Medicare Special Needs Plans: Lessons from Demonstration Programs for Dual Eligible Beneficiaries

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Demonstration Programs Evaluation Background

- **11 dual eligible beneficiary Medicaid waiver demonstration programs**
  - **Provide Medicare/Medicaid benefits**
  - **Coordinated and comprehensive care for duals**
- **Three states: Wisconsin, Minnesota, Massachusetts**
- **Purpose of evaluation:**
  - **Describe the populations and approaches**
  - **Lessons for Medicare Special Needs Plans**

Areas of Investigation

- **Enrollee characteristics and utilization**
- **Medicare and Medicaid payment approaches**
- **Contracting for and managing community care services**
- **Coordinating acute care and community care**
- **Marketing to people with special needs**

Demonstration Program
Dual Eligible Population

	Minn	Wisc	Mass	All <65 disabled
Total enrollees per program	1000-2948	400-486	341-606	211-305
Average age	80	76-79	75-76	47-52
% Nursing home certified	19-26	87-95	22-49	88-99
% Institutionalized	44-47	5-13	0-1	1-10
%Non-NHC in community	30-34	0	51-77	0-3
Medicare HCC risk scores 2005	1.43-1.56	1.91-2.36	1.51-2.05	1.53-2.28
Frailty factors	.15-.21	.39-.45	.30	.45-.70

*Annualized from first half of 2005

Dual Eligible Demonstration Program Enrollment Update 2005- 2006

	2005	2006 (Oct)	Change
Minnesota	6254	33,000	Increased number of plans from state programs
Wisconsin	1800	1800	Passive enrollment
Massachusetts	1686	4821	Active growth strategies

Demonstration Dual Eligible Beneficiaries Utilization 2005*

	Minn	Wisc	Mass	All <65 disabled	Average Medicare HMO Plan (2004)
Hospital days /member/year	1.7-2.2	2.9-5.1	2.4-5.8	4.6-6.8	1.5
Outpatient MD visits/member/year	3.8-16.3	3.3-5.0	3.3-37.0	5.4-6.0	8.4
Prescriptions/ member/year	85	109-177	39-87	108-190	21.3**
Pharmacy $$/ member/year	$3312-3396	$1308-5184	$2520-$3828	$6696-9384	
Percent having personal attendant	17	38-94	6-26	44-85	

*Annualized from first half of 2005
** Includes plans with pharmacy benefit caps

Medicaid Capitated Services for Waiver Programs: Full-risk Capitation*

- Medicare copayments and deductibles
- Prescription drugs (now Medicare)
- Supportive services (e.g. transportation)
- Community care waiver benefits
- Personal care attendant benefits
- All or some risk for custodial nursing facilities

* Mn and Wi

Enrollment of Dual Eligible Beneficiaries into Programs

- Varied by state based on history and program type
- Word of mouth
- Through medical groups
- Through community health centers, aging networks
- Members of state's own Medicaid HMOs
- Few referrals from community care waiver programs in any state

Contracting Services and Coordinating Care Models

Contracting models

- **In-house or self-management**
- **Management sub-contracted to waiver programs**
- **Combination of both**

Coordinating care models

- **Single coordinator**
- **Nurse/ social worker team**
- **Multidisciplinary team**
- **Use of electronic health record**

Features Promoting Integration of Services

- **Physicians:**
  - **Interest or “physician champion”**
  - **Critical mass of the plan's patients**
  - **Co-location of a care manager in the practice**
- **Care manager clinical or “team”**
- **Nurse practitioners or nurses accompany patients on visits**
- **Nurse practitioner/physician teams for NH**
- **Small size “hands on”**

Challenges in Particular Coordination Areas

Managing the personal care attendant

- Care coordinator/purchased services model versus consumer-directed PCAs
- Contracts outside agencies for training and paying PCAs
- Family members as PCAs
- Excessive expectations of new enrollees

Merging clinical and coordination services

- Especially when care coordinators are not clinical
- Need MD or NP engagement

Lessons Regarding Medication Management

- **Works best when coordinator is clinical member of team**
- **Access to prescriber**
- **Support at point of service**
- **Continued med reevaluation – e.g. post hospitalization**
- **Nursing home coordination – through special teams**
- **Pharmacist input from plan side for: clinical consulting, formulary management, utilization review, etc.**

Summary of Comprehensive Dual-Eligible SNP Model

- **Voluntary enrollment of duals & Medicaid-only**
- **Risk-adjusted rates & full-risk capitations from Medicare & Medicaid.**
- **Medicaid rate includes community care services & all or some risk for custodial nursing homes**
- **Prescription drugs through the Medicaid capitation (now shifted to Medicare with Medicaid supplement)**
- **Special efforts to coordinate medical and social care services.**

Lessons for Special Needs Plans

- **Integration of services critical point in management**
- **Care coordination model varies: clinical versus social; individual versus team**
- **Contracting versus internal provision of services**
- **PCA services management is important factor**
- **Physician engagement is also key**

Summary: Challenges for Creating Comprehensive Dual-Eligible SNPs from Demonstrations

- **Health plans: Contract for, take risk for, & integrate the full range of acute and long-term care services; different financing streams**
- **States: Choose among the targeting and benefit models, develop payment approaches, & work out relationships among provider organizations**
- **CMS: Transition demo supports into the SNP program, e.g., integrated approaches to financing, benefits, service delivery, & marketing**