-SNPs were an average of 8 percent higher. These bids indicate that on average, these plans do not expect to provide Medicare Part A and Part B services to their enrollees at a cost that is below FFS spending. They also suggest that, under 2013 PPACA-revised payment levels for MA plans, D-SNPs, including FIDE-SNPs, may not be able to successfully bid in lower benchmark areas. The D-SNP and FIDE-SNP Part A and Part B bids are higher

than the Part A and Part B bids from all MA plans and from all SNPs. MA plans' 2012 bids are 2 percent lower than risk-adjusted FFS (98 percent of FFS spending) and all SNP plans' bids are 1 percent higher than risk-adjusted FFS spending (Medicare Payment Advisory Commission 2012).

Flexibility to use Medicare funds to cover nonclinical services

The Commission has discussed whether to extend PACE providers' flexibility to use Medicare funds to cover nonclinical services to FIDE-SNPs. PACE staff report that this flexibility helps them provide enrollees with services that will maintain or improve their health status and allow them to continue living in the community.

CMS has extended flexibility to use rebate dollars to cover nonclinical services to high-quality D-SNPs that are "highly integrated." CMS defines high integration as having a state contract to cover Medicaid benefits and long-term care services to the extent that state policy permits the SNP to capitate those services. This definition includes FIDE-SNPs and D-SNPs that cover long-term care but have limits from the state on the amount of long-term care services that are covered (such as limits on the number of nursing home days that are covered). The plans that meet this integration criterion and specified quality standards will have flexibility to offer supplemental benefits that are nonskilled in-home support services, such as assisting with activities of daily living (e.g., eating, drinking, bathing); in-home food delivery for beneficiaries who cannot prepare their own food; respite care, counseling, and training for caregivers; home assessments and modifications, such as installing hand rails; and adult day care services.

The flexibility to cover nonclinical services with rebate dollars raises the question of whether this flexibility could apply to the entire payment for Medicare Part A and Part B services, like the flexibility given to PACE providers. Under this arrangement, integrated plans would still have to track their spending on Medicare Part A and Part B benefits in order to submit bids for those services. While covering nonclinical services could lead to reductions in Part A and Part B services, it is not clear whether with this flexibility plans would change their bidding behavior. PACE providers receive payments based on the county benchmarks used to pay MA plans but do not submit bids, so this concern does not pertain to PACE.

Several questions remain if policymakers want to allow a subset of MA plans serving dual-eligible beneficiaries to

cover nonclinical services. Should this flexibility apply to rebate dollars or to the entire Medicare payment for Part A and Part B services? Should flexibility be extended to all FIDE-SNPs, partially integrated D-SNPs that provide long-term care benefits, or only high-quality plans?

CMS demonstrations on integrated care programs

In 2011, the Medicare–Medicaid Coordination Office at CMS announced two demonstrations through which states can develop and implement integrated care programs for full-benefit dual-eligible beneficiaries (partial-benefit dual-eligible beneficiaries are not included in the demonstrations). Both demonstrations will be implemented through the Medicare–Medicaid Coordination Office in partnership with the Center for Medicare & Medicaid Innovation (Innovation Center). CMS is providing financial resources and technical assistance to states to develop the integrated care programs, and states are expected to involve stakeholder groups during the design of the programs and during the demonstrations. The demonstrations are a positive direction forward and there is potential to learn from them about improving quality of care and reducing Medicare spending. There are, however, a number of outstanding issues to address that could strengthen the structure and evaluation of the demonstrations.

Evaluation and expansion of the models tested under the demonstrations

The Medicare authority for the demonstrations is through the Innovation Center. States may request to make changes to their Medicaid program simultaneously with the demonstrations and will need to request existing Medicaid authorities (waivers, state plan amendments) to make those changes. The demonstrations are expected to last three years. Under Innovation Center requirements, the demonstrations must be evaluated on measures of quality of care—including patient-level outcome measures—and on measures of Medicare and Medicaid spending. CMS is still determining the quality and cost data that will be collected through the demonstrations but is considering a range of process and outcome measures, program costs, and measures of beneficiary experience. The models tested under the demonstration can be expanded more readily than previous demonstrations because, under the authority of the Innovation Center, the Secretary may expand the duration and scope of the models through rulemaking if she finds

that the expansion would reduce spending without reducing quality of care or would improve quality of care without reducing spending and if the chief actuary of CMS certifies that the expansion will not increase spending.

