



# **Promoting Integrated and Coordinated Care for Medicare Beneficiaries**

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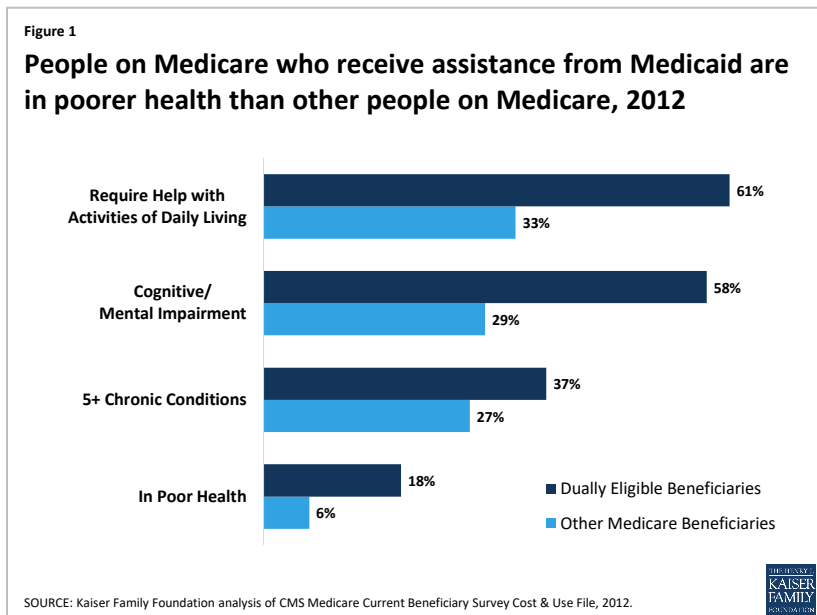
Chairman Tiberi, Ranking Member Levin, and Honorable Members of the Committee, I am Dr. Gretchen Jacobson, Associate Director of the Program on Medicare Policy at the Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, Calif., is an independent, nonprofit, and nonpartisan source of facts, analysis and journalism about health care and health policy issues. We have no connection to Kaiser Permanente.

I am honored to be here to testify on the topic of Promoting Integrated and Coordinated Care for Medicare Beneficiaries. Over the years, the Medicare program has developed several approaches for integrating and coordinating care for people who are dually eligible for Medicare and Medicaid, as well as other high-need, high-cost Medicare beneficiaries. My testimony today will focus on three of these approaches: Special Needs Plans, the Program of All-Inclusive Care for the Elderly, and value-based insurance design for beneficiaries who choose to enroll in Medicare Advantage plans. I will highlight the complex health needs of this population and some of the opportunities and challenges presented by these approaches.

### People Dually Eligible for Medicare and Medicaid

The 11 million people dually eligible for Medicare and Medicaid (6.5 million seniors and 4.6 million people under the age of 65 with significant disabilities) account for one in five people on Medicare.<sup>1</sup> Most low-income people on Medicare who receive assistance from Medicaid have incomes below the federal poverty level (\$12,060 per year for an individual in 2017) and have little in savings or other assets. By definition, people on Medicare who receive assistance from Medicaid have relatively low incomes, but they also differ from others on Medicare in terms of demographics, medical and long-term care needs, and service utilization. Sixty percent of all dually eligible beneficiaries are women. Fifty percent of dually eligible beneficiaries are younger than 65 with significant disabilities.<sup>2</sup>

Low-income people on Medicare who receive assistance from Medicaid tend to have more chronic conditions, as well as cognitive and functional limitations, than others on Medicare: about six in ten (61 percent) need assistance with one or more activities of daily living, such as eating, bathing, and dressing; more than half (58 percent) have a mental condition or cognitive impairment; one-third (37 percent) have five or more chronic conditions; and about one in six (18 percent) rate their health status as poor, more than three times the rate among other people on Medicare (Figure 1).<sup>3</sup>



As a result of having greater medical, functional, and cognitive needs, low-income people who are eligible for both Medicare and Medicaid also use more health care services than others on Medicare, including hospital stays, emergency visits, home health care, and skilled nursing facility stays (Figure 2).<sup>4</sup> With relatively high rates of cognitive and physical limitations, it is not surprising that a substantially larger share of people dually eligible for Medicare and Medicaid live in a

