Dual Eligible Care in a SNP vs. FFS: Preliminary Findings from a Natural Arizona Experiment

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Care Alignment for Dual Eligibles and the Arizona Context

The Promise of Care Alignment (1)

- **Dual eligibles typically receive uncoordinated Medicaid and Medicare services**
  - **Interactions between long-term care (Medicaid) and acute care services (Medicare) can be problematic for beneficiaries and providers**
  - **Medicaid "support" services like transportation and home health/personal care that can complement Medicare-paid acute care can be difficult to arrange**

The Promise of Care Alignment (2)

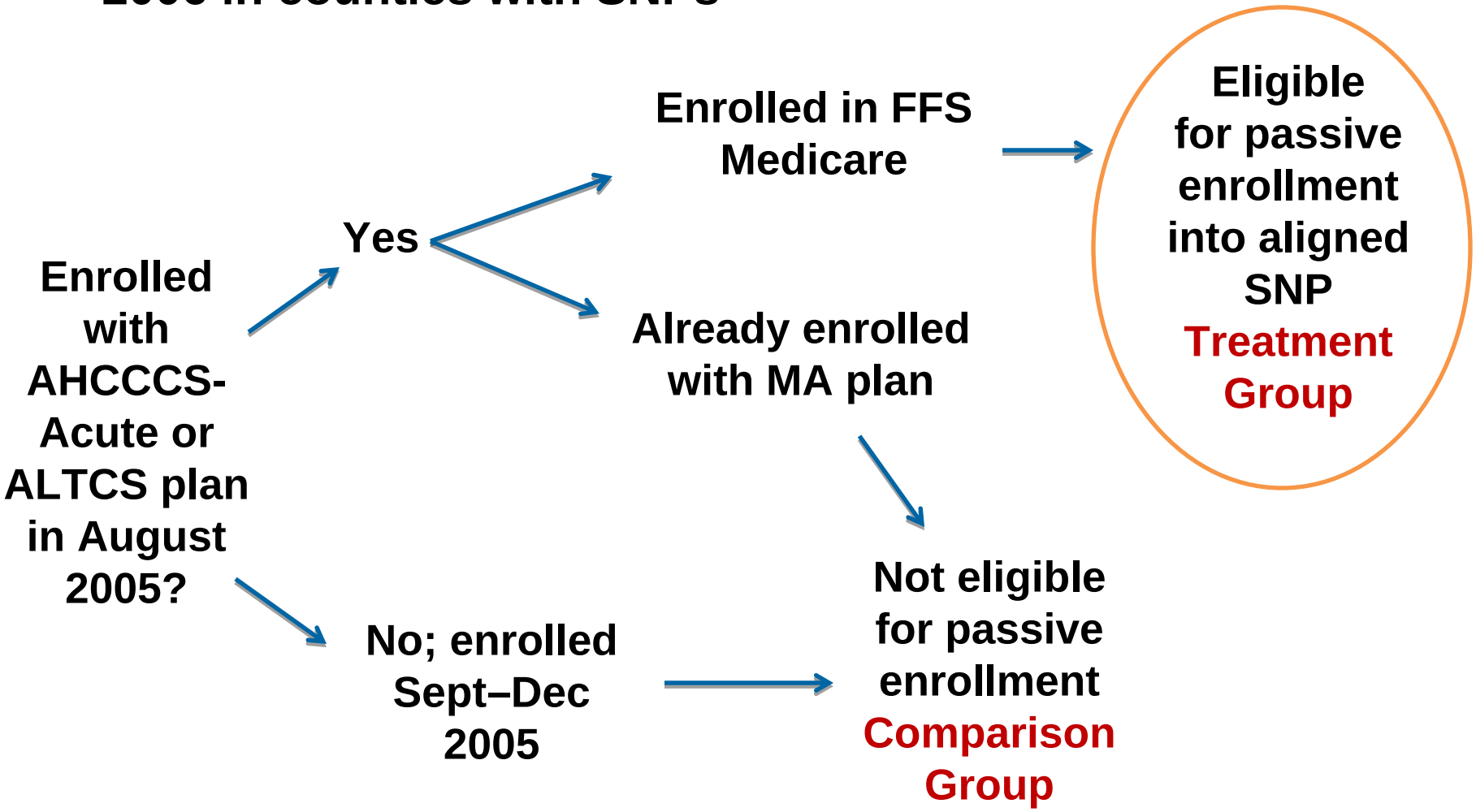
- **Enrollment with the same managed care company for both Medicaid and Medicare services ("alignment") creates incentives and opportunities for reduced hospitalizations**
  - **No incentives to shift costs across programs**
  - **Incentive to leverage Medicaid support services to reduce hospitalizations**
  - **Timely access to information necessary for good care coordination**
    - Especially information on hospital admissions and discharges, Rx drug use, and physician visits
- **Arizona provided early opportunity to test marginal effect of Medicare alignment, when Medicaid services already managed**

