Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead

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Summary

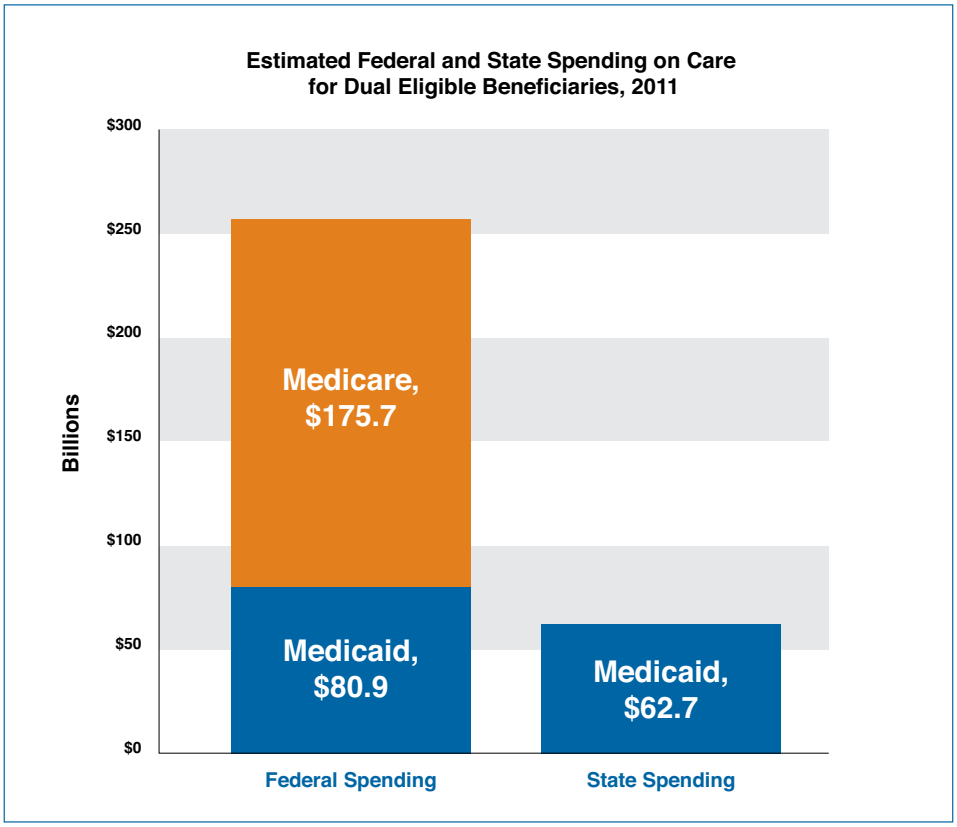
At 40 percent of Medicare's and of Medicaid's costs,[1] the 9 million dual eligibles,[2] who receive benefits from both programs, are a focus of efforts to slow growth in entitlement spending. But, given the two programs' responsibilities, policy-makers are relying far too heavily on states to find the solution.

Dollars spent on dual eligibles are overwhelmingly federal; potential savings come from better management of Medicare-financed acute care services; and enhanced state, rather than federal, responsibility for overall spending increases the risk of cost-shifting to Medicare and may undermine quality of care for vulnerable beneficiaries.

Why Dual Eligibles are Primarily a Medicare Responsibility

The federal government is overwhelmingly responsible for spending on dual eligibles, and improvements in Medicare-financed services—at the core of the Affordable Care Act's (ACA's) payment and delivery reform—are the most direct path to better care at lower costs.

- **The federal government pays the bulk of care costs for dual eligibles.** Of the $319.5 billion estimated as spent on duals in 2011, 80 percent ($256.6 billion) are federal dollars, more than two-thirds of which flowed through Medicare.[3]



- **Improvement in Medicare-financed care is the key to spending control.** Prevention of unnecessary hospital use—almost fully financed by Medicare—is widely recognized as the most immediate target for both spending reductions and quality improvements in care for dual eligibles.
  - » Dual eligibles experience far higher rates of "potentially preventable hospital admissions" than other Medicare beneficiaries: more than twice as high for pressure ulcers, asthma and diabetes; 52 percent higher for urinary tract infection; and over 30 percent higher for chronic obstructive pulmonary disease and bacterial pneumonia.[4]
  - » Estimates of potentially avoidable rehospitalizations of nursing home residents—which shift costs from Medicaid-financed nursing benefits to Medicare-financed hospital and skilled nursing facility (SNF) benefits—range from 18 percent to 40 percent.[5]
- **The ACA charges Medicare with improving medical care.** Better coordination of Medicare-financed care for beneficiaries at high risk of hospitalization is at the heart

