

# Dual Eligibles: State Imperative and Federal Opportunity

Barbara Coulter Edwards

Principal

January 16, 2009

# The Truth About MediCAID

---

- About 25% of total Medicaid enrollment consists of people who qualify because they are low income and are aged, blind or disabled (ABD).
- The ABD population accounts for 70% of total spending in MediCAID.

# The Truth About MediCARE

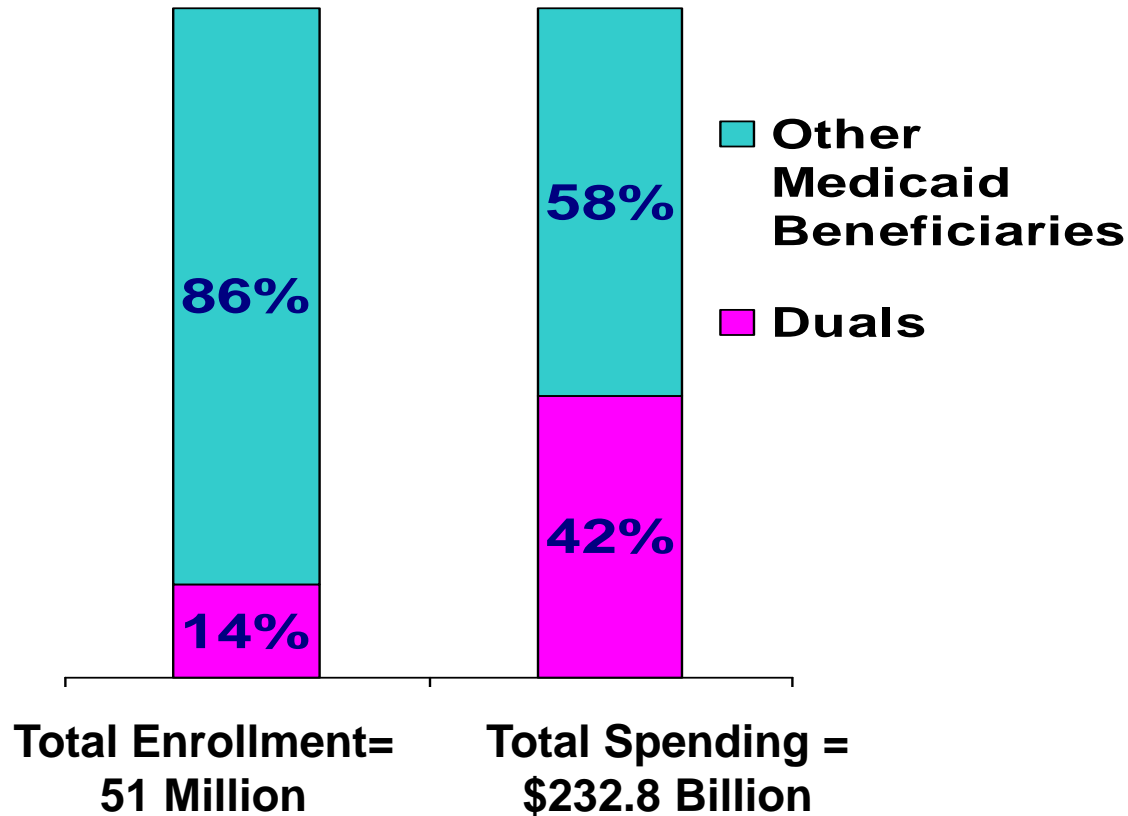
---

But an “already insured” subset of ABD  
drives 40% of total MediCAID spending:

*ABD who are dually eligible for MediCARE*

# Medicaid Fills the Holes in Medicare

## Dual Eligibles as Percent of Medicaid 2002:



SOURCE: Medicare data - KFF analysis of MCBS 2002 Cost and Use File. Medicaid data - KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

# The Problem

---

We identified the sickest, most vulnerable and most expensive population - people who are:

- Poor and aged
- Poor and frail, disabled, chronically ill
- Low income and needing long term care