Financial alignment models

CMS is collaborating with states to test two types of integrated care programs that are intended to align Medicare and Medicaid financing: a capitated model and a managed FFS model. States can implement one or both models. As of April 2012, nine states released proposals for the capitated model for a 2013 start date, another nine states released proposals for the capitated model for a 2014 start date, and five states released proposals for the managed FFS model for a 2013 start date (Medicare-Medicaid Coordination Office 2012).

Under the capitated model, CMS signs a three-way contract with a state and a health plan, and the health plan will receive a blended Medicare and Medicaid capitation rate. CMS works with each state to develop the Medicare and Medicaid capitation rates for the health plans and the terms of the contracts. Within a state, a standard contract and rate-setting methodology apply to all health plans participating in that state's demonstration. CMS intends to set the rates at a level that provides for upfront savings to both CMS and the state.

CMS intends to use a Medicare spending baseline that consists of Medicare FFS and MA spending in each state and that is specific to the geographic area where the demonstration plan is operating. The payment system for the demonstration plans will therefore differ from the MA payment system that PACE and D-SNPs (including FIDE-SNPs) are paid under and companies operating a D-SNP, FIDE-SNP, or MA plan alongside a demonstration plan will be paid under different payment systems. The Medicaid portion of the capitation rate will also be developed according to baseline spending.

In addition to improved financial alignment, the capitated model demonstration will test better administrative alignment between Medicare and Medicaid, such as integrating these programs' separate appeals processes. CMS's preference is to use the MA network adequacy requirements for medical services and prescription drugs and state Medicaid standards for Medicaid-covered services. Enrollment flexibilities, such as opt-out enrollment for Medicare benefits, could also be tested and some states have expressed interest in using passive

enrollment with an opt-out provision. It is likely that the state proposals will vary in the structure of opt-out enrollment. CMS may also test giving the plans the flexibility that PACE providers currently have to use Medicare funds to cover nonclinical services.

The managed FFS model does not involve capitation or having one entity (a health plan or a provider) integrate the Medicare and Medicaid benefits and maintains FFS for dual-eligible beneficiaries' Medicare benefits. Under this model, states finance a care coordination program for dual-eligible beneficiaries. CMS does not specify the type of care coordination model; however, it could include paying a per member per month fee to primary care physicians, a medical home, or an accountable care organization. States receive a retrospective performance payment if their managed FFS programs meet certain quality thresholds and if the programs result in Medicare savings net of the federal portion of any increased Medicaid costs. It is not clear how much of the Medicare savings are to be shared with the states through the performance payment.

State demonstrations to integrate care for dual-eligible individuals

CMS awarded 15 states contracts of up to \$1 million each to design a program that covers primary, acute, long-term care, and behavioral health.⁸ States were expected to submit their design proposals in the spring of 2012 and CMS will determine whether to approve the proposals for implementation. The contracts were awarded before announcement of the financial alignment models. It is likely that many of the 15 states will propose the capitated model or the managed FFS model from the state demonstrations, but the 15 states have the discretion to propose other models.

Outstanding issues with the CMS demonstrations

The Commission supports the goals of the demonstrations and believes they provide an opportunity to learn more about how to improve care management and quality of care for dual-eligible beneficiaries. As the Commission has previously reported, the current FFS Medicare and Medicaid systems for most dual-eligible beneficiaries have conflicting incentives, which can discourage care coordination and lead to poor quality of care and higher Medicare and Medicaid spending (Medicare Payment Advisory Commission 2010a). The demonstrations are an opportunity to test how to encourage care coordination, improve quality of care, and reduce spending by reducing

some of the conflicting financial incentives between Medicare and Medicaid.