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of payment and delivery reforms promoted by the ACA. Reporting on the experience from Medicare care coordination demonstrations, Randy Brown emphasized that significant reductions in hospital use (from 17 to 24 percent) and in Medicare costs (by 10 to 20 percent) were achieved by interventions that targeted beneficiaries at risk of preventable admissions; emphasized in-person patient-coordinator contact; collected and responded to timely information on hospital admissions and emergency room visits, established close relationships between care coordinators and primary care physicians; and actively promoted training in self-management skills.[6]

The Risk From Putting States and Medicaid in the Lead

States' expenditures on dual eligibles focus overwhelmingly on long-term supports and services—not medical care. Although states have developed managed care for Medicaid's younger enrollees, they lack experience in managing dual eligibles' medical care, and face continued incentives to substitute federal Medicare for state Medicaid spending, in order to control their expenditures.

- **Medicaid pays for dual eligibles' long-term, not acute, care.** 70 percent of Medicaid's total spending for dual eligibles goes to long-term services and supports (77% when its payments for Medicare Part B premiums are excluded).[7] Only 30 percent of dual eligibles actually receive these services;[8] for most dual eligibles, Medicaid plays a limited, primarily financial role–paying premiums, some cost-sharing, and wrap-around services (such as vision and dental care) that Medicare does not cover.
- **States recognize that Medicare, not Medicaid, will be the primary beneficiary of care improvements.** Along with federal rules assuring dual eligibles, like other Medicare beneficiaries, a choice of providers, limited financial returns from better coordinated acute care and reduced hospital use have deterred states from investing in delivery innovations.[9]
- **Most Medicaid managed care plans do not deal with dual eligibles.** Although Medicaid has come to rely heavily on managed care for the bulk of its beneficiaries who are low-income children and families, Medicaid managed care plans lack both experience and capacity to handle the care needs of the most expensive dual eligibles.[10]
- **Offering states an opportunity to share in these financial benefits—without sufficient constraints—risks enabling, rather than reducing, cost-shifting from state to federal budgets.** Assigning states responsibility over Medicare, as well as Medicaid funds for dual eligibles (as authorized by the ACA and contemplated in some policy proposals[11]), would allow states to substitute Medicare funds for expenditures Medicaid would otherwise make. Noting the power of this incentive, the Medicare Payment Advisory Comission (MedPAC) advises caution in its pursuit.[12]
- **A single-minded budgetary focus, whether in Medicare or Medicaid, runs the risk of promoting cost savings at beneficiaries' expense.** Dual eligibles, as Medicare beneficiaries, are entitled to consumer protections not always available to low-income Medicaid beneficiaries. Without substantial oversight, shifting responsibility for their Medicare services to Medicaid programs may forfeit these protections and create financial incentives to limit care for high-need beneficiaries.[13]

The Need for Medicare Leadership

The Affordable Care Act significantly elevated attention to better care for dual eligibles through the establishment of the Medicare-Medicaid Coordinated Care Office, which has launched a number of initiatives to better align the programs. However, with respect to payment and delivery reforms, the focus is overwhelmingly on state and Medicaid, rather than federal Medicare, initiatives. Medicare must step up—with measures that include the following:

- **Aggressive oversight and "pay-for-performance" in Medicare Special Needs Plans (SNPs).** Medicare Special Needs Plans, specialized Medicare Advantage plans, were created in 2003 legislation, with the authority to serve specialized populations, including dual eligibles and residents of institutions. Dual eligibles constitute about a million of the 1.3 million people enrolled in SNPs.[14] But unlike payment and delivery reforms newly authorized by the ACA, Medicare pays SNPs on a capitation basis, and does not hold them accountable for performance on measures related to patient experience, hospital admission and readmission rates, emergency room use, medication errors, or institutionalization for long-term care.[15] Medicare should significantly alter SNP reporting requirements and, even more important, tie payment rates to performance standards related to quality care.
- **Emphasis on dual eligibles, especially those using long-term supports and services, in ACA-authorized Medicare payment and delivery reforms.** Running the gamut from pay-for-performance initiatives that include penalties to hospitals for excessive readmissions; through innovations to improve transitional care for patients leaving the hospital and bundle hospital and post-hospital payment; to financial incentives for providers who agree to serve as "medical homes" or, more broadly, accountable care organizations, ACA initiatives promote better primary care and care coordination to reduce unnecessary use of expensive services. Although, the Centers for Medicare and Medicaid Services (CMS) are only beginning to implement these initiatives, they seem to have little if any focus on the dual-eligible population—which, as noted at the outset, has been regarded as Medicaid's, not Medicare's responsibility. But chronically ill

people with impairments—about half of whom are dual eligibles—are likely to benefit substantially from these initiatives, and yield Medicare substantial savings in the process. Research for a forthcoming SCAN Foundation analysis of 2006 data shows that dual-eligible beneficiaries with chronic conditions and functional limitations are one-third more likely than beneficiaries with three chronic conditions and no impairments to use inpatient hospital care (32% vs. 24%); and, as a result, incurred more than 50 percent higher hospital spending per beneficiary ($4,900 vs. $3,200 per beneficiary).[16]

