

Addressing America's Health Care Value Crisis

America's health costs are extraordinarily high and rising. Total national health expenditures represented 17 percent of the Gross National Product in 2010 and are projected to reach nearly 20 percent by 2020 and more than 40 percent by 2050. Yet according to the Institute of Medicine, approximately one third of this enormous investment is poised to be spent on goods and services that improve no one's health. Clearly America's health system faces a crisis of value. This National Coalition on Health Care Policy Brief is part of a series, designed to explore issues and priorities related to addressing this crisis.

This series examines a range of options including some policies on which the National Coalition on Health Care has yet to take a formal position. Discussion of any particular policy in this document implies neither support nor opposition by NCHC or its member organizations.

Curbing Health Costs, Improving Quality: Care for High Cost Beneficiaries in Medicare and Medicaid

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The Institute of Medicine estimates that inefficiently delivered services accounted for \$105 billion in national health spending in 2009, and overuse of services generated another \$210 billion the same year.¹ Addressing the growth in national health expenditures will require serious attention to this extraordinary level of waste.

However, this \$315 billion a year in waste is not spread evenly throughout the population. The strongest predictors of high patient spending are the presence of multiple chronic diagnosis and functional limitations.² These patients, the system's sickest and frailest, use the most services and

¹ Institute of Medicine. (2010). *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. Washington, DC: Yong P, Saunders R, and Olsen L, ed.

² The Lewin Group. (2010, Jan). *Individuals Living in the Community with Chronic Conditions and Functional Limitations*. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2010/closerlook.pdf>.

suffer the most from delivery system inefficiencies that lead to inappropriate overuse (for example, preventable hospitalizations).

If our goal is to move the needle on costs and quality, then it will be crucial to deliver higher-quality, integrated care for these high-cost, high-need enrollees. This paper examines three possible strategies for achieving this goal: expanding the availability of existing integrated care models, encouraging beneficiary enrollment in integrated care models, and implementing broader structural reforms to public programs which serve these high-cost-high-need enrollees.

STRATEGY ONE: EXPAND AVAILABILITY OF INTEGRATED CARE MODELS

We discuss below two models that have potential to expand the number of high-cost, high-need enrollees receiving this level of care: Medicare Special Needs Plans (SNPs) and the Program for All Inclusive Care for the Elderly (PACE).

Model: Special Needs Plans

Medicare Special Needs Plans (SNPs) are a special form of Medicare Advantage plans established by the 2003 Medicare Modernization Act to provide services to three specific populations of Medicare enrollees: beneficiaries with specific chronic conditions (chronic condition Special Needs Plans or C-SNPs), beneficiaries receiving institutional-level care services (institutional Special Needs Plans or I-SNPs), and dual eligibles (dual eligible Special Needs Plans or D-SNPs).

While 90% of all SNP enrollees are duals, non-dual Medicare beneficiaries facing chronic conditions or needing institutional level care are also eligible to enroll in SNPs. Expansion of high-quality SNP plans could prove to be a constructive strategy to lower costs and improve care for high-cost, high-need beneficiaries.

A limited number of the SNP plans have demonstrated significant improvements in value. XL Health C-SNP, the largest C-SNP in the country, has shown substantial gains in primary care outcomes and reduced hospitalizations among beneficiaries with diabetes.³ United Health's EverCare D-SNP showed substantially greater adherence to evidence-supported standards of care.⁴ An analysis of SCAN Health Plan, a dual-SNP in California and Arizona, has found a substantial reduction on spending with substantial quality improvements.⁵ CareMore, owned by

³ Cohen R, Lemieux J, Schoenborn J, Mulligan T. (2012, Jan). Medicare Advantage Chronic Special Needs Plan boosted primary care, reduced hospital use among diabetes patients. *Health Affairs* 31(1):110-9.

⁴ Wenger NS, Roth CP, Martin D, Nickels L, Beckman R, Kamberg C, Mach J, Ganz DA. (2011, Oct). Quality of care provided in a special needs plan using a nurse care manager model. *Journal of the American Geriatrics Society*,59(10):1810-22.