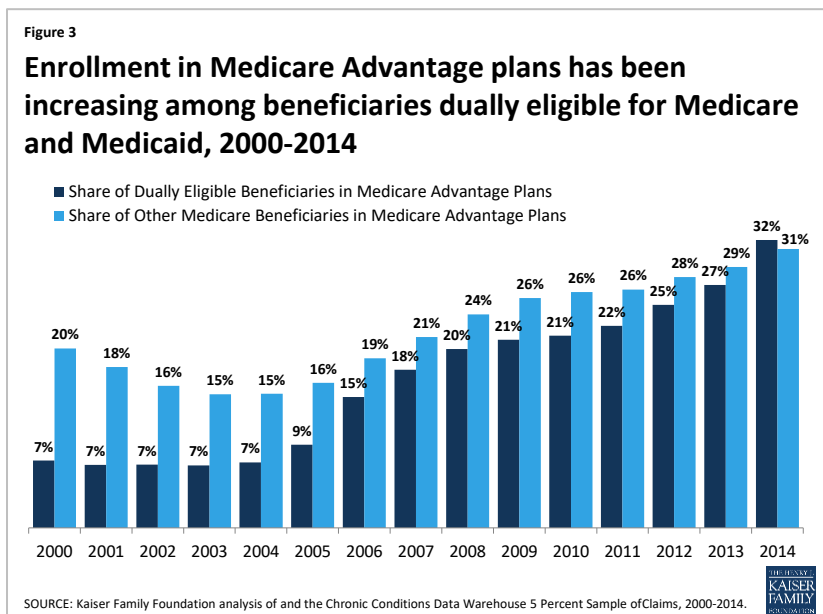
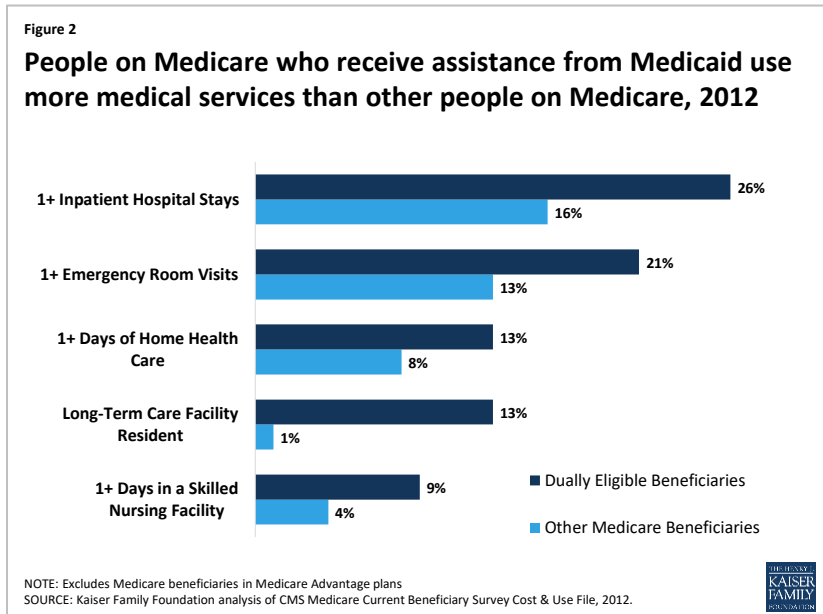
facility, such as a nursing home or mental health facility (13 percent versus 1 percent of other people on Medicare).<sup>5</sup> Due to their high health care needs, dually eligible beneficiaries face the risk of fragmented care and could benefit from integrated and more closely managed care.

Most dually eligible beneficiaries are in traditional Medicare, and some are in payment and delivery system reform models that are designed to both improve the quality, and lower the costs, of care. The financial alignment demonstrations that several states are undertaking with the Centers for Medicare and Medicaid Services (CMS) are the largest of these efforts targeted to dually eligible beneficiaries.<sup>6</sup> As of March 2017, more than 392,000 dually eligible beneficiaries were enrolled in these demonstrations.<sup>7</sup>

### Enrollment of Dually Eligible Beneficiaries in Medicare Advantage Plans

While most people who are dually eligible for Medicare and Medicaid are in traditional Medicare, nearly one in three (32 percent) were in Medicare Advantage plans – a similar percentage as the share of other beneficiaries enrolled in Medicare Advantage plans (Figure 3).<sup>8</sup> About half of dually eligible beneficiaries in Medicare Advantage plans (1.4 million of 2.8 million) were enrolled in Special Needs Plans (SNPs). Enrollment of dually eligible beneficiaries into Medicare

