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Community Catalyst

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The "Dual Eligible" Opportunity

Improving Care and Reducing Costs for Individuals Eligible for Medicare and Medicaid

Karen Davenport, Renée Markus Hodin, and Judy Feder December 2010

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Doing What Works Advisory Board

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Introduction and summary

The 8.8 million so-called "dual eligibles," or individuals who qualify for and are enrolled in both the Medicare and Medicaid public health insurance programs, are some of the sickest and poorest patients in our nation's health care system. Not surprisingly, they are some of the most expensive patients as well. Policymakers and program managers have long sought solutions for improving the quality and efficiency of care delivered to these individuals.

Implementation of the Affordable Care Act, the health reform law enacted in March, 2010, offers new opportunities for achieving these goals by experimenting with different approaches to see what works. One of those options is to allow the states to assume full financial and programmatic responsibility for managing the health care of dual eligibles, in contrast to today's practice of sharing the financial costs and management challenges related to these patients across two programs—one managed by the states and the federal government (Medicaid) and one managed only by Washington (Medicare)—each with different coverage and payment parameters. Other approaches may be identified and tested through demonstration programs authorized by the new law.

These opportunities must be pursued, however, only under circumstances that lead to better health outcomes for this group of particularly sick and poor individuals. The Centers for Medicare and Medicaid Services, or CMS, which manages the two public health insurance programs at the Department of Health and Human Services, has two new avenues for improving care for dual eligibles. One is the new Federal Coordinated Health Care Office, which is charged with improving integration between the two programs, eliminating cost-shifting between Medicare and Medicaid, and improving quality of care. And the other is the Center for Medicare and Medicaid Innovation, which is charged with identifying a range of pilot projects related to the reform of health care payment and delivery systems, with particular emphasis on improving the coordination, quality and efficiency of care—steps that can benefit dual eligibles in particular.

These two new offices within CMS offer a range of new opportunities to improve the care of dual eligibles while lowering the costs of their care. As both new offices begin to make program decisions to implement the new health reform law, we believe they should embrace five key principles:

- Start with a well-designed health care delivery system
- Ensure strong beneficiary protections
- Engage dual eligibles and their families in program design
- Ensure combined Medicare/Medicaid funds enhance health care delivery
- Establish a culture of quality improvement

In the pages that follow this paper will detail how these principles can be applied in practice by CMS and its two new offices. But first will come a brief presentation of who dual eligibles are and why they have special needs, and then what lessons we can learn from existing practices and key health care demonstration programs designed to improve the quality of care and lower the cost of that care for dual eligibles. Armed with this analysis, we advance recommendations for improving the health care of individuals eligible for Medicare and Medicaid—recommendations that reflect the practical needs of these patients and the progressive values that underpin the common good in our society.

Who are the dual eligibles?

Medicare and Medicaid beneficiaries who qualify for and are enrolled in both public health insurance programs and meet program eligibility rules based on age, disability, and income are known as "dual eligibles." The vast majority of our nation's more than eight million dual eligibles receive full Medicaid benefits as well as help with paying their Medicare premiums and cost-sharing expenses, such as the deductibles and co-insurance related to hospital care, physician visits, and other Medicare-covered services. Other dual eligibles receive assistance with Medicare premiums and cost-sharing through the Medicaid-operated Medicare Savings Programs for low- to moderate-income Medicare beneficiaries, which cover these costs but do not include other Medicaid benefits.

The Medicare and Medicaid benefit packages overlap, but Medicare is the primary payer for most acute care, with Medicaid covering enrollee cost-sharing and filling in gaps where the programs differ. More specifically, an individual with full Medicaid benefits will have most of their physician visits, outpatient or inpatient hospital care, and other acute care paid by Medicare, with Medicaid covering the services that Medicare does not cover, such as long-term care services, some kinds of home health care, and some medications, medical devices, supplies, and deductibles. Medicaid will also cover the patient's Medicare coinsurance.

Dual eligibles are more likely to use a range of medical services, including inpatient and outpatient hospital care, emergency room care, and skilled nursing care, than other Medicare enrollees because of their poor health and higher levels of health impairments compared to typical Medicare or Medicaid enrollees. For the same reasons, they are also more likely to require long-term supports and services.

Dual eligibles over age 65, for example, are more likely to suffer from a chronic condition such as diabetes, heart disease, or Alzheimer's disease than other elders with Medicare coverage. And dual eligibles under 65 years of age are more likely to have mental illness and mental retardation compared to other disabled individuals. This higher degree of impairment means that many dual eligibles need a more extensive range and different type of services than others with Medicare coverage.