⁵ Avalere Health. (2010, Mar 15). Specialized Medicare Advantage Plan Saves Money Compared to Traditional Medicare Fee-For-Service. Retrieved from <http://www.avalerehealth.net/wm/show.php?c=&id=848>

Wellpoint, offers SNP plans that have achieved substantial health outcome improvements for a range of costly conditions.⁶

Despite their promise, however, the SNP program is not a panacea. Enrollment today is concentrated in five large states and Puerto Rico, and even within those states, SNPs continue to serve only a fraction of dual eligibles.⁷ With this limited reach, SNPs lack the capacity as of today to deliver care for all high-cost beneficiaries. Further, MedPAC's June 2012 Report to Congress notes that not all SNP plans offer integrated care and that the quality data which would allow comparison between all Special Needs Plans and Medicare FFS is not available. Researchers from the Urban Institute have argued that the SNP program would benefit from additional public reporting by SNPs, increased oversight, and the inclusion of pay for performance for the program.⁸

Turning to Special Needs Plans as the primary solution for dual eligible or other high-cost, high-need beneficiaries would be unwise. However, provided adequate steps are taken to monitor and encourage quality in the program, policymakers can and should consider steps to help those SNPs which deliver superior care at lower costs to serve more enrollees in more areas of the country.

Policy Option: Enhance quality reporting and value-based payment for SNPs

One option would be to adjust CMS' quality rating and bonus program, in order to provide separate ratings and bonuses for SNPs. Currently, CMS assigns a 1-5 star rating to all Medicare Advantage plans based on various measures of plan quality, and offers bonuses to plans with high ratings. However, the rating is assigned to the plan sponsor, not the specific plan. A Special Needs Plan receives the same rating as other Medicare Advantage plans offered by that sponsor.

Separate star ratings for SNPs would help more beneficiaries identify and enroll in high-value SNPs, even as the plan bonuses would make participation in the SNP market more attractive to those plans with the capacity to deliver higher value care for patients.

Proper implementation, however, would require ensuring that the SNP evaluation standards are at least as rigorous as those applied for other Medicare Advantage plans. A special effort should be made to ensure this new SNP-specific rating system is focused on outcome measures, rather than process focused on quality metrics.

Policy Option: Streamline state contracting with SNPs

⁶ Hoops A. (2011, Jan). CareMore: A Model for Caring for Those At Greatest Risk. Powerpoint demonstration. Retrieved from <http://www.ahip.org/AHIPResearch/AHIPBriefingJan2012/>.

⁷ Lewin Group. (2011, Feb). *2010 SNP Alliance Profile and Advanced Practice Report*. Retrieved from <http://www.nhpg.org/media/12019/2011lewinprofilefinal.pdf>

⁸ Feder J, et. al. (2011, Oct). Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead. Retrieved from <http://www.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf>.

Current law requires dual SNPs to contract with state Medicaid programs by 2013. Currently, only nine states contract with SNPs to deliver Medicaid services.⁹ Further, initiatives to contract with SNPs must be submitted to the federal Center for Medicare and Medicaid Services and approved as an amendment to the states' Medicaid plans or, or as part of demonstration programs. The uncertainty associated with these requirements can discourage states from pursuing a SNP contract.¹⁰

It may be desirable to make the process of state contracting easier for states. Congress could direct CMS to establish a template state Medicaid plan amendment to help those states interested in contracting with SNPs to provide Medicaid services. To ensure that such a template does not lead states to contract with low-performing SNPs, any such template should provide guidelines for selecting high-quality SNPs.

