EXECUTIVE BRIEFING 2

# Caring for Vulnerable Populations

Approximately 9.2 million Medicaid beneficiaries are dual eligibles — low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. Dual eligibles are among the sickest and poorest individuals, and they must navigate both government programs to access necessary services, relying on Medicaid to pay Medicare premiums and cost-sharing to cover critical benefits not covered by Medicare.

Care for dual eligibles is fragmented, lacking management and coordination at the program level. Different eligibility and coverage rules in Medicare and Medicaid contribute to these difficulties. The current system lacks sufficient care coordination, which inhibits access to critical services and encourages cost-shifting between providers and payers. All of these factors adversely affect this population's quality of care and health outcomes.

The Affordable Care Act established two federal entities that will be involved in efforts to study and improve care for dual-eligible beneficiaries. This creates a tremendous opportunity for hospitals to take the lead in developing integrated delivery programs for the dual-eligible population.

## WHO IS A DUAL ELIGIBLE?

About 6 in 10 dual eligibles are 65 and older, and more than one-third are younger individuals with disabilities. They are three times more likely than the rest of the Medicare population to be disabled and have higher rates of diabetes, pulmonary disease, stroke, mental disorders and Alzheimer's disease. The varying and extensive physical and mental health comorbidities increase care complexity, making service use extremely high among this population and care coordination particularly challenging (see Health Service Use Among Dual Eligibles vs. Medicare Population, page 18).

Dual eligibles are the most expensive population within both the Medicare and Medicaid programs. Annual mean per person spending for all dual eligibles was $19,400 with Medicaid covering slightly more than half of the spending. Spending per person with more than one mental or cognitive condition increased to approximately $38,500. Although they are a relatively small percentage of the overall Medicare and Medicaid populations, they account for almost one-third of overall Medicare and Medicaid spending (see Dual Eligibles vs. Medicare and Medicaid Population and Spending, page 18).

## COVERAGE AND PAYMENT POLICIES

The current distribution of costs and the management of dual eligibles across Medicare and Medicaid require the coordination of two programs with different coverage and payment parameters. For this population, Medicare generally covers acute care services while Medicaid may reimburse for different combinations of Medicare premiums, cost-sharing and long-term care services, depending on the beneficiary.

Legally, the government payers are structured to operate as two separate programs, and their interaction is complicated by 50 separate state Medicaid policies. Financially, the current policy creates incentives to shift costs to the other payer, often hindering efforts to improve quality, increase access and coordinate care. State-run Medicaid plans have little incentive to improve coverage on long-term and supplemental services for dual eligibles — which ideally would reduce hospitalizations, readmissions and unnecessary emergency department visits — because potential savings would accrue primarily to Medicare. Better discharge planning under Medicare could help to avoid a lengthy Medicaid-reimbursed nursing home stay, but without program coordination, there is no incentive for Medicare to support it.

As such, dual eligibles are forced to navigate a system with two sets of payers and benefits. This fragmentation results in unnecessary, duplicative and missed services. Integrating Medicare and Medicaid services can ensure that dual-eligible beneficiaries receive the right care in the right setting. Coordinated care through aligned financial incentives potentially offers one seamless set of benefits and providers, high-

IMAGE FROM SHUTTERSTOCK

quality care and less confusion. For state and federal policymakers, coordinated care potentially can reduce fragmentation, increase flexibility in the types of services provided, enhance budget predictability, align incentives and control the costs of caring.

## EXISTING SERVICE DELIVERY MODELS

Existing efforts to integrate the health care of dual eligibles at the federal and state levels demonstrate both the promise and perils of such programs. The current widespread options can be grouped into three broad categories. These plans are not mutually exclusive, and states have adopted a combination to suit their population's needs as well as to cover both Medicare- and Medicaid-reimbursed services. While some states have introduced other integrated models, they are not included due to the limited number of beneficiaries.

