

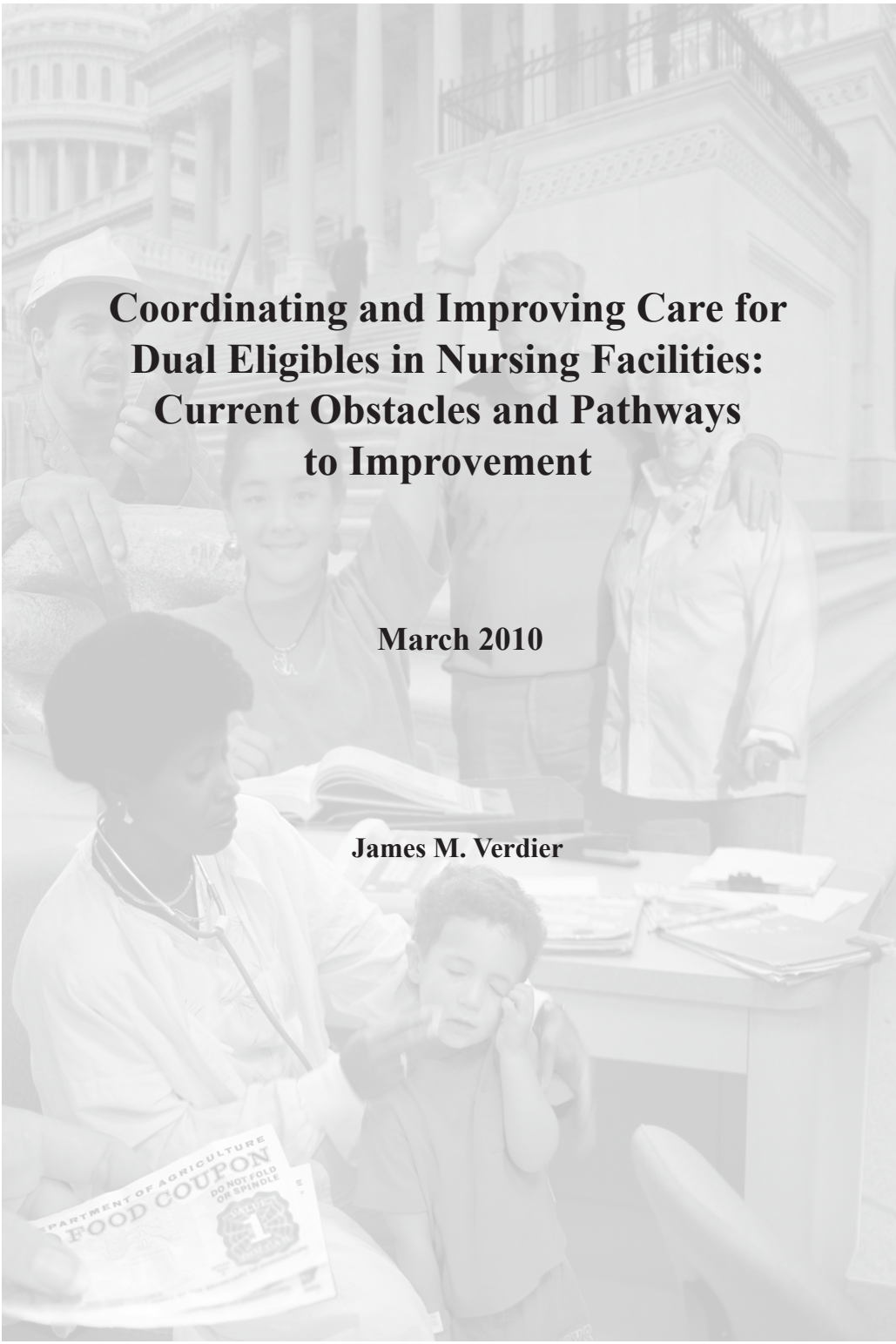
POLICY BRIEF

**Coordinating and
Improving Care for
Dual Eligibles in
Nursing Facilities:
Current Obstacles
and Pathways
to Improvement**

March 2010

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Residents of nursing facilities who are dually eligible for Medicare and Medicaid make up over half of all nursing facility residents. These dual eligibles are enmeshed in a care delivery and coverage system that is highly complex, fragmented, and uncoordinated. Their prescription drug coverage is the responsibility of payers who usually have no responsibility for the rest of residents' nursing facility care. Those responsible for their nursing facility care have few, if any, incentives to provide care that will enable residents to avoid unnecessary hospitalizations.

