SUBMISSION TO THE PIONEER INSTITUTE’S 2012 BETTER GOVERNMENT COMPETITION

BY GRACE-MARIE TURNER, GALEN INSTITUTE AND ROBERT HELMS, PH.D., AMERICAN ENTERPRISE INSTITUTE

PROVIDING IMPROVED CARE MANAGEMENT FOR MEDICARE/MEDICAID DUAL-ELIGIBLE BENEFICIARIES

Medicaid’s historic and most important job is to take care of the nation’s most vulnerable and truly needy citizens. Changes are needed so the program has the resources to continue to meet that challenge. And, because Medicaid expenditures represent a large and growing share of state budgets, taxpayers need assurances that the money is being spent to get the best value for the dollar.

An important group for policymakers’ attention should be those who need Medicaid the most, those who have the fewest resources to receive care outside the program, and those who consume the greatest share of Medicaid’s resources. That would suggest that those dually eligible for Medicare and Medicaid should be the first focus of attention.

Medicaid will be most effective if these patients are managed at the state and local level. To achieve that goal, changes are needed in federal Medicaid policy to adopt new incentives to implement more flexible and more effective care-coordination and disease-management programs for recipients, especially those with disabilities and chronic illnesses.

Dual eligibles are Medicaid’s most vulnerable recipients, yet they often fall into a fragmented care delivery system that perpetuates episodic rather than coordinated care. Patients may have difficulty accessing the medical care they need, and information about their care can be scattered among providers and facilities facing two or more different payment systems and sets of program rules.
More than nine million Medicaid recipients (15%) are dual eligibles, accounting for 39% of Medicaid spending. On average, total spending for duals, including Medicare and Medicaid contributions, is twice as high as that for non-duals -- $28,518 compared to $14,204. Most dual eligibles have very low incomes, substantial health needs, and are more likely to live in nursing homes compared to other beneficiaries. Long-term care services account for the majority (69%) of Medicaid expenditures for dual eligibles.

Because physicians and others treating these patients often don’t have the patient’s complete medical profile, patients can face gaps as well as duplication in treatments with no one to help coordinate their care. In addition, providers are paid for procedures, regardless of outcomes and without rewards for improving quality. This leads to worse care for patients and a waste of taxpayer dollars.

**Our expertise**

Grace-Marie Turner and Robert Helms served on the federal Medicaid Commission from 2005-2006, attending more than 14 hearings. In many of them, patients and state officials testified about the need for better-coordinated care for dual-eligible patients. We heard numerous examples of state experiments that provide better care and lower costs and were convinced that policy changes are needed to facilitate more such programs. In this paper we outline the changes that would be required in federal programs and financing to facilitate improved systems of care for millions of the most vulnerable patients on the Medicaid and Medicare programs.

Some of the ideas that we offered in the initial policy proposals, which we summarize below, have been adopted in an early demonstration program by the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. One of our fellow commissioners from the Medicaid Commission, Melanie Bella, is the new director of the Office and is very familiar with our policy recommendations.

So far, 25 states, including Massachusetts, have notified Washington they are making plans to participate in the new federal demonstration program which Ms. Bella is directing to facilitate integrated care for dual-eligible beneficiaries. The goal is to develop “person-centered models that promote coordination missing from today’s fragmented system.” (A meeting was held in Boston on February 16, 2012, to discuss the specifics of care coordination.)

While describing the details of the new federal program is outside the scope of this paper, we will describe our larger vision for care coordination, components of which are being implemented by the Medicare-Medicaid Coordination Office. We outline our vision and the core recommendations for changes in federal health policy which we believe will allow dual-eligible patients to get better care by giving states more resources and flexibility involving their care. Much work remains to be done.
The goal

A comprehensive program that integrates Medicare and Medicaid coverage allows providers to focus on the best way to design and provide benefits to dual-eligible beneficiaries so they receive the right care in the right setting.

New funding mechanisms must be tied to the success of providers and health plans in coordinating patient care, gathering sharable information on the patient’s medical care, and giving patients more information so they can be partners in managing their health.

Coordinated, patient-centered care, facilitated by electronic data gathering, would provide an important foundation to improve the quality of care. This new program would offer dual-eligible recipients a medical home where they can receive a seamless continuum of medical care and care management under one program.

