Medicare's different models for caring for beneficiaries with chronic conditions

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March 11, 2015

MEDPAC

Medicare beneficiaries with chronic care needs

- In 2010, more than two-thirds, or 21.4 million beneficiaries, had two or more chronic conditions
- Almost two-thirds of beneficiaries with 6 or more chronic conditions were hospitalized and 16% had 3 or more hospitalizations during the year
- The nearly one-third of beneficiaries with 0 or 1 chronic condition accounted for only 7% of Medicare spending, whereas the 14% with 6 or more chronic conditions accounted for 46% of Medicare spending

Source: Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 edition

Medicare models overview

FFS	ACO	MA
30 million	5 million	16 million
Default choice	Attributed	Enrolled
Pay by service	Mixed payment: FFS payment +/- shared savings	Pay full capitation for enrollees
Some value-based purchasing	All Parts A&B Quality incentive	All Parts A&B Quality bonus
No provider risk	Limited provider risk	Full provider risk

Special needs plans (SNPs) within MA

- **D-SNPs**: For Medicare-beneficiaries dually eligible for Medicare and Medicaid
  - Largest, at 1.58 million enrollees (2014). As of 2014, D-SNPs were available to about 82% of all Medicare beneficiaries.
- **C-SNPs:** For specified chronic or disabling conditions
  - 288,000 enrollees; as of 2014, C-SNP of at least one disease type available to slightly over half of all Medicare beneficiaries
- **I-SNPs:** For beneficiaries in institutions (e.g., nursing homes) or in community at institutional level of care
  - 50,000 enrollees; as of 2014, available to slightly less than half of all Medicare beneficiaries

Issues to consider when comparing Medicare models

- Payment benchmarks
- Quality measurement
  - Fewer measures
  - Outcome, population-based measures
- Risk adjustment
- Patient engagement

Payment policy

- How Medicare pays influences providers' and plans' willingness to serve Medicare beneficiaries and sometimes beneficiaries' incentives to choose a specific model

- Different payment approaches in each model:
  - FFS: Per-unit basis, few limits on volume, payment accuracy varies
  - MA: Administratively set benchmarks; historically set well above FFS, by 2017 will average approximately 101% of FFS
  - ACO: Spending targets set based on historical spending of ACO population; challenges with sustainability

- MedPAC has long recommended financial neutrality between MA and FFS, and is now considering putting ACOs on a similar benchmark system

Risk adjustment

- Poor risk adjustment can lead to inaccurate payments (too high or two low) and patient selection
- Three different methods
  - FFS: case-mix models in PPSs
  - MA: HCC system
  - ACOs: Historical benchmarks
- Evidence of additional coding among MA plans

Risk adjustment recommendations

- HCC risk adjustment model underpredicts costs for the sickest patients and overpredicts costs for the healthiest patients

- MedPAC has identified some improvements to the model:
  - Including count of beneficiary's chronic conditions
  - Using two years of data
  - Separating full and partial duals

Quality measurement

- Measuring quality and paying based on quality outcomes has the potential to improve care
- Each model measures quality differently:
  - FFS: some value-based purchasing, depending on site
  - MA: 5-star system
  - ACO: 30+ measures; payments based on meeting quality benchmarks
- Issues with current system

Patient engagement

- Strategies to engage patients can improve adherence to care plans, provide financial incentives to be healthy
- Different engagement in each model:
  - FFS: weak patient incentives, limited tools for conveying quality or value
  - MA: strong incentives; patient enrollment, differential cost sharing, care management
  - ACO: mixed incentives; current lacks tools to modify patient cost sharing, direct patients to high value providers; retrospective enrollment makes beneficiary outreach difficult

Patient engagement recommendations

FFS

- Benefit redesign:
  - Catastrophic cap
  - Replace coinsurance with copays
  - Rationalize deductible
  - Discourage first-dollar coverage

ACOs

- Allow two-sided risk ACOs to waive copays for primary care visits
- Attribution via a wider range of professionals

- Discussed in March 2015 meeting: financial incentives for beneficiaries