Going The Distance To Improve The Care Span: The “Duel” Over The Dual Eligibles And The Implications For Health Reform

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This presentation at a glance

- The “Care Span” – definitions

- Dual eligibles debate as Ground Zero and test case for how quickly reforms can or should proceed

- State demonstration projects: plans and prospects

- Concerns raised by broad group of stakeholders

- Debate as “proxy war” for larger issues of Medicare and Medicaid reform, now playing out over some of nation’s most vulnerable people
The “Care Span”

- Our ongoing series of articles
- June 2012 thematic issue
- Chronic care, acute care, and long-term services and supports
- Delivered to elderly and the mentally and physically disabled, up to and including death
Care Coordination/Avoidable hospital use

- Advanced Illness/End of Life

- Half of older Americans (51%) visited emergency department in last month of life; 77% of those seen in ED admitted to hospital

- 68% of admitted died in hospital

- Americans’ broad preference is to die at home

- Emergency department use in last month of life rare when enrolled in hospice one month before death

Source: Alexander K. Smith et al, “Half of Older Americans Seen In Emergency Department In Last Month of Life; Most Admitted To Hospital, And Many Die There,” Health Affairs, June 2012
Innovations: Acute Care for Elders Units (ACE)

- Specially designed hospital units; at Mount Sinai Medical Center in NYC, it’s mobile (deployed to patients wherever located in hospital)

- Care delivered by interdisciplinary teams including geriatricians, advanced practice nurses, social workers, pharmacists, physical therapists

- Key interventions include medication reconciliation and reduced use of catheters

- Results from randomized controlled trial: hospital length of stay 6.7 days versus 7.3 days for controls

- Lower inpatient costs: $9,477 per patient versus $10,451

- Source: D Barnes et al, “Acute Care For Elders Units Produced Shorter Hospital Stays At Lower Costs While Maintaining Patients’ Functional Status.” Health Affairs, June 2012, pp. 1227 ff.
Coordinated Care

- Evaluation of Medicare Coordinated Care Demonstration Project*

- Four of eleven programs reduced hospitalizations by 8–33 percent among enrollees who had a high risk of near-term hospitalization.

- What worked: when care coordinators
  - supplemented telephone calls to patients with frequent in-person meetings;
  - occasionally met in person with providers;
  - acted as a communications hub for providers;
  - delivered evidence-based education to patients;
  - provided strong medication management;
  - provided timely and comprehensive transitional care after hospitalizations.

Articles About the Dual Eligibles, June 2012 Issue

- “The Coming Experiments in Integrating and Coordinating Care for ‘Dual Eligibles’” – Harris Meyer
- “There is Little Experience and Limited Data To Support Policy Making On Integrated Care for Dual Eligibles” – Marsha Gold et al
- “Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans” – Patricia Neuman et al
- “Users of Medicaid Home And Community-Based Services Are Especially Vulnerable To Costly Avoidable Hospital Admissions” – R. Tamara Konetzka et al
The Dual Eligibles

- More than 9 million people enrolled in both Medicare and Medicaid

- Heterogeneous group of low-income people, including
  - 5.6 million seniors; elderly and disabled
  - 5.7 percent of duals have Alzheimer’s
  - 3.6 million younger people with physical or mental disabilities
  - 34 percent of duals have a mental illness; majority have multiple chronic illnesses
  - Sometimes institutionalized; most live in community
  - More than ½ have incomes below $10,000 a year
Distribution Of Dual-Eligible Beneficiaries, By Selected Characteristics, 2008.

Neuman P et al. Health Aff 2012;31:1186-1194

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Distribution Of Spending For Dual-Eligible Beneficiaries, By Service, 2008.

Neuman P et al. Health Aff 2012;31:1186-1194
Duals as Poster Children for Fragmentation of US Health Care

- Overlapping benefits
- Fragmented financing between federal and state governments
- Skewed incentives; avoiding hospitalizations saves money for Medicare but not Medicaid
- More than $6.4 billion spent annually on hospitalizations for preventable conditions, e.g., pressure ulcers
- Fewer than 1 percent are in integrated care delivery systems, including Special Needs Plans integrated with Medicaid, or Program of All Inclusive Care for the Elderly (PACE)
- More than 4 in 5 duals are in fee-for-service Medicare or Medicaid and a standalone Medicare prescription drug plan
Case In Point

- *Health Affairs* Blog Post by Robert Master of Commonwealth Care Alliance, October 22, 2012

- Greatest opportunity for improvement concentrated in “20 percent of duals with high needs for long term services and supports, accounting for about 60 percent of all expenditures and 72 percent of Medicaid expenditures.”

- Includes individuals with severe physical disabilities, developmental disabilities, serious mental illness, frail and homebound elders with significant difficulties in Activities of Daily Living

- Many also clients of state departments of mental health or developmental services or Area Agencies on Aging support networks
Story of Mary J.

- 36 year-old with cerebral palsy, spastic quadriplegia, severe dysarthria (throat muscle spasticity causing significant speech and swallowing problems), mild intellectual impairments, insulin dependent diabetes and a seizure disorder

- At significant risk for aspiration pneumonia; requires feeding tube to her stomach; frequent insulin adjustments to control blood sugar

- Has lived independently with close family involvement since leaving a state school at age 22
Story of Mary J.