Opportunity for Care Alignment in AZ (1)

- **Long-standing mandatory enrollment in Medicaid's capitated managed care plans through**
  - **Arizona Health Care Cost Containment System (AHCCCS) Acute Care Program**
    - Behavioral health services carved out
  - **Arizona Long-Term Care System (ALTCS) for enrollees who require a nursing-home level of care**
    - Full integration of Medicaid acute, behavioral, and LTC
    - Greatest potential for alignment to improve outcomes
- **Medicare Advantage (MA) special needs plans (SNPs) authorized to serve Medicaid beneficiaries starting in 2006**
- **Many existing AHCCCS-Acute and ALTCS plans choose, at the state's urging, to offer a SNP**
  - **Emphasis on continued access to Rx, given launch of Medicare Part D**
  - **Separate contracts/capitation payments from Medicare and Medicaid**

Opportunity for Care Alignment in AZ (2)

- One-time passive enrollment into aligned SNPs in January 2006 in counties with SNPs



Opportunity for Care Alignment in AZ (3)

- After introduction of SNPs and passive enrollment of some beneficiaries
  - Aligned beneficiaries receive Medicaid and Medicare through the same managed care plan
  - Unaligned beneficiaries receive Medicare through a different SNP or MA plan or via fee-for-service (FFS)
- Research question
  - Does managing Medicaid and Medicare services through the same managed care plan lead to better hospitalization outcomes for beneficiaries?

Data Analysis and Preliminary Findings

Methodology

- **Sample population**
  - **Cohort of beneficiaries enrolled during 2005–2006 in Medicaid plans that offered SNPs in 2006**
    - In one of five AHCCCS-Acute plans (n = 49,409)
    - In one of two ALTCS plans (n = 6,440)
- **Followed outcomes for cohort through 2010**
- **Treatment and comparison groups**
  - **Dual eligibles who qualified for passive enrollment in 2006 (treatment group)**
  - **Dual eligibles in same Medicaid plan in the same counties who did not qualify for passive enrollment (comparison group)**
    - Face same delivery-system factors affecting hospitalization outcomes

Alignment Status, 2006 and 2010: AHCCCS-Acute

	Treatment		Comparison	
	2006	2010	2006	2010
Sample Size	28,422	18,093	20,987	10,781
Aligned (%)	92.8%	76.2%	10.6%	31.0%
Unaligned (%)				
MA plan	0.7%	14.2%	34.4%	36.0%
FFS Medicare	6.5%	9.6%	54.9%	33.0%

Note: Beneficiaries were free to opt out of passive enrollment or to actively choose enrollment in an aligned SNP if they were not eligible for passive enrollment.