Model: Program for All Inclusive Care for the Elderly

In the Program for All Inclusive Care for the Elderly (PACE), Medicare and Medicaid contract on a capitated basis with non-profit organizations which provide the full range of benefits to frail and elderly enrollees through an interdisciplinary team of providers. The program is typically structured around an adult day care center, which provides an alternative to full-time institutionalization in nursing homes for an enrollee population that has an average of 7.9 health conditions and 3.6 limitations on activities of daily living.¹¹ As a result, PACE has demonstrated significant reductions in hospital admissions, mortality, and nursing home utilization.¹²

However, PACE enrollment is currently confined to beneficiaries aged 55 and over and those who are certified as eligible for nursing home care. Programs are not available in all locales, and 20 states have no PACE program at all. PACE programs served only 22,000 beneficiaries in 2010.¹³ Given PACE's limited scale, PACE, as currently structured, is not a panacea to address the needs of

⁹ Verdier J. (2011, Jun 28). Defining the Role of SNPs in 2011 and 2012. Powerpoint presentation. Retrieved from http://www.mathematica-mpr.com/publications/PDFs/health/macongress_verdier_62811_rev.pdf

¹⁰ Democratic Governors Association. (2011, Oct 11). *Achieving \$164 Billion in Savings from Dual Eligibles*. Unreleased policy paper obtained by IWP news. Retrieved from <http://healthpolicynewsstand.com/Inside-CMS/Inside-CMS-04/12/2012/menu-id-316.html>.

¹¹ Mukamel DB, Peterson DR, Temkin-Greener H, Delavan R, Gross D, Kunitz SJ, Williams TF. (2007, Sep). Program characteristics and enrollees' outcomes in the Program of All-Inclusive Care for the Elderly (PACE). *Milbank Quarterly* 85(3):499-531. Retrieved from <http://www.npaonline.org/website/download.asp?id=2109>.

¹² Aguiar C. (2011, Nov 3). Coordinating care for dual eligibles through the PACE program. Presentation to MedPAC. Retrieved from http://www.medpac.gov/transcripts/November%20PACE%20slides_Public.pdf.

¹³ Bloom S, President and CEO, National PACE Association. (2011, Jun 21). Dual Eligibles: Understanding This Vulnerable Population and How to Improve Their Care. Testimony before the U.S. House Energy and Commerce Subcommittee on Health. Retrieved from <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/062111%20Dual%20Eligibles/Bloom.pdf>.

all high-cost dual eligibles. Nonetheless, policymakers may wish to consider steps to expand PACE to serve a greater number of enrollees.

Policy Option: Implement MedPAC recommendations

The Medicare Payment Advisory Commission (MedPAC) recently examined the program and has offered several recommendations to Congress to expand the program.

1. Remove the age limit for eligibility for PACE, allowing the program to serve disabled Medicare recipients below age 55.
2. Develop appropriate risk-adjusted quality measures to enable PACE providers to participate in the Medicare Advantage quality bonus program by 2015.
3. Improve the Medicare Advantage (MA) risk adjustment system, pay PACE providers based on improved MA benchmarks, and permit PACE providers to participate in quality bonus programs available to MA plans that are rated highly for plan quality. These bonuses should encourage both market entry and program expansion among high quality PACE providers.
4. Prorate Medicare capitation payments to allow payment for enrollees receiving services for only part of a month.
5. Create a temporary outlier protection for all new PACE sites for the first 3 years, in order to ensure that new PACE programs are not overwhelmed by costs for by a few ultra-high cost beneficiaries.

Combined, these steps should be capable of expanding the number of individuals receiving integrated care and services through PACE. Policymakers could also consider adapting the PACE model to address the needs of Medicaid-only disabled enrollees.

STRATEGY TWO: INCREASING ENROLLMENT COORDINATED CARE MODELS LIKE PACE AND HIGH-VALUE SNPS

Increasing the supply and availability of integrated care approaches like PACE and SNPs, may not be enough. Maximizing the impact of these integrated models on health spending and quality will require encouraging more beneficiaries to enroll in them.

Policy Option: Better information and ease of enrollment

Under current CMS regulations, dual eligible and institutionalized beneficiaries have the ability to enroll in another Medicare plan outside of the normal, yearly open enrollment period. However, non-dual, non-institutionalized beneficiaries only have the ability to switch to a Medicare

Advantage plan with a star rating of 5 outside of the normal open enrollment period¹⁴. Currently, only a small number of plans nationwide have that designation.

