

# Ideas for Managing Costs and Improving Care Delivery for High-Cost Medicaid Beneficiaries

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# Ideas for Managing Costs and Improving Care Delivery for High-Cost Medicaid Beneficiaries

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## INTRODUCTION

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Debates over how to contain Medicaid cost growth often follow a predictable pattern. They begin with a search for cost-containment ideas from the private sector. Given current trends, the list of ideas starts with increasing enrollee cost sharing and eliminating or capping benefits. Noting the disproportionate impact such policies would have on elders and people with disabilities, policymakers propose to exclude those eligibility groups from the new cost-cutting policies. Analysts then point out that, since these excluded groups account for 68% of Medicaid spending, even if the policies are wildly successful they will yield little in the way of savings.<sup>1</sup> Acknowledging these limits, but having few ideas on hand that would generate savings among the highest cost Medicaid enrollees, the policies are adopted anyway. Poor mothers and children then lose eligibility or services because the policy levers to reduce the costs associated with this population are easier to find and pull than they are for the others served by Medicaid.

This dynamic is largely due to the fact that long-term care and disability policy discussions have taken place in entirely different arenas than discussions of policies designed to provide health insurance for the 47 million Americans without health insurance or to protect coverage for the 30 million very low-income adults and children served by Medicaid.<sup>2</sup> Yet, all of these policies come together within the Medicaid program. And when Medicaid faces budget pressures, the failure to control costs for one group may mean the loss of coverage for another.

The Medicaid Commission appointed by Health and Human Services Secretary Mike Leavitt is poised to make recommendations for comprehensive Medicaid reforms by the end of 2006. Many governors are pursuing waivers and state plan amendments that fundamentally alter the nature of the program and the Centers for Medicare and Medicaid Services (CMS) is willing to entertain and approve a broad range of ideas arising from the states. The Deficit Reduction Act of 2005 (DRA) made the largest structural changes in the program since its enactment in 1965. In this environment, a conversation regarding all aspects of the Medicaid program is needed.

In Medicaid, like in private insurance, a small group of high-cost individuals account for the bulk of expenditures. In 2001, 7.6 percent of enrollees whose care cost more than \$10,000 each annually accounted for roughly two-thirds of Medicaid spending (65.3 percent), and 3.6 percent of enrollees with annual care costs above \$25,000 each accounted for nearly half (48.8 percent) of Medicaid spending.<sup>3</sup> Most of these high-cost enrollees are elderly or disabled, and several chronic conditions are commonly reported among them, including high blood pressure, heart disease, and diabetes.<sup>4</sup>

If Medicaid could meet the needs of these high-cost groups in a manner that preserves or improves quality while containing costs, the fiscal pressures on the program would abate.

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<sup>1</sup> Holahan and Cohen, *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004* (Kaiser Commission on Medicaid and the Uninsured, May 2006). Urban Institute estimates for 2004 based on data from Medicaid Financial Management Reports, MSIS and HMA.

<sup>2</sup> Ibid.

<sup>3</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* (March 2006). Based on 2001 Medicaid Statistical Information System data.

<sup>4</sup> Ibid.

In order to identify ideas for doing just that, the National Academy for State Health Policy (NASHP) engaged in a project that led to this paper. NASHP staff conducted 28 one-hour semi-structured telephone interviews with key informants representing state agencies, researchers, providers, and consumers during August, September, and October 2006.<sup>5</sup> Informants were asked to describe innovations in Medicaid policy that would improve services to high-cost Medicaid beneficiaries and/or improve the cost effