FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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# HEALTH REFORM OPPORTUNITIES: Improving Policy for Dual Eligibles

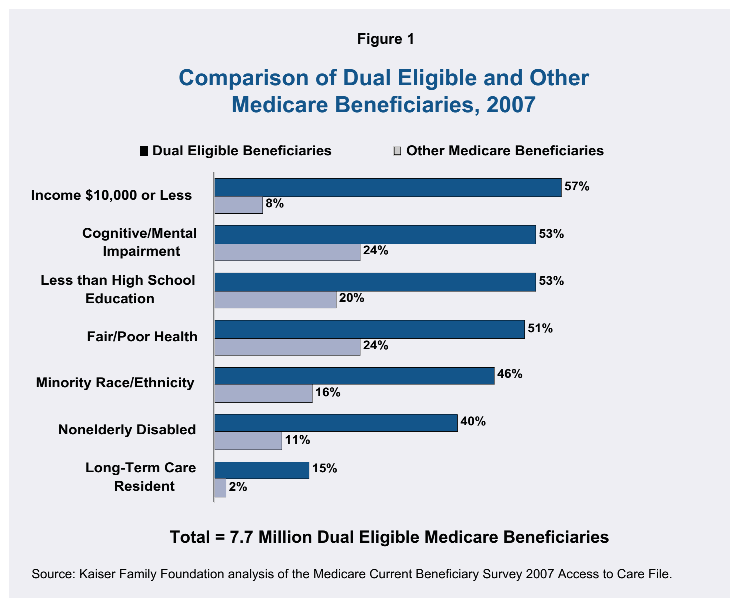
Health reform presents an opportunity to realign federal and state policy for nine million people who are covered by both Medicare and Medicaid (known as "dual eligibles") who tend to be among the poorest, sickest, and highest cost people covered by both programs. Today, Medicare, the nation's health insurance program for 46 million elderly and disabled people, pays primarily for acute care services, while Medicaid pays for Medicare premiums and cost-sharing, as well as additional services not covered by Medicare, such as long-term care. Navigating two programs with different program rules and financing incentives is complex for beneficiaries and providers, complicates care coordination, and can result in cost-shifting between the two programs. Dual eligibles account for nearly half of all Medicaid spending, limiting the ability of states to fund other pressing priorities. Realigning federal and state responsibilities for duals as part of health reform could provide improved coordination and management of services, better accountability and more stable financing for health reform.

This brief examines the federal and state roles for dual eligibles and lays out policy options that could improve health policy for dual eligibles, focusing on opportunities to improve coverage, delivery and payment, and financing. As Congress considers health reform, provisions related to the treatment of dual eligibles are being discussed and this brief highlights several, including those in H.R. 3200.

## Why reexamine federal and state roles for dual eligibles?

### Dual eligibles are a vulnerable population.

Nearly nine million dual eligibles rely on both Medicare and Medicaid to obtain needed health and long-term care services. Dual eligibles are poorer and sicker than others on Medicare (Figure 1). Unlike Medicare, Medicaid is a means-tested program, so duals are all low-income—57% have incomes of $10,000 or less. Two-thirds of duals are age 65 or older, while one-third are under age 65 and disabled. Duals are much more likely than other Medicare beneficiaries to have mental health conditions or be cognitively impaired. They account for a disproportionate share of the under-65 disabled on Medicare, and are much more likely than others on Medicare to reside in nursing homes. This high level of need for health and supportive services, combined with less education and strained financial circumstances, means that dual eligibles often face significant challenges in navigating the complexities of multiple programs to obtain appropriate and timely care.