- **SNF payment policies to prevent unnecessary hospitalizations for nursing home residents.** Nursing homes that hospitalize their residents fail to provide residents adequate nursing and medical care, increase Medicare hospital costs, and, when the patient returns to the nursing home, receive Medicare SNF payments at rates higher than those Medicaid pays. Because this practice reduces Medicaid's costs while increasing Medicare's, correcting it is unlikely to become a state priority. Medicare must take the lead.

  Inappropriate hospital admissions and SNF readmissions are a sign of poor-quality care that can be addressed through Medicare payment policy—going beyond CMS's solicitation of proposals to "help states" reduce these unnecessary hospitalizations[17], as well as a modest 2009 value-based-payment initiative rewarding SNFs that reduce preventable admissions.[18] To recognize its responsibility to provide dual eligibles quality medical care and quality SNF care, Medicare should: 1) finance nurse practitioners in nursing homes to coordinate frail residents' care (United Healthcare's Evercare program has already demonstrated, relative to control groups, that this strategy can cut hospitalizations and emergency room use in half);[19] 2) apply performance standards, like those now applied to hospitals, to penalize SNFs with excessive rates of preventable hospitalizations for their residents (whether or not they are receiving SNF care).

The Bottom Line: Medicare Should Do Its Job

Medicare leadership in improving the efficiency and quality of care for dual eligibles does not eliminate the value of state Medicaid initiatives, whether to better coordinate all care dual eligibles receive or, even more important, the long-term care that is Medicaid's focus. And, where states invest in care improvements that produce savings, sharing those savings with Medicare may be appropriate.

But states pay for only 20 percent of spending on dual eligibles, very little of which goes toward acute care, where savings and quality improvement are most readily achievable. These services are Medicare's responsibility, and the savings are Medicare's to pursue. Allowing state initiatives to absolve Medicare of responsibility for improving the quality and efficiency of the care it finances simply does not make sense. Getting better value for Medicare dollars for dual eligibles, along with all beneficiaries, is simply Medicare's job.

Notes

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3 Coughlin et al., forthcoming.

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5 Medicare Payment Advisory Commission. *Aligning Incentives in Medicare.* Report to the Congress. Washington, D.C.: MedPAC, June 2010, p. 141. (http://www.medpac.gov/documents/Jun10_EntireReport.pdf).

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7 Rousseau D, Clemans-Cope L, Lawton E, Langston J, Connolly J, Howard J. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2010. (http://www.kff.org/medicaid/upload/7846-02.pdf).

8 Authors' calculation from the FY2007 Medicaid Statistical Information System.

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10 Verdier et al., p. 16.

11 Musumeci MB, Connoll J, Howard J, Jacobson G. Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2011. (http://www.kff.org/medicaid/upload/8215.pdf).

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13 Prindiville K. *Ensuring Protections for Senior Citizens in Integrated Models.* National Senior Citizens Law Center, July 2011. (http://www.nsclc.org/areas/medicare-part-d/KFF%20Duals%20Event%2071311.pdf); Center for Medicare Advocacy, Inc. *Recommendations for Beneficiary Protections in Mode Approved by CMMI.* Willimantic, CT: Center for Medicare Advocacy, Inc., July 2011. (http://www.medicareadvocacy.org/2011/07/recommendations-for-beneficiary-protections-in-models-approved-by-cmmi).

14 MedPAC, June 2011.

15 Ibid.

16 Analysis by Avalere Health, LLC of the 2006 Medicare Current Beneficiary Survey, Cost and Use File, conducted for Komisar HL, Feder J. *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-term Care Needs: Coordinating Care across All Services.* The SCAN Foundation, forthcoming, October 2011. (www.TheSCANFoundation.org).

17 Centers for Medicare and Medicaid Services. *Demonstration to Improve Care Quality for Nursing Facility Residents: Initiative to Reduce Preventable Hospitalizations.* Baltimore, MD: CMS, July 8, 2011, https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4022&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

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