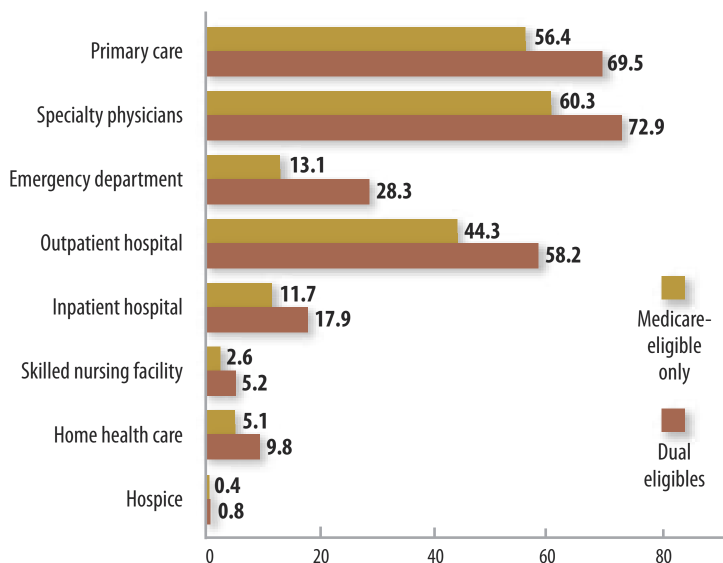
**1. Special Needs Plan:** SNPs are specialized Medicare Advantage Plans that receive capitated premiums to pay for traditional and nontraditional Medicare-covered services. New and expanding SNPs now are required to contract with the state to provide some Medicaid coordination.

**2. Program of All-Inclusive Care for the Elderly:** PACE is a fully integrated, provider-based managed care plan, incorporating all Medicare and Medicaid primary and acute services, in addition to long-term health care. PACE providers assume full financial risk for participants without limits on quantity, period or scope of services.

**3. Medicaid Managed Care:** MMC models vary widely and include both fee-for-service arrangements with additional payment to further care coordination and risk-based models, which provide one capitated payment to cover all services.

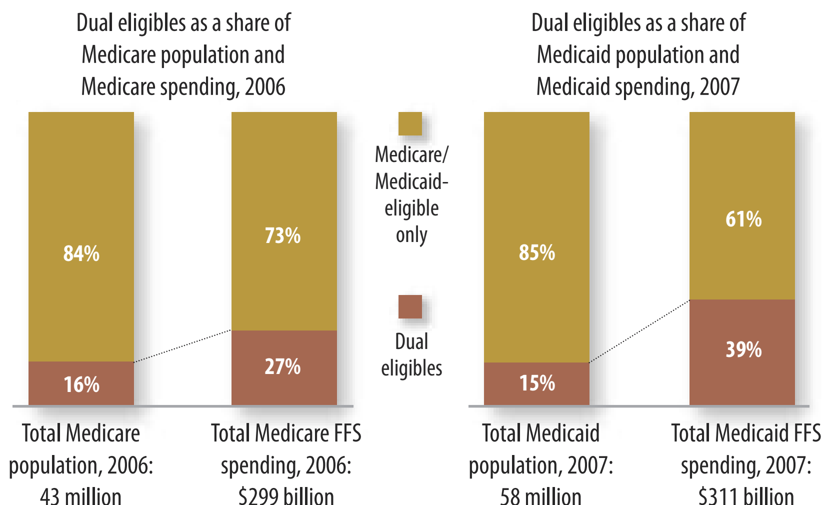
While these plans offer several opportunities for integration, truly aligned plans have failed to expand to more than 2 percent of the overall dual-eligible population (not including non-Medicaid affiliated SNPs) for several reasons including the variations among state Medicaid regulations, differences between state and federal requirements that complicate plan development, and disparities within the dual-eligible population that make it harder to develop one comprehensive plan.

### Health Service Use Among Dual Eligibles vs. Medicare Population




Source: "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending." Kaiser Commission on Medicaid and the Uninsured, July 2010.

### Dual Eligibles vs. Medicare and Medicaid Population and Spending




Source: "The Role of Medicare for the People Dually Eligible for Medicare and Medicaid." Kaiser Family Foundation, January 2011.

## POLICY DEVELOPMENTS

The Affordable Care Act offers new opportunities for states and the federal government to align Medicare and Medicaid to establish more efficient, better-coordinated care for dual eligibles. The Centers for Medicare & Medicaid Services has two new avenues for improving care. The Federal Coordinated Health Care Office will study and analyze the best methods to integrate benefits under the Medicare and Medicaid programs and improve coordination between the federal government and the states for dual eligibles.