Expanding this special election period to SNPs programs with a 4 or 4.5 star rating could enhance the likelihood that high-cost, high need Medicare- and Medicaid-only beneficiaries will switch to high-quality SNPs.

Policy Option: Incentives for Enrollment in High-Quality PACE and SNP programs

Although expanding the availability of coordinated care options may be important, information alone is not always sufficient to move consumer behavior. In health care, consumers can be particularly reluctant to consider changing plans or providers. It may be necessary to provide added incentives to seek out the care options that will help them improve their health.

Provided that SNPs and PACE programs receive quality ratings under CMS' 5-star rating system, beneficiaries could be given financial inducements to switch to highly rated options- either through adjusting copays or through one time or periodic cash payments.

However, a beneficiary incentive program of this kind would have to be implemented carefully. Offering these incentives to every Medicare beneficiary would generate prohibitive costs. Instead, these inducements would have to be limited to those beneficiaries whose claims patterns suggested they would most benefit from highly integrated care. To ensure the inducements were not actually driving up costs, the incentives should be limited to enrollment in those SNPs that achieved lower costs than traditional Medicare for a similar population.

STRATEGY THREE: IMPLEMENT STRUCTURAL REFORMS TO MEDICARE AND MEDICAID

The steps discussed above could expand the number of high-cost beneficiaries receiving high-quality integrated care. However, these steps alone may not succeed in expanding high-quality, well-coordinated care to all or even most of the high-cost, high need beneficiaries in public program.

The Department of Health and Human Services is already pursuing steps that could broaden coordination of care for dual eligible beneficiaries. Through the CMS Office of Medicare and Medicaid Coordination's Financial Alignment demonstration, twenty-six states have proposed to move nearly three million dual eligibles to new integrated models of care- either into managed care plans or into a managed fee-for-service programs, wherein providers are paid a care management fee to coordinate care in addition to fee-for-service payments. As designed, these demonstrations are scheduled to proceed for three years. If, at that time, the CMS actuary finds

¹⁴Center for Medicare and Medicaid Services. (2010, Aug 17). Medicare Managed Care Manual. Retrieved from <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnroll/downloads/FINALMAEnrollmentandDisenrollmentGuidanceUpdateforCY2011.pdf>.

them to improve care and save money, the Secretary of HHS will have the authority to expand them or make them a permanent part of Medicare and Medicaid.

However, critics have raised a number of objections to this approach. Consumer advocates have expressed concern that state Medicaid programs will shift duals to managed care plans before those plans have the capacity or the provider networks needed to manage the varied needs of dual eligibles.¹⁵ MedPAC and some members of Congress have noted that the size and scale of these changes stretch the definition of “demonstration” and actually constitute a real program change.¹⁶ Additionally, as noted above, significant numbers of high-cost, high-need beneficiaries are eligible for Medicare only or Medicaid only; even if wildly successful, the current alignment demonstrations would do little for these enrollees.

In recent testimony to Congress, the Director of the Office of Medicare and Medicaid Coordination, Melanie Bella, has indicated that CMS will be reviewing these proposals carefully. According to Bella, demonstrations will be held to Medicare Advantage standards and CMS intends to approve demonstrations affecting nearly 2 million beneficiaries, not the full three million proposed by states.¹⁷

Despite these assurances, skeptics of this model continue to doubt its efficacy. They question how quality and access standards will be enforced, how payments would be calculated, and how savings would be allocated between states and Medicare.

Still others have suggested different approaches to reforming and integrating care for dual eligible and other high-cost, high-need beneficiaries. We examine below alternative proposals for structural reform of Medicare and Medicaid designed to improve care and lower costs for high-cost, high-need beneficiaries.