Indeed, 24 percent of dual eligibles need assistance with three or more activities of daily living—everyday tasks such as dressing, bathing, and toileting—compared to the 6 percent of other Medicare beneficiaries who need help with these tasks.[1] This means their care is more complicated and more costly than care for the average Medicare or Medicaid enrollee—issues we turn to in the next section of this paper.

Financing and delivering care to dual eligibles

Because of their poorer health status and greater needs, particularly for high-cost services such as inpatient care and nursing home care, dual eligibles are the most expensive population within both the Medicare and Medicaid programs. These individuals use health and long-term care services disproportionate to their share of program populations. Specifically, dual eligibles comprise 18 percent of Medicaid enrollees but consume 46 percent of total program spending. Similarly, dual eligibles comprise 16 percent of Medicare enrollees, but consume 25 percent of total Medicare spending.[2]

Dual eligibles' relatively high rate of health-care consumption also signals the challenges inherent in managing patients with multiple conditions across many health care providers and both payers, Medicare and Medicaid. Many dual-eligible patients and their families experience difficulties navigating the American health care system as they try to cope with the hand off between acute and post-acute or long-term care, coordinating care across multiple specialists, and dealing with coverage issues. The fragmentation and division of responsibility across the Medicare and Medicaid programs only intensifies these problems for dual eligibles.

What's worse, skewed financial incentives discourage health care providers and the Medicare and Medicaid programs from coordinating their care, leading to costly but inefficient care. These two public health insurance programs often work at cross purposes because each program has the incentive to shift liability to the other through coverage interpretations and other strategies that avoid costs. This dynamic fragments care as each program seeks to limit its costs and enrollees shift between acute and long-term care settings. This dynamic is exacerbated because Medicare bears the most responsibility for acute care while Medicaid covers long-term care. Because of these separate financing streams and conflicting incentives, the two programs cannot realize equal savings from their investments in improved care.

Better long-term care coordination, for example, may result in reduced hospitalizations. But this means any investments by state Medicaid programs may result in Medicare savings, which in turn means little benefit accrues to the Medicaid program. States and health care providers have experimented with approaches that can realign these incentives and improve care, some of which have become permanent elements of the Medicare and Medicaid programs.

Experiences in integrating care for dual eligibles

Existing efforts to integrate the health care of dual eligibles, and other experiences with changing payment incentives, demonstrate both the promise and the perils of such experimentation. For instance, the Program of All-inclusive Care for the Elderly, or PACE, a model that integrates care at the health care provider level, boasts an established track record of widespread satisfaction and cost savings for dual eligibles. PACE enrollees, who receive a comprehensive set of medical and supportive services coordinated by an interdisciplinary care team, have better health outcomes, including lower rates of nursing home admission and lower mortality rates than non-PACE populations, while costs for these enrollees are 16 percent to 38 percent less than Medicare fee-for-service costs for frail elders.[3]

But this health care delivery system also faces roadblocks. While enrollment in PACE programs, for example, has grown since the model moved from demonstration status to permanent Medicare provider status with the Balanced Budget Act of 1997, it remains a modest part of the Medicare program, with only 18,000 enrollees nationwide in 2010.[4] And this model, which is oriented around enrollee participation in an adult-day center and intensively integrates services around a defined care team, often requires enrollees to change existing provider relationships—a change that can be detrimental for (and unattractive to) dual eligibles.

In addition, the up-front costs of integration can be daunting to the nonprofit entities who comprise the majority of PACE sponsors. As noted in reviews of PACE expansion efforts, the up-front costs of creating care teams, establishing adult day centers, and investing in information systems (among other expenses) are difficult to manage for small community organizations, and challenging for many existing hospitals and health care systems seeking to add a PACE program.[5]

Other efforts to integrate care for dual eligibles, such as Medicare Advantage Special Needs Plans, or SNPs, which were authorized under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, have a mixed track record. These risk-based health plans were intended to better serve benefi-

ciaries in one of three risky categories: individuals who are dual eligible, who have severe or disabling chronic conditions, or who are institutionalized. The program offered the promise of improving care for dual eligibles while also reducing the cost of that care by specializing in caring for these kinds of patients and by managing care in a capitated environment.

