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Medicaid Advantage:

A medical home for dual-eligible beneficiaries

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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. Any changes should respect the strengths of the program today and also recognize the challenges it faces in the future.

MEDICAID: THE SAFETY NET

Medicaid began as an afterthought to the legislation creating Medicare in 1965 but has since grown to be the largest health care financing program in the United States. Medicaid served an estimated 60 million people in 2006¹, and local, state, and federal governments spent an estimated \$320 billion on the program last year.²

Medicaid provides a safety net for our health care system, and millions of people with low incomes and disabilities see it as a lifeline. It fills gaps in our private health sector that is dominated by employment-based health insurance, picking up millions of people who do not qualify for or cannot afford job-based coverage.

Because Medicaid is a joint federal-state program, it benefits to some extent from the principles of federalism, allowing Medicaid to be more flexible than

Medicaid Advantage

This proposal outlines a new Medicaid Advantage program that would integrate acute and long-term care benefits for dual-eligible beneficiaries into a single program, managed by the states, to provide a medical home and better coordinated care for beneficiaries.

Medicare. States have used this flexibility to experiment with ways to better meet the needs of their citizens.

THE CHALLENGES FACING MEDICAID

While Medicaid has strengths, it also faces many challenges. The program is primarily intended to cover the poor and medically needy, but over time it has evolved to cover many people with lower-middle and middle incomes -- while still denying coverage to many people who are much poorer. The program also pays nursing home care bills for many middle- and even upper-income elderly.³

In addition, Medicaid has expanded coverage into higher income levels in some states, discouraging workers from participating in private, employment-based coverage and adding to taxpayer burdens to pay for coverage that could have been financed privately.⁴ For others, Medicaid eligibility is a disincentive to work. Eligibility is designed as a cliff that encourages recipients to stay on the program rather than to move gradually into productive employment and private coverage.

Those who are eligible for Medicaid have a very rich entitlement to benefits but often have trouble finding private physicians who will see them. Recipients are often relegated to Medicaid factories or to crowded hospital emergency rooms to receive medical care. And when they do get care, it is often uncoordinated among the physicians, clinics, and hospitals where they receive treatment.

While the federal-state partnership provides Medicaid with some limited benefits of federalism, states' flexibility is constrained by extensive rules and regulations which force them to go through long, complex, and time-consuming appeals to request program changes intended to better meet the needs of their citizens.

In addition, political leaders too often focus on how much Medicaid is spending and not on whether the money is being spent wisely to produce the best outcomes.

The growth in costs is a major threat to the financial future of Medicaid, and the funding formula is skewed to put both states and the federal government into financial straightjackets.

The Federal Medicaid Assistance Percentage (FMAP) is the financing formula through which the federal government shares the cost of Medicaid with each state. The federal government pays at least half and sometimes as much as 76 percent of a state's Medicaid costs. Because of FMAP, states do not bear the full cost of each additional dollar they spend on Medicaid, and states are thereby encouraged to expand Medicaid benefits and enrollment. In addition, when there is a downturn in the economy and state revenues decline, the states still face pressures to continue to provide coverage for these expansion populations while bearing

new expenses from additional citizens entitled to benefits because their economic condition has deteriorated. Further, even though poorer states receive a larger percentage FMAP, the wealthiest states still collect the largest dollar-per-capita match. FMAP has the perverse result of directing more federal resources to states with wealthier populations than to poorer states.⁵

Clearly, Medicaid needs to be modernized to address these problems and allow it to meet future challenges.

THE KEY QUESTION

But before making changes to Medicaid, policymakers would do well to make clear decisions about the role of Medicaid in the health sector of the future.

It is increasingly clear that Medicaid's problems cannot be solved with one set of solutions. Medicaid is trying to fill many gaps resulting from huge changes in our society, from economic changes that mean fewer workers receive health insurance through their jobs, to changing family structures that mean aging parents are cared for in institutions rather than at home.

We believe that solutions should respect the value of federalism, move toward simplification, and put the program on a path toward financial sustainability. Solutions also must be targeted so that Medicaid addresses more effectively and efficiently the distinctive needs of different populations.

FIRST PRIORITIES

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

Almost 7.5 million Medicaid recipients (14%) are dual eligibles, accounting for 40% of Medicaid spending.⁶ On average, total spending for duals, including Medicare and Medicaid contributions, is more than twice as high as that for non-duals -- \$20,941 compared to \$11,377.⁷ Most dual eligibles have very low incomes, substantial health needs, and are more likely to live in nursing homes compared to other Medicare beneficiaries. Long-term care services account for the majority (66%) of Medicaid expenditures for dual eligibles.⁸

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.

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.

Tomorrow's Medicaid programs will be most effective if they are managed at the state and local level in order to be as close to the patient as possible. To achieve that goal, Medicaid must 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.

A comprehensive program that integrates Medicare and Medicaid coverage would allow 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 should 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 paper will outline a new *Medicaid Advantage* program that would offer dual-eligible recipients a medical home where they can receive a seamless continuum of medical care and care management under one program.