Alignment Status, 2006 and 2010: ALTCS

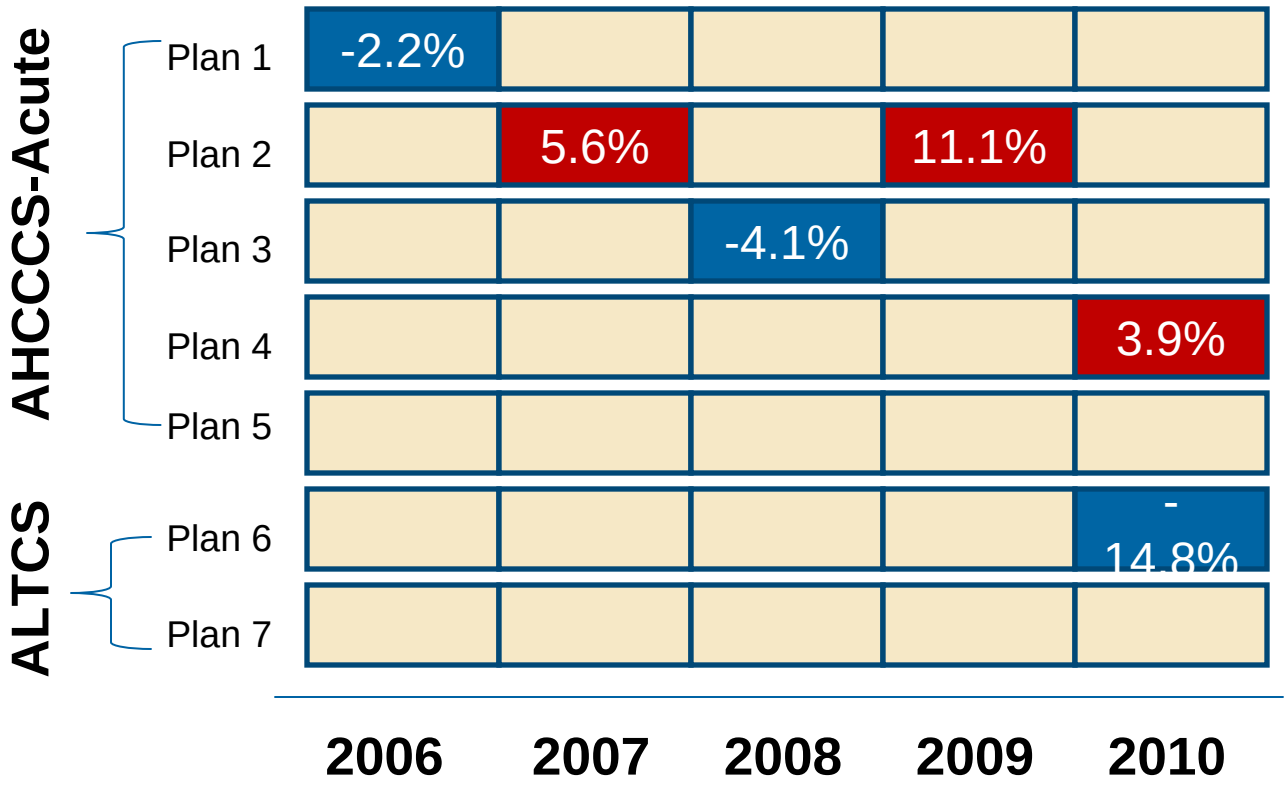
	Treatment		Comparison	
	2006	2010	2006	2010
Sample Size	2,653	1,099	3,787	1,159
Aligned (%)	96.6%	88.4%	20.4%	31.4%
Unaligned (%)				
MA plan	0.3%	5.4%	39.7%	40.5%
FFS Medicare	3.1%	6.2%	39.8%	28.1%

Note: Beneficiaries were free to opt out of passive enrollment or to actively choose enrollment in an aligned SNP if they were not eligible for passive enrollment.

