

Memorandum

To: Department of Health and Human Services
Fr: Social HMO Consortium
Re: Docket ID 2004S-0170
MMA Section 1013: Priority Topics for Medicare, Medicaid and SCHIP Research
Date: June 30, 2004

I. Background on Medicare Policy Coalition

The Medicare Policy Coalition for High-Risk Beneficiaries (MPC) represents innovative health plans and care systems dedicated to enrolling and serving high-risk beneficiaries. This population includes frail, chronically ill seniors and younger disabled persons who have functional or cognitive impairments, multiple chronic conditions or complex medical needs, including dually eligible beneficiaries. The primary focus of the Coalition is to improve payment and performance for high-risk beneficiaries. Coalition policy research and analysis is directed toward ensuring that capitated payment and risk-adjusted methods for high-risk beneficiaries are fair and adequate and that they strengthen plans' operational capabilities for serving special needs beneficiaries. We are also working to promote performance evaluation systems that more accurately measure plans' effectiveness in addressing problems and risks attendant to special needs beneficiaries. The intent of our policy and research efforts is to create business incentives to promote more effective health systems for Medicare's most vulnerable beneficiaries through specialized geriatric and chronic care programs and interventions.

Many of the MPC members represent pioneers in the geriatric and disability communities that have participated in Medicare and Medicaid demonstrations to test innovative financing and delivery methods for frail elderly and adult disabled beneficiaries. These demonstrations include Evercare, Social HMOs, PACE, Medicare/Medicaid Integration programs and disease management programs. The MPC recommendations outlined below are intended to build upon the learnings from these demonstrations, as well as private sector efforts, and to forge new ground in improving health care quality and outcomes for high-risk Medicare beneficiaries with special needs.

II. Recommended CMS Research Priorities

Our recommendations are divided into two categories. The first recommendation regarding outcome measures is intended to provide a general framework for measuring the effectiveness of health care programs and services for high-risk beneficiaries. This framework provides the basis for the three recommendations that follow regarding research on the impact of various health care delivery, financing and administrative methods on care and outcomes for high-risk populations.

A. Define Outcome Measures for High-Risk Populations

Current evaluation methods are based on an acute care model that gives priority to process measures over outcomes and cure over prevention and care. Effective evaluation of plans serving high-risk Medicare beneficiaries requires a shift in orientation from treatment of acute conditions – with an expectation of cure -- to a focus on chronic conditions. Chronic care interventions are targeted toward preventing or delaying the progression of disease and disability, maximizing functional capacity and minimizing the “cascading” of disease and disability that is common among beneficiaries with multiple conditions and limited health reserves. Special needs plans should be evaluated on their effectiveness in addressing the *unique* risks faced by high-risk beneficiaries such as those associated with frailty, disabilities and comorbidities. For example:

- ?? Beneficiaries with multiple chronic conditions typically are taking multiple medications simultaneously, placing beneficiaries at higher risk of adverse drug interactions.
- ?? Nursing home residents are at risk of unnecessary hospitalizations for acute conditions because access to physicians and reimbursement is greater in a hospital setting.
- ?? Frail seniors living at home are at risk of nursing home placement when they lose self-care capabilities.
- ?? Beneficiaries with four or more chronic conditions are 99 times more likely to be hospitalized for an ambulatory care sensitive condition that could have been prevented with appropriate ambulatory care (Wolff, Starfield et al 2002)).
- ?? Hospitalization places seniors at significant risk for such outcomes as delirium, functional decline, incontinence, depression, pressure sores, polypharmacy, iatrogenic illness and other adverse impacts, which sometimes are never fully reversed or resolved (Emese Somogyi-Zalud, 1999).

Modifications to our current performance evaluation systems are needed to account for these and other risks unique to high-risk beneficiaries with special needs. Evaluation of plans serving high-risk Medicare beneficiaries could be enhanced in three ways:

1. Evaluate and enhance clinical knowledge about the relationships among frailty, disability and comorbidities and further refine definitions of each clinical entity.

