

Supporting Integrated Care for Dual Eligibles

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Health care costs for adults who are dually eligible for Medicare and Medicaid are nearly five times those of other adults covered by Medicare. Integrating the delivery of care and financing for these high-need beneficiaries is among the greatest opportunities in our health care system for simultaneously improving care and controlling rising costs.

When policymakers created the Medicare and Medicaid programs 40 years ago, they did not envision that over eight million Americans would eventually be eligible for both programs.¹ Nor could they have anticipated the intense care needs and exceedingly high costs associated with caring for these beneficiaries (known as “dual eligibles”). Today, the majority of people who are dually eligible receive fragmented and poorly coordinated care. And the state and federal officials responsible for their care are increasingly frustrated by the lack of coordination and financial misalignments between the two programs.

In spite of recent efforts to create vehicles for integrating care through Special Needs Plans (SNPs), more than 80 percent of dual eligibles remain in fee-for-service. This keeps them in “treatment silos” connecting with one provider at a time — even when they have five doctors — and getting one prescription at a time — even when they take 15 different pills a day.

With a new federal Administration, increasing recognition of the current system’s costs and failures, and recent legislation for SNPs,² states and health plans may have additional opportunities to pursue integrated solutions that could improve the quality and cost-effectiveness of care for dual eligibles. This brief outlines the rationale for integrating care for duals, reasons why integration has been slow to

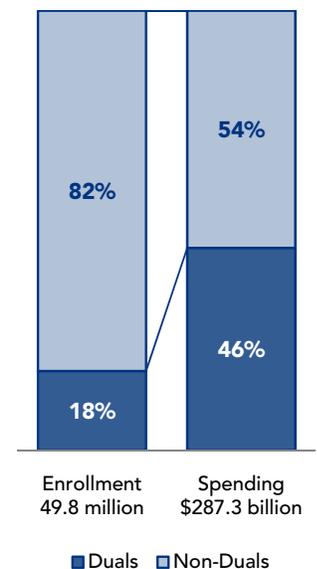
progress, and emerging vehicles for achieving fully integrated care.

Who are the Duals?

While Medicare and Medicaid generally cover different populations, there are more than eight million people who are eligible for both programs. Dual eligible beneficiaries are the most chronically ill patients within both Medicare and Medicaid, requiring a complex array of services from multiple providers. Although Medicare covers basic health care services, including physician and hospital care, dual eligibles rely on Medicaid to cover long-term supports and services as well as to pay Medicare premiums and cost-sharing.

Dual eligibles are by definition low-income: 60 percent live below the poverty level, with as many as 94 percent living below 200 percent of poverty.³ Compared to the general Medicare population, dual eligibles are three times more likely to be disabled and have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer’s disease.⁴ While dual eligibles represent just 18 percent of Medicaid enrollees and 16 percent of Medicare enrollees, they account for 46 percent of total Medicaid expenditures and 25 percent of total Medicare expenditures.^{5,6} In 2005, the total cost to Medicare and Medicaid for care provided to dual eligibles was roughly \$215 billion.⁷

Dual Eligibles’ Share of Medicaid Enrollment and Spending, FFY 2005



Source: Urban Institute estimates based on data from MSIS and CMS Form 64, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2008.

Benefits of Integration

Because Medicare and Medicaid are each governed by their own policies and procedures, dual eligibles are forced to navigate two sets of providers, benefits, and enrollment policies (Figure 1). Integrating Medicare and Medicaid services can help ensure that dual eligible beneficiaries receive the right care in the right setting, rather than receiving care driven by conflicting state and federal rules and siloed funding streams. Ideally, integrated programs should include the following elements:

- **Strong patient-centered primary care base**, i.e., an accountable care home;
- **Multidisciplinary care team** that is structured to address the full range of a beneficiary’s needs (medical, behavioral, social);
- **Comprehensive provider network** that meets the needs of the target population and supports the care coordination model;

- **Robust data-sharing and communications systems** that guarantee continuous access to services and promote coordination of care across settings;
- **Consumer protections** that ensure access to longstanding community providers and involve consumers in program design/governance; and
- **Financial alignment** that addresses fragmented systems of care through blended funding and/or shared gains and risks of providing services.