Issues at a Glance

The fragmentation of care for dually eligible Medicare and Medicaid beneficiaries is an ongoing concern. Potential ways of reducing this fragmentation and improving nursing facility care for dual eligibles include

- Concentrating responsibility and accountability for prescription drug use in nursing facilities in Medicare Part D drug plans that specialize in serving nursing facilities, or in managed care plans that are also responsible for nursing facility, hospital, and physician care
- Providing financial incentives for nursing facilities to reduce avoidable hospitalizations either directly through pay-for-performance reimbursement incentives, or through managed care arrangements that allow nursing facilities to benefit from hospital savings
- Shifting responsibility for long-term nursing facility care from Medicaid to Medicare, with provisions to ensure that Medicaid-funded home- and community-based services remain coordinated with nursing facility care

Fragmentation Is Longstanding

The fragmentation of health care for dual eligibles—people who qualify for both Medicare and Medicaid—has been an ongoing concern in both acute and long-term care settings.¹ Medicare covers hospital, physician, and post-acute skilled nursing facility care and—since 2006—prescription drugs. Medicaid covers most long-term nursing facility care and home- and community-based services (HCBS), and both programs cover home health care.²

As a result, separate payers are responsible for similar services in similar settings, but have essentially no responsibility for services needed by dual eligibles in other settings. Both payers and providers seek to shift costs to one another, accountability for provider performance

Note: In this policy brief, NF refers to the long-term Medicaid nursing facility benefit, and SNF refers to the short-term Medicare skilled nursing facility benefit. When nursing facility services that are not limited to either Medicare or Medicaid as a primary payer source are referred to, the term “nursing facility” is spelled out.

The adverse effects of this complex situation are perhaps most pronounced for dual eligible residents of nursing facilities, who often have extensive care needs, may suffer from dementia and other cognitive limitations, and may have limited support from family members and others.

As a result of Part D, accountability for prescription drug cost and use for dual eligibles in NF settings, which was previously concentrated in the same payer that was responsible for all other aspects of NF care for dual eligibles, has now been divided among multiple payers, most of whom have no responsibility for any aspects of NF care other than prescription drug use.

and quality is difficult to pin down, and dual eligibles are left to navigate—usually with little assistance—a system that few people understand or can explain.

The adverse effects of this complex situation are perhaps most pronounced for dual eligible residents of nursing facilities, who often have extensive care needs, may suffer from dementia and other cognitive limitations, and may have limited support from family members and others. During the time dual eligibles are in nursing facilities, Medicare may be responsible for all of their care some of the time (SNF services), some of their care all of the time (physician services and prescription drugs), and little of their care for long periods of time (NF services), except when they are hospitalized, in which case Medicare is again responsible for all of their care for a period of time. As a result, continuity and coordination of care can suffer, and fragmentation of payer and provider responsibility can result in misaligned and sometimes perverse incentives.

Can anything be done to improve this situation? In theory, having one payer (such as Medicare or Medicaid) and one accountable provider entity (such as a managed care organization) responsible for all the care for dual eligibles in nursing facilities could lead to better coordination, accountability, and quality. However, achieving such a result would require a much larger leap than is customary in health care policymaking. For this reason, this policy brief focuses initially on two areas in which more incremental steps to improve nursing facility care for dual eligibles may be possible: (1) increasing accountability for prescription drug use and (2) reducing avoidable hospitalizations. It then discusses a broader change that could lay the groundwork for more fundamental improvements—shifting responsibility for all NF care for dual eligibles from Medicaid to Medicare—and some of the concerns such a major change might raise. It concludes with a short list of areas for additional research that could further illuminate these issues.

Prescription Drugs in Nursing Facilities: Challenges and Strategies

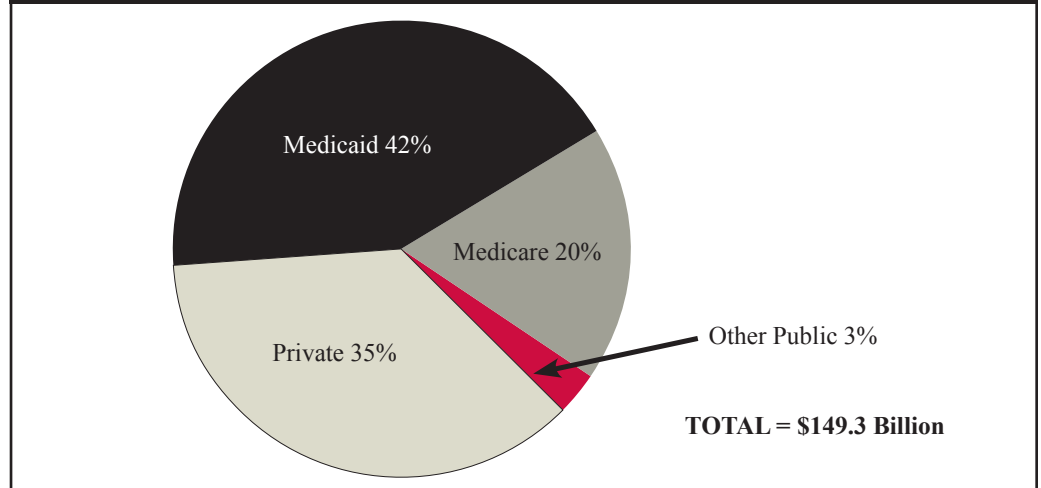
Prior to 2006, state Medicaid programs paid for prescription drugs for dual eligible residents during long-term NF stays, while Medicare paid for their drugs during short-term post-hospital SNF stays.³ In 2006, Medicare assumed responsibility for paying for most prescription drugs for all dual eligibles under the new Medicare Part D program, including those for dual eligible NF residents, who account for more than half of all residents of nursing facilities in the United States.⁴ State Medicaid programs remain responsible for all other long-term NF services for dual eligibles.