EARLY SUCCESS IN THE STATES

The Medicaid Commission, on which we served in 2005-2006, heard numerous testimonies demonstrating the creativity of state and local governments in developing programs to target services to their vulnerable dually-eligible residents, often through contracts with private health care organizations.⁹ Cost-effectiveness studies of state Medicaid coordinated care programs have demonstrated that they generally save states money while providing better access to care for recipients.¹⁰

Vermont obtained a waiver to fine-tune delivery of long-term care services and demonstrated that better care can be provided more cost-effectively in appropriate settings when solutions are tailored to individual needs. We heard about similar examples in New York, Massachusetts, Arizona, and other states.¹¹

States are much more adept at tailoring these programs to their citizens than the Federal government because they are closer to the people being served and are more familiar with patients' needs and the resources of the community to meet those needs. But states are not able to shoulder the full financial burden of providing these services. Continued Federal funding is essential.

OTHER OPTIONS FOR COORDINATED CARE

The federal government has recognized the need to better integrate care for dually-eligible populations and has developed several programs as a result. The Program for All-Inclusive Care for the Elderly (PACE), targeted waivers, and Special Needs Plans (SNP) are the primary Medicare programs designed to achieve this goal.

- PACE is a capitated benefit program authorized by the Balanced Budget Act of 1997 and developed to provide better coordinated long-term care for Medicare and Medicaid recipients who have been certified as eligible for nursing facility care.¹² PACE enables states to provide defined services to Medicaid recipients as a state option, and Medicare and Medicaid funds are integrated to allow a contracted plan to provide the care.

The state plan must include PACE as an optional Medicaid benefit before the state and HHS can enter into a program agreement with PACE providers.

While the program has had some success, it is a Medicare program with a Medicaid option and has not been widely adopted. And the BBA limits the number of PACE programs that may be implemented annually. As of March 2007, there were 36 PACE sites in the U.S. serving limited geographic areas.¹³

- Waivers: Several states (Massachusetts, Minnesota, and Wisconsin¹⁴) obtained waivers to combine Medicaid and Medicare funds to purchase health care services for dually-eligible populations. But the waiver negotiations each took several years, limiting the appeal to other states interested in using this approach.
- Special Needs Plans. The Medicare Modernization Act created a new coordinated care option called Special Needs Plans as part of the Medicare Advantage program.¹⁵ SNPs are distinct from regular Medicare Advantage plans in that they can enroll a group of individuals with “special needs,” such as 1) institutionalized beneficiaries; 2) beneficiaries with severe or disabling chronic conditions; and 3) dual eligibles.

SNPs are able to offer a full array of medical services, including supplemental benefits, through a single plan with a single benefit package and set of providers. Medicare Advantage payments to SNP plans are risk adjusted based upon beneficiary health conditions, dual eligible status, disability eligibility, and institutional status.

In 2006, 276 SNPs are available, with more than 500,000 enrollees, including 440,000 dually-eligible beneficiaries.¹⁶

Absent other legislation, SNP authorization in the MMA will sunset in December of 2008.

But even with these programs, the Federal government – through the Centers for Medicare and Medicaid Services – still is in control of decisions for PACE, state plan waivers, and SNPs, providing states much less flexibility than if they were running the plans themselves. For example, states must get authorization to put a dually-eligible patient into a managed care plan – an unnecessary administrative hurdle.

Some people have called for Medicare to take full responsibility for duals, but this centralization would move away from, rather than toward, more finely-tuned care for this vulnerable population. States need more flexibility than Medicare's top-down system of rules can provide for patients requiring tailored care and services. Several states have demonstrated that they are up to the task of providing care that is managed at the patient level, and states' requests for more flexibility in managing dual-eligible populations suggest that many more would follow given the proper incentives and program flexibility.

RECOMMENDATION FOR A NEW MEDICAID ADVANTAGE PROGRAM

The new *Medicaid* Advantage we are proposing would allow dual-eligible recipients to participate in a single program where they would receive comprehensive, coordinated care. *Medicaid* Advantage would be modeled after the Medicare Advantage program, but with states rather than the federal government as the primary managers of the programs. In summary:

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.

MECHANISMS

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 *Medicaid Advantage* 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 participate in the program.
 - *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. While current risk adjustment procedures are far from perfect, present systems do provide a foundation to begin. Moving forward, the states and the federal government should work together and do additional research to improve the effectiveness of these adjustments. In the process of encouraging better outcomes, however, medical professionals should not be discouraged from accepting higher risk patients with more complex medical needs.

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.

USING INCENTIVES TO GET BETTER OUTCOMES

Medicaid Advantage would minimize the current incentive to avoid caring for the most costly patients and would better align incentives for Medicare, Medicaid, plans, and recipients. Medicaid Advantage would allow states to:

- 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
- Share in the savings achieved through innovative policies, such as disease management and care coordination
- Streamline cumbersome rules governing marketing, enrollment, performance monitoring, quality reporting, rate setting, bidding, and grievances and appeals
- Eliminate redundant and inefficient spending
- Provide both the Federal and state governments more predictability in budgeting for the significant part of their Medicare and Medicaid spending on dual eligibles.

Expansion of coordinated care programs is key to improving the quality of care for these Medicaid patients. New Medicaid Advantage plans would be close to the patient, collecting and evaluating treatment data and results to make sure patients are getting appropriate care and that Medicaid dollars are being well spent. That means setting goals, not micromanaging processes, and allowing health plans to determine how to improve quality by adapting care to individual circumstances and needs.

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ENDNOTES

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