Linking a Comprehensive Payment Model to Comprehensive Care of Frail Elderly Patients

A Dual Approach

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FRAIL OLDER PATIENTS WITH MULTIPLE CHRONIC CONDITIONS and complex health care needs receive services that are fragmented, incomplete, inefficient, and ineffective.[1] Many of these patients are vulnerable to poor health outcomes because of age, multiple comorbidities, and poverty. Older adults with chronic health conditions spend a higher percentage of their income on health care.[2] As a result, many frail elderly adults receive Medicare for physician and hospital care, and Medicaid, which covers some out-of-pocket costs and personal and social care services. Six million elderly adults are enrolled in both Medicare and Medicaid, also known as dual eligibles; they comprise 21% of Medicare beneficiaries.[3]

At the federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicare and Medicaid programs. Unlike Medicare, for which all financing is federal, Medicaid funding is shared between the federal government and the states, and therefore, many Medicaid administrative decisions are made by states. Most Medicaid beneficiaries receive services through managed care; in many states this delivery model is mandatory. In contrast, a minority of Medicare beneficiaries receive services through managed care, which for Medicare is voluntary.[4]

Managed care has emerged as a potential organizational structure to coordinate the payment and program administration for dual-eligible individuals, to support the integration of medical and social services for this population. For dual-eligible individuals in managed care, health plans receive separate capitated payment from the federal government for Medicare services and the state government for Medicaid services. To date, the enrollment numbers remain relatively low with fewer than 140 000 individuals (2% of dual-eligible individuals) enrolled in these programs nationwide.[5]

The Program for All-inclusive Care for the Elderly (PACE) is one such program for community-dwelling elders who are nursing home–eligible. PACE provides a single set of requirements regarding Medicare and Medicaid services, allowing PACE organizations to enter into capitation agreements with Medicare and Medicaid for their respective services, fully integrating funding, management, and clinical decisions.[4] In February 2010, 18 000 dual-eligible individuals were enrolled in PACE programs in 30 states.

Some states have developed demonstration programs other than PACE to test models of integrated payment and service delivery for this population, stimulated by the Medicare Modernization Act of 2003, which enabled the creation of Medicare Advantage Special Need Plans. Eight states (Arizona, Massachusetts, Minnesota, New Mexico, New York, Texas, Washington, and Wisconsin) have integrated the full range of Medicare and Medicaid benefits (primary care, acute care, behavioral health, and long-term care) for approximately 120 000 dual-eligible beneficiaries through Medicare Advantage Special Need Plans.

Integrated Medicare and Medicaid managed care programs have many potential advantages, including a focus on prevention, care coordination, and access to home and community-based services. Evaluation of integration projects has been limited to observational studies, the best of which have used appropriate control groups and statistical techniques. Results suggest that dual-eligible beneficiaries in these programs, as compared with those receiving services outside of managed care, have better access to home and community-based long-term care services[6] and lower use of high-cost services such as emergency department visits, hospitalizations,[7] and nursing home stays.[8,9] The voluntary nature of program participation and case selection by plans limits the ability to distinguish whether these programs are truly successful or whether the results are merely a reflection of underlying differences in the health and needs of the populations who receive care through managed care vs fee-for-service. The cost-effectiveness of these programs is unproven and is dependent on the ability of plans to substitute lower-cost services for high-cost ones.[4] Decision makers need more rigorous evaluation of these projects to establish their effectiveness, safety, and costs, and to determine the degree to which results can be generalized to important subgroups of the elderly population.

There are challenges at the patient, clinician, and administrative levels of the state and federal agencies that hinder

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broader adoption of these models. Medicare beneficiaries are concerned that they will lose their freedom to choose or have to change their clinician if managed care organizations selectively contract with a limited number of clinicians, and that cost considerations for managed care plans that are prepaid for the delivery of services will reduce the quality and availability of services. Clinicians have concerns about the additional requirements of care management, the financial effects of operating within a fixed managed care budget, and the risk of jeopardizing their relationship with patients if they are put in the position of having to limit services. A critical aspect of overcoming the shared concerns of patients and clinicians is ensuring that the rates paid to plans for these patients are actuarially sound. Setting the rates includes the need to make judgments about the reasonable costs of necessary services. High payment rates create an incentive for plans to reap large profits without managing the service, and low rates may induce plans to limit necessary services. A recent Government Accountability Office report highlighted the significant problems CMS has in providing oversight of the rate-setting process in Medicaid managed care for a population that is less complex than the dual-eligible population.[9]

Most managed care programs serving dual-eligible individuals require federal approval or waivers. The most restrictive policy in implementing managed care for dual-eligible individuals is the requirement to demonstrate separately within Medicare and within Medicaid that managed care as a delivery model is budget neutral compared with the fee-for-service model. Even when it might be possible to demonstrate budget neutrality for both programs combined, it may be difficult to accomplish that for each payer because most of the savings from integrated plans comes from lowering Medicare expenses for hospital and emergency department use at the cost of better (higher) Medicaid home and community-based services.[8] Setting aside the administrative requirement, states are reluctant to partner their Medicaid programs with Medicare in providing managed care for dual-eligible beneficiaries, when they perceive that their investment in home and community-based services primarily returns savings to the federal government in the form of lower Medicare costs.

As a part of federal health reform,[10] CMS recently established a new Coordinated Health Care Office (CHCO) to integrate benefits and improve care coordination for dual-eligible beneficiaries. CHCO will be responsible for providing education and tools necessary to develop programs that align benefits for dual-eligible individuals under Medicare and Medicaid, as well as to support state and federal efforts to coordinate contracting and oversight for integrating Medicare and Medicaid programs through managed care. The new law also establishes a Center for Medicare & Medicaid Innovation within CMS that can test new models of health care delivery and broadly implement successful ones without returning to Congress for additional approval. Listed among the potential opportunities in this provision is one that would give states management responsibility for Medicare and Medicaid funds to test fully integrated care for their dual-eligible beneficiaries. Some states may be interested in pursuing this opportunity, but CMS will be cautious in testing managed care models that are mandatory for dual-eligible individuals and in handing Medicare beneficiaries' individual entitlements over to states when states may divert them toward shortfalls in their overall budgets rather than toward care. In addition, the Secretary of Health and Human Services is required to submit an annual report to Congress that includes recommendations for legislation that could improve care coordination and benefits for dual-eligible individuals.

With increasing health care costs and an aging population, the United States needs to expedite the development and scaling up of cost-effective models of integrated care. Health care reform has given CMS new authority to promote the process. To move ahead, CMS should establish explicit goals for reforms and ensure that there are robust data from which to draw clear conclusions about current and alternative program success.

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