Part D introduced a new set of payers for prescription drugs for dual eligibles in NF settings. Before Part D, the Medicaid agency in each state generally paid specialized long-term care pharmacies (LTCPs) for drugs for dual eligibles in NF settings, and most nursing facilities were served by just one LTCP. Under Part D, Medicare contracts with a large number of private Part D plans, which in turn purchase drugs for dual eligibles and other Medicare residents of nursing facilities from LTCPs.

As a result of Part D, accountability for prescription drug cost and use for dual eligibles in NF settings, which was previously concentrated in the same payer that was responsible for all other aspects of NF care for dual eligibles, has now been divided among multiple payers, most of whom have no responsibility for any aspects of NF care other than prescription drug use. Some of the details and consequences of this fragmentation of responsibility are set out below, followed by some options for increasing accountability for prescription drug use in NF settings.

Role of Part D Plans. Part D plans include stand-alone prescription drug plans (PDPs) and Medicare Advantage managed care plans that include prescription drugs (MA-PDs). These

Total Projected Nursing Home Care Expenditures, by Source of Payment Calendar Year 2010



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, “National Health Expenditure Projections 2009-2019,” Table 13, January 2010.

plans do not have responsibility for any aspects of the Medicaid NF care provided to dual eligibles other than their prescription drugs.⁵ In addition, nursing facility residents typically account for only about 5 percent of total PDP and MA-PD enrollees, so these plans have limited incentives to focus their attention on the special prescription drug needs of nursing facility residents, or on the special characteristics of drug use in nursing facility settings.⁶

Role of Long-Term Care Pharmacies. Part D plans purchase drugs for dual eligibles and other Medicare residents of nursing facilities from LTCs. Most LTCs contract with multiple Part D plans, and as a result individual nursing facilities and their residents may be served by a number of different plans. LTCs supply drugs and special packaging and delivery services; they also employ consultant pharmacists who review drug use in the facilities and advise physicians on appropriate prescribing.⁷

Consumer Choice in Nursing Facilities Under Part D. The underlying premise of Part D is that consumer choice of drug plans, pharmacies, and drugs will provide an important element of accountability, resulting in lower prices and greater consumer satisfaction. Importing this consumer choice model into the nursing facility setting has not always worked as expected, since nursing facility residents often have cognitive difficulties and other problems that present obstacles to exercising informed choice. In addition, although nursing facility residents may be able to choose from a number of PDPs and MA-PDs,⁸ as a practical matter the resident’s ability to choose a plan and a pharmacy is fairly constrained when only one pharmacy serves the facility and most available PDPs and MA-PDs work through that pharmacy.

The “consumer choice” model of accountability that underlies Part D may thus be less applicable in nursing facility settings than in the community, where individual Medicare enrollees generally have a wide choice of pharmacies. Nursing facilities may also find it more complex administratively to deal with multiple Part D plans rather than with a single state Medicaid agency.⁹

Limited Leverage of Part D Plans in Nursing Facility Settings. The fact that nursing facility residents are only a small portion of any PDP’s or MA-PD’s enrollment means that these plans

The fact that nursing facility residents are only a small portion of any PDP’s or MA-PD’s enrollment means that these plans have limited incentives and limited means to influence prescription drug utilization in nursing facilities for either cost control or quality improvement purposes.

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There are particular concerns about the use of antipsychotic drugs in nursing facilities relating to both safety and costs.