Key Outcomes and Data Sources

- **Effects of alignment on probability of**
  - **Any hospitalization**
  - **Any readmission (excluding rehab)**
- **Enrollment records matched to inpatient discharge records from AZ Department of Health**
  - **Overcomes problem of under-reporting hospitalizations for dual eligibles in Medicaid encounter data**

Effects of Alignment on Probability of Hospitalization

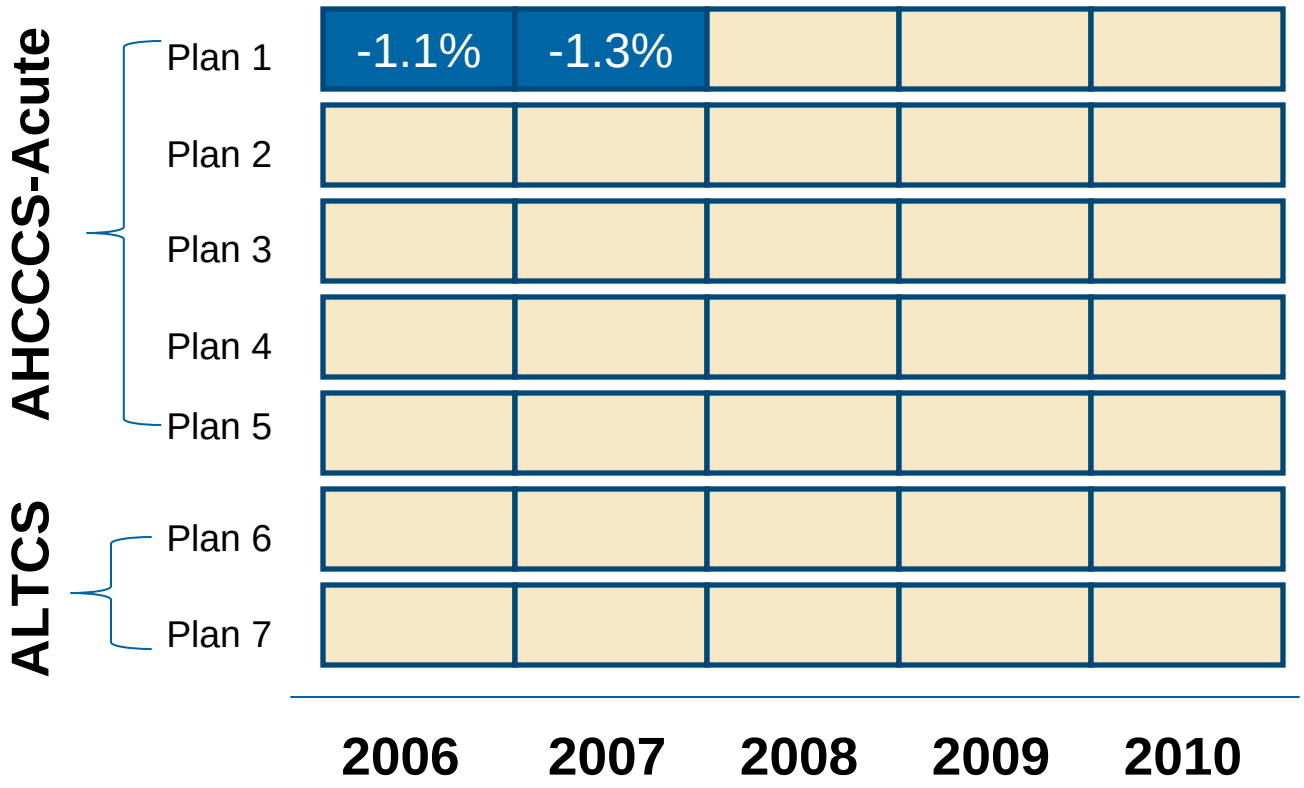


Key

- Alignment associated with fewer hospitalizations
- No significant effect
- Alignment associated with more hospitalizations

Note: Statistically significant estimates by plan and follow-up year; compared to FFS Medicare only

Effects of Alignment on Probability of Readmission



Note: Statistically significant estimates by plan and follow-up year; compared to FFS Medicare only

Analytic Summary

- **Few statistically significant differences in hospital use between aligned and unaligned beneficiaries**
- **No consistent patterns or trends suggesting improved outcomes for individual plans or overall, for ALTCS or AHCCCS-acute**
- **Within each plan, consistent findings whether the comparison group**
  - **Includes or excludes those enrolled with MA plans**
  - **Includes or excludes those who first enrolled from September–December 2005**

Health Plan Perspectives on Study Findings

Discussions of Results with AZ SNPs

- **Goals were to learn more about**
  - **What they were doing (or not) in 2006–2010 to reduce hospitalizations for aligned and unaligned dual eligibles**
  - **Obstacles to reducing hospitalizations**
  - **What they learned from their SNP implementation experience in 2005-2006 and later years**
  - **Advice for other health plans, states, and CMS on ways to improve integrated care for dual eligibles**

What Did "Alignment" Mean in AZ in 2006–2010?