Policy Option: Move Duals to Medicaid Managed Care

Some have argued that state Medicaid programs should be required to enroll all dual eligibles (or in some cases all Medicaid beneficiaries) into Medicaid Managed Care Organizations (MMCOs).¹⁸

¹⁵ Letter to Senator Patty Murray and Rep. Jeb Hensarling. (2011, Nov 14). Retrieved from

<http://www.familiesusa.org/assets/pdfs/11-14-11-Dual-Eligibles-final-sign-on-letter-to-Joint-Select-Committee.pdf>

¹⁶ Medicare Payment Advisory Commission. (2012, Jul 11). Letter to CMS Administrator, Marilyn Tavenner. Retrieved from http://medpac.gov/documents/07112012_MedPAC_Comment_CMS_demos_states_integratedcare_dualeligibles.pdf.; Republican Members of the Senate Finance Committee. (2012, Jun 11). Letter to CMS Administrator, Marilyn Tavenner. Retrieved from https://www.naphs.org/Senate%20Republican%20Letter_6_12.pdf.

¹⁷ Bella, M. (2012, Jul 18). Testimony before the U.S. Senate Special Committee on Aging.

¹⁸ President’s Commission for Fiscal Responsibility and Reform. (2012, Dec). *Moment of Truth: Report of the President’s Commission for Fiscal Responsibility and Reform*. Retrieved from

http://www.momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010. Thorpe, K. (2011, Sept 28). *Potential Savings Associated with the Blue Cross and Blue Shield Association’s Building Tomorrow’s Healthcare System The*

The President's Commission on Fiscal Responsibility and Reform, commonly known as the Simpson Bowles commission, recommended moving all duals to Medicaid managed care. Amidst the deliberations of the Congressional super-committee in 2011, Maryland Governor Martin O'Malley offered a similar proposal. But even if no such nation-wide effort to move duals to MCOs is adopted, budgetary pressures seem likely to push more state Medicaid programs in this direction

This approach has the advantage of making a single entity responsible for all of the enrollees' care. However, critics correctly point out that many MCOs lack experience providing either the complex health services used by seniors, which Medicare covers, or even long-term supports and services, which Medicaid covers. Additionally, while addressing duals, this approach would do nothing to improve value for high-cost Medicare-only beneficiaries. Politically, the proposal has serious problems as well; a wholesale shift of these often vulnerable enrollees is likely to generate a firestorm of opposition from consumer advocates. It would represent a fundamental change in Medicare coverage for a substantial number of low-income Medicare beneficiaries, based solely on their income, not on their health care needs.

Policy Option: Move Duals to Medicare

It is important to note however, that moving duals to Medicaid managed care is far from the only alternative for reforming care for dual eligibles. In 2005, the National Governors Association proposed shifting responsibility for dual eligibles entirely to the federal government.¹⁹ More recently, analysis from the Urban Institute has argued that in the wake of new reforms included in the Affordable Care Act, Medicare—not the states—should take the lead in delivering care to duals.²⁰

Congress could consider making Medicare responsible for the services currently provided to duals through Medicaid, such as long-term care, services and supports, and medical services like dental and vision, not available through traditional Medicare. Medicaid would continue to be responsible for delivering care to children and non-disabled adults under 65.

This approach would be a significant, structural reform to federal health program. It would ensure that the responsibility for dual eligibles was no longer fragmented between Medicare and state Medicaid programs. Long-term services and supports, as well as other services provided by state Medicaid programs today could be integrated into evolving accountable care and medical home models now taking shape in traditional Medicare. Medicare Advantage plans, including SNPs,

Pathway to High-Quality, Affordable Care in America. Retrieved from <http://www.bcbs.com/why-bcbs/health-reform/economic-analysis.pdf>.

¹⁹ National Governors Association. (2005, Feb). Dual Eligibles: Making the Case for Federalization. Retrieved from <http://www.allhealth.org/briefingmaterials/MakingthecaseforFederalization-NGA-311.pdf>.