Research conducted by Dr. Linda Fried et al at Johns Hopkins University suggests that frailty, disability and comorbidities are distinct, but highly interdependent clinical entities (Fried, Ferrucci et al. 2004). They recommend improving our ability to distinguish among these entities, refining their definitions and criteria, developing standardized approaches to screening and risk adjustment and promoting exploration of interventions to prevent onset and adverse outcomes for each condition. They suggest that, due to causal relationships and co-occurrence of these conditions, our ability to differentiate these conditions and target therapies will help enhance outcomes and potentially prevent one condition from causing or exacerbating another. Of special interest is (1) further evaluation of frailty indicators (e.g., generalized weakness, poor endurance, weight loss) and the establishment of a generally accepted definition of frailty (e.g., a specified number of defined indicators); and (2) evaluation of best practices for preventing or delaying the onset of frailty and disability.

2. Identify which indicators are most relevant in measuring outcomes and evaluating quality for Medicare beneficiaries over 65 who are frail, disabled and/or have comorbidities.

- a. Which population characteristics should be used to produce a comparative analysis of quality and cost outcomes across Medicare Advantage plans, special needs plans and fee-for-service arrangements (e.g., demographic factors, diagnoses, functional impairments, frailty factors)?
- b. What risk factors are unique to this population (e.g., polypharmacy and adverse drug interactions, preventable hospitalizations and iatrogenic illness, etc.)?
- c. What data sources currently are available for obtaining the population characteristics and outcomes identified above?
- d. What new data are needed and what existing surveys might be expanded to obtain additional information (e.g., Health Outcome Survey, Medicare Current Beneficiary Survey)?

- e. How could the existing oversight methods be modified to more accurately evaluate plan performance for plans targeting high-risk beneficiaries? For example, the Evercare demonstration substitutes MDS data for HEDIS data as a primary measure of quality.

3. Identify which indicators are most relevant in measuring outcomes and evaluating quality for under-65 disabled Medicare beneficiaries who are physically disabled, developmentally disabled and mentally ill or impaired.

- a. Which population characteristics should be used to produce a comparative analysis of quality and cost outcomes across Medicare Advantage plans, special needs plans and fee-for-service arrangements (e.g., demographic factors, diagnoses, functional impairments, frailty factors)?
- b. What risk factors are unique to this population?
- c. What data sources currently are available for obtaining the population characteristics and outcomes identified above?
- d. What new data are needed and what existing surveys might be expanded to obtain additional information?
- e. How could the existing oversight methods be modified to more accurately evaluate plan performance for plans targeting high-risk beneficiaries?

B. Clinical Approaches and Delivery Systems: Best Practices in Geriatric Care and Chronic Care.

CMS has conducted numerous demonstrations in the past two decades testing various financing and clinical approaches for improving care and outcomes for high-risk Medicare beneficiaries. The first generation Social HMO models focused largely on approaches to prevent or delay nursing home placement. Evercare focused on geriatric approaches to aggressive primary care for nursing home residents to prevent unnecessary hospitalizations and the attendant costs and adverse health outcomes common among frail seniors. Dual eligible demonstrations are exploring strategies for integrating Medicare and Medicaid financing and administration to simplify access to care and reduce administrative inefficiencies. Several care management and disease management programs are in various stages of testing.

While CMS did not establish a consistent approach to the evaluation of these programs, there is much to be learned from a review of best practices identified through these demonstrations. We recommend a combination of quantitative and qualitative analysis of specialty programs for frail elderly, adult disabled and medically complex Medicare beneficiaries that can be conducted within the constraints of available data. Findings regarding best practices in areas such as the following should be widely disseminated:

- ?? High-risk screening and assessment
- ?? Service delivery models
- ?? Clinical interventions for frail, disabled and medically-complex Medicare beneficiaries
- ?? Measures to prevent or minimize the risks identified in A (2) and (3) above.