Some SNPs, such as plans in Massachusetts, Minnesota, and Wisconsin that started as health care providers in demonstration programs that pre-date the Medicare Modernization Act, have fulfilled this promise, largely through improving access to community-based long-term care services and reducing nursing home utilization.[6]

CMS, however, allowed other SNPs to begin enrolling beneficiaries without first demonstrating that they had a sufficient health care provider network to meet the unique needs of their dual-eligible enrollees. As a result, too many plans have inadequate networks to meet the demand for care while many enrollees are unable to navigate internal plan processes.[7]

Finally, all dual SNPs contract with the Medicare program to manage and deliver Medicare benefits to these special-needs groups, but all are not required to also contract with state Medicaid programs to offer Medicaid benefits to their dual-eligible enrollees—and most special-needs plans do not hold Medicaid contracts. Most SNPs, therefore, do not integrate financing and care delivery across the two programs, nor across acute care and long-term care—even though this integration was a key feature of the successful demonstrations that pre-dated the SNP program.

Under the new health reform law this must change by 2013, when all dual-eligible SNPs will be required to contract with states for dual eligibles' Medicaid benefits.[8] This change should give SNPs a stronger platform for coordinating care across the full spectrum of enrollees' needs.

Health care reform offers new opportunities to improve care

The Affordable Care Act offers new opportunities for states and the federal government to combine Medicare and Medicaid to establish more efficient, better coordinated care for dual eligibles. Generally speaking, the new law seeks to improve the quality and efficiency of care by changing health care payment arrangements for individual health care providers, institutions, and state governments, particularly by enabling greater experimentation with Medicare and Medicaid payment systems.

In particular, the law establishes a new office charged specifically with improving the delivery of care for dual eligibles. The Federal Coordinated Health Care Office at CMS is charged with improving the integration of dual eligibles' access to Medicare and Medicaid benefits, eliminating cost-shifting between the two programs, and improving the quality of health and long-term care services.

Other components of the new health care law are aimed at payment and delivery reforms that particularly target dual eligibles. The new Center for Medicare and Medicaid Innovation at CMS is broadly responsible for testing payment and service delivery models likely to reduce spending while improving quality of care. The law gives the Innovation Center broad latitude to identify promising pilot projects and other demonstration efforts within the two programs, giving preference to the improvements in coordination, quality, and efficiency of care—efforts that can particularly benefit dual eligibles.

The new law specifically enables the Innovation Center to explore approaches that allow a state to manage and oversee all Medicare and Medicaid funds in order to fully integrate the health care of dual eligibles. Although integrating Medicare and Medicaid financing can facilitate a high level of coordination between the programs, financing changes alone do not guarantee parallel changes in health care delivery and other key characteristics of effective integration. And without ensuring well-designed, well-administered, and accountable delivery systems, giving states full use of Medicare dollars runs the risk of undermining dual eligibles' access to care and replacing state resources with federal funds. Moving forward with this model, therefore, demands special attention, as we recommend in the next section of this paper.

Moving forward

States today are facing tough financial times. Total state budget deficits are likely to approach $140 billion across all states in fiscal year 2012.[9] This means some states may find managing Medicare funds for dual eligibles an attractive proposition, albiet with benefits and risks. On one hand, states may be able to better coordinate care. On the other hand, they may be tempted to substitute federal funds for current state Medicaid spending.

To ensure any states that are given power to manage Medicare and Medicaid funds for dual eligibles deliver improved efficiency and better care for low-income, elderly, or disabled individuals, the states and the federal government should adhere to several key principles. These principles are intended to guard against the known risks of underservice and shifting of costs and to ensure improvements in efficiency. These principles include:

- Starting with a well-designed health care delivery system
- Ensuring strong beneficiary protections
- Engaging dual eligibles and their families in program design
- Ensuring that combined Medicare/Medicaid funds enhance health care delivery
- Establishing a culture of quality improvement

Let's examine each of these in turn.

Start with a well-designed health care delivery system

The critical first step in integrating care for dual eligibles is designing a practical, achievable, and reasonable health care delivery system that can meet their individual needs and preferences. Whether integrated services are delivered through a fully or partially capitated health plan or through the state Medicaid program itself, this delivery system must be real and robust enough to meet the needs of this complex population. Specifically, states must:

- Create programs or plans tailored to the particular needs of different groups of the dual eligibles, such as physically disabled adults, frail elderly, and those with chronic mental illness

- Create health delivery systems that help dual eligibles and their families access and navigate the full range of services, including acute care, behavioral health care, community-based long-term services and supports, and nursing home care

- Emphasize high-quality primary care services, including through the use of multidisciplinary teams

- Allow dual eligibles and their families access to a broad network of health care providers, including primary care providers, specialists, and home attendants

- Use a comprehensive assessment process to evaluate dual eligibles' needs and create an individualized care plan to address these needs

- Develop strategies for engaging and educating health care providers, dual eligibles, and their families on the particular model of care being used and the kind of consumer protections in place

