Preparing private plans to better serve dual-eligible beneficiaries

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Context for today's discussion

- Commission's goal is to improve care coordination for dual eligibles
- Focus is on capitated Medicare-Medicaid coordination programs (MMCPs). Commission recommended that D-SNPs that are MMCPs be reauthorized and made permanent (March 2013)
- There are few MMCPs. Most Medicare Advantage (MA) plans lack experience with continuum of services for dual eligibles in a capitated environment
- Improving MA plans' readiness for dual eligibles will prepare them for current law and various reform strategies
- Idea is for Commission to identify strategies for MA plans to implement over the next few years to better serve dual eligibles

Presentation overview

- Background on dual eligibles including an overview of Medicare and Medicaid spending
- Findings on key practices of MMCPs
- Options for moving forward on strategies to prepare MA plans

Pathways to dual eligibility

Dual eligibles become eligible for both programs in a variety of ways

If under age 65:	If age 65 and over:
Qualify for Medicare through: • Disability through SSDI (including ESRD) **Qualify for Medicaid through**: • Low income / assets • Medically needy (spend down)	**Qualify for Medicare through**: • Age **Qualify for Medicaid through**: • Low income / assets • Medically needy (spend down)

Partial-benefit and full-benefit dual eligibles

Partial-benefit dual eligibles

- Receive Medicaid assistance with Medicare premiums and cost-sharing, and no other Medicaid benefits. Eligible for Part D LIS.

Full-benefit dual eligibles

- Receive all services Medicaid covers in their state as well as assistance with Medicare premiums and cost-sharing. Eligible for Part D LIS.

Medicare and Medicaid benefits

- Medicare is the payer for all primary and acute care services for dual eligibles
- Medicaid provides:
  - Services that “wrap around” and supplement Medicare’s acute care benefit
  - Long-term care services and supports (LTSS)
  - Behavioral health services (mental health and substance abuse)

Demographics and spending for dual eligibles in Medicare FFS, 2009

- Dual eligibles more likely to be minorities than non dual eligibles
- Combined Medicare and Medicaid spending $172B; $29,307 combined per capita
- Total federal (Medicare and federal portion of Medicaid) spending on dual eligibles was estimated $141B
- 66% of dual eligibles non-users of LTSS, Medicare accounted for 83% of spending on these dual eligibles; 34% of dual eligibles LTSS users, Medicare accounted for 40% of spending
- About 16% of the dual eligible population had at least one severe or persistent mental illness (SPMI), Medicare accounted for 57% of spending

Potential for savings from MMCPs is unclear

- Literature suggests that MMCPs reduces utilization of certain high cost services (e.g., hospitalizations, nursing home use)
- Medicare: program savings depends on how capitation rates compare to FFS rates
- Medicaid: savings to the Medicaid program may be possible from shifting Medicaid LTSS services from nursing homes to the community setting (but consistent evidence is unclear)

Overview of qualitative analysis

- Prior Commission work documented key activities of MMCPs (June 2011):
  - Assess patient risk, individualized care plan, reconcile medication, transition care, medical advice available 24/7, regular contact with enrollee, centralized electronic health record
- Recent analysis – interviews in five states with MMCPs (FL, NC, MA, MN, WI)
  - Interviewed primary care providers, behavioral health providers, community-based care managers, beneficiary advocates, MMCP care managers
  - Findings include
    - More information on barriers to care coordination: complexities of dual eligibles, providers treating dual eligibles in silos
    - Additional MMCP key practices to overcome barriers

Barrier: Complex medical and non-medical needs affect dual eligibles' physical health

- Dual eligibles' care can be affected by physical health (e.g., frailty or disabilities), mental health, and other cognitive deficiencies (e.g., dementia), in addition to poverty

- Some dual eligibles' care needs will not likely be resolved in a few physician or care manager visits

Key practice: provide intensive care management in the community

- High-contact, in-person care that is not limited to a few visits (e.g., attending doctor visits with beneficiaries)
- Conducting home visits to assess dual eligibles' living situations and limitations (e.g., root cause analyses)
- Understanding baseline behavior for beneficiaries with behavioral health needs
- Maintaining knowledge of and refering dual eligibles to social services and other resources available in their communities

Barrier: Dual eligibles' providers operate in silos

- Dual eligibles can receive care from multiple medical providers, behavioral health providers, LTSS, and social services
- Providers frequently do not communicate with one another
- Lack of communication is not limited to transitions between Medicare and Medicaid services

Key practice: coordinate across silos

- Some MMCP care managers follow dual eligibles' care across all of their providers, including services the MMCP does not cover
  - EHRs help, but ability to share electronic health information across all providers is generally not available
- Some MMCPs embed care managers with primary care or acute care providers

Key practice: leverage care management resources in the community

- Community care management resources include:
  - State- or county-based care managers
  - Aging services organizations
  - Federally qualified health centers (FQHCs)
- MMCPs leverage these resources by contracting with them or coordinating with them
- FQHCs are uniquely positioned to coordinate care for dual eligibles
  - Offer multiple services utilized by dual eligibles, often at same clinic site
  - Some applying to become medical homes

Strategy to improve care coordination for dual eligibles through MA plans

- Strategy: MA plans adopt key activities of MMCPs
- Issues to consider:
  - Which key activities should MA plans adopt?
    - The MMCP key activities are care coordination activities that are not Medicare benefits
  - How should MA plans be encouraged to adopt the key activities?
    - Through regulation?
      - Plan model of care requirements
    - Through incentives such as quality measures and bonus payments?

Strategy to address conflicting financial incentives between Medicare and Medicaid

- Strategy: financially align Medicare and Medicaid benefits
- Issues to consider:
  - Strategy under current law?
    - Federalize
      - All Medicaid benefits for dual eligibles
      - Payment of Medicare cost-sharing
      - Medicaid benefits for a particular dual eligible subgroup
    - Block grant Medicare and Medicaid to states
    - Financial alignment demonstrations
  - Strategy only in the context of CPC system?

Commissioner discussion

- Strategy: MA plans adopt key activities of MMCPs
- Strategy: financially align Medicare and Medicaid benefits under one program (Medicare or Medicaid)

Pathways to dual-eligibility vary

Individuals can become dual-eligible by first becoming eligible for Medicare and then Medicaid, or by becoming eligible for Medicaid first, and then Medicare. For example:

- *Medicaid → Medicare:* An adult who is under age 65 and has low income qualifies for Medicaid. Once this person turns 65, they then "age" into the Medicare program, becoming dually-eligible.

- *Medicare → Medicaid:* A Medicare beneficiary who begins to incur high medical costs, and then qualifies for Medicaid coverage through medically needy categories.