CMS Medicaid Perspective: Dual Eligibles

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Almost 7 Million Full Dual Eligibles

- Impoverished elderly and people with disabilities: many are frail, vulnerable, with complex chronic, acute and LTC needs
  - 64% female
  - 41% minority
  - 79% single, divorced, widowed, separated
  - 51% self report Fair or Poor health
  - 57% have cognitive or mental impairment

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High Cost Population

- Average combined Medicare and Medicaid spending = $37,900 per dual
  - Average Medicare spending per dual eligible is about twice the average amount for non-duals (high acute care expenditures)
  - 58% of Medicaid spending on dual eligibles is for LTC services and supports
- $307 billion in combined total spending in 2010

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Least Likely to Receive Coordinated Care

- Fragmented service delivery between Medicare and Medicaid systems
- Most states exclude dual eligibles from enrollment in Medicaid managed care arrangements
- Even if duals enrolled in managed care for Medicaid, Medicare enrollment is optional

DEHPG's Goals for Integration

1. Integration across primary, acute, behavioral health and long term services and supports
2. Person-centered approach to benefit design, financing, and delivery systems
3. Consumer-directed services that promote community integration
4. Care management to improve linkages, outcomes and health status

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DEHPG's Goals for Integration (cont)

5. Single or fully reconciled regulatory framework
   – Quality, health and welfare standards for HCBS within managed care models
   – Strong beneficiary rights and effective beneficiary education and information for self-direction
6. Payment reform to encourage improved value (better outcomes, reduced cost trends)

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Current Models of Integration

- PACE
  - Completely integrated model
  - Single payment to PACE provider for all Medicare and Medicaid services
  - Targeted to beneficiaries with NF level of care
  - Tied to adult day care site
  - Difficult to bring to scale

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Current Models of Integration

- Dual Eligible SNPs
  - Medicare Advantage option for Medicare
  - Some state Medicaid programs contract with dual SNPs for Medicaid services
  - Not fully integrated: “Medicare and Medicaid stand close together” but operate separately
  - Challenges reported by states

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State Interest in New Models

- State as administrative agent for Medicare
- Single administrative requirements: marketing, grievances, enrollment, managed care
- Shared savings, other incentives for state participation
- Clear path to Medicare and Medicaid authority
- All Payer approaches to system reform

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Federal Coordinated Health Care Office (Affordable Care Act)

- Bring together Medicare and Medicaid at CMS to
  - More effectively integrate benefits and
  - Improve coordination between Federal government and states to assure full access to services for duals

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Goals Include

- Simplify processes
- Improve quality
- Increase duals' understanding and satisfaction
- Eliminate regulatory conflicts
- Improve care continuity and assure safe and effective transitions
- Eliminate cost shifting

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Responsibilities of New Office

- Support states, MA plans, providers and others in developing programs that align Medicare and Medicaid
- Support states in aligning acute and LTC services for duals
- Encourage coordination of contracting and oversight by States and CMS
- Coordinate with MEDPAC and MACPAC
- Study and report to Congress

Next Steps

- Formal establishment of new Office
- Identify and understand authorities for new opportunities under ACA
- Assess what states have learned through current integration initiatives
- Explore beneficiary attitudes and needs
- Address challenges in existing opportunities and models

Current Resources

- Integrated Care Toolkit (SNPs) - http://www.cms.gov/IntegratedCareInt/
- Programs of All-Inclusive Care for the Elderly - http://www.cms.gov/pace/
- Other information on community services and long term supports - http://www.cms.gov/CommunityServices/

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