C. Financing Methods for High Risk Beneficiaries

Managed care payment methods have the *potential* to enhance quality, outcomes, cost-effectiveness and client satisfaction since providers can direct dollars to whatever interventions and services they deem most clinically effective and economically efficient. To the extent that this flexibility enhances coordination of care among providers caring for the same patient, reduces medical errors and improves outcomes, managed care payment methods have the potential to produce savings and reduce inefficiencies.

Managed care financing only can be effective, however, if payment rates are appropriately adjusted to account for population-based risk. The new CMS-HCC risk adjustment methodology for Medicare Advantage plans is a much more accurate indicator of risk for special needs beneficiaries than the former demographic model. The frailty adjuster further enhances payment accuracy for selected demonstrations receiving this adjustment to account for functional impairment related costs that the CMS-HCC methods do not capture. Further research is needed, however, to determine how well the frailty-adjusted CMS-HCC method explains risk and costs. Additional research also is warranted to determine whether the frailty adjuster adequately accounts for frailty factors that are not related to functional impairment. Fried et al indicate that frailty and functional impairment are two distinct clinical entities, yet the ‘frailty adjuster’ is based solely on functional impairments. Additional factors may need to be included in the risk adjustment methodology to fully account for frailty related costs.

To ensure adequate payment and promote the development of special programs for high-risk beneficiaries, CMS should evaluate:

- 1. Interventions and Outcomes.** Evaluate the impact of capitated payment methods on clinical decision-making, care interventions and treatment approaches and determine how changes in treatment methods affect outcomes for frail elderly, disabled and beneficiaries with serious chronic conditions.
- 2. Risk adjustment.** Continue refining the CMS-HCC risk adjustment methods, including the frailty adjustment, to improve payment accuracy for the highest-risk populations.
- 3. Frailty factors.** Evaluate whether the inclusion of new frailty factors, such as those identified by Fried and others (e.g., generalized weakness, poor endurance, slow gait speed) could further account for unexplained variation in risk that is not accounted for by diagnostic and functional data to improve payment accuracy for high-risk Medicare beneficiaries. Also identify refinements to the Health Outcomes Survey and Medicare Current Beneficiary Survey to capture new frailty factors in fee-for-service and managed care data.
- 4. Pharmacy risk adjustment.** Evaluate which diagnoses, conditions or combinations of conditions generate greatest drug use and costs and the adequacy of Medicare Advantage pharmacy risk adjustment relative to these costs.

D. Medicare/Medicaid Coordination for Dual Eligibles

Medicare beneficiaries who are dually eligible for Medicaid services are a costly subgroup of the Medicare population. About 38% of duals have cognitive or mental impairments, 22% have multiple physical impairments and 23% are institutionalized. About a third of duals have limitations in 3-6 activities of daily living. Between 15-17% of Medicare beneficiaries were dually eligible in 2001, costing the Medicare program approximately 60% more than for non-duals and representing between 22-26% of

overall Medicare spending. Across all payors, spending for duals is about twice that of non-duals or almost \$21,000 annually.

According to MedPAC's June 2004 Report, public policy for the dually eligible "creates incentives to shift costs between payers, often hinders efforts to improve quality and coordinate care and may reduce access to care." Differences in administrative requirements for Medicare and Medicaid risk contracting such as enrollment, grievance, data collection, quality assurance and other oversight and payment rules also hinder coordination of benefits and services and promote cost-shifting between payors. For example:

- ?? Medicaid and Medicare plans that cover the same services, albeit under different circumstances, have the incentive to shift the costs to the other payor.
- ?? Medicaid plans have no incentive to pay for services such as care management to reduce hospitalizations since Medicare is the primary payor of inpatient hospital costs. Medicare plans have no incentive to pay for preventive services that are likely to reduce the need for long-term care services since Medicaid is the primary payor of long-term care.
- ?? Medicare and Medicaid plans have difficulty determining if their enrollees are eligible for the other program. This leads to a delay in access to benefits provided by the other payor.
- ?? Medicaid may not cover services provided by non-Medicaid approved providers, leading to gaps in coverage. Coverage gaps also result from differences in Medicare and Medicaid enrollment and disenrollment rules.
- ?? States do not have to pay full cost-sharing on Medicare-covered services since they are permitted to limit their liability to what they would have paid if the enrollee was only Medicaid eligible, creating financial disincentives to serve this high-cost population.