The Center for Medicare & Medicaid Innovation will test innovative payment and service delivery models to improve quality and reduce unnecessary costs. In April 2011, CMS announced the 15 states that were selected to receive up to $1 million to design a delivery system and payment

## Promising Models and Program Elements

| | Core Elements | Description | Successful Programs |
|---|---|---|---|
| 1 | Complete comprehensive assessment and reassessment. | Complete patient evaluation upon entrance to the program as well as regularly scheduled assessments to adjust care plans to evolving patient needs. | Hopkins ElderPlus, Johns Hopkins Health System, Baltimore |
| 2 | Conduct periodic visits. | Include periodic visits (in person, by telephone or via Internet) with the patient and his/her family and caregivers at home, complementing regularly scheduled medical care. | Geriatric Resources for Assessment and Care of Elders, Wishard Health Services, Indianapolis |
| 3 | Implement protocol-based planning. | Evaluate and employ evidence-based protocols to manage common conditions affecting geriatric and other vulnerable populations, reducing unwarranted provider variation. | Holy Cross Hospital Geriatric Emergency Department, Silver Spring, Md., and BOOST Program at SSM Saint Mary's Health Center, St. Louis |
| 4 | Incorporate person-centered care principles and practices. | Place the individual and those affiliated (family members, other informal caregivers, client advocates and peers) at the center of all planning decisions to achieve better results and promote self-direction. | AtlantiCare Special Care Center, Atlantic City, N.J. |
| 5 | Utilize team-based care management centered on primary care. | Coordinate medical, behavioral and long-term support services through the work of a multidisciplinary, accountable and communicative care team. Integrate primary care physicians as the core of the care team, supporting and collaborating with the multidisciplinary group. | The Acute Care for Elders Tracker at Aurora Health Care, Milwaukee, and Commonwealth Care Alliance, Massachusetts |
| 6 | Facilitate data-sharing and integrated information systems. | Provide mechanisms and create the necessary data-sharing arrangements to collect, store, integrate, analyze and report data in a timely manner to promote care coordination. | CMO, the Care Management Company, at Montefiore Medical Center, New York City |
| 7 | Align financial incentives. | Organize financial arrangements and potential savings to encourage cooperation and alignment across the continuum of care. | Fairview Partners, Fairview Health Services, Red Wing, Minn. |
| 8 | Develop network and community partnerships. | Expand beyond the hospital and encourage relationships with nursing homes and long-term care providers, public health departments, community centers and other organizations to improve care coordination and transition. | The Care Coordination Network at Summa Health System, Akron, Ohio |
| 9 | Provide non-health care services. | Provide nonclinical services such as transportation to appointments to assist patients in receiving needed care and living healthier lives. | These elements are integrated throughout the programs listed above. |
| 10 | Offer home-based care. | Incorporate timely, patient- and family-centric, home-based care options. | |
| 11 | Organize center-based day care. | Form or partner with a program that utilizes a center-based day care model. | |
| 12 | Incorporate cultural competency and equity-of-care standards. | Develop care teams with awareness of the individual's cultural perspective and language fluency, and hold them accountable for quality metrics aimed at reducing incidences of care disparities. | |

Source: "Caring for Vulnerable Populations," AHA 2011

model to improve coordination across primary, acute, behavioral health and long-term support systems for dual eligibles. Three months later, CMMI announced the pilot testing of two different shared savings models to improve care for this same population: a state, CMS and health plan will enter into a contract that distributes a prospective blended payment to the managed care plan for providing coordinated care; or a state and CMS enter into an agreement that makes the state eligible to benefit from savings resulting from managed fee-for-service initiatives. The programs vary by state and county, as participating entities have varied the programs based on geographic and population demographics.

## WHAT SHOULD HOSPITALS DO?

In the current hospital economic climate, it is necessary for financial incentives to be aligned, and this will be addressed legislatively at the federal, state and even local levels. The pilot projects are taking great leaps forward in coordinating care at the payer level. Even if successful, these plans will take several years to expand beyond the current pilot format. And while integration at the payer level facilitates care coordination, it does not guarantee the same intensity among providers. Additionally, coordinated payments for this population demand that organizations improve quality, transitions and efficiency. While hospitals have made considerable strides in caring for vulnerable populations, both on-site and through partnerships with other institutions, true care coordination remains a challenge.

