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## Merging a Divided System: The Need to Integrate Care for Individuals Participating in Both the Medicare and Medicaid Programs

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# Case Study - Merging a Divided System: The Need to Integrate Care for Individuals Participating in Both the Medicare and Medicaid Programs

*by Regina L. Anderson-Cloud, M.S.*

## **Educational Objectives**

1. Identify the underlying premises of the need to integrate care between the Medicare and Medicaid programs for individuals eligible for both insurances.
2. Discuss innovations aimed at assisting older adults with an improved Medicare/Medicaid system.
3. Describe relevant health care concerns related to the current fragmentation of the health care system for older adults who possess both Medicare and Medicaid.

## **Background**

When the Medicare and Medi-caid programs were conceived, the need to think of a full continuum of integrated care and services was not really on the forefront of the U.S. health care agenda. The origination of these two insurance programs evolved in many ways independently, with states in control of the general workings of the Medicaid program and the federal government administering Medicare.

The somewhat independent evolution of Medicare and Medicaid has yielded two very different insurance coverage systems with resulting problems for the population frequently referred to as "**dual eligibles**;" those eligible for coverage under both programs. These problems are evident in that the systems have very different coverage rules and benefit criteria, separate administrative oversight, unique grievance rules and appeal policies, and a general lack of coordination of health care delivery or care planning. Additionally, another serious and sharp division between the two insurance programs is that Medicare is the primary payer of acute care, while Medicaid is primarily responsible for funding long-term care. The result, traditionally, has been cost shifting between the two programs and fragmented health care delivery, which has been viewed by consumers as inefficient and costly. Disincentives in the administration of both programs have been cited as factors contributing to a health care system that is biased toward institutionalization (Wiener and Skaggs, 1995).

With the fragmentation and inherent divergence that has occurred in health care delivery for the population of dual eligibles, state policy makers have sought solutions aimed at an integrated system of health care. According to the Muskie School Public Service and the National Academy for State Health Policy (1997), states have been prompted to merge these two very different insurance programs based upon the influence of three primary factors: (1) the desire to improve continuity of care across settings and to provide flexible benefits that prevent or reduce institutionalization; (2) the need to control costs; and (3) an interest in expanding managed care to all Medicaid beneficiaries and minimizing the administrative complexities of operating both fee-for-service and risk-based systems.

The state of Virginia, under a grant from the Robert Wood Johnson Foundation called "**The Medicare/Medicaid Integration Program**," is one of a small number of states working to develop pilot programs to integrate Medicare and Medicaid. Virginia's program is entitled "**Virginia Cardinal Care**." While some programs are farther along in development than Virginia Cardinal Care, most states have similar program goals. The goals of the Virginia Cardinal Care Program are to provide improvements in quality of life to consumers while assuring an efficient use of care resources through:

- delaying or deterring institutional placement;
- improving access to care;
- providing for a model of care coordination that reduces fragmentation and inefficiencies in the current delivery system;
- promoting improved health status and/or decreased progression of disability through screening, chronic disease management, education, and prevention; and
- improving patient/caregiver satisfaction over the current fee-for-service system.

The integrated care models of most states seek to pool Medicare and Medicaid funding in a managed care arena. With this pooling of funds, an emphasis is placed on improving the care delivery system and new provisions that allow providers flexibility in delivering services aimed at keeping individuals well and in their homes longer.

Similar to the model being proposed by the state of Virginia, most state models also first attempt to develop programs for integration of Medicare and Medicaid for the largest segment of dual eligibles, those age 65 and older. Once experience is gained in serving the older adult population, states will move to develop related programs for those under age 65. Additionally, most states venture into integration projects on a pilot basis hoping to gain experience that will bridge to larger programs.

The following case study is provided to illustrate the need for integration of Medicare and Medicaid for individuals age 65 and older.

### **Case Study**

It was not unusual for Peggy to have terrible pain from her worsening arthritis. What was unusual to her was that she was feeling worse physically and it was not just the pain. She was more tired, unsteady on her feet, and dizzy at times. Her stomach bothered her and she was obviously losing weight.

With her son living away, Peggy's closest contacts were her friends. Some had become concerned about her recently, especially with the weight loss, but they guessed that she was "just going down hill."

Time passed, and Peggy grew weaker. She stopped attending church as she had done weekly for at least 60 of her 83 years. She saw her doctor routinely and was told that she needed to try eating more. He told her to buy Ensure and drink at least two cans a day. She tried, but with her best efforts, she still did not feel well. Although she quietly figured that this was part of her approach toward death, she tried to

keep up a bright front with her son when he called. She would just tell him that she was "getting old" and that she "guessed old Arthur (itis)" was getting the best of her.