There are several potential ways of increasing accountability for prescription drug use in nursing facilities, including concentrating responsibility in a smaller number of specialized Part D plans, returning responsibility for prescription drugs for dual eligibles in NF settings to Medicaid, and increasing the role of Medicare Institutional Special Needs Plans.

have limited incentives and limited means to influence prescription drug utilization in nursing facilities for either cost control or quality improvement purposes. The drugs that are provided to dual eligibles in nursing facilities are determined largely by the nursing facilities and the LTCPs, primarily through LTCP formularies and the activities of LTCP consulting pharmacists, in consultation with prescribing physicians.¹⁰ LTCPs can use these levers to shift prescribing toward drugs for which the LTCP receives rebates from the manufacturer, thereby increasing LTCP income but not necessarily the quality of care received by nursing facility residents.¹¹

In theory, Part D plans could exert greater control over prescription drug use and cost in nursing facilities by, for example, (1) employing their own consulting pharmacists to review nursing facility drug use, (2) making greater use of prior authorization to limit LTCPs' ability to shift market share to specific drugs in order to obtain higher rebates from manufacturers, and (3) negotiating more aggressively with LTCPs to reduce Part D payments for drugs. In order for any of this to occur, however, individual Part D plans would need to have a larger market share of prescription drug utilization in nursing facilities than they now do.

Improving Quality While Controlling Costs

Quality. The quality of drug use in nursing facilities has been a long-standing concern. Nursing facility residents often have unusually complex health care needs, combined with cognitive difficulties and limited family support that may increase their vulnerability to inappropriate care. Most prescription drugs have not been rigorously tested in the elderly, so their effects are often uncertain. The nursing facility environment itself has characteristics that may make appropriate use of medications difficult to ensure, including limited physician involvement and high turnover of nursing facility staff.¹²

Cost. The dollar amounts involved in drug use in nursing facilities are substantial. In Medicaid, spending on prescription drugs for dual eligibles in NF settings was just under \$4.6 billion in 2005—nearly 20 percent of Medicaid spending on prescription drugs for dual eligibles in that year and nearly 11 percent of all Medicaid spending on prescription drugs.¹³

Antipsychotic Drug Use. There are particular concerns about the use of antipsychotic drugs in nursing facilities relating to both safety and costs.¹⁴ Press coverage of potentially inappropriate antipsychotic use in nursing facilities in late 2007 prompted Senator Charles Grassley of the Senate Finance Committee to request an investigation by the Inspector General of the Department of Health and Human Services.¹⁵ Again, the dollar amounts in Medicaid in 2005 were substantial, reflecting the widespread use of antipsychotics among dual eligibles in NF settings. Medicaid spent nearly \$512 million on antipsychotic drugs for full-year dual eligible NF residents of in 2005, over 17 percent of all Medicaid prescription drug expenditures for full-year dual eligibles in NF settings. Nearly 45 percent of these dual eligible NF residents used an antipsychotic in 2005, at an average cost of \$162 per prescription.¹⁶

Increasing Accountability

There are several potential ways of increasing accountability for prescription drug use in nursing facilities, including concentrating responsibility in a smaller number of specialized Part D plans, returning responsibility for prescription drugs for dual eligibles in NF settings to Medicaid, and increasing the role of Medicare Institutional Special Needs Plans (I-SNPs), a type of Medicare Advantage managed care plan. The first two options are discussed below, and the I-SNP option is discussed in the section on avoidable hospitalizations, since the greatest potential benefit of I-SNPs lies in their incentives to reduce such hospitalizations.

Concentrating Responsibility for Nursing Facility Drugs in a Smaller Number of Part D

Plans. Accountability for drug use quality and cost in nursing facilities under Part D could potentially be improved by reducing the number of PDPs serving each nursing facility and providing incentives for PDPs to specialize in serving nursing facilities. This would reduce to some extent the fragmentation of responsibility that now exists under Part D, with nursing facilities, prescribing physicians, consultant pharmacists (usually employed by LTCs), LTCs, and multiple Part D plans all responsible for some aspects of drug use by dual eligibles in nursing facilities.

The Medicare Payment Advisory Commission (MedPAC) suggested in 2007 that one way of accomplishing this would be to hold periodic competitions to select regional PDPs for nursing facilities. This would limit the number of PDPs serving individual nursing facilities and give these PDPs incentives to develop more specialized capabilities for serving nursing facilities.¹⁷ It could also ease some of the current administrative burdens on nursing facilities and LTCs, since they would have to deal with fewer plans. The choices for nursing facility residents would also be less complex and more manageable. MedPAC noted, however, that modifications in PDP reimbursement arrangements and additional quality and performance reporting requirements would likely be needed to increase PDP incentives to improve prescription drug use quality and reduce costs in nursing facilities.