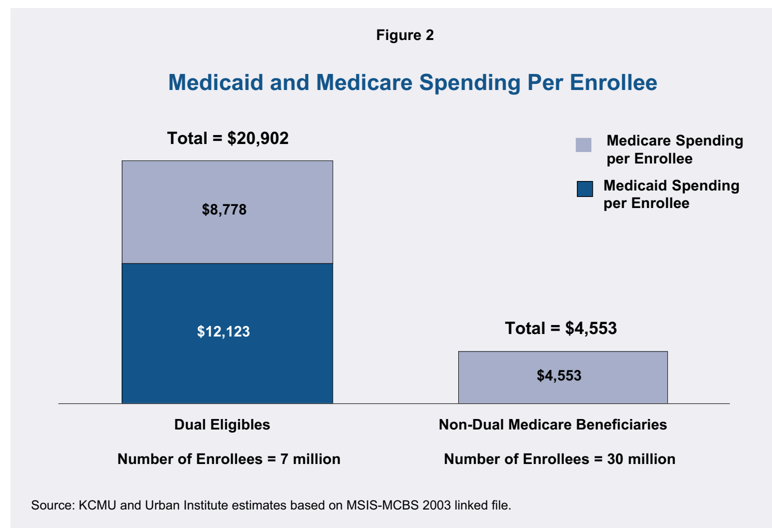

### Dual eligibles must navigate both Medicare and Medicaid to obtain health and long-term care services.

Medicare beneficiaries have a legal right to services covered by Medicare, including hospital, physician, other outpatient services, and prescription drugs. Dual eligibles are also entitled to supplemental benefits covered under Medicaid, such as help with Medicare's cost-sharing requirements, and coverage of benefits not covered under Medicare. Medicare's financial obligations for the Part B premium ($96.40 per month in 2009) and cost-sharing (for example, $1,068 deductible in 2009 on inpatient hospitalization per spell of illness) are widely

acknowledged as too steep for low-income beneficiaries to meet. In addition, Medicare's benefit package has service limits (inpatient psychiatric hospital, therapy) and does not include many services, most notably long-term care, but also vision, dental, case management and medical transportation services.

**State Medicaid programs, jointly financed by the federal and state governments, fill these gaps for many low-income Medicare beneficiaries.** All states are required to offer Medicare Savings Programs that pay the Medicare Part B premium and, in some instances, cost-sharing requirements. In addition, Medicaid provides coverage of a broader set of medical and long-term support services not covered by Medicare for dual eligibles. Medicaid programs are required by federal law to provide assistance to certain low-income Medicare beneficiaries and can also receive federal matching payments for broader coverage. However, Medicare beneficiaries who need help with long-term care must be impoverished before Medicaid provides assistance. As a result, the availability of Medicaid services for Medicare beneficiaries, particularly long-term care services and supports, is limited and varies substantially across states.

**Medicare and Medicaid spending on dual eligibles is significant.** Dual eligibles are a high-cost population, with combined Medicare and Medicaid spending totaling nearly $200 billion in 2005. On a per-person basis, Medicare and Medicaid spending averaged over $20,000, about five times greater than spending on other Medicare beneficiaries ($4,500) in 2003 (Figure 2). This higher level of spending reflects their greater health needs and utilization of services compared to other Medicare beneficiaries. Dual eligibles often have multiple chronic conditions and are more likely to be hospitalized, use emergency rooms and long-term care services than other Medicare beneficiaries. Younger duals who are disabled and the oldest duals who rely on nursing home care are the most expensive. Dual eligibles with certain conditions, including cerebral palsy, Parkinson's disease, Alzheimer's disease, and multiple sclerosis have substantially higher per capita spending than other duals.




## How could health policy for dual eligibles be improved to support the objectives of health reform?

As policy makers consider reform options to improve the health care system for all Americans, focusing on opportunities to improve coverage, delivery and payment, and financing for dual eligibles could yield substantial benefits for a vulnerable group and savings for government programs through better coordination of services. There are a number of ways to improve how eligibility for additional assistance is determined and administered, how help with premiums and cost-sharing and additional services are financed, and how care is delivered and coordinated. In assessing these options, it is important to keep in mind the frail nature of beneficiaries, their greater need for services and higher costs and the need to structure options that don't impinge on the legal entitlement to Medicare services.

**Finance and administer Medicare premiums and cost-sharing payments for dual eligibles at the federal level.** In order to obtain and access Medicare benefits, low-income Medicare beneficiaries need financial assistance with Medicare Part B premiums and the cost-sharing requirements associated with use of Medicare services. Federal law requires state Medicaid programs to provide this assistance, although states have expressed longstanding concerns over the cost of these requirements. State payment responsibilities for dual eligibles are projected to continue to rise in the future: as Medicare premiums and cost-sharing rise, Medicaid is obligated to cover rising costs on behalf of dual eligibles. Between 2009 and 2011, for example, Medicare Part B premiums

for dual eligibles are projected to increase by nearly 25%. Since the Balanced Budget Act of 1997, states have been permitted to pay providers Medicaid rather than Medicare rates on Medicare cost-sharing amounts for dual eligibles, which can lead to access problems for beneficiaries. Full federal financing of the costs of Medicare premiums for duals would reduce state Medicaid spending by an estimated $3.7 billion and fully federally funded cost sharing for Medicare covered services would save states an additional $7.6 billion, according to a recent Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis based on one-year savings in 2005 dollars.

Decades ago when policymakers turned to Medicaid as the vehicle to provide this financial assistance, now referred to as Medicare Savings Programs, to low-income Medicare beneficiaries, Medicare did not have a mechanism to screen for eligibility and provide this type of help. With the enactment of the Part D prescription drug plan, the federal government now administers the Low-Income Subsidy (LIS) program, providing assistance to nearly 10 million low-income Medicare beneficiaries with income up to 150% of the federal poverty level (Figure 3). These federal responsibilities could be extended to the Medicare Savings Programs to standardize the way that low-income Medicare beneficiaries receive financial assistance.

The federal government could also simplify program rules associated with providing financial assistance to low-income Medicare beneficiaries by using a uniform income level to establish eligibility at the Part D level, and by providing uniform benefits across the MSP programs. Currently low-income Medicare beneficiaries receive different levels of assistance from MSP programs and Part D depending on small differences in income and resources. A provision in H.R. 3200 seeks to increase the asset limit used to determine eligibility for the MSP program and for the Part D low-income subsidies to $17,000 per individual and $34,000 per couple and indexes the asset limit to inflation in subsequent years. It also eliminates Part D cost sharing for non-institutionalized duals who would require institutional care if not for provision of home and community-based care under Medicaid. In December 2008, the Congressional Budget Office (CBO) estimated the cost to the federal government of these and other provisions designed to help MSP and LIS recipients to be $11.9 billion over 10 years. Increased participation in MSP programs would also increase state costs.

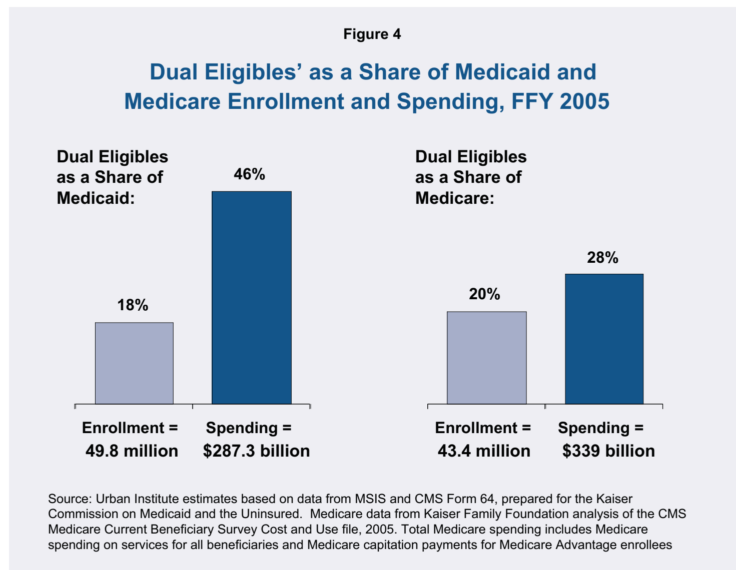
Figure 3

**Medicare Savings Programs and Part D Eligibility Pathways**

| **Medicare Savings Programs** (administered by states) | **Income Eligibility** | **Asset Limit** | **Medicare Premiums and Cost Sharing** |
|---|---|---|---|
| Qualified Medicare Beneficiaries (QMB) | Up to 100% FPL | $4,000 (individual)<br>$6,000 (couple) | Medicaid pays Medicare premiums (Part B and if needed, Part A) and cost sharing. |
| Specified Low-Income Medicare Beneficiaries (SLMB) | Between 100% and 120% FPL | $4,000 (individual)<br>$6,000 (couple) | Medicaid pays Medicare Part B premium. |
| Qualified Working Disabled Individuals (QDWI) | Working, disabled individuals with income up to 200% FPL | $4,000 (individual)<br>$6,000 (couple) | Medicaid pays Medicare Part A premium. |
| Qualifying Individuals (QI) | Between 120% and 135% FPL | $4,000 (individual)<br>$6,000 (couple) | Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding. |
| **Medicare Part D** (administrated by the federal government) | **Income Eligibility** | **Asset Limit** | **Part D Premiums and Cost Sharing** |
| Low Income Subsidy | Up to 135% FPL | $8,100 (individual)<br>$12,910 (couple) | Medicare pays full premium and cost sharing assistance. |
| Low Income Subsidy | Between 135% and 150% FPL | $12,510 (individual)<br>$25,010 (couple) | Medicare pays Sliding scale premium and cost sharing assistance. |

Note: In 2009, 100% of the federal poverty level (FPL) was $10,830 per month per individual. Source: Kaiser Family Foundation and CMS.

