Care coordination programs for dual-eligible beneficiaries

Christine Aguiar and Carlos Zarabozo

March 9, 2012

MEDPAC

Overview of today's presentation

- D-SNPs and FIDE-SNPs
  - Background
  - Quality of care
  - Medicare payments
  - Extension of PACE flexibility to cover non-clinical benefits
  - Likelihood of expansion
- CMS financial alignment demonstrations
- Issues to explore moving forward

Background on D-SNPs and FIDE-SNPs

- D-SNPs
  - Type of MA special needs plan that only enrolls duals
  - Considered integrated care programs only if cover Medicaid benefits
  - Must have a state contract by 2013, but contract does not have to cover Medicaid benefits
  - Over 300 D-SNPs; enroll about 1.16 million beneficiaries*
- FIDE-SNPs
  - Subset of D-SNPs
  - Have state contracts to cover all long-term care services
  - Fewer than 20 plans; account for about 2% of all duals enrolled in D-SNPs**

*Source: February 2012 SNP comprehensive report from CMS

**Source: MedPAC estimates based on proprietary information from CMS

Not clear whether D-SNPs and FIDE-SNPs offer better quality of care than FFS

- Limited number of available measures and unable to compare SNPs to FFS on majority of measures
- D-SNPs
  - HEDIS measures
    - Can only use a proxy method to compare to non-SNPs
    - Results are mixed; D-SNPs generally perform more poorly
  - CAHPS person-level data
    - No difference for influenza vaccination rates among D-SNPs, duals in FFS, and duals in non-SNP MA plans
- FIDE-SNPs
  - Compared to other SNPs on SNP-specific HEDIS measures
  - Generally performed better than other SNPs

MEDPAC

Source: Analysis of HEDIS and CAHPS data from CMS

D-SNPs and FIDE-SNPs currently paid and bid higher than FFS

- Similar to MA plans in general, D-SNP and FIDE-SNP payments exceed FFS (estimated to be paid between 10-12% above FFS in 2012)
- Risk-adjusted 2012 Medicare A/B bids between 4-8% above FFS
- Not clear if these plans can provide A/B services below FFS

Source: MedPAC analysis based on MA bid data from CMS. Estimates are risk-adjusted weighted plan averages and are compared to risk-adjusted fee-for-service

Extension of PACE flexibility to cover non-clinical services

- Should this flexibility be extended and if so, how?
  - Flexibility with entire Medicare payment or with the difference between the bid and the benchmark
- Which plans should be given the flexibility?
  - High quality plans only
  - FIDE-SNPs only
  - FIDE-SNPs and D-SNPs that partially integrate long-term care services

Wide expansion of D-SNPs and FIDE-SNPs could be challenging

- Inconclusive results on quality of care
- Higher Medicare spending raises the question of whether they should be expanded under current payment system
- Expansion of FIDE-SNPs limited by number of states that contract with plans for all Medicaid benefits

Elements of these plans can be incorporated into other programs

- Key care coordination elements of D-SNPs and FIDE-SNPs could be incorporated into larger scale programs:
  - Assessing patient risk
  - Developing an individualized care plan
  - Conducting medication reconciliation
  - Guiding enrollees through transitions in care
  - Establishing medical advice that is available 24/7
  - Maintaining regular contact with enrollees
  - Maintaining a centralized electronic health record

Overview of CMS financial alignment demonstrations

- Capitated model
  - 3-way contract between CMS, a state, and a health plan
  - Medicare rates to be based on FFS and MA spending within a state
  - Intention is to set Medicare and Medicaid rates at a level that provides for upfront savings to both programs
  - Health plans may be permitted to use Medicare funds to cover Medicaid services
- Managed FFS model
  - States finance care coordination for duals within FFS
  - States can share in Medicare savings produced by the program if they meet a quality threshold

Framework for possible directions moving forward

Improve existing programs	• D-SNPs and FIDE-SNPs • CMS demonstrations
Issues related to program expansion	• Care management of disabled beneficiaries • PACE without walls • Opt-out enrollment
Broad issue of bifurcated payment system	• Medicare or Medicaid assumes financial responsibility for all benefits

Explore remaining issues with D-SNPs and FIDE-SNPs

- Define criteria to be a FIDE-SNP, e.g., should it include plans that partially integrate long-term care?
- Determine if flexibility to use Medicare dollars to cover non-clinical services should be extended
- Explore changes to the payment system and alternative payment systems
- Continue analyzing improvements to risk-adjustment system
- Analyze improvements to quality reporting

Address outstanding issues with CMS demonstrations

- Comment on Medicare savings
  - How can Medicare savings be generated?
  - Should the capitation rates be adjusted to achieve savings?
  - Should states share in the Medicare savings?
  - Should the beneficiary benefit from the savings?
- Explore how Medicare payments should be risk-adjusted
- Explore quality and cost data that should be collected

Explore other issues related to program expansion

- Identify care management needs of the disabled population (physically disabled, developmentally disabled, and severely mentally ill)
- Further analyze the “PACE without walls” concept
- Develop an opt-out enrollment strategy

Address broad issue of bifurcated payment systems

- Explore whether Medicare or Medicaid should assume financial responsibility for all duals' services
- Address the many issues that would be implicated if one program was financially responsible for all duals' services

Commissioner discussion

- Discuss the findings of our analyses
- Identify and prioritize issues to address moving forward