Returning Responsibility for Prescription Drugs in NF Settings to Medicaid. The current fragmentation of responsibility for dual eligibles' prescription drug use and care quality in NF settings could be reduced in some respects by returning responsibility to Medicaid for prescription drugs for dual eligibles in these settings. There are several problems with this approach, however. First, a reversion to Medicaid responsibility, after several years of Part D coverage, could be disruptive for nursing facilities, Medicaid agencies, and Part D plans. Second, there was wide variability in the extent and thoroughness of state Medicaid agency oversight of prescription drug use in NF settings prior to 2006, and that variability would likely continue if Medicaid responsibility were restored.¹⁸ Third, a substantial degree of fragmentation of responsibility and lack of continuity would remain, since Part D plans would continue to serve non-dual-eligible Medicare-covered residents of nursing facilities, many of whom would likely shift to Medicaid coverage if they "spent down" to Medicaid income and asset eligibility levels during the course of their nursing facility stay.

Reducing Avoidable Hospitalizations

Because Medicare pays for almost all hospital care received by dual eligibles, there are few financial incentives for Medicaid programs to limit the hospitalization of Medicaid NF residents. Nursing facilities can benefit financially if Medicaid NF residents are hospitalized for three days or more and then return to the nursing facility, since nursing facility care following such a stay is generally reimbursed at higher Medicare SNF rates for a period of time. Medicaid programs also usually pay nursing facilities at least part of the cost of holding the NF bed open while the resident is in the hospital.¹⁹

MedPAC SNF Proposals. In its March 2008 Report to the Congress, MedPAC recommended that Medicare payments to SNFs incorporate a pay-for-performance element based on the number of potentially avoidable rehospitalizations for five selected conditions within 100 days.²⁰ MedPAC has been using this as a measure of SNF performance since 2000. As MedPAC notes, however, Medicare SNF payments accounted for only 21 percent of nursing facility revenue in 2006, so Medicare payment incentives could have only a limited impact on overall nursing facility behavior.

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Since I-SNPs are at risk financially for Medicare hospital and other services, savings from reduced use of those costly services could be used to fund efforts to reduce that use.

Enrollment in I-SNPs has been very limited, however, with Evercare, a UnitedHealthcare company, dominating the I-SNP marketplace for institutional care.

CMS Nursing Home Value-Based Purchasing Demonstration. The Centers for Medicare & Medicaid Services (CMS) began a Nursing Home Value-Based Purchasing Demonstration in 2009 with selected Medicare SNFs in three states (Arizona, New York, and Wisconsin). In this demonstration, CMS will provide financial incentives to SNFs that demonstrate high quality care or improvements in care, with a special emphasis on reduction in avoidable hospitalizations.²¹

State Pay-For-Performance Initiatives. Medicaid programs in at least seven states (Georgia, Iowa, Kansas, Minnesota, Ohio, Oklahoma, and Utah) currently base NF reimbursement at least in part on various pay-for-performance measures.²² At this point, however, none of these Medicaid initiatives include potentially avoidable hospitalizations as a measure of Medicaid NF performance, perhaps in part because Medicaid programs do not pay for these hospitalizations for dual-eligible nursing facility residents. The Medicaid initiatives focus instead on measures such as staff turnover and retention and direct care hours per patient day that can directly affect the quality and cost of the Medicaid NF benefit.

Potential Impact of Institutional Special Needs Plans

Although Medicare MA-PDs are financially at risk for Medicare hospital services, and thus have an incentive to reduce hospitalizations, most MA-PDs have only a small number of institutionalized dual eligibles among their enrollees, so their actual leverage over nursing facilities and LTCs is limited, as noted earlier. One potential exception is I-SNPs, which are a form of MA-PD that was authorized by the Medicare Modernization Act of 2003 to specialize in serving Medicare beneficiaries in nursing facilities.²³

How I-SNPs Could Improve Care. Since I-SNPs are at risk financially for Medicare hospital and other services, savings from reduced use of those costly services could be used to fund efforts to reduce that use. Such efforts could include:

- Placing the plan's own consulting pharmacist in the nursing facility to ensure that prescription drug use is appropriate and does not place residents at risk for hospitalization
- Placing nurse practitioners in the nursing facility to supplement the nursing facility staff and provide the kind of preventive care that may reduce hospitalizations²⁴
- Paying the nursing facility a higher rate to enable the facility to provide some intensive care services for residents that might otherwise have to be provided in a hospital²⁵

Limited Enrollment in I-SNPs. Enrollment in I-SNPs has been very limited, however, with Evercare, a UnitedHealthcare company, dominating the I-SNP marketplace for institutional care. As of January 2010, there were 74 I-SNPs nationwide, with a total enrollment of just 101,368, a small fraction of the more than 9 million enrollees in MA-PD plans.²⁶ I-SNP enrollment has declined in the past year by over 19 percent, and prospects for future enrollment growth are limited under current rules.²⁷

The main obstacle to the enrollment growth of I-SNPs is that they cannot serve Medicare beneficiaries in nursing facilities unless (1) the nursing facility agrees to contract with the I-SNP and (2) individual residents then agree to enroll in the I-SNP. Nursing facilities are not required to contract with I-SNPs, and residents may not enroll in an I-SNP unless the facility is willing to contract with the plan.²⁸