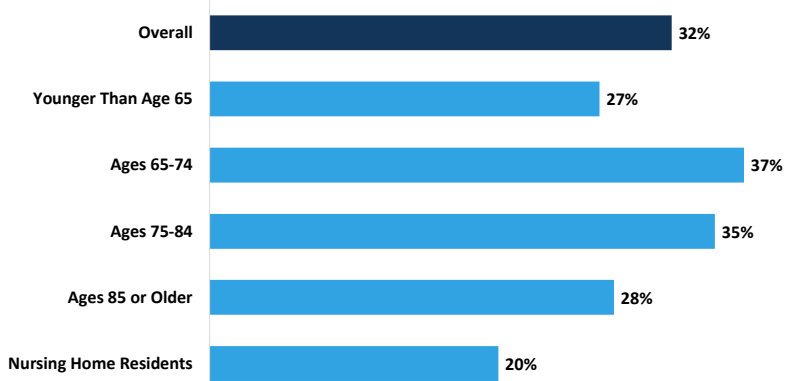
Advantage plans has increased at a similar rate to the overall growth in Medicare Advantage enrollment.



Some dually eligible beneficiaries are under-represented in Medicare Advantage plans. For example, dually eligible beneficiaries who are younger than age 65 and have a significant disability disproportionately do not enroll in Medicare Advantage plans. Only 27 percent of dually eligible beneficiaries under the age of 65 were enrolled in Medicare Advantage plans compared to 37 percent of dually eligible beneficiaries between the ages 65 and 74 in 2014 (Figure 4).

Figure 4

**A smaller than average share of dually eligible beneficiaries ages 85 or older, younger than age 65, and residing in nursing homes are enrolled in Medicare Advantage plans, 2014**



SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use File, 2014.



Additionally, only 20 percent of dually eligible beneficiaries who reside in nursing homes and 28 percent of dually eligible beneficiaries ages 85 or older were enrolled in Medicare Advantage plans in 2014.

For the dually eligible beneficiaries enrolled in Medicare Advantage plans that are not SNPs, many questions remain about their care and experience. For example, do Medicaid programs pay the cost-sharing on behalf of dually eligible beneficiaries in Medicare Advantage plans? How well do Medicaid programs coordinate with Medicare Advantage plans in providing Medicaid benefits? What extra benefits do Medicare Advantage plans offer that are attractive to dually eligible beneficiaries?

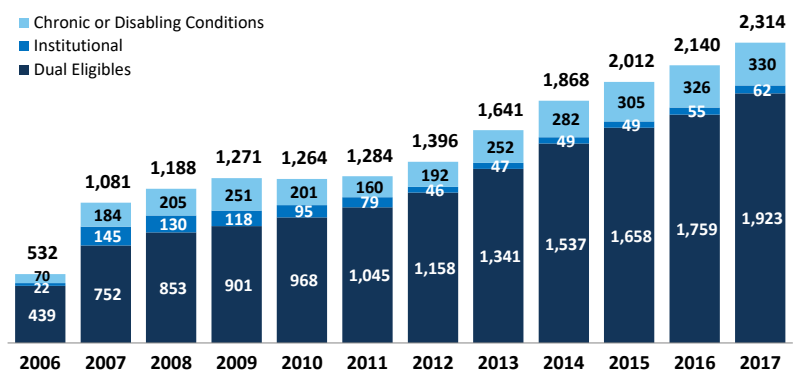
**Special Needs Plans’ Role for Dually Eligible and Other Medicare Beneficiaries**

Special Needs Plans (SNPs) are a type of Medicare Advantage plan that restricts enrollment to specific types of beneficiaries with significant or relatively specialized care needs. These include beneficiaries who are dually eligible for Medicare and Medicaid (D-SNPs); require a nursing home or institutional level of care (I-SNPs); or have chronic or disabling conditions (C-SNPs). By limiting enrollment to certain high-need beneficiaries, SNPs may be able to develop care management techniques that are tailored to their covered population. In total, 2.3 million Medicare beneficiaries are enrolled in SNPs so far in 2017, including 1.9 million in D-SNPs, about 330,000 in C-SNPs and 62,000 in I-SNPs (Figure 5).<sup>9</sup>

Figure 5

**Enrollment in Special Needs Plans has been increasing, 2006 – 2017**

Number of Beneficiaries in SNPs, in thousands



NOTE: Numbers may not sum to the total due to rounding.  
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2006-2017.