The demonstrations are also an opportunity to test how to tailor capitated and FFS overlay models to different subgroups of dual-eligible beneficiaries. The Commission has stated that these two models hold promise to improve care coordination for dual-eligible beneficiaries. Capitated, risk-based programs that integrate financing and care delivery offer the most promise for improving care coordination. FFS overlays can also provide coordination of services and are a better fit for states that are not interested in capitated or managed care-based programs (Medicare Payment Advisory Commission 2011b). In addition, through the three-way contracts, the capitated model demonstration can test how to overcome some of the barriers to the development of integrated care programs, such as separate Medicare and Medicaid administrative rules and procedures, stakeholder resistance, and lack of experience with managed long-term care (Medicare Payment Advisory Commission 2010a).

However, we want to ensure that the dual-eligible beneficiaries who participate in the demonstrations are matched with care delivery organizations that can meet their needs and improve the quality of the care they receive. The dual-eligible population is very heterogeneous; it includes physically disabled individuals, relatively healthy individuals who are low income, frail individuals, those with multiple chronic diseases, individuals with severe mental illness, individuals with dementia, and developmentally disabled individuals. All of these subgroups of dual-eligible beneficiaries have varying care needs and different challenges accessing high-quality care. Dual-eligible beneficiaries also differ by the intensity of their care needs with the healthier individuals requiring less intense services and the most complex individuals, such as the nursing home certifiable, requiring near constant care. It is therefore important that the demonstrations be structured to test which care management models and financial incentives improve quality of care for subgroups of dual-eligible beneficiaries. It is also important that the demonstrations ensure that beneficiaries have alternative sources of care if the demonstration plans fail to meet their needs. There are a number of outstanding issues with the demonstrations, and there is a short time period for CMS and states working toward an implementation date of January 1, 2013, to resolve these issues.

Ensuring beneficiary protections during the demonstrations

Three characteristics of the demonstrations—the large proposed scope, the standards for the plans that are participating in the capitated model demonstrations, and passive enrollment with intelligent assignment—could have negative effects on dual-eligible beneficiaries' access to and quality of care.

Scope of the demonstrations We question whether the large scope of the demonstrations is in the best interest of the dual-eligible beneficiaries. Most states pursuing the capitated model are proposing to enroll most or all dual-eligible beneficiaries in a state or entire subgroups of beneficiaries (such as disabled individuals under the age of 65) in a state into a health plan. The demonstrations are an opportunity to test care management models for the different subgroups of dual-eligible beneficiaries. However, the varied and complex needs of many of these individuals leads us to question whether care management models should be tested on large numbers of dual-eligible beneficiaries or entire subgroups within a state.

The large scope makes the demonstrations appear to be large-scale program changes rather than true demonstrations. We are concerned in any given state whether large numbers of dual-eligible beneficiaries should be enrolled in programs whose effectiveness and quality of care are unproven. It is unlikely that all the health plans participating in the capitated model have experience managing and being at risk for all Medicare benefits and all Medicaid benefits, including long-term care. We also do not know whether the plans will have the capacity to serve large numbers of dual-eligible beneficiaries who will be enrolled in the program at the same time.

The large scope also makes it more difficult to transition large groups of beneficiaries with complex care needs out of the demonstration if plans fail to meet beneficiaries' needs or if beneficiaries choose to leave the demonstration. The transitions to the demonstration and then back to FFS or another plan could complicate beneficiaries' access to providers and care management plans.

Finally, the scope complicates the evaluation of the demonstrations. If most or all dual-eligible beneficiaries in one state are enrolled in the demonstration, there will not be a sufficient sample of comparable beneficiaries in FFS to be able to test whether the demonstrations improved quality of care and reduced Medicare and Medicaid

spending relative to FFS. CMS may instead use a research methodology that compares beneficiaries enrolled in a demonstration in one state with beneficiaries in FFS in another state. However, it will be difficult to find a comparable population in another state because Medicaid benefits, eligibility, and provider payments differ from state to state. Alternatively, CMS could use a pre–post demonstration study design. This study design would be limited by the availability of quality of care and spending measures before the demonstration was implemented. Also, the study design is not as strong as it would be with an intrastate control group.