Constraints on I-SNP Contracting with States to Cover Medicaid Services. I-SNPs currently do not contract with states to cover NF and other Medicaid services for dual eligibles. In part, this absence of I-SNP contracts with states is due to limited incentives on the SNP side: only

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about half of current I-SNP enrollees are dual eligibles, and the I-SNP care model focuses more on reducing Medicare hospital use than on integrating care for dual eligibles.²⁹

Increasing Incentives for Nursing Facilities to Contract with I-SNPs. If Medicaid NF payments and Medicare SNF payments were more closely related to nursing facility performance on measures such as reducing avoidable hospitalizations and inappropriate prescription drug use, nursing facilities would have greater incentives to contract with I-SNPs and other entities that could help them improve performance in these areas. As noted above, some state Medicaid agencies have begun to build quality-related performance measures into their NF reimbursement systems, and Medicare is currently conducting a Nursing Home Value-Based Purchasing Demonstration that is testing quality-related payment incentives. As MedPAC has noted, however, Medicare alone has limited leverage over nursing facility behavior, since it accounts for only a small share of the nursing facility marketplace.³⁰

Shifting Responsibility from Medicaid to Medicare

A major change that could lay the groundwork for more fundamental improvements in nursing facility care for dual eligibles would be to shift responsibility for all their NF care from Medicaid to Medicare. This would facilitate steps that could improve the coordination and quality of care for dual eligibles in nursing facilities, including more cost-effective and appropriate use of prescription drugs and reductions in avoidable hospitalizations.

Impact on Prescription Drug Use. With respect to prescription drug use, the current Medicare approach of including payment for prescription drug costs in the per diem SNF payment to nursing facilities could be extended to NF services. This would align incentives in a way that would encourage nursing facilities, LTCs, and Part D drug purchasers to act as partners in seeking cost-effective use of drugs. If drugs were included in the per diem, nursing facilities would not want to pay more for drugs than is necessary to provide appropriate care and LTCs as their agent would have a similar goal. Part D purchasers would share that cost-effectiveness goal, since they are at risk for drug costs and would prefer lower costs.

Although this option would address many of the cost concerns about use of prescription drugs in nursing facilities, it may not adequately address quality-of-care concerns, especially for stand-alone PDPs that are responsible only for drugs and not other aspects of beneficiary care. To address that concern, nursing facility quality monitoring and pay-for-performance incentives would need to be focused directly on measures of appropriate drug use. Since Medicare is now the major purchaser of prescription drugs for nursing facility residents, it is in a good position to develop and implement such measures.

Impact on Avoidable Hospitalizations. With respect to avoidable hospitalizations, Medicare coverage of all publicly financed nursing facility care would increase the opportunities for Medicare Advantage managed care organizations—including I-SNPs—to extend managed care approaches to the nursing facility setting and to fund improvements in nursing facility care with savings from reduced hospitalizations. For nursing facilities that continued in fee-for-service Medicare, Medicare’s ability to influence nursing facility behavior through pay-for-performance incentives focused on reducing avoidable hospitalizations would increase, since its share of the nursing facility market would be substantially larger.

A change as major as shifting responsibility for NF services from Medicaid to Medicare would raise a number of important concerns, including the financial and administrative impact on both

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Another concern is that state support for HCBS might be adversely affected if the savings in NF expenditures that may result from these programs were to benefit Medicare rather than Medicaid.

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programs. Perhaps the most important concern, however, is the potential impact on coordination of care between HCBS programs in Medicaid and nursing facility care.

Implications for State and Federal Financial and Administrative Responsibilities. Shifting responsibility for Medicaid NF care for dual eligibles to Medicare would represent a major change in the allocation of financial and other responsibilities between states and the federal government. Medicaid expenditures for NF care for dual eligibles currently account for over 90 percent of Medicaid NF expenditures and over 15 percent of total Medicaid expenditures.³¹ Medicaid has covered the NF benefit since the program's inception in 1965, and a number of states have invested substantial resources in developing NF reimbursement methods and quality monitoring systems, so shifting responsibility for this benefit to Medicare could require some significant financial and administrative adjustments for both Medicaid and Medicare.³² Nursing facilities would likely find it less difficult to adapt to such an arrangement. More than 90 percent of all nursing facilities are dually certified to serve both Medicare and Medicaid beneficiaries, so the facilities are accustomed to dealing with both payers.³³

Implications for Medicaid HCBS Programs. Most states have developed extensive HCBS programs that are aimed at providing alternatives to NF care for beneficiaries for whom care in the community is feasible and preferable.³⁴ Apart from the relatively limited Medicare home health benefit, comparable programs do not exist in Medicare. Shifting responsibility for HCBS programs from Medicaid to Medicare would therefore represent a substantially bigger challenge than shifting the Medicaid NF benefit to Medicare. This raises the question of whether HCBS programs could continue to operate effectively in Medicaid if all NF services were shifted to Medicare.