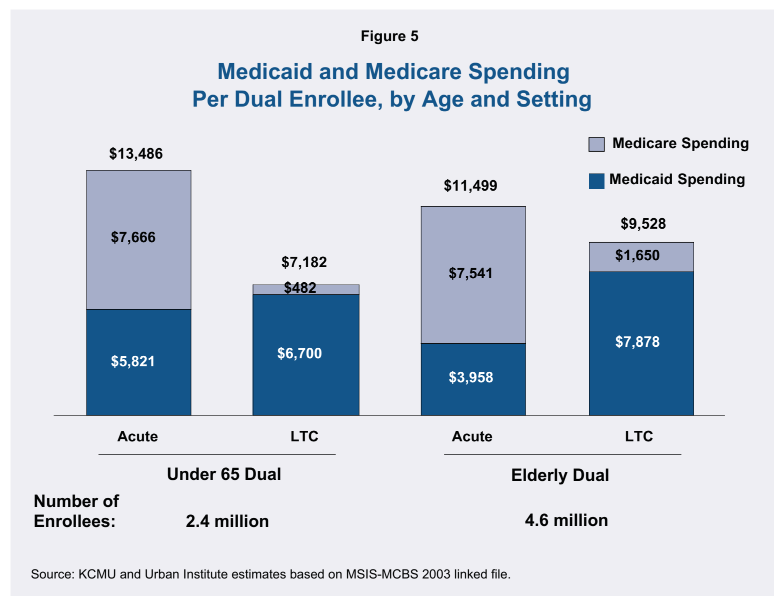
Resources among dual eligibles at these income levels are minimal but a resource test can be cumbersome for beneficiaries and add administrative complexity to the eligibility determination. Making these changes would simplify the administration of financial assistance for low-income Medicare beneficiaries. As health reform looks at providing low-income subsidies to non-Medicare populations, it provides an opportunity to revisit how low-income assistance is provided under Medicare, and to whom.




**Improve federal coordination of Medicare and Medicaid services for dual eligibles.** Although "dual eligibles" account for only 18% of Medicaid enrollment and 20% of Medicare enrollment, they account for a disproportionate share of spending in both programs. Nearly half (46%) of all Medicaid expenditures and 28% of Medicare spending were made on their behalf in 2005 (Figure 4). The concentration of high health care utilization under both Medicare and Medicaid presents opportunities to reduce duals' overall health care expenditures by better coordinating and integrating the two programs' services. However, differing administrative authority and operations coupled with the size of Medicare and Medicaid can make it difficult to identify overlapping policy, financing and care delivery issues for the duals. Better coordination within CMS between Medicare and Medicaid could help integrate and improve care for dual eligibles and overcome some of the current federal-state joint management issues for this population. H.R. 3200 creates an office within CMS to improve coordination between Medicare and Medicaid for dual eligibles, with a zero cost estimate according to CBO.

**Eliminate the two-year Medicare waiting period for disabled Medicaid enrollees.** Currently, people under age 65 who are disabled and qualify for Social Security Disability Insurance (SSDI) must wait two years before Medicare coverage begins. An estimated 1.8 million low-income disabled individuals rely on Medicaid for services during this interim period. Eliminating the waiting period would provide more consistent coverage for the "pre-duals" and free up state resources to focus on other vulnerable populations, but would increase costs to the Medicare program costing the federal government $113 billion over 10 years ($41 billion over five years) and saving the states $32 billion over the same time period, according to a December 2008 CBO estimate.

**Adopt payment strategies to foster improved delivery of medical and long-term care services for dual eligibles.** Reflecting their substantial health needs, dual eligibles often see multiple providers, use multiple prescription drugs, and do not have a single entity coordinating their care. High-cost dual eligibles also frequently rely on both acute and long-term care services (Figure 5). They may not be well served by incentives providers face to provide services based on Medicare and Medicaid reimbursement. The split of services between Medicare and Medicaid, and the overlap in coverage of some services such as home health, DME, and skilled nursing, creates incentives for cost-shifting between the programs rather than to provide care in the most efficient way. Separate Medicare Part D prescription drug plans add yet another level of complexity. Navigating between the Medicare and Medicaid programs can be challenging for beneficiaries with different program rules and different covered benefits and may result in unnecessary care, including hospital and nursing home admissions.