- Has never had a primary care relationship because none suited to her needs exists
- Receives care from an array of specialists
- Frequent hospitalizations for predictable complications, such as pneumonia
- One 14-month stay in a Medicaid-funded post-acute rehabilitation hospital following an episode of pneumonia
- “There are 1.8 million stories like Mary’s out there that create the imperative for the reimagined and redesigned care that is only possible with Medicare and Medicaid integrated financing.”
Costs and Spending
Spending related to dual eligibles

- Medicare is primary payer and covers hospitals, physicians, prescription drugs
- Medicaid covers long-term care and is secondary payer for Medicare-covered services
- In 2008, duals were 20 percent of Medicare population (16 percent now)
  - 31 percent of Medicare program costs (27 percent now)
- 15 percent of Medicaid population (15 percent now)
- 39 percent of Medicaid program costs
- TOTAL CARE COSTS: Approximately $315 billion a year
Innovations under Affordable Care Act

- Federal Coordinated Health Care Office/ now the Federal Medicare-Medicaid Coordination Office

- State demonstrations to integrate care for dual eligible individuals for up to 3 years, beginning in 2013

- 15 states received up to $1 million to support program design

- California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, Wisconsin

- Alignment Initiative to more effectively integrate benefits under two programs; e.g., different coverage standards for those who need durable medical equipment in community
State Demonstration Models: Originally, 2 Categories

- First model

- Plans provide comprehensive coverage to duals and receive single capitated payment based on Medicare and Medicaid health plan rates in given geographic area

- Payment rate must achieve savings for federal government and states

- 20 states expected to participate in model 1
State Demonstration Models: Originally, 2 Categories

- Second model
  - Managed fee-for-service delivery, which may include ACOs or Medicaid health homes for primary care
  - States make up-front investments in management of integrated delivery systems and in home- and community-based care
  - Medicaid programs share savings that accrue to Medicare
  - Six states expected to participate in model 2
  - Two states pursuing both models (Washington and New York)
States’ Plans for Duals

Key:
- Light blue – capitated managed care
- Dark blue – managed fee-for-service
- Green – both
- Maroon – not pursuing demo

Source: National Senior Citizens’ Law Center
CMS has signed Memorandums of Understanding with Massachusetts and Washington

MOUs expected in 2012 with California, Ohio and Illinois

Negotiations with other states to continue in 2013

Four states (California, Illinois, Massachusetts and Ohio) to start enrollment in capitated plans in 2013

2-3 million duals could now be enrolled, as against CMS’s original projection of 1-2 million
“Duel” Over the Duals

- CMS/Obama Administration, including Medicare-Medicaid Coordination Office
- States and state Medicaid agencies
- Care providers; health plans; integrated delivery systems
- Advocates for seniors and disabled

Melanie Bella, director, Medicare-Medicaid Coordination Office
Concerns

- Very little capacity in existing managed care plans that are equipped to deal with these populations

- Only 20 health plans have experience receiving capitated payments to provide dual eligibles with Medicare and Medicaid services

- Lack of focus by federal government on improving Special Needs Plans

- Fear that plans would not have adequate network of providers serving these beneficiaries
Concerns

- Concern that savings from capitation would not be reinvested in expenditures to improve care management, coordination, etc.

- Concern that enrollees' participation should be voluntary; perhaps encouraged through enhanced benefits, such as additional personal care services.

- Insistence that all enrollees should have option of receiving care from current providers; especially important for home and community based services.
Concerns: Enrollment

- “Passive enrollment” with opt out provision
- Beneficiaries to be assigned to a health plan unless opt out
- “Intelligent assignment” – beneficiaries to be matched to a plan based on information about needs – e.g., which health plan has most of beneficiary’s providers in-network
- Will beneficiaries truly understand opt-out choice?
- Need for multi-channel beneficiary education
Concerns: Savings

- Duals tend to be high cost either to Medicare or Medicaid, but not both

- CMS has proposed allocating savings without providing evidence that sharing based on the proportion of Medicare and Medicaid spending will be equitable

- Some states see demonstrations as giving them Medicare funds to supplement Medicaid funds; if there are no Medicare savings, Medicare trust fund dollars will end up subsidizing state Medicaid expenditures
Perspectives of MedPAC: Letter to HHS, July 2012

- MedPAC: Supportive of goals, but concerned.
- “Given the diversity of the care needs of the dual-eligible population, a common approach to full integration and care coordination may not be best suited for all beneficiaries.”
- Concern that scope of some demonstrations too broad; some states proceeding too quickly to enroll duals without paying enough attention to diverse needs of populations
- Health plans don’t have enough experience to manage diverse duals populations
Perspective of Congressional Budget Office

- Requiring dual eligibles to enroll in managed care alone would not save money
- Additional arbitrary cap on Medicare and Medicaid spending would have to be imposed
- Cap would have to be below current spending on duals
- Risks from that approach would be profound
Perspectives of Some Stakeholders

- Why not have Medicare assume full responsibilities for dual eligibles once they become Medicare-eligible?

- 10 percent of dual eligibles now enrolled in Medicare Advantage plans

- Why not a broader Medicare-only demonstration, with states assessed a “clawback” amount similar to Medicare Part D?
The Shape of Things To Come?

The Politics
Proxy War?

- Foreshadows battle over Medicaid block grants and per-capita cap proposals, in testing whether savings projections are realistic?

- Foreshadows ongoing disputes over Medicare reforms, premium support, in testing whether needs can be met within funding constraints?

- Raising issues of how fast to move; how much can be saved; how much disruption in lives; how ready are new arrangements to care for people?
The End

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