Improved infrastructure, integra-

tion, and collaborative relationships are the keys to providing better care for vulnerable populations beyond the fragmented arrangements reinforced by the current fee-for-service programs. With the ACA Medicaid and Children's Health Insurance Program coverage expansion by 2014, combined with a potential reduction in Medicaid payment rates, hospitals have the opportunity to address the patient, provider and system barriers that have impeded progress toward improved care coordination and a positive impact on the quality of care and cost for the vulnerable populations they serve.

## PROMISING MODELS AND PROGRAM ELEMENTS

It is not realistic or financially feasible for every organization to develop comprehensive care coordination plans solely for the dual-eligible population. However, dual eligibles have similarities with other populations that require a high intensity of inpatient and outpatient medical and social services. AHA believes that strategies to improve care for dual eligibles and other vulnerable populations also have spillover benefits for patients with chronic conditions, regardless of payer type.

The 2011 AHA Committee on Research identified 12 core elements that can be implemented by hospitals to improve care coordination (see page 19). While not mutually exclusive, the core elements represent foundational essentials that may be combined in various arrangements depending on each organization's population, infrastructure capabilities and ideal outcomes. The committee also identified successful care management programs that, while incorporating many of the core elements, demonstrate one element particularly well.

Each hospital and health care system must match its community's needs and demographics with the appropriate model. Some programs require a significant amount of up-front funding and others do not. However, the majority of programs enforce improved communication and data exchange across care transitions.

It is complicated to measure the success of these programs, especially in the short term. Overcoming the patient, provider and system-level barriers requires patience. Additionally, the applicable metrics will depend on the program implemented. Organizations can use metrics to measure their progress in program implementation (see Care Program Metrics, above). Organizations must realistically apply these metrics to their own situations. **T**

*The 2011 American Hospital Association Committee on Research was chaired by* **Teri Fontenot***, president and CEO of Woman's Hospital, Baton Rouge, La., and chair of the American Hospital Association, and* **Alfred G. Stubblefield***, president emeritus, Baptist Health Care, and president, Baptist Leadership Group, Pensacola, Fla. To read the complete "Caring for Vulnerable Populations" report, go to www.aha.org/caring.*

## Care Coordination Program Metrics

### Utilization

Depending on the attributed patient population, some of these metrics may see increased or decreased numbers. For example, for patients who never received appropriate treatments, the number of labs ordered should increase, but improved care coordination for the most complex patients should reduce the number of ordered labs.

Examples of program measures:

- Number of emergency department visits
- Number of hospital admissions
- Number of preventable readmissions
- Number of surgical procedures
- Number of labs and tests ordered
- Number of missed appointments
- Hospital length of stay
- Electronic health record meaningful use

### Cost

Measuring cost is complicated for these programs. While it is desired for total cost of care to remain constant or decrease, in the beginning programs may see a shift in spending from inpatient and post-acute care to primary, home and preventive care.

Examples of program measures:

- Total cost of care
- Cost per inpatient hospital stay
- Cost of specialty care visits
- Cost of primary care visits
- Mental health care spending
- Durable medical equipment costs
- Non-health care service spending
- Cost of employed care coordinators
- Home health care costs

### Quality/Outcomes

While all organizations strive for improved quality and outcome metrics, the desired measures will vary based on patient population. The programs centered on older and more complex patients should achieve improved quality of life; for younger patients, clinical outcomes will be a more important focus.

Examples of program measures:

- Length of survival
- Assessing Care of Vulnerable Elders measures
- Health status questionnaire
- "Activities of Daily Living" improvement
- Hospital Compare process of care measures
- Mortality
- Medication compliance

### Satisfaction

Care coordination programs must monitor satisfaction among all customers: patients, their families and affiliated providers.

Examples of program measures:

- Patient satisfaction in all settings — inpatient, ambulatory, nursing home
- Affiliated partner satisfaction
- Provider satisfaction (employed and affiliated)
- Patient satisfaction
- Patient family/caregiver satisfaction

Source: "Caring for Vulnerable Populations," AHA 2011