- **Strategies to improve Medicare post-acute benefits.** According to a recent study by Jencks et al. 2009, nearly one-third of Medicare beneficiaries who were discharged from the hospital were re-hospitalized within 90 days, in part due to a lack of follow-up care, and the cost of these readmissions to Medicare in just one year (2004) was $17.4 billion. Duals have a high likelihood of being hospitalized, with one quarter using inpatient services during the year compared to 16% of non-dual Medicare beneficiaries, and could benefit from more coordinated post-acute care. One strategy designed to improve quality of care and reduce costs would be to create a new benefit under Medicare to support and coordinate care for beneficiaries as they move from a hospital setting to their homes, skilled nursing facilities or rehabilitation centers. The Medicare transition benefit would provide coverage for services designed to help patients recover during those first critical days and weeks after leaving the hospital and reduce the risk of rehospitalization. H.R. 3200 includes Medicare provisions to bundle payments for post-acute care services on a demonstration basis and to reduce payments for readmissions.

  Another strategy would be to modify the homebound requirement in Medicare's home health benefit. Currently an individual is only eligible for Medicare home health if they have a post acute or chronic care need and if they are under the care of a physician and unable to leave the home. Relaxing current restrictions to consider someone homebound if they cannot leave their home without technical or physical assistance from others could help reduce rehospitalizations and forestall entry into nursing facilities.

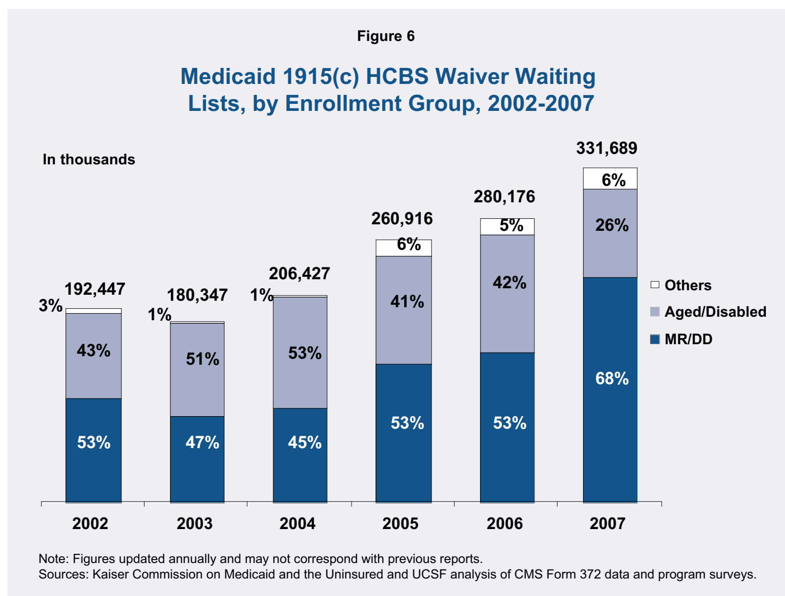
- **Strategies to improve delivery of care under the current Medicare and Medicaid program structure.** A number of payment reform proposals are currently being discussed for all Americans that could also be applied to the dual eligible population. These range from expanding models that emphasize primary care and chronic care coordination arrangements to include long-term services and supports to more fully integrated models that would offer the full array of Medicare and Medicaid benefits in a coordinated manner. In pursuing efforts to integrate and coordinate care, it is important to ensure that dual eligibles do not lose their right to Medicare benefits guaranteed by federal law.

  An increased emphasis on primary and coordinated care is demonstrated in the medical home model whereby a provider or team of providers takes responsibility for providing and arranging care in a coordinated fashion. An example of a medical home model focusing on high-cost patients is the Guided Care model, a form of Patient-Centered Medical Home, operating as a demonstration program in Medicare that pays primary care practices risk-adjusted care management fees, in addition to fee-for-service payments, and bonuses based on performance and on quality outcomes. Similarly, Community Care of North Carolina, an enhanced medical home model in Medicaid that includes local non-profit community networks, provides and manages care on a fee-for-service basis, plus a management fee. Early results are promising in lowering overall costs and improving care. Examining how these types of approaches could be used to more fully address the medical and long-term service support needs of dual eligibles merits attention. H.R. 3200 includes a medical home pilot project targeted at high-need Medicare beneficiaries.