An integrated Medicare and Medicaid program for dual-eligible beneficiaries would:

- Integrate acute and long-term care benefits into a single program they would oversee in which competing private plans (or the states) would provide a coordinated care management program for dually-eligible beneficiaries

- Streamline cumbersome rules governing marketing, enrollment, performance monitoring, quality reporting, rate setting, bidding, and grievances and appeals

- Eliminate redundant and inefficient spending

- Share in the savings achieved through innovative policies, such as disease management and care coordination

- Provide both the federal and state governments more predictability in budgeting for the significant part of their Medicare and Medicaid spending on dual eligibles.

Dual financing for dual eligibles

Dual-eligible recipients would participate in a single program, which we call Medicaid Advantage, where they would receive comprehensive, coordinated care. The states, rather than the federal government, would be the primary managers of the programs.

Medicaid Advantage plans would provide the services currently financed separately through Medicare and Medicaid, including hospitalization and skilled nursing care, physicians’ visits, personal care, home and community based services, prescription drugs, diagnostic and laboratory tests, etc.

The states and the federal government would continue to share the costs of caring for duals, as they do today. The federal government would continue to provide financial
support to the states for Medicare benefits, but through a risk-adjusted, capitated system of Medicare payments. The states would continue to pay their Medicaid portion of the benefit.

States or the plans they select could manage services for dual-eligible beneficiaries. Many states likely would choose to contract with private health plans that would be responsible for providing the full spectrum of Medicare and Medicaid benefits.

In addition, the plans would be responsible for collecting and evaluating treatment and outcomes data and for providing this information to the states. States would, in turn, audit the reports and monitor the plans to make sure that Medicaid dollars are being spent to provide the best quality of care for beneficiaries.

The federal government would set and monitor goals, not micromanage processes, so that the states, in conjunction with health plans, can work to improve the quality of care and design plans to fit the needs of patients.

HOW IT WORKS

The states would have the option of participating in the new Medicaid Advantage program to develop a better system of providing more efficient, coordinated care for their dually-eligible residents.

- Participating states would contract with competing health plans to provide the full spectrum of care for dually-eligible populations and would enroll individuals into these integrated Medicaid Advantage care management plans.

  - Dual-eligible patients could choose from among competing plans.
  - States could decide to automatically enroll dual-eligible patients in a Medicaid Advantage plan if patients do not actively enroll or are not enrolled by a family member or guardian.
  - Patients would have the right to opt-out of Medicaid Advantage and back in to traditional Medicare and Medicaid coverage.
  - Private health plans would participate in a bidding process to offer services in Medicaid Advantage, submitting bids representing their cost of providing Medicare and Medicaid-covered services to dual eligibles as well as other services specified by the states.
  - States would contract with the plans they select to provide care.
  - Medicaid Advantage plans would be required to provide core Medicaid and Medicare services to duals, but states would have more authority and flexibility to tailor benefit packages to the specific needs of patients without having to request waivers.
  - States would closely monitor plans and networks to make sure they meet their contractual obligations, and the federal government would monitor and audit their reports.
States could provide incentives for plans to compete on the basis of quality and value and could reward health plans that provide higher quality care at a reduced price. States could also share in a portion of these savings.

Plans should have flexibility to partner with recipients by offering incentives that encourage patients to participate in their care management.

*States would have the option of managing the care and assuming the risks themselves, as Kentucky is doing with its new KY HealthChoices Medicaid reform plan.

- **Financing:** The states and the federal government would each contribute, as they do today, to the costs of providing services currently financed separately through Medicare and Medicaid for dually-eligible beneficiaries. A new pool of funds would be created that includes federal and state Medicaid contributions plus federal Medicare and Part D contributions. These would be combined into one funding stream to finance care for duals through the new Medicaid Advantage plans.

States would gain new flexibility in designing benefit packages in exchange for receiving a capitated, risk-adjusted payment from Medicare which would have fewer strings attached.

States and the federal government already have some experience with the basic mechanisms that would be needed to calculate payments for this new program. The rate-setting and risk-adjustment systems that Medicare currently uses to pay Medicare Advantage plans and that states use to pay for standard Medicaid managed care programs would provide a foundation for calculating payments.