Plan experience It is unclear how CMS and the states are going to ensure that dual-eligible beneficiaries are matched with the best care management models to meet their needs given the participating plans' lack of experience with this population. Our work suggests that about 20 health plans have experience being capitated and at risk for all Medicare and Medicaid benefits. These plans do not operate in every state that has proposed a demonstration, most do not operate state wide, and all of these plans do not serve every subgroup of dual-eligible beneficiaries. Therefore, many of the plans participating in the capitated program will lack experience being at risk under capitated payments for all Medicare and Medicaid services. They will also lack experience serving all or most of the subgroups of dual-eligible beneficiaries on a near state-wide basis. It is not clear that every plan that participates in the demonstration will be able to establish provider networks and provider payment rates that encourage high-quality care and care coordination for services with which they lack experience. When selecting plans for the demonstration, CMS and the states will have to balance having plans available to participate in the demonstration with selecting plans with enough related experience for there to be a reasonable expectation that the plans will succeed in serving the dual-eligible beneficiaries.

We also do not know the standards that plans participating in the capitated model will have to meet. CMS has documented a number of standards that are non-negotiable. However, there are also standards called “preferred requirement standards” that are CMS’s starting points for negotiations with states, and it is unknown how much these standards will change during state negotiations. Areas that have some of these preferred requirements include the Medicare benefit package, plan participation in Part D, Medicare network adequacy, and administrative requirements such as the appeals process and marketing.

Plan selection is moving quickly in some states, and it is unclear how plans will be chosen to participate. Plans must meet both CMS and state requirements to participate in the capitated model demonstration. We do not know what role quality rankings will play in selecting plans in each state. Plan participation standards should be transparent and should at least consider quality ranking, provider networks, plan capacity, and experience with Medicaid and Medicare services for dual-eligible enrollees.

CMS and the states also need resources to monitor beneficiaries’ experiences in the demonstration plans. It will be necessary to monitor access to and quality of care as close to real time as possible if beneficiaries will be passively enrolled in plans whose care management models and financial incentives have not been tested. It is not clear whether every state will have the resources and capacity to closely monitor the demonstration plans. It is also unclear how, and with what resources, CMS will collaborate with each state on oversight and monitoring.

Passive enrollment CMS and states propose to use passive enrollment with an opt-out provision for the capitated model demonstrations. Under this enrollment strategy, states will assign beneficiaries to a health plan through “intelligent assignment” unless the beneficiaries opt-out of the demonstration or select a health plan.

We have documented that low beneficiary enrollment is a barrier to the expansion of integrated care programs (Medicare Payment Advisory Commission 2010a). Passive enrollment with intelligent assignment can be used to increase enrollment into integrated care programs with proven experience providing high quality of care. However, passive enrollment with intelligent assignment needs to be appropriately executed in order to be effective. Dual-eligible beneficiaries’ needs vary greatly across subgroups and many of these individuals have high levels of need. Some dual-eligible beneficiaries’ access to care and quality of care could be negatively affected if they are not matched with appropriate care management models. We do not know whether every state has the resources and information on dual-eligible beneficiaries to make intelligent assignments that best match beneficiaries’ needs to appropriate care management plans. Further, we question whether every health plan will offer high-quality care and appropriate care management models to make those assignments meaningful. We also do not know whether CMS and each state will require plans to meet certain quality or experience criteria to be eligible for passive enrollment.

The structure of the passive enrollment policy is an important beneficiary protection for ensuring access to care. CMS's plans for the structure of passive enrollment are inconsistent with some state proposals and these differences will need to be reconciled. CMS plans for beneficiaries to be notified of the passive enrollment and opt-out procedures beginning October 1, 2012, for states that intend to implement the demonstrations on January 1, 2013. However, some state proposals suggest that beneficiaries will first be enrolled in the demonstration and then given the opportunity to opt out. CMS has also stated that beneficiaries will be allowed to opt out on a month-to-month basis. However, some states have proposed a lock-in period when beneficiaries cannot disenroll from the demonstration or change plans within the demonstration.