Mechanisms for Integrating Care

Special Needs Plans

With the passage of the Medicare Modernization Act of 2003 (MMA), Medicare Advantage health plans could be designated as SNPs, thereby creating a new vehicle through which states could integrate Medicare and Medicaid for dual eligible beneficiaries.⁹ As SNPs, health plans can target one of three high-need populations: (1) dual eligibles; (2) beneficiaries requiring an institutional level of care; and (3) beneficiaries with chronic conditions. For dual eligibles, these newly designated specialty health plans are uniquely positioned to coordinate Medicare and Medicaid benefits.¹⁰

Enrollment in a SNP does not automatically translate into integrated care for dual eligibles, however. The true value of SNPs for dual eligibles lies in the potential relationships between these health plans and state Medicaid agencies. Through these relationships, states and SNPs can offer the full array of Medicare, Medicaid, and supplemental benefits within a single plan so that beneficiaries have one benefit package and one set of providers to obtain the care they need.

Despite the potential of SNPs for integrating care, however, only a handful of states currently operate fully integrated programs. Of the roughly 1.5 million dual eligibles receiving care via Medicare

Figure 1: Mattie’s Health Insurance Coverage

Mattie, dual eligible, age 77, has diabetes and hypertension, and several strokes have caused weakness on her left side.⁸ She has many providers: a personal care attendant who helps her to live alone at home, a social worker who helps address her depression, and a variety of specialists to whom she often has trouble getting to because of mobility problems.

Without Integrated Care	Integrated Care
✗ Three ID cards: Medicare, Medicaid, and prescription drugs	✓ One ID card
✗ Three different sets of benefits	✓ One set of comprehensive benefits: primary, acute, prescription drug, and long-term care supports and services
✗ Multiple providers who rarely communicate	✓ Single and coordinated care team
✗ Health care decisions uncoordinated and not made from the patient-centered perspective	✓ Health care decisions based on Mattie’s needs and preferences
✗ Serious consideration for nursing home placement; Medicare/Medicaid only pays for very limited home health aide services	✓ Availability of flexible, non-medical benefits that help Mattie stay in her home

Advantage plans (including SNPs), only about 120,000 are in programs that fully integrate Medicare and Medicaid services. This may be partly due to a lack of administrative support or to competing state priorities. It may also be linked to questions regarding what makes SNPs uniquely qualified to care for a high-needs population, particularly since many of these organizations have no prior experience caring for dual eligibles.

Indeed, several small, non-profit entities have sought to demonstrate how SNPs can be designated “special.” These “Model SNPs” generally have local, community-based roots, which enable them to tailor care packages to beneficiaries’ needs rather than relying on one-size-fits-all approaches.¹¹ Most of them also use Medicare and Medicaid capitation payments flexibly to create medical/behavioral/long-term care homes for beneficiaries and seek consumer involvement in program governance and design. Finally, these programs are more likely to reinvest the savings from avoiding unnecessary hospitalizations and institutionalizations to strengthen community-based services.

Alternative Models for Integration

While some states are working to integrate care through SNPs, capitated managed care is not feasible in every state or region. For example, in rural areas it is often a challenge to get sufficient plan and provider network participation. States, particularly those with a strong primary care case management infrastructure, are beginning to explore alternatives for integrating care for duals. Gainsharing demonstrations and what is referred to as a “Medicaid Duals Demonstration” (see Figure 2) are two relatively new alternatives that could ultimately offer states and/or other organizations significant new opportunities to develop integrated programs. Through these options, the state could work alone or with an entity (e.g., provider group or administrative service organization) to provide Medicare and Medicaid services at

Figure 2: Potential Alternative Vehicles for Integrating Care*

Vehicle	Description
Gainsharing Demonstration (e.g., Section 646 of the Medicare Modernization Act)	Physician groups, integrated health systems, or regional coalitions join together and use an alternative payment system to support integration of services for dual eligible beneficiaries on a fee-for-service basis (e.g., provider network receives a per member per month fee for enhanced care management benefits and a portion of the resulting Medicare savings are reinvested in the project or for coverage expansions).
Medicaid Duals Demonstration	State with a well-established infrastructure for health plan/insurer functions (e.g., network development, claims payment, utilization management, etc.) receives Medicare funding and assumes risk for managing the Medicare and Medicaid benefit (directly or via contract/arrangement with an external entity that may or may not be at risk).