- **Most plans reported using the same care management approach for aligned and unaligned dual eligibles**
  - **In 2007, between 33 and 53 percent of each plan's dual eligibles were aligned**
- **Plans attempted to gain clinical information to facilitate discharge planning for hospitalizations whether plan was primary Medicare payer or secondary Medicaid payer (for beneficiary cost sharing)**
  - **Information flow more timely and complete when primary payer**
- **Plans began implementing more intensive approaches to managing hospital care at the end of our follow-up period (late 2009 into 2010)**
  - **For example, telehealth monitoring for 90 days post-discharge**
  - **Largely, still no difference between approach for aligned and unaligned members**

Some of Our Take-Aways

- **Alignment ≠ integrated care**
  - **Limited effort to take advantage of alignment during the study period of 2006-2010**
- **Achieving full care integration requires substantial commitment of health plan time and resources to:**
  - **Gain adequate knowledge of both Medicare and Medicaid**
  - **Form effective care coordination teams**
  - **Develop relationships with hospitals to obtain needed real-time information on admissions, discharges, and care provided in the hospital**
  - **Develop processes and resources to facilitate effective transitions into and out of hospitals**
  - **Develop information systems to get the right information to the right people at the right time**

Implications for the CMS Financial Alignment Demonstrations

Goals of the Financial Alignment Demonstrations

- Extend well beyond reducing hospitalizations
- Include improvements in
  - Administrative and systems coordination
  - Quality and coordination of care across settings
  - Beneficiary access to and utilization of care
  - Beneficiary satisfaction and experience
  - Beneficiary health status and outcomes
  - Long-term care rebalancing and diversion from unneeded institutional care
  - Overall cost savings for Medicare and Medicaid

Demonstrations Have Resources that Were Not Available in AZ

- **Provided through CMS Medicare-Medicaid Coordination Office (MMCO), established in 2010**

- **Include**
  - **Improved access to Medicare data on dual eligibles for states to help with program design, care planning, and performance measurement**
  - **Technical assistance for states through the Integrated Care Resource Center (http://www.integratedcareresourcecenter.com/)**
  - **Joint CMS-state capitated rate-setting for Medicaid and Medicare services**
  - **Three-way contracting among states, CMS, and health plans**
  - **Joint readiness reviews of health plans**
  - **More coordinated administrative, performance measurement, and reporting requirements**

Further Implications

- **Fully integrating care for dual eligibles is not easy, even when the context is favorable, as in AZ**
  - **Health plans must devote substantial resources to obtaining and acting on timely information on all services used or needed by dual eligible enrollees**
- **Medicaid health plans without Medicare experience, or Medicare plans without Medicaid experience, may face a steep learning curve in the demonstrations**
- **In states with high penetration of effective managed care plans among dual eligibles, should not expect large impacts on care and cost to occur right away**

New Opportunities for States to Monitor Service Use Among Dual Eligibles

- **As of 2012, MA plans required to submit encounter data to CMS**
- **States contracting with these plans in the demonstrations can require the plans to submit Medicare encounter data directly to the state as well**
- **Would enable states to**
  - **Do more timely oversight of health plans**
  - **Compare plan performance on a wide variety of Medicare, Medicaid, and care coordination measures**
  - **Monitor trends in hospitalization outcomes using the same type of analytic approach that we did, much more quickly and easily**
    - No need to get Medicare hospital discharge data from a separate source

For More Information

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