- Implement new health information technology systems such as electronic health records to maintain current health information and exchange data between and among physicians, case managers, and other health professionals

- Facilitate connections to community-based supports and services that will help with patients' nonmedical care needs

- Use shared decision-making tools and evidence-based programs such as the Stanford Chronic Disease Self-Management Program, which helps patients manage their own health[10]

Ensure strong beneficiary protections

Any demonstration of a new model for dual-eligible care delivery and financing that allows a state to manage Medicare funds must ensure that beneficiaries retain the protections they currently have under both programs. Specifically, states must ensure:

- Participation in any plan or program must be voluntary so that beneficiaries—not the state Medicaid program—retain control over their health care choices

- Participating dual eligibles must retain the ability to continue seeing health care providers with whom they have existing and beneficial relationships if those providers are outside of the network

- Health care provider payment rates must be sufficient to assure access to needed care, such as payment levels equivalent to Medicare rates

- Combined control of Medicare and Medicaid must include the beneficiary protections from each program, such as grievance and appeal rights, that are most favorable to beneficiaries[11]

Engage dual eligibles and their families in program design

Dual eligibles and their families should have a say in how states integrate Medicare and Medicaid services. CMS can involve them from the beginning of this process by creating a formal avenue for consumer consultation in both the Innovation Center and the Coordinated Health Care Office.

These offices should consult dual eligibles, their families, and their representatives (such as consumer advocates) about the types and design of models to be tested, and ensure that they play an ongoing role in the models' implementation, including governance. In addition, health care advocates for dual eligibles as well as dual eligibles and their families could engage in outreach and education efforts and assist with enrollment and referral for these programs.

Ensure combined Medicare/Medicaid funds enhance health care delivery

Coordination across Medicare and Medicaid for people who rely on both programs has the potential to redirect resources from unnecessary hospital and nursing home use to better preventive and primary care as well as and home and community-based long-term services and supports. Achieving that goal means allowing Medicare savings from reduced hospitalizations, for example, to offset investments in improved Medicaid services, particularly management and home and community-based care.

Improved health care delivery also requires mechanisms to assure that Medicare funds add to, rather than substitute for, appropriate Medicaid spending. States managing care for dual eligibles must be held strictly accountable for providing care that demonstrates both measurable quality improvements and cost-effectiveness. Accountability requires adequate infrastructure to meet delivery system requirements that will ensure full access to appropriate services, coordinate care, and drive other quality improvements.

In addition to the payments to states for care of dual eligibles, the federal government should develop options for providing start-up support tied to specific investments, thus allowing both flexibility and accountability in the use of Medicare funds.

Establish a culture of quality improvement

States assuming responsibility for dual eligibles' care must regularly assess health outcomes and use this information to continuously improve quality. To do so, states must:

- Use measures of clinical quality based on patients' health outcomes, care coordination, avoidable hospitalizations, readmissions and emergency department use, adverse drug interactions, and resource use. These measures should encompass the full range of providers involved in an integrated health care delivery model
- Incorporate strategies for evaluating the experience of dual eligibles and their families in state-run integrated programs alongside steps for translating it into concrete program improvements
- Make performance data publicly available in plain language to dual eligibles and their families
- Collect and stratify data by race, ethnicity, primary language, disability, and gender so that health disparities can be identified and addressed

Conclusion

All of the recommendations in this paper for implementing the Affordable Care Act to meet the health care needs of dual eligibles are predicated on the critical goal of providing better care at lower cost. Because of their extensive care needs and fragmented financing, dual eligibles stand to benefit considerably from innovations in payment and delivery that better integrate care.

But the pursuit of innovation, including but not limited to allowing states to pursue integrated care by managing federal Medicare funds alongside the Medicaid funds they already manage, requires critical attention to health care delivery arrangements, beneficiary engagement and protection, accountability as well as opportunity for enhanced investments, and commitment to quality improvement. Only if the health care needs of dual eligibles remain paramount will the benefits of care integration be fully realized.

Endnotes

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doing what works

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- Building a foundation for smarter decision-making by enhancing transparency and performance measurement and evaluation

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About Community Catalyst

Community Catalyst is a national nonprofit advocacy organization working to build the consumer and community leadership that is required to transform the American health system. We believe that this transformation will happen when consumers are fully engaged and have an organized voice. Our staff of experienced policy analysts, attorneys, community organizers, and communications specialists has worked with organizations in over 40 states. We have helped these organizations achieve wide-reaching reforms in many areas including Medicaid policy, prescription drug prices, and diversity in the health care workforce.

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