To enhance coordination between the two programs, we need to better understand how specific statutes, regulations and interpretive guidelines hinder coordination between the two programs and how this fragmentation affects costs and outcomes. We also need to identify strategies for linking Medicare and Medicaid data, ensuring that all providers, plans and purchasers have access to data from both programs. Some degree of uniformity in Medicare and Medicaid reporting requirements also is needed so that data can be pooled. The inability to aggregate Medicare and Medicaid data severely limits our ability to develop a comprehensive picture of the risks and costs of serving duals and measuring aggregate, long-term outcomes at the system level. Until we fully understand and can quantify the costs of *not* coordinating Medicare and Medicaid benefits, Congress is unlikely to muster the political will to pass legislation establishing a population-based, integrated program for duals.

To enhance our understanding of regulatory barriers to effective care for duals and data analysis capabilities, we recommend the following:

1. **Barriers to coordination.** Identify and prioritize legislative and regulatory barriers to effective coordination of Medicare and Medicaid benefits for the dually eligible and develop a prototype model for duals that has a single administrative, financing and oversight structure.
2. **Medicaid data.** Identify Medicaid data requirements for plans/providers serving the dually eligible that are not collected by Medicare, but which could be useful in: (1) helping better define

the population demographically and clinically; (2) measuring risk and costs; or (3) evaluating outcomes.

3. **Medicare/Medicaid linked data.** Evaluate what have we learned from the CMS Medicare/Medicaid linked data study that could help improve risk adjustment methods and performance measures for special needs beneficiaries and specialized MA plans. For example, does the ability to link data enhance plans' and providers' ability to (1) identify client eligibility for both benefit programs, thereby increasing access to needed services through dual coverage; (2) target high-risk beneficiaries, implement preventive measures and prevent or delay further disability progression; (3) assess the total costs of care for dually eligible across providers and settings for episodes of care as well as longitudinally?
4. **Impact of Medicare and Medicaid coverage on acute and long-term care services.** The Evercare demonstration evaluation showed that more aggressive primary care and subacute care in a nursing home setting can dramatically reduce inpatient hospital use. What can we learn from Evercare and other demonstrations for frail and disabled Medicare beneficiaries about substitution effects, the impact of Medicare coverage on Medicaid spending or the impact of Medicaid coverage on Medicare spending?
5. **Impact of shift in pharmaceutical coverage:** Will the shift in responsibility for coverage of pharmacy benefits from Medicaid to Medicare hinder states' ability to access pharmacy data? If so, will this limitation have an adverse impact on appropriate care and outcomes?

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We appreciate the opportunity to submit recommendations to CMS on research priorities that may enhance Medicare and Medicaid services for high-risk beneficiaries. If you would like to discuss these recommendations further, please do not hesitate to contact Valerie Wilbur at 202-624-1508.

Endnotes

Fried, L. P., L. Ferrucci, et al. (2004). "Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care." J Gerontology A Biol Sci Med Sci **59**(3): 255-63.

Medicare Payment Advisory Commission, "Dual Eligible Beneficiaries: An Overview." Report to the Congress: New Approaches in Medicare, June 2004.

Emese Somogyi-Zalud, "Hazards of Hospitalization Among the Elderly." Washington VAMC and George Washington University Medical Center, Presentation, April 1999.

Wolf, Starfield and Anderson. "Prevalence, Expenditures and Complications of Multiple Chronic Conditions in the Elderly." Archives of Internal Medicine, Vol. 162, November 11. 2002.