One important concern is whether the coordination and communication between HCBS and NF providers and program operators that is needed to make HCBS programs successful could be maintained if all NF services were the responsibility of Medicare. Another concern is that state support for HCBS might be adversely affected if the savings in NF expenditures that may result from these programs were to benefit Medicare rather than Medicaid. Whether NF expenditures are in fact reduced as a result of HCBS programs remains an open question, since many beneficiaries who are enrolled in these programs would not actually choose to use NF services, but they nonetheless incur HCBS costs.³⁵ This "woodwork" effect, in which people who would not want to enter an NF are attracted by an alternative benefit that enables them to remain in their homes, serves as an important testament to the popularity of the Medicaid HCBS benefit. As a result of this popularity among both users and potential users, states would likely want to retain and expand the HCBS benefit to the extent they have the resources to do so, even if the potential savings in NF expenditures were to accrue to Medicare rather than to Medicaid.

Looking Ahead

The issues discussed in this policy brief could be further informed by research in the following areas:

- **Part D Drug Use in Nursing Facilities.** Little is publicly known at this point about Part D drug use in nursing facilities, since CMS is still in the process of making Part D data available to researchers.³⁶ Part D enrollment and drug use and cost data for 2006 and 2007 are now available, and data for 2008 will be available in the summer of 2010. Data on plan characteristics for 2006 and 2007 are also available now, and data on prescriber and pharmacy characteristics for those years will be available in late spring of 2010. With these data, Part D drug use in nursing facilities for dual eligibles for 2006 and later

Are there any systematic differences between those enrolled in PDPs, MA-PDs, and I-SNPs?

years can be compared to Medicaid prescription drug use in NF settings for dual eligibles before Part D to see what changes may have occurred as a result of shifting responsibility for drug use and cost from state Medicaid agencies to private Part D plans.³⁷ Has overall use of drugs by dual eligibles in NF settings increased or decreased? Have there been changes in the types of drugs that are being used? Are there any systematic differences between those enrolled in PDPs, MA-PDs, and I-SNPs? Between those enrolled in Part D plans with larger and smaller percentages of nursing facility residents?

- **Potentially Avoidable Hospitalizations Among Nursing Facility Residents Enrolled in I-SNPs and Other MA-PD Plans.** The data MedPAC currently collects on rehospitalization of SNF residents within 100 days for five selected conditions could be analyzed to determine whether residents enrolled in I-SNPs and other MA-PD plans have fewer avoidable hospitalizations.
- **I-SNP Performance on HEDIS and Structure and Process Measures.** CMS has contracted with the National Committee for Quality Assurance (NCQA) to help evaluate the quality of care being provided in SNPs. SNPs and other MA plans are required to report a variety of Healthcare Effectiveness Data and Information Set (HEDIS) measures, including antidepressant medication management, potentially harmful drug-disease interactions in the elderly, and use of high-risk medications in the elderly.³⁸ SNPs are also required to report their performance on a series of structure and process measures, including complex case management, care transitions, institutional SNP relationships with nursing facilities, and coordination of Medicare and Medicaid coverage.³⁹ I-SNP performance on these measures, compared to that of other SNPs and other MA plans, could be used to assess whether I-SNPs are in fact adding value for beneficiaries in terms of improved prescription drug use, reductions in avoidable hospitalizations, and other measures of performance and quality.
- **Potential Impact on Medicaid HCBS Programs if NF Services Were Shifted to Medicare.** Medicaid directors, HCBS directors, beneficiaries, providers, and other stakeholders could be interviewed to obtain their assessment of how Medicaid HCBS programs might be affected if Medicare became responsible for NF services. Would coordination between Medicaid HCBS service providers and nursing facilities be more difficult if Medicaid no longer paid for NF care? Would these programs have less political support if any savings from reduced nursing facility utilization benefitted Medicare rather than Medicaid?

With this additional information and analysis, the care of dual eligibles in nursing facilities could be addressed more effectively as a central concern, rather than as a side effect of policies adopted primarily for other purposes.

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Endnotes

¹ See, for example, Edward Alan Miller and William G. Weissert, “Strategies for Integrating Medicare and Medicaid: Design Features and Incentives,” *Medical Care Research and Review*, vol. 60, no. 2, June 2003, pp. 123-156; and David C. Grabowski, “Medicare and Medicaid: Conflicting Incentives for Long-Term Care,” *Milbank Quarterly*, vol. 85, no. 4, 2007, pp. 579-610.

