Promoting Integrated and Coordinated Care for Medicare Beneficiaries

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My name is David Grabowski, and I am a Professor in the Department of Health Care Policy at Harvard Medical School. I would like to thank Chairman Tiberi, Ranking Member Levin, and the Distinguished Members of the Committee for giving me the opportunity to speak today about integrated and coordinated care for Medicare beneficiaries. This testimony is derived in large part from the academic work I have done related to this issue.[1-5] Before I begin my substantive remarks, I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC which I was appointed to last month.

A long-standing policy goal has been the development of coverage models that promote coordinated, high-value care for dual-eligible and chronically ill Medicare beneficiaries. Unfortunately, the traditional fee-for-service payment system has not typically achieved this objective. Dual eligible beneficiaries have three health insurance cards (Medicare, Part D, and Medicaid) with three different sets of benefits. Given this bifurcated coverage under Medicare and Medicaid, each program has the narrow interest in limiting its share of costs, and neither program has an incentive to take responsibility for care management or quality of care. Ultimately, this fragmented model of coverage does little to encourage cost containment or high quality care.

Under an integrated model of care, enrollees ideally have a single set of comprehensive benefits covering a range of services including physician, hospital, prescription drug, and long-term care services. They have an individualized care plan with a coordinated team of health providers. The hope is that this integrated care can be delivered in lower-cost community settings, which is consistent with most beneficiaries' preferences.

One model that has the potential to financially and clinically integrate services is the Medicare Advantage Special Needs Plans (SNPs). SNPs were authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, with the idea of attracting a different type of beneficiary into Medicare Advantage. SNPs target one of three types of beneficiaries: Medicare-Medicaid eligible enrollees via dual eligible SNPs (D-SNPs), individuals residing in nursing homes or in the community who are nursing home certifiable via institutional SNPs (I-SNPs), and individuals with severe or disabling chronic conditions via the chronic condition SNPs (C-SNPs).

Today, over 2 million Medicare beneficiaries are enrolled in SNPs, which is greater than the number of Medicare beneficiaries in all other integrated care programs combined. SNPs enjoy some unique regulatory advantages over regular Medicare Advantage plans such as special month-to-month enrollment rules. Thus, it is vitally important that we understand whether there is anything "special" about special needs plans to justify their unique status.[6] Two areas where SNPs have the opportunity to provide benefits are through improved quality and better integration.

In terms of quality, my early research[2] and separate work[7] commissioned by the Centers for Medicare and Medicaid Services (CMS) generally did not find that special needs plans offered better quality when compared to regular Medicare Advantage plans. This research raised the

question of whether SNPs offer value to beneficiaries above traditional Medicare Advantage plans. The CMS-commissioned work suggested quality was relatively better in D-SNPs and I-SNPs compared with C-SNPs. Recent analyses conducted by MedPAC[8] suggest better performance in the D-SNPs and I-SNPs relative to traditional Medicare Advantage plans. However, MedPAC has found that the C-SNPs generally perform similar—or even worse—relative to regular Medicare Advantage plans.

In terms of integration, if the D-SNPs are going to offer a true integrated product, they need to clinically and financially integrate with Medicaid. As a bit of history, the first generation of D-SNPs had little relationship with Medicaid. They basically acted like a regular Medicare Advantage plan. Congress recognized this issue and required SNPs under the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 to have a contract with Medicaid. This was a *necessary* step towards encouraging integration but unfortunately it was not *sufficient* towards ensuring meaningful integration.

In response to MIPPA, D-SNPs have established contracts to coordinate Medicaid long-term care and behavioral health services for the beneficiary. However, most D-SNPs do not actually cover these Medicaid services. As a result, the majority of dually eligible beneficiaries in D-SNPs still have two separate insurance cards with two different sets of benefits for Medicare and Medicaid services. The typical D-SNP is not at-risk for Medicaid spending or accountable for Medicaid outcomes. This type of arrangement is not true financial and clinical integration. A minority of state Medicaid programs have managed to overcome this issue by allowing the D-SNP to cover Medicaid services.[9] Alternatively, a single managed care company can operate both a D-SNP and a Medicaid plan, which would allow some coordination across the two products.[9] Unfortunately, these arrangements are still the exception rather than the rule.

Moving forward, I would encourage action in four areas on the part of your Committee. First, all D-SNPs should be both clinically and financially integrated with Medicaid. Otherwise, it is hard to make a case for this model over Medicare Advantage. Second, SNPs must show that they offer higher quality to beneficiaries to justify their existence. As noted above, the C-SNPs have shown relatively lower quality as compared with other models. Third, Medicare has historically underpaid for full dually eligible individuals in Medicare Advantage. This underpayment issue has been linked to low enrollment in the recent CMS Financial Alignment Initiative demonstration for duals.[10] CMS recently adjusted payments upward for Duals to address this issue but continued oversight is needed to ensure that payments to SNPs are adequate to encourage high-quality care for the sickest, frailest Medicare beneficiaries. Finally, outside of an early CMS evaluation,[11] there has not been a recent major government-commissioned study of the SNPs. If we are going to continue to put public dollars into this program, we need a more rigorous and nuanced understanding of which SNP models work for which Medicare beneficiaries.

In summary, the theory behind financial and clinical integration of services for those frailest, most vulnerable beneficiaries is compelling. In practice however, we have not achieved meaningful integration in the majority of SNPs to date. Reforms that encourage true integration will help ensure high-value care for our frailest Medicare beneficiaries.

REFERENCES

1. Grabowski DC. Special Needs Plans and the coordination of benefits and services for dual eligibles. *Health Aff. (Millwood).* Jan-Feb 2009;28(1):136-146.
2. Maciejewski ML, Wang V, Grabowski DC, Lin PJ. Early evidence on the quality of care provided by special needs plans. *Medical care.* Oct 2011;49(10):891-896.
3. Grabowski DC, Bramson J. State Initiatives to Integrate the Medicare and Medicaid Programs for Dually Eligible Beneficiaries. *Generations.* 2008;34(3):54-60.
4. Grabowski DC. Care coordination for dually eligible Medicare-Medicaid beneficiaries under the affordable care act. *J Aging Soc Policy.* 2012;24(2):221-232.
5. Grabowski DC. Medicare and Medicaid: conflicting incentives for long-term care. *Milbank Q.* 2007;85(4):579-610.
6. Verdier J, Gold M, Davis S. *Do We Know If Medicare Advantage Special Needs Plans Are Special?* Menlo Park, CA: Henry J. Kaiser Family Foundation;2008.
7. National Committee for Quality Assurance. *Medicare Special Needs Plans Performance Results: HEDIS 2015*: Prepared for Centers for Medicare & Medicaid Services;2015.
8. Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* Washington, DC: Medicare Payment Advisory Commission March 2013.
9. Milligan CJ, Woodcock CH. *Coordinating Care for Dual Eligibles: Options for Linking State Medicaid Programs with Medicare Advantage Special Needs Plans*: Commonwealth Fund;2008.
10. Grabowski DC, Joyce NR, McGuire TG, Frank RG. Passive Enrollment Of Dual-Eligible Beneficiaries Into Medicare And Medicaid Managed Care Has Not Met Expectations. *Health Aff. (Millwood).* May 01 2017;36(5):846-854.
11. Schmitz R, A. M, Schore J, Shapiro R, Verdier J. *Evaluation of Medicare Advantage Special Needs Plans: Summary Report*: Report Submitted to Centers for Medicare & Medicaid Services;2008.