A nurse from the hospital called Peggy's son because she had fallen in the bathroom during a dizzy spell. She was in the local hospital with a broken hip, and surgery would be necessary. It looked as if she may never walk again. Her son was advised that she may need nursing home placement or a similar level of care for the rest of her life.

What had happened to her? Why the decline in her health, the loss of weight, the unsteadiness, the dizzy spells?

Out of concern, Peggy's son requested a review of her complete physical condition once she was safely recovering from surgery. Much to her family doctor's surprise, the review found she had been taking four different medications prescribed to treat her arthritic pain, only one of which had been prescribed by him.

When the family doctor asked about the other three drugs, Peggy, feeling embarrassed that he had discovered the other drugs, explained that she had heard of a few other doctors who were good at treating arthritis and that she had been to see them as well. Each doctor had prescribed different medication for the same symptoms. None of the doctors had asked if she was taking anything else for her arthritis; each assumed he was the only physician treating her condition. Because she had gone to doctors in different areas of the city, she had also used different pharmacies for each doctor's prescription. Therefore, no one knew, except for her, that she had been given all of these drugs.

The doctor's discovery, prompted by her son's concern, revealed that in her efforts to receive relief from chronic arthritic pain, she had been poisoning her system with the interactions of the four drugs. Thus, she experienced the side effects of a severely upset stomach, weight loss, dizziness, and weakness. These side effects were directly related to the fall that resulted in the broken hip which, unfortunately, would alter the course of her remaining years.

## **Discussion**

This case is a severe example, and the placing of blame could be aimed in many different directions. Was it Peggy's fault for doctor shopping and not telling her routine doctor that she was taking new medicines? Was it the fault of the doctors involved for not asking about other medicines she was taking? Was it her family doctor's fault for not looking for reasons for her recent decline? Was it her son's fault for not visiting more frequently and identifying the stark changes in her condition? Was it her friends' fault for not taking a more active role in discerning what was wrong?

The reality is that the "blame game" really does not benefit anyone when irreversible damage has already been done. The challenge is to try to seek solutions that will structure a system aimed at reducing the probability of the negative outcomes seen in the case above.

Separate articles could be written on the difficulty in managing arthritis in old age, of coping with chronic pain, or about the perils of polypharmacy for the aging population. However, key to this case

are many concomitant factors related to the health care of the aging, especially the vulnerable older adult population that is eligible for both Medicaid and Medicare. The concern, as evidenced in the case study, is of how quickly negative outcomes that lead to eventual nursing facility placement can occur when symptoms and/or conditions go untreated. Too often, changes, side effects, and symptoms are dismissed with a "she's getting to be that age" or "he's done well for so long, it must be time that he..."

How can integrated care from the Medicare and Medicaid programs make a difference?

The goals of programs like Virginia Cardinal Care are to work on a one-on-one basis with older adults in health screening, preventative strategies, monitoring of existing conditions, and health education. Through the use of the principles of managed care, especially with vulnerable populations, health plans and providers are motivated by the obvious incentives of keeping the population they serve at the highest functional level possible for the longest period of time. Managed care principles have often proven to yield improved outcomes while reducing cost in the care of older adults. For example, Leveille et al. (1998) found that overall function can be improved and that inpatient hospital utilization can be significantly reduced when applying health care management principles to a population of chronically ill older adults. Moreover, Wasson et al. (1998) suggested that potential cost savings in better management of inpatient hospital usage could provide significant funds for use toward supportive services aimed at providing essential care in the home versus the institutional/long-term care environment.

In addition to applying new principles to managing care through primary care physicians and care coordination models, the integration of Medicare and Medicaid in managed care decreases the incentives toward cost shifting between the two payment sources. Linking payment systems provides a consumer-focused system versus a payer-driven system.

As states like Virginia continue to plan and work toward innovations that yield integrated structures and services, many challenges loom. Current problems with payment from the Health Care Financing Administration (HCFA) for Medicare managed care services are a key challenge. Payment systems, as well as administrative structures, must strive to be amenable to change to support the population in need. Many states, advocates, and other concerned parties are working with HCFA as well as Congress to work toward positive change for dually eligible beneficiaries. With all this activity, and with the support of those like the Robert Wood Johnson Foundation, a better health care system for Medicare and Medicaid eligibles is sure to emerge.

### **Study Questions**

1. In your experience, have you seen a need to merge the Medicare and Medicaid programs? What suggestions could you make to policy makers about how this could be achieved most effectively?
2. An early effort to merge care and services for a subset of dual eligible beneficiaries has been PACE (Program of All-Inclusive Care for the Elderly). Research the PACE program model and detail the differences and similarities between PACE and programs like Virginia Cardinal Care.

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