**Examples are not meant to serve as an exhaustive list of options.*

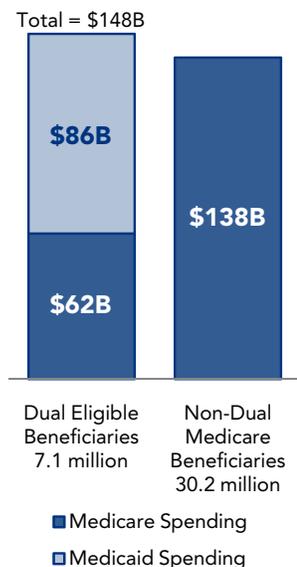
varying levels of financial risk, including a mechanism for sharing in any resulting savings.

Challenges to Integration

Despite interest among states, a number of challenges impede them from developing and implementing both SNP and new alternative models of integrated care. These include:

- Administrative/Operational Challenges.** The administrative complexities in Medicare and Medicaid regulations and policies make it difficult for states and SNPs to integrate benefits for duals. There are ambiguities and/or conflicts in a number of areas, including marketing and enrollment; rate setting and financing; grievances and appeals; and performance monitoring and reporting. States interested in alternatives may face obstacles in securing the necessary waiver or demonstration authority from CMS. In addition to the investments of time and resources needed to complete the waiver process, stakeholders may need new information systems to ensure real-time exchange of data among all those responsible for the care of dual eligibles.

Total Medicare and Medicaid Spending for Dual Eligibles vs. Other Medicare Beneficiaries, 2003



Source: KCMU and Urban Institute estimates based on MSIS-MCBS 2003 linked file.

- Financial Misalignment.** Because Medicare covers the majority of medical care for duals, Medicaid programs that invest resources in improving care for duals may not see short-term returns on their investments. Rather, financial benefits achieved through reductions in Medicare-covered inpatient or emergency room services flow almost exclusively to the federal government or to SNPs. New mechanisms to ensure that both Medicare and the states could share in short- and long-term savings would facilitate more rapid adoption of integrated care models.
- Low Enrollment.** Although integrated care programs can help dual eligibles more effectively access their health care benefits, enrollment is low in most programs. This may be due, in part, to voluntary enrollment. While states can mandate Medicaid program enrollment, Medicare is voluntary due to the freedom of choice requirement. Poor consumer engagement may also result from often complicated SNP enrollment processes as well as inadequate communication to consumers regarding the benefits of integrated programs.
- Forging State-SNP Relationships.** Relatively few contracts have been established between states and SNPs. To begin to address this issue, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included a requirement that new or expanding dual eligible SNPs develop a contract with a Medicaid agency by 2010. Yet, although well intentioned, many ambiguities remain, including specific contracting requirements and problematic timing issues. Information sharing is another critical means to improve relationships between states and SNPs. Although the 2008 and 2009 SNP applications require plans to provide information to Medicare regarding their model of care and to develop care plans for beneficiaries, this information is not currently shared with states.¹² Promoting this ongoing dialogue between states and SNPs could ensure

that programs are tailored to meet beneficiaries' complex needs.

- Developing and Bringing Model SNPs to Scale.** Model SNPs are typically provider-sponsored organizations adept at managing care for the frail elderly and people with disabilities, but often have little to no experience as Medicare insurers. By entering the SNP market, many of these plans have to become insurance companies for the first time, requiring access to capital, significant operational infrastructure, and knowledge of the Medicare world.