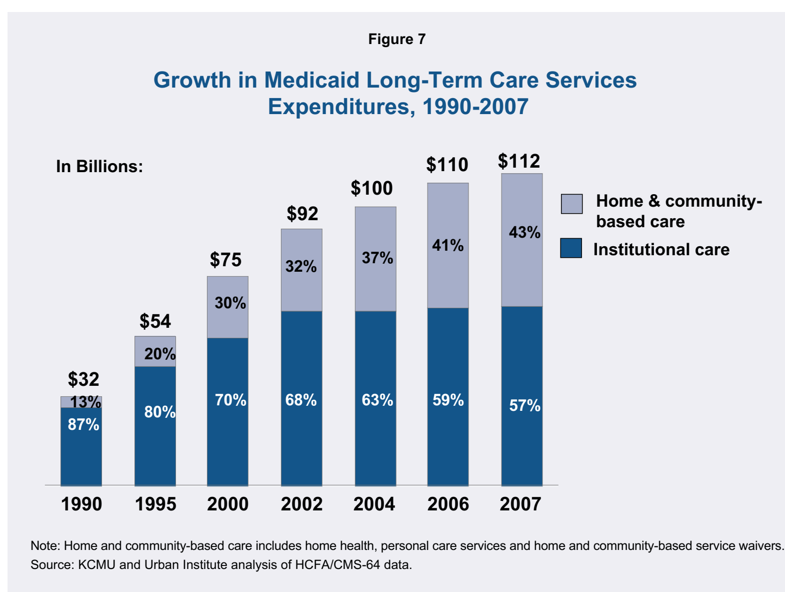
  A number of integrated models, including Medicare demonstrations, state Medicaid waivers and Medicare Special Needs Programs (SNPs), have developed to bridge the two separate systems of care that dual eligibles face, but remain limited in achieving broad scale reform. Although more fully integrated care can result in reduced hospitalization and institutional costs, the financial incentives in Medicare and Medicaid are not aligned to promote these outcomes. Early savings due to reductions in acute care through better primary care and care coordination accrue to Medicare, while savings to Medicaid through reductions in long-term care service use take much longer to achieve. Sharing early Medicare savings with the states and helping with start-up costs would provide greater financial impetus for states to participate in models to integrate care for dual eligibles. Consumer protections assuring voluntary enrollment, access to services and quality of care would need to be a priority in a capitated system given the vulnerable nature of the dual eligible population and in view of the entitlement to Medicare services. The federal government could also develop non-capitated models that include sharing savings with states through Medicare demonstration projects that allow a broad range of providers, including physician groups, integrated health systems, or regional coalitions to join together and utilize an alternative payment system to support integration of services for dual eligible beneficiaries on a fee for service basis.

  H.R. 3200 extends the time period for SNPs serving dual eligibles to January 2016 and grandfathers plans that had a contract with a state to operate an integrated Medicaid-Medicare program. CBO estimates the costs of these and other changes to reach $0.1 billion over 10 years.

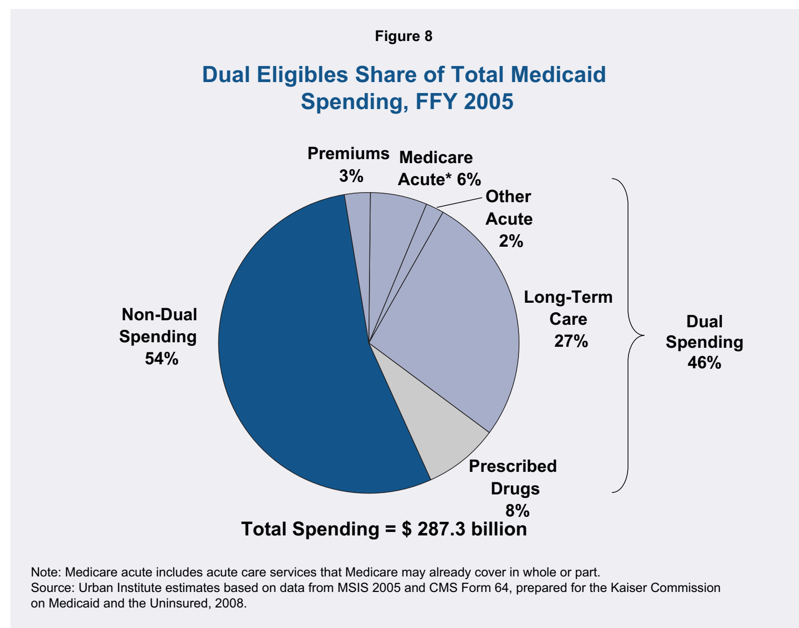
– **Strategies to improve access to Medicaid home and community-based services.** Dual eligibles rely heavily on long-term care services and supports and many dual eligibles, particularly those over age 80, continue to use institutions. However, obtaining services in community-based settings is preferred by enrollees and can typically be provided at lower cost. Medicare does not play a large role in financing long-term care, providing only short-term post-acute home health and skilled nursing facility care. Medicaid is the primary funding source for long-term home and community-based services. The availability of these services has been increasing, but the number of people on waiting lists for these services has also been growing (Figure 6).