# The Problem Compounded

---

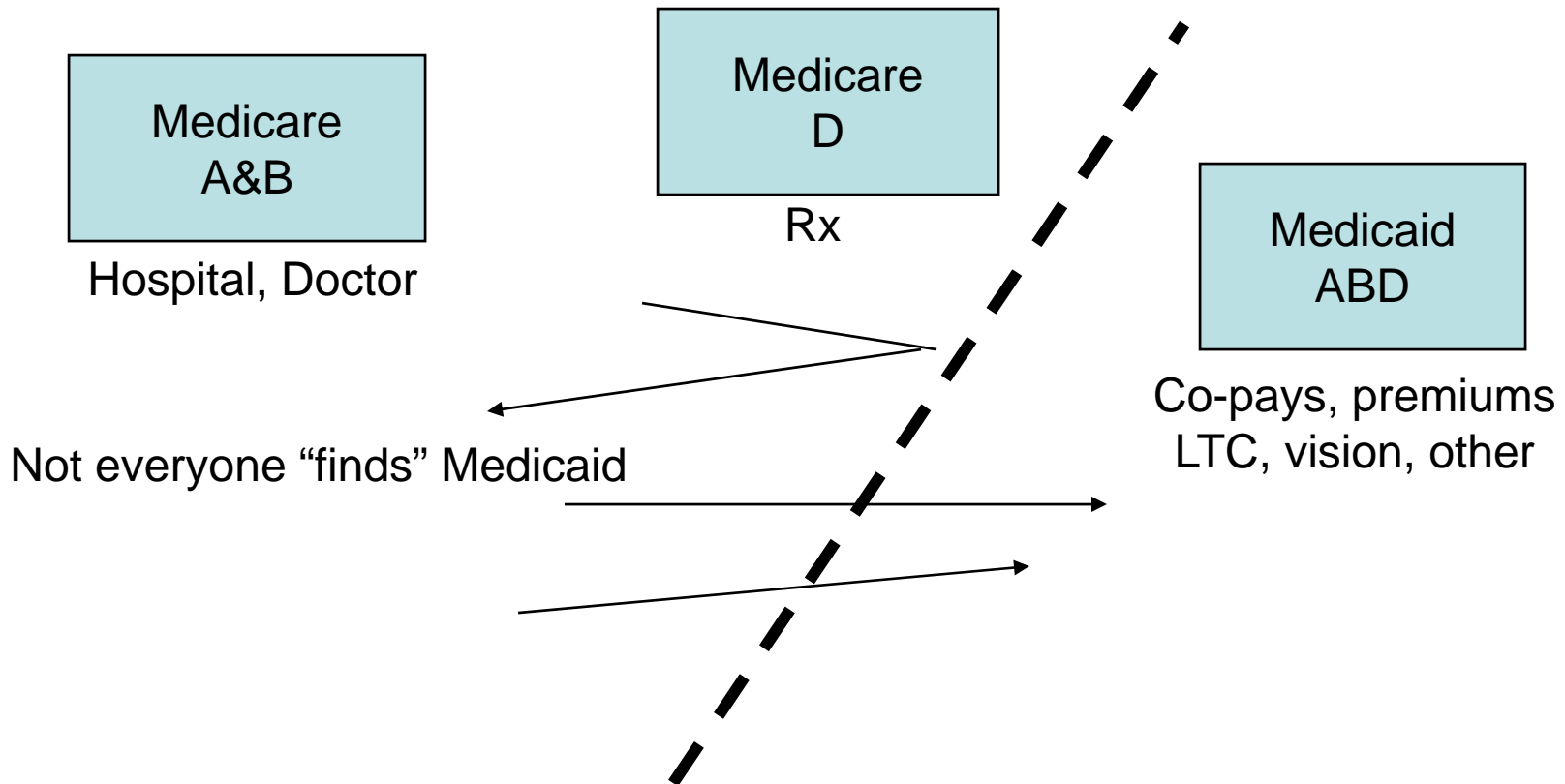
And then we designed a system of health coverage that requires these poor, old, frail and/or disabled people to navigate two separate, uncoordinated government health programs to get the care they need.

## **Result?**

They're the least likely to have coordinated, cost effective care.

# Beneficiaries' Perspective

3 health ID cards - no coordination



# States' Perspective

---

Cost of duals to MediCAID is “uncontrollable”

LTC is biggest cost of duals; people develop the need while covered by MediCARE

- How much is preventable with better primary and acute care?