CMS is developing a system of risk adjustment that includes not only health status but also geographic payment variation, frailty, and other factors which could be employed in this new program. The agency would use its actuarial data and payment history in determining the capitated rate it pays per dual-eligible patient. This funding stream would continue to be updated.

- **There would be three funding streams for the new Medicaid Advantage program:**

  - **Federal Medicare payments**, which are generally provided through Medicare’s defined benefit structure, would be allocated to the states through a new funding mechanism. The federal government would develop a system of capitated, risk-adjusted Medicare payments. Subsidies would be adjusted to avoid selection bias and to assure access and quality treatment to the sickest beneficiaries. These payments would be sent from the federal government to the states to fund the Medicare portion of services for dual-eligible residents. This is not a block grant
because funds would follow each recipient and would be adjusted for that patient’s risk profile.

○ **State funds**: States would continue to pay their share of Medicaid costs. They would have two options in setting their payments for the Medicaid portion of services for their dual-eligible residents:

Those states that decide to contract with private plans to provide coordinated care for their dual populations could calculate an actuarially-sound capitated rate for the state’s share of Medicaid services. The plans, not the state, would be at risk.

Those states that decide to operate the program themselves and assume the risk (as well as potentially garnering more savings) could make contributions based upon their own Medicaid payment experience for services for duals. While many states have experience in setting payments for Medicaid managed care, their experience is primarily with acute care services, not long-term care support. As a result, they would need assistance in calculating these payments to fund their share of Medicaid services for duals.

In either case, a transition period would be required where the federal government and the states would share the risk until they have gathered enough information to refine this new system of payments.

Whether a state chooses to contract with Medicaid Advantage managed care plans or to operate the program itself, it would still receive a federal match for its Medicaid contribution based upon existing formulas.

○ **Drug coverage**, currently paid by Medicare, would be integrated into the Medicaid Advantage plans. Medicare would calculate a Part D allocation that would be returned to each state in the form of a capitated, risk-adjusted payment. This would be another part of the patient’s Medicaid Advantage funding stream.

Since implementation of Part D that assigned duals to drug plans, skilled nursing facilities have had many problems tracking many different drug plans and formularies for these residents. Medicaid Advantage would provide a mechanism to coordinate drug coverage, as well as medical care, through one plan.

States would have access to the pharmacy data that they lost after the transition to Part D in January, 2006.
• Management:

Once the Medicaid Advantage plan has agreed on a contracted fee, the plans contracted by the states would be at risk for providing care to dual eligibles (except for those states that decide to carry the risk themselves). The plans or state contractors would be responsible for providing care, for collecting and providing performance data on treatments and outcomes for each patient, and for reporting this information to the states for their monitoring activities. These plans would be accountable for outcomes with close oversight by the states, but they would have greater flexibility to provide the care that meets the needs of patients.

The federal government and the states would be responsible for carefully monitoring the plans and for bringing action against plans that do not meet their contractual obligations.

Improving quality of care for dual eligibles is an important goal of this new Medicaid Advantage proposal. But in order to pay for quality, we first must be able to measure it. Therefore, payments to Medicaid providers should be tied to objective measures of medical outcomes. To make outcome measurements fair, risk adjustments must be incorporated into the measurements so medical professionals are not discouraged from accepting higher risk patients.

Particularly challenging are managing patients with serious and chronic mental illness. Providing targeted case management, rehabilitation services, medication management, community mental health center services, and other less-costly services through a Medicaid Advantage medical home could reduce the use of expensive hospital and emergency room services while providing improved care for these patients.

An integrated program would minimize the current incentive for providers to avoid caring for the most costly patients and would better align incentives for Medicare, Medicaid, and plans to provide the best care for recipients.

The future

We believe that the best control over health care decisions is through doctors and patients. State and local governments that are closer to patients are in a better position to facilitate delivery of better-coordinated care. But even more policy changes are needed at the federal level to loosen the regulatory reins and give states more control over resources so they can develop programs to better serve patients. The policies we have outlined here already are providing a roadmap to state and federal officials to facilitate these changes, and we look forward to working with the Pioneer Institute and sister organizations in states throughout the country to refine them further.

Thank you for considering our submission to your Better Government Competition.


4 AZ, CA, CO, CT, HI, IA, ID, IL, MA, MI, MN, MO, NC, NY, OK, OH, OR, RI, SC, WA, WI, TN, TX, VA, and VT.