² In this policy brief, NF is used to refer to the long-term Medicaid nursing facility benefit, and SNF is used to refer to the short-term Medicare skilled nursing facility benefit (which can last for up to 100 days following an inpatient hospital stay of at least three days). When nursing facility services that are not limited to either Medicaid or Medicare as a primary payer source are referred to, the term “nursing facility” is spelled out. Overall, Medicaid is the primary payer source for nearly 65 percent of nursing facility residents, Medicare for just under 15 percent, and other sources (mainly private) for a little over 20 percent. C. McKeen Cowles, “Nursing Home Statistical Yearbook, 2008,” McMinnville, OR: Cowles Research Group, 2009, Table III-7. Individual facilities commonly receive payment from all of these sources.

³ Under the Medicare SNF benefit, prescription drugs are included in Medicare’s per-diem payment to the nursing facility. Medicare pays for drugs during SNF and hospital stays under Medicare Part A, and for some physician-administered drugs under Medicare Part B. Under Medicaid, the Medicaid agency pays separately for prescription drugs outside of the NF per-diem payment, except in New York, where the NF per-diem payment includes most prescription drugs.

⁴ A.L. Jones, L.L. Dwyer, A.R. Bercovitz, and G.W. Strahan, “The National Nursing Home Survey: 2004 Overview,” National Center for Health Statistics, Vital and Health Statistics, Series 13, No. 167, June 2009. (See Tables 5 and 8 on pages 17 and 20.) In 2004, 59.7 percent of nursing facility residents were being paid for by Medicaid when the National Nursing Home Survey interviews were conducted, and 88.3 percent were age 65 or older and thus, presumably, also covered by Medicare.

⁵ While MA-PDs do have responsibility for Medicare-paid hospital and SNF care for dual eligibles, PDPs are responsible only for their drug costs. Over 80 percent of dual eligibles are currently enrolled in PDPs and fewer than 20 percent in MA-PDs. See footnotes 1 and 2 in the February 2009 Centers for Medicare & Medicaid Services table at <http://www.statehealthfacts.org/comparetable.jsp?ind=307&cat=6>. Accessed March 3, 2010.

⁶ David G. Stevenson, Haiden A. Huskamp, and Joseph Newhouse, “Medicare Part D, Nursing Homes, and Long-Term Care Pharmacies,” prepared for the Medicare Payment Advisory Commission, No. 07-02, June 2007, pp. 16-17.

⁷ The Lewin Group, “CMS Review of Current Standards of Practice for Long-Term Care Pharmacy Services: Long-Term Care Pharmacy Primer,” prepared for the Centers for Medicare & Medicaid Services, December 30, 2004. Available at <http://www.cms.hhs.gov/Reports/downloads/LewinGroup.pdf>. Accessed September 3, 2009.

⁸ PDPs and MA-PDs are required to offer standard LTCP contracts to all LTCPs operating in their service areas. See Centers for Medicare & Medicaid Services, “Medicare Prescription Drug Benefit Manual,” Pub. 100-18, Section 50.5, July 3, 2008.

⁹ For a detailed discussion of these issues, see Medicare Payment Advisory Commission, “Report to the Congress: Promoting Greater Efficiency in Medicare,” Washington, DC: MedPAC, June 2007, pp. 167-183 (“Delivering Part D benefits to residents of long-term care facilities”).

¹⁰ The Lewin Group, “CMS Review of Current Standards of Practice for Long-Term Care Pharmacy Services,” December 2004.

¹¹ Sarah Lueck, “In Nursing Homes, A Drug Middleman Finds Big Profits,” *Wall Street Journal*, December 23-24, 2006, p. 1. See also Stevenson et al., “Medicare Part D, Nursing Homes, and Long-Term Care Pharmacies,” prepared for the Medicare Payment Advisory Commission, No. 07-02, June 2007, pp. A-1 to A-6.

¹² For an early and extensive discussion of many of these issues, see Jerry Avorn and Jerry H. Gurwitz, “Drug Use in the Nursing Home,” *Annals of Internal Medicine*, vol. 123, no. 3, August 1995, pp. 195-204.

¹³ Mathematica and Centers for Medicare & Medicaid Services, “Statistical Compendium: Medicaid Pharmacy Use and Reimbursement in 2005.” National Comparison Table N.1a. Available at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/08_MedicaidPharmacy.asp. Accessed September 2, 2009. Prescription drugs accounted for approximately 10 percent of total Medicaid expenditures in 2005. Kaiser Commission on Medicaid and the Uninsured, “The Medicaid Program at a Glance,” March 2007. Available at <http://www.kff.org/medicaid/upload/7235-02.pdf>. Accessed December 18, 2009.

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