CMS and the states will also have to ensure that beneficiaries are educated about their choice to opt out or enroll in the demonstration, that beneficiaries are matched to plans that can best meet their needs, and that beneficiaries' access to care is not disrupted during the enrollment transition. It may be difficult for some dual-eligible beneficiaries to be informed about their choices, particularly those who are cognitively impaired and may need help to understand their choices.

It may be necessary for some beneficiaries to have access to their existing provider networks, care management plans, and prescription drugs after enrollment, at least for some period of time. Some dual-eligible beneficiaries establish their own provider networks within FFS and have long-standing relationships with those providers. We do not know whether every state demonstration will provide beneficiaries with this access after enrollment. It will also be important for plans to locate and comprehensively assess beneficiaries soon after they are enrolled, and it is unclear whether the plans have the capacity and experience to accomplish this assessment. The Commission maintains the importance of integrated care programs contacting beneficiaries as soon as possible after enrollment to assess their needs and establish a plan of care.

Additional issues to address

The Commission will be looking into additional issues to address with other aspects of the CMS demonstrations.

- ***Taking upfront savings from the capitation rates and allocating those savings***—CMS intends to achieve savings under the capitated model by setting the Medicare and Medicaid capitation rates to the demonstration plans below current spending on dual-eligible beneficiaries. CMS will allocate the savings to Medicare and the state based on the proportion that each program contributes to baseline spending. This raises two issues: whether savings should be taken out of the capitation rates upfront or whether CMS should test if and how capitated models can reduce Medicare and Medicaid spending and whether the savings should be allocated this way or through an alternative method.
- ***Risk-adjustment methodology and flexibility with Medicare funds***—CMS has not stated which methodology it intends to use to risk-adjust Medicare payments to the capitated plans, but the agency will have to make this decision over the next few months. CMS will also have to decide whether all or some demonstration plans will have flexibility to use Medicare funds to cover nonclinical services.
- ***Data collection and evaluation methodology***—CMS still has to determine which data it will collect to monitor and evaluate the demonstrations. It will be particularly important to collect data to monitor whether the plans are limiting access to care or producing poor quality of care and to evaluate whether the demonstration models improve quality of care and reduce costs relative to FFS.

The Commission's greatest concern is that all dual-eligible beneficiaries in a state will be enrolled in the demonstration, representing a program change rather than a demonstration. The Commission will continue to consider this and other concerns as we move forward. ■

Endnotes

- 1 MedPAC analysis of the 2010 Medicare Denominator File. The number includes full and partial dual-eligible beneficiaries. Beneficiaries were defined as dually eligible if they had dual-eligible status for at least one month when they were eligible.
- 2 The following states have at least one PACE: AL, AR, CA, CO, FL, IA, KS, LA, MA, MD, MI, MO, NJ, NM, NC, ND, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, and WI.
- 3 MedPAC analysis of 2009 data from the Medicare Beneficiary Database/CMS Medicare Entitlement file and the 2009 Medicare Denominator File.
- 4 The remaining enrollees were in the “other” race category (2.3 percent), Native American (0.4 percent), and the “don’t know” category (0.2 percent).
- 5 The 15 conditions are chronic alcohol and other drug dependence, certain autoimmune disorders, cancer (excluding precancer conditions), certain cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, end-stage liver disease, end-stage renal disease requiring dialysis, certain hematologic disorders, HIV/AIDS, certain chronic lung disorders, certain mental health disorders, certain neurologic disorders, and stroke.
- 6 Commission estimates based on proprietary information from CMS.
- 7 Commission analysis of 2009 data from the Medicare Beneficiary Database/CMS Medicare Entitlement file and the 2009 Medicare Denominator File.
- 8 The 15 states are: CA, CO, CT, MA, MI, MN, NC, NY, OK, OR, SC, TN, VT, WA, WI.

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