Rx for duals still partially a state cost (state payments are revenue to MediCARE)

- States no longer have control of Rx costs/use

# States' Perspective

---

MediCARE “cost controls” are often cost-shifts to MediCAID

- Rising co-pays, premiums - QMB, SLMB
- MediCARE benefit limits (therapy, MH, home care)

Is CMS sometimes missing one “M”?

# State Imperative

---

Growth in the cost of treating chronic, disabling conditions is major driver of MediCAID state budgets over time

- Medical inflation, aging population

States must gain better control over these costs to sustain MediCAID program for all populations

- Especially true if states are expected to play a role in covering the uninsured

# Barriers to Care Coordination - Duals

---

Financial incentives not properly aligned

- CMS hasn't allowed states to count MediCARE savings toward "budget neutrality" on 1115 waiver reforms

MediCAID is secondary payer – hard for “tail to wag the dog” re: improved primary and acute care

MediCARE doesn't share timely data on duals with states

# Results - Care Fragmentation

---

Many states have begun to enroll ABD population into managed care plans - but most exclude duals

- Can't mandate MediCARE managed care - Freedom of Choice

Younger ABD enroll in MediCAID managed care while in pre-MediCARE “waiting period” - then disenroll once MediCARE eligible

# State Use of SNP Contracts

---

Some states have contracted with  
MediCARE SNPs

- Encourage managed care, coordination
- Prevent, delay need for long term care with better managed primary, acute care
- Manage long term care
- Access to MediCARE data
- Maximize value of MediCARE benefits

# Challenges re: SNPs

---

MediCARE and MediCAID managed care regulations are different

- enrollment, grievances, fair hearings, marketing

Cost of start up for states

- actuaries, amended regulations to accommodate MediCARE, procurement, public input, federal negotiations, IT modifications

# Challenges re: SNPs

---

## Can't mandate MediCARE enrollment

- Only a portion of duals end up with both MediCARE and MediCAID in one managed care plan

## New Mexico statewide waiver for long term care, contracting with SNPs

- Mandatory enrollment for MediCAID
- Expect less than 10% penetration on MediCARE side
- Complicated for health plans, reduces savings

# There's Potential Here, But...

---

Study published by Association of  
Community Affiliated Plans (ACAP)

- MediCARE savings accrue quickly from enrolling duals in SNPs/managed care
- MediCAID savings (from reduced LTC) accrue over several years
- MediCAID start-up costs therefore create a barrier to state adoption

The Lewin Group, *Increasing Use of the Capitated Model for Dual Eligibles*, 11/08

# Proposals for Duals

---

NGA (2007) proposed “federal government should assume full financial responsibility for duals”

- Simplified administration of enrollment, low income subsidies for maximum beneficiary participation
- Align financial incentives for care management
- But means new costs and benefits under MediCARE (LTC, etc.)

NGA HHS-27, *Medicaid Reform Principles*, 3/5/07

# Proposals for Duals

---

## Galen Institute (2007): Create MediCAID

Advantage – duals as “first focus”

- Allow duals to participate in single program, *designed, managed by states* or state- contracting private plans.

Federal role – set and monitor goals, pay risk-adjusted MediCARE capitation

Turner, GM, Helms, R, *Medicaid Advantage: A medical home for dual-eligible beneficiaries*, 3/30/07

# Proposals for Duals

---

Other policy reforms to encourage dual managed care:

- Allow state flexibility re: geographic areas, populations
- Allow mandatory enrollment (MediCARE & MediCAID) or an “opt-out” option
- Share savings 50/50 between state and CMS
- Assure strong federal and state oversight

# Federal Opportunity

---

There are real, immediate federal savings to gain from improved care coordination for Duals.

Improved coordination brings improved quality, outcomes, service for beneficiaries.

States are interested, especially if they can offset up-front administrative costs

# Federal Opportunity

---

Incentivize states as partners:

- Share early federal savings
- Count MediCARE savings toward MediCAID waiver budget neutrality
- Simplify the process by allowing MediCARE flexibility (enrollment, regulations)
- Share timely data on duals