Enrollment of dually eligible beneficiaries in D-SNPs varies greatly by state. In six states, more than one in four dually eligible beneficiaries were enrolled in D-SNPs (AZ, FL, HI, MN, NY, TN), but in nearly half of all states (24 states), 5 percent or fewer dually eligible beneficiaries were enrolled in D-SNPs.<sup>10</sup>

SNPs for people with specific chronic conditions, or C-SNPs, are another potential approach for managing the care of high-need, high-cost Medicare beneficiaries. Most C-SNPs focus on the same chronic conditions; 97 percent of people in C-SNPs are in plans that focused on cardiovascular disorders, heart failure, chronic lung disorders, and/or diabetes, in 2017. The minority of C-SNP enrollees (less than 9,000 people) are in plans focusing on other conditions, including 1 percent in plans for people with mental illnesses, 1 percent in plans for people with HIV/AIDS, and 1 percent in plans for people with end-stage renal disease.<sup>11</sup>

While information is available about how many people are receiving their care through SNPs, little is known about what additional services or benefits enrollees are receiving, how plans are tailored to meet the needs of enrollees, and to what extent the quality of care and outcomes differ across plans. The Medicare Payment Advisory Commission (MedPAC) examined how well SNPs performed on quality measures compared to other Medicare Advantage plans and concluded that, in certain cases, SNPs were better for beneficiaries with special health conditions.<sup>12</sup> The Commission recommended that Congress permanently reauthorize all of the I-SNPs, only D-SNPs that are integrated with Medicaid, and only the C-SNPs that focus on end-stage renal disease, HIV/AIDS, and severe mental illness; the Commission recommended not reauthorizing D-SNPs that are not integrated with Medicaid and C-SNPs that focus on other chronic conditions.<sup>13</sup>

## **The Role of PACE in the Medicare Program**

High-need Medicare beneficiaries also have the option of enrolling in the Program of All-Inclusive Care for the Elderly (PACE) to receive their health care. PACE is a provider-based program that integrates Medicare and Medicaid benefits for people who are dually eligible. People are eligible to enroll in a PACE program if they are 55 or older, require a nursing home level of care, are able to live safely in the community, and live in the service area of a PACE organization. People can enroll in the PACE program if have either Medicare or Medicaid, or both, or if they pay for the program out of pocket. Unlike SNPs, PACE providers have statutory waivers that expand the scope of services they can provide to their enrollees. PACE programs can enroll beneficiaries only on the first day of each month because PACE providers receive a prospective per enrollee payment from Medicare and Medicaid at the beginning of each month.<sup>14</sup>

The first PACE program was established in the 1970s, and since that time they have expanded across the country. Currently, there are more than 120 PACE programs. The total number of Medicare beneficiaries enrolled in PACE has more than doubled over the past several years, increasing from almost 17,000 people in 2010 to more than 36,000 in 2017.<sup>15</sup> However, each PACE program tends to be relatively small, and questions have been raised about whether they could be replicated on a larger scale.<sup>16</sup> On average, each program includes 287 Medicare beneficiaries, ranging from less than 20 people to over 2,000 people in 2017.<sup>17</sup>

The literature suggests that the PACE program increases longevity, reduces nursing home use, and decreases unnecessary hospital use and emergency room visits.<sup>18, 19, 20 21</sup> However, data on the quality of individual PACE programs is not publicly available, making it difficult to assess how quality varies across PACE programs.

MedPAC has made several recommendations regarding PACE programs, such as broadening the eligibility criteria to include people younger than 55,<sup>22</sup> developing quality measures for PACE programs, prorating payments to providers to allow beneficiaries to enroll in PACE for a partial month, and establishing an outlier protection policy for PACE providers serving beneficiaries with unusually high costs.<sup>23</sup>

## **Value-Based Insurance Design in the Medicare Advantage Program**

Medicare Advantage plans are currently required to offer to all enrollees the same benefit package, regardless of specific enrollees' health status. In the past, the designs of Medicare Advantage plans' benefit packages and cost-sharing were found to discriminate by enrollees' health status by charging more for non-elective services (such as dialysis or Part B-covered drugs) than they charged for more discretionary services (such as physician visits).<sup>24</sup> These differences in benefit packages resulted in healthier Medicare beneficiaries selectively enrolling into some plans and sicker beneficiaries enrolling in other plans.<sup>25</sup> As a consequence, Medicare Advantage plans' cost-sharing is now more tightly regulated, with limits on cost-sharing for most Medicare Part A and Part B services.

