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Medicaid and the Dual Eligible Population

by The Honorable Arlene Wohlgemuth & Spencer Harris

"The programs were never designed to work together … There's tremendous financial misalignment between Medicaid and Medicare." –Melanie Bella, Centers for Medicare and Medicaid Services, The Wall Street Journal, June 27, 2011

The label "dual eligible" refers to a client who is eligible for both Medicare and Medicaid due to age, income level, and need for long-term care. In recent years these clients have received critical scrutiny because of the high costs associated with their care. Some of these costs are high because many individuals in this population, "have complex medical and chronic care needs that require lengthy stays in a variety of long-term settings."[1] Currently, Texas has roughly 328,500 individuals that are fully eligible for both Medicare and Medicaid.

Texas provides care to most of the Aged, Blind, and Disabled (ABD) population through the STAR+PLUS managed care program. Of the state's 328,500 dual-eligibles roughly two-thirds reside in the urban areas of the state and are enrolled in STAR+PLUS. These clients are statistically more likely to have fewer financial resources and greater health care needs than other beneficiaries. Nationwide, 55 percent of them have incomes of $10,000 or less, 54 percent have a cognitive or mental impairment, and 41 percent are non-elderly disabled individuals.[2]

Under STAR+PLUS the client chooses a Managed Care Organization (MCO) to manage Long Term Services and Supports (LTSS). Medicare, meanwhile, provides acute care needs. While this structure has been effective at reducing costs on LTSS through care management and coordination, the dual delivery system has made it difficult for both programs to adequately and comprehensively assess client needs.

Through rigorous care coordination under STAR+PLUS, Texas has seen cost reductions of 22 percent for in-patient care; 15 percent acute out-patient care (including emergency room care); 15 percent for non-physician services, ambulatory care, home health, and behavioral health; and 10 percent for LTSS.

Each STAR+PLUS client has access to a Service Coordinator for assessment of long term needs. Besides helping dual eligible beneficiaries identify acute care providers who accept Medicare, the coordinator informs the providers of clients' individual health care needs. Last summer, dual eligibles came under federal scrutiny due to the huge costs they generate. Texas' deputy executive commissioner for Health and Human Services Operations, Billy Millwee, told the U.S. House of Representatives Energy and Commerce Committee that,

> "Dual Eligibles confront a care system in which Medicare provides their acute care services, with most of their long-term services and supports provided by Medicaid. This bifurcation makes it difficult for either state or federal programs to assess the needs of these clients and address their health care … By increasing appropriate preventive and supportive care in the community, a corresponding reduction of acute care costs is possible. … Texas believes that this same savings is achieved for the acute care services provided to the persons in STAR+PLUS that have both Medicare and Medicaid."[3]

A subsequent report in *The Wall Street Journal*, with numerous accounts from Texas, buttressed the federal government's concerns. Janet Adamy wrote,

> "Victor Maceyra, a quadriplegic, was living on his own in Temple, Texas, holding down a job, when he hurt his left shoulder last year after toppling his wheelchair. He moved into rehabilitation centers for therapy. The shoulder got better, and he wanted to go home. But Medicare and Medicaid couldn't agree on which one would pay for an aide to bathe him and help him use the toilet, nor on whether he qualified for such services at all, he says. As each program tried pushing him to the other, Mr. Maceyra remained at a

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live-in rehabilitation center for six months after his shoulder healed, at government cost."[4]

In response, Health and Human Services (HHS) Secretary Kathleen Sebelius announced new cost-fighting initiatives. The most significant of these is designed to test two payment models for dual eligibles. One model would use a capitated, blended payment rate between the state, HHS, and a health plan to provide services to the dual eligible population. The result would be a coordinated funding stream that pays a single sum of money for each beneficiary for all of their care needs. The other payment model would deliver care through e a managed fee-for-service structure between the state and HHS. Both payment models identify a key problem in dual eligible care delivery: namely, a state that finds ways to reduce costs for Medicare fails to share in the savings. Allowing the state to share in savings from innovations would align favorable results with incentives to keep seeking such results.

In September, 2011, Texas sent a non-binding letter of intent to the Director of Medicare-Medicaid Coordination Office to inform them that Texas was pursuing the capitated payment model initiative through the STAR+PLUS program. This proposal would include the more expensive areas of care including nursing facility payments. Three policies will be particularly beneficial. The first is the automatic enrollment of dual eligibles into a MCO. This will allow for a single entity to coordinate the continuum of care for each client while still being held accountable to the state. The second policy is the integration of Medicare and Medicaid nursing facility payments. This will help to end the complications associated with which program is paying for a client's nursing facility and is aimed at encouraging consistency of care. Finally, the third policy of note is to support individuals receiving care in community based settings. This will help keep individuals in less expensive community based settings, thereby saving money for the state.

Of the state's 328,500 dually-eligible clients 214,500 are expected to be eligible for the demonstration project. In order to achieve maximum success the state should follow the application's recommendation that eligible clients be required to enroll in the demonstration project. Furthermore, to ensure client and provider satisfaction the state should continue to practice the rigorous contract and network management that has made STAR+PLUS successful in recent years.

HHS' new initiatives on cost savings allow for positive changes to care delivery for the dual eligible population, and the state's leadership should be applauded for pursuing them. Congress can go even further by including funding for acute care in a block grant for the Medicaid program, helping dual eligibles achieve full care integration and coordination under Medicaid. Opponents contend that block grants for dual eligibles would inevitably result in the shifting of costs to low-income seniors through reduced payments. However, the state is already reducing payments made to providers for the dual eligible population. Block grants would allow the state to utilize presently unavailable savings through care coordination and integration. ✯

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[1] Health and Human Services Commission, *Medicaid Reform Strategies for Texas* (HHSC, 2007).

[2] Janet Adamy, "Overlapping Health Plans are Double Trouble for Taxpayers," *The Wall Street Journal* (27 June 2011).

[3] House Energy and Commerce Committee, Health Subcommittee, Testimony of Billy Millwee, Associate Commissioner of Medicaid and CHIP Texas Health and Human Services Commission (21 June 2011).

[4] Janet Adamy, "Overlapping Health Plans are Double Trouble for Taxpayers," *The Wall Street Journal* (27 June 2011).