Dual eligible beneficiaries and care coordination

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Medicare Payment Advisory Commission

- Independent, nonpartisan
- Advise the Congress on Medicare issues
- Principles
  - Ensure beneficiary access to high quality care in an appropriate setting
  - Give providers an incentive to supply effective, appropriate care and pay equitably
  - Assure best use of taxpayer dollars
Why is MedPAC looking at duals?

- Complex care populations
- Dual eligible beneficiaries consume disproportionate share of both programs’ spending
  - 16% of Medicare beneficiaries but one quarter of Medicare spending
  - 18% of Medicaid enrollees but almost half of Medicaid spending
- Programs work at cross purposes that impede care coordination
<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>•Hospital care</td>
<td>•Medicare cost sharing</td>
</tr>
<tr>
<td>•Physician and ancillary services</td>
<td>•Nursing home care</td>
</tr>
<tr>
<td>•Skilled nursing facility care</td>
<td>•Coverage for hospital and SNF care once</td>
</tr>
<tr>
<td></td>
<td>Medicare benefits exhausted</td>
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<tr>
<td>•Home health care</td>
<td>•Optional services (vary by state):</td>
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<td></td>
<td>dental, vision, home and community based</td>
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<td>services, personal care, and home health</td>
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<td>care not otherwise covered.</td>
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<tr>
<td>•Hospice</td>
<td>•Some drugs not covered by Medicare</td>
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<tr>
<td>•Prescription drugs</td>
<td>•Durable medical equipment not covered by</td>
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<tr>
<td>•Durable medical equipment</td>
<td>Medicare</td>
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Examples of conflicting incentives of Medicare and Medicare programs

• Patient transfers from nursing home to hospital

• Ambiguous coverage for home health care
Characteristics of dual eligible beneficiaries

Compared to other beneficiaries, dual eligible beneficiaries are more likely to:

- Be minorities
- Have poorer health status
- Have more ADL limitations
- Live in an institution or alone
- Have lower education level
Prevalence of chronic conditions varies widely across dual eligible beneficiaries

Percents are shares of all full year dual eligible beneficiaries who qualify for full Medicaid benefits.

Per capita spending in 2005 by dual eligible group

Nursing home spending is key driver of total per capita spending

![Bar chart showing spending by group]

- Total
- No nursing home spending
- Top nursing home spending

- All
- Aged
- Under 65 and disabled
Total per capita spending increases with dementia and number of chronic conditions

Note: Analysis includes all full year dual eligible beneficiaries who qualify for full Medicaid benefits.
Four-fold difference in per capita spending across duals with physical or cognitive impairments

<table>
<thead>
<tr>
<th>Impairment group</th>
<th>Spending relative to average</th>
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<tbody>
<tr>
<td>No or one physical impairment</td>
<td>0.5</td>
</tr>
<tr>
<td>Developmentally disabled</td>
<td>1.2</td>
</tr>
<tr>
<td>Mentally ill</td>
<td>1.7</td>
</tr>
<tr>
<td>2+ physical impairments</td>
<td>1.9</td>
</tr>
<tr>
<td>Dementia</td>
<td>2.1</td>
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</tbody>
</table>

Service mix varies by chronic condition

Note: Analysis includes all full year dual eligible beneficiaries who qualify for full Medicaid benefits.
State-SNP integrated managed care programs

- Some Medicare Advantage Special Needs Plans (SNPs) integrate Medicare and Medicaid payments and benefits.

- Eight states initiated state-SNP integrated programs (AZ, MA, MN, NM, NY, TX, WA, WI):
  - Some started as Medicare demonstrations (MN, MA, and WI).
  - Some built on top of statewide mandatory Medicaid managed care programs (AZ, NM, and MN).

- Enrollment is voluntary for Medicare services and program enrollment is generally low:
  - Approximately 120,000 duals (under 2% of all duals) are in fully integrated SNPs.

- Outcomes research is limited, with generally lower rehospitalization and ER use.
Program of All-Inclusive Care for the Elderly (PACE)

- Provider-based program for the nursing home-certifiable elderly
- Services provided at an adult day care center
- All services, including care transitions, coordinated by an interdisciplinary team
- PACE employs most of its providers and contracts for services such as hospital and nursing home care
- Outcomes: lower rates of hospitalization and nursing home utilization
- Limited enrollment: 72 PACE organizations in 30 states enroll almost 18,000 enrollees
Challenges to expanding enrollment in integrated care

- Lack of state and managed care plan experience with managing long-term care
- Stakeholder resistance
- Voluntary enrollment
- Requires initial financial investments; Medicaid savings accrue later from avoided nursing home use
- Separate Medicare and Medicaid administrative rules and procedures
Additional expansion challenges

- **State-SNP managed care model:**
  - All states are not likely to adopt this model
  - The requirement that dual-eligible SNPs contract with their states is not likely to result in more fully integrated programs

- **PACE:**
  - Day care based model is not a match for all dual-eligible subgroups
  - Having to change primary care providers can discourage enrollment
Next steps

- Interview and visit programs that fully integrate Medicare and Medicaid for duals
  - Also analyzing North Carolina’s model - a medical home and shared Medicare savings model that offers care management to duals through not-for-profit primary care networks

- Understand features of “best practices”

- Consider approaches targeting subgroups of duals