Policy Implications

While there have been a number of attempts to foster more widespread and "scaleable" integration for dual eligibles over the years, there has been limited progress in improving the coordination and cost-effectiveness of care for this high-need, high-cost population. Policymakers seeking to support integrated care programs can consider the following steps:

- Expand the options for integrating care beyond those currently available to states.** Congress and CMS can provide greater authority for testing innovative alternatives in states where SNPs are not active and duals are served by the Medicare fee-for-service system. In particular, new alternative options for integration can be supported through grants, enhanced match, demonstrations or pilots, streamlining waiver requirements, etc.
- Enable Medicare and Medicaid stakeholders to share savings generated from the integration of services for dual eligibles.** Congress and CMS can support mechanisms (e.g., Section 646 of the Medicare Modernization Act) that would enable states, plans, and the federal government to share savings (e.g., from reduced emergency department and inpatient use) generated from integrating primary, acute, behavioral, and long-term supports and services for duals.

- **Create avenues for consumers to declare what they want and/or need from integrated care programs.** States and SNPs can create vehicles for capturing consumer preferences, raising consumer awareness, and building consumer demand for well-coordinated, patient-centered systems of care.
- **Eliminate administrative barriers preventing integrated care from achieving its potential.** CMS can work with states to further streamline conflicting Medicare and Medicaid policies and procedures in areas such as marketing, quality reporting, and grievances and appeals. One idea being discussed is the creation of an office to coordinate care for dual eligibles within CMS that establishes one place to go for policies, procedures, and tools to support integration.

Particularly now, with the nation committed to achieving meaningful health care reform, there is an unprecedented window of opportunity for policymakers to confront the administrative, financing, and statutory barriers that hinder integrated care for dual eligibles. Indeed, people who are dually eligible for Medicare and Medicaid are among the country's most chronically ill and costliest health care patients. Addressing their complex needs more effectively and aligning payments to support better care can significantly improve the lives of more than eight million Americans and go a long way in curbing the ever-escalating Medicaid and Medicare costs for taxpayers.

This policy brief and CHCS' ongoing efforts with states and CMS to support integrated care for dual eligibles are made possible through support from The Commonwealth Fund.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is working directly with states, health plans, and federal policymakers to develop and support programs that integrate care for adults who are dually eligible. To learn about CHCS' *Transforming Care for Dual Eligibles* initiative or to download resources from "Designing Integrated Care Programs: An Online Toolkit," visit www.chcs.org.

Endnotes

- ¹ J. Holahan, D. M. Miller, and D. Rousseau. "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005." Kaiser Commission on Medicaid and the Uninsured, February 2009.
- ² The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted in July 2008.
- ³ *Report to Congress: New Approaches in Medicare*. Medicare Payment Advisory Commission, June 2004. http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf
- ⁴ Ibid.
- ⁵ J. Holahan, et al., op cit.
- ⁶ *Healthcare Spending and the Medicare Program, A Data Book*. Medicare Payment Advisory Commission. June 2008. <http://www.medpac.gov/chapters/June08DataBookSec3.pdf>
- ⁷ CHCS estimate based on *Healthcare Spending and the Medicare Program, A Data Book*, Medicare Payment Advisory Commission, June 2007; and J. Holahan, et al., op. cit.
- ⁸ Case study from Robert J. Master, MD, Commonwealth Care Alliance, Massachusetts.
- ⁹ The MMA established SNP authority through 2008 and recent legislation extended that authority through 2010. Proposed legislation may extend authority through 2013.
- ¹⁰ C. Milligan and C. Woodcock. *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer*. The Commonwealth Fund, February 2008.
- ¹¹ For a "Model SNP" example, see the Commonwealth Care Alliance, a not-for-profit care delivery system in Boston launched in 2003; visit <http://www.commonwealthcare.org/index.html> for a program overview.
- ¹² The 2008 and 2009 SNP applications asked applicants to provide a model of care, defined as "the applicant's proposed approach to providing specialized care to the SNP's targeted population, including a statement of goals and specific processes and outcome objectives for the targeted population to be managed under the SNP, and differentiates how this plan has added value for special needs populations when compared to other MA plans."