Reducing reliance on costly institutional services by building on progress underway in the states would further shift the setting of long-term care from institutions to home and community-based settings (Figure 7). Equalizing access to home and community-based services is one way to reduce the inherent institutional bias in Medicaid and to give beneficiaries a choice in long-term care service settings. The federal government has supported efforts to transition people from nursing homes to the community, but these efforts are limited. Medicaid HCBS services have been provided primarily as waiver services, but easing restrictions on who can be served through the Medicaid state option by increasing income eligibility up to 300% of SSI and increasing the federal match rate could help to promote these alternatives. Raising the income eligibility to 300% of SSI would increase Medicaid spending by an estimated $2.7 billion over five years, according a December 2008 estimate by CBO. Providing adequate support in the form of wages and benefits for the long-term care workforce could strengthen HCBS community-based options for Medicaid beneficiaries, as could increased caregiver support programs. Broader reforms to long-term care policy would also increase options for dual eligibles.




**Assume full financial responsibility for dual eligibles at the federal level.** The federal government already pays for roughly three-quarters of spending on dual eligibles through the fully federal Medicare program and the federal share of the Medicaid program (averaging 57%). States pay for the remainder of Medicaid spending. State Medicaid programs must balance the significant care needs of the dual eligibles, who account for a disproportionate share of Medicaid spending, with the needs of other state residents, including children and parents in low-income families who rely on the program for health insurance and people with disabilities who rely on Medicaid for medical and long-term care needs. There is significant variation in the dual eligibles share of total Medicaid spending and enrollment across the states, reflecting both variation in states' demographic profiles as well as state policy choices affecting the extent of Medicaid coverage provided to the aged and disabled versus non-disabled adults and children.




Spending on dual eligibles accounts for nearly half of Medicaid spending (Figure 8). Payment for Medicare premiums and cost-sharing on Medicare covered services for dual eligibles comprises 10% of total Medicaid spending and payments for other acute and long-term care services comprise 30% of Medicaid spending. In 2006, prescription drug spending for the duals was shifted to Medicare through Part D, but state Medicaid programs are still required to make a substantial contribution towards this benefit, referred to as the clawback payment. Although states are required to pay for Medicare premiums and the prescription drug clawback payment, they have no control over these costs. States must have balanced budgets and many are struggling in this economic downturn to maintain current program coverage. At the same time, health reform discussions are likely to increase state responsibility for covering the low-income population. Fully financing services for dual eligibles at the federal level could provide greater incentives to improve care management across acute and long-term care services, lessen eligibility disparities and the availability of long-term care services across states, and readily free up state resources to be used for other priorities. Full federal financing for all Medicaid long-term care services, Medicare premiums and cost sharing as well as federal assumption of Medicaid acute care services not currently covered by Medicare (e.g. transportation, dental and vision services) would result in an estimated $46.8 billion in savings over one year to the states while increasing federal costs, according to a recent Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis in 2005 dollars.

## Conclusion

As the nation considers national health care reform, it is an opportune time to look toward improving federal policy for dual eligibles. Improving the delivery and coordination of services could lead to enhanced quality of care received by dual eligibles and translate to more efficient spending on a high cost population. Establishing a national route to provide financial assistance for low-income Medicare beneficiaries, developing systems that provide integrated acute and long-term services and supports, increasing the availability of home and community-based services and providing more stable financing are all key components of creating a more rational and cost-efficient system of care for the millions of Americans who rely on both Medicare and Medicaid to meet their health care needs.

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