Requiring plans to offer the same benefits to all enrollees may limit plans' ability to selectively enroll healthier beneficiaries, but it may also hinder plans' ability to provide all of the benefits that may aid people with chronic conditions. Value-based insurance design would allow Medicare Advantage plans to enhance benefits for enrollees with specific chronic conditions, and would not require plans to provide those extra benefits to enrollees without those select conditions. This year, CMS began permitting Medicare Advantage plans to test a value-based insurance design model for enrollees with specific chronic conditions. Such a model could be structured to focus on managing the health care of enrollees with high-needs or high-costs or those with less complex chronic conditions.

Medicare Advantage plans are eligible to participate in this CMS model if they operate in one of the seven participating states (AZ, IN, IA, MA, OR, PA, and TN), and meet other eligibility criteria; three more states (AL, MI, and TX) are scheduled to be added to the model in 2018.<sup>26</sup> Medicare Advantage plans in these areas must also have at least 2,000 total enrollees in order to participate in the model. Participating plans have several options for enhancing the benefits of enrollees with the target chronic conditions, including reducing cost-sharing for specific services, reducing cost-sharing for specific providers, reducing cost-sharing for enrollees participating in disease management programs, or providing coverage of supplemental benefits.

In 2017, 8 out of 34 firms offering Medicare Advantage plans in the eligible states are participating in the model. These firms are testing the model in three of the seven eligible states (IN, MA, and PA), and all of the firms are focusing the model on enrollees with hypertension, diabetes, chronic obstructive pulmonary disease (COPD), and/or congestive heart failure.<sup>27</sup> CMS has not yet reported how these firms are enhancing their plans' benefit packages for enrollees with these conditions.

A value-based insurance design model could provide Medicare Advantage plans the flexibility to tailor their benefits to the needs of their enrollees, providing plans another tool for managing the care of high-need Medicare beneficiaries. However, as with any change in Medicare benefits, oversight is needed. It may be worth examining whether marketing of enhanced benefits could disproportionately attract and reward more educated, highly motivated beneficiaries with the resources to manage their chronic conditions while potentially creating access barriers for less educated, poorer Medicare beneficiaries. If this approach is shown to be effective for people with certain conditions, it may be appropriate to consider how the benefits could be provided more broadly to other beneficiaries with chronic conditions in Medicare Advantage plans or traditional Medicare.

MedPAC has recommended permitting Medicare Advantage plans to use value-based insurance design to enhance benefits for individuals with specific chronic conditions.<sup>28</sup> The CMS model that is currently being tested could help to inform the future direction of value-based insurance design in Medicare, if appropriate information is collected and reported about enrollee participation, costs, and outcomes.

## Summary

Over 2 million people on Medicare are currently receiving their Medicare benefits through SNPs and the PACE programs. These approaches for integrating and coordinating the care for high-need, high-cost Medicare beneficiaries have the potential to improve the quality of care and outcomes for these beneficiaries. However, given the significant needs of their enrollees, it is important to understand more about how well SNPs and the PACE programs are serving this vulnerable population. In particular, what additional services or benefits are SNPs providing to improve the management of care? How well do D-SNPs coordinate care with state Medicaid programs? What services are I-SNPs providing to the most vulnerable patients in nursing homes, and to what extent are they succeeding in reducing unnecessary hospitalizations? In addition, for both SNPs and PACE programs, how do the quality of care and outcomes vary across plans and programs? These questions are important to answer because of the growing number of vulnerable Medicare beneficiaries covered by these approaches.

Value-based insurance design could be a new model for Medicare Advantage plans to manage the care of either beneficiaries with less complex chronic conditions or high-need, high-cost Medicare beneficiaries. More information would help to clarify how the model might work in practice for these beneficiaries. For instance, what enhanced benefits are plans offering through value-based insurance design? Who should decide what services or providers are high- versus low-value? What protections are needed to ensure that value-based insurance design does not lead to less standardized benefits and more confusion for Medicare beneficiaries? Answers to questions such as these could help inform a thorough evaluation of a value-based insurance design for Medicare Advantage, which is critical given the significant needs of this population.

An additional question to be considered relates to the provider networks available to beneficiaries in SNPs, PACE programs, and Medicare Advantage plans with value-based insurance design models: how do their provider networks affect enrollees' care and health outcomes?<sup>29</sup> Limiting access to providers for dually eligible and other high-need beneficiaries could have a large impact on their care.

For dually eligible beneficiaries, Medicaid helps to shield them from unaffordable medical and long-term care costs. Appropriately managing the care of these beneficiaries could help to ensure the fiscal sustainability of both Medicare and Medicaid in the years to come. At the same time, it remains important to ensure adequate protections are in place to retain access to health care services, providers, and high quality care for the sickest and poorest on Medicare.

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