²⁰ Feder, J. (2011, Oct). Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead. Urban Institute. Retrieved from <http://www.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf>.

could provide a benefit package to their enrollees which encompassed both the medical services now paid by Medicare and the long-term and other services now paid by Medicaid.

However, the budgetary details are important. In implementing such a change, the federal government assumes the portion of duals costs currently born by states. Given that state Medicaid spending on duals amounted to \$55.3 billion in 2007, and Medicaid program spending has been growing since then, the impact on federal spending could be substantial.²¹ It is difficult to imagine that federal policymakers, constrained by current budgetary difficulties, would agree to shoulder those costs without a compensating reduction in federal support for Medicaid's non-dual enrollees. While states, freed from the cost of providing services to duals, would theoretically have the funds to absorb such a reduction, some states might seek to use those resources for purposes other than bolstering Medicaid for those left in the program.

Policy Option: Hybrid approach combining care coordination and fee-for-service

Others have advocated a third alternative- one that occupies a middle ground between a traditional fee-for-service Medicare and fully capitated managed care models.

Eight of the twenty-six states applying for the dual alignment demonstration have proposed some variant on a primary care case management approach, whereby providers receive regular fee-for-service payments, combined with a performance-based per member per month payment to coordinate care for the duals. It would also be possible to develop policies which could extend that sort of approach nationwide for both duals and high-cost Medicaid- and Medicare-only beneficiaries

In a variant on this approach, at least two major national health plans have suggested that Medicare be empowered to contract with health plans to provide care coordination and other services in Fee-for-Service Medicare.²² Under this approach, plans would not bear full risk for patient costs as Medicare Advantage plans do, but they would be empowered to deploy clinical interventions and provide care coordination services that lower costs and improve care for high-cost individuals. Plans would also be able to provide payment incentives to providers that deliver value.

²¹ Kaiser Family Foundation. (2012, Apr). The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare. Issue Paper. Retrieved from <http://www.kff.org/medicaid/upload/7895-02.pdf>.

²² Blue Cross Blue Shield Association. (2011, Oct 4). Building Tomorrow's Healthcare System: The Pathway to High-Quality, Affordable Care in America. Retrieved from <http://www.bcbs.com/why-bcbs/health-reform/pathway.pdf>; United Health Group. Roadmap for Transforming America's Health System. Retrieved from <http://www.unitedhealthgroup.com/hrm/health-system-roadmap.pdf>.

As part of their broader Medicare reform proposal, the Senior's Choice Act, Senators Tom Coburn (R-OK) and Richard Burr (R-NC) have advanced their own version of a middle ground approach. These Senators would allow traditional Medicare enrollees that meet certain medical criteria to enroll in a new voluntary care coordination benefit.²³ When beneficiaries encounter major health challenges, the benefit would kick in and provide the sort of evidence-based care coordination services needed to avoid hospitalizations, improve care transitions, and lower costs without sacrificing quality. While the Senior's Choice Act includes a plan to implement premium support, this particular provision could be enacted either as part of such a proposal or as an independent measure.

CBO has yet to score any such proposal, but saving estimates from other sources are substantial. In his evaluation of a Blue Cross Blue Shield Association proposal, Emory University economist Ken Thorpe estimates that \$105 billion in net savings could be realized over ten years.²⁴ United HealthCare's Center for Health Reform and Modernization has estimated that extending just one of its programs, the Evercare care coordination program for frail nursing home patients, could save \$170 billion over ten years.²⁵

²³ Office of Senator Tom Coburn. Senior's Choice Act. Retrieved from http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9.

²⁴ Thorpe K. (2011, Sept 28). Potential Savings Associated with the Blue Cross and Blue Shield Association's Building Tomorrow's Healthcare System The Pathway to High-Quality, Affordable Care in America. Retrieved from <http://www.bcbs.com/why-bcbs/health-reform/economic-analysis.pdf>.

²⁵ United Health Group. Transforming America's Health Care System. Retrieved from <http://www.unitedhealthgroup.com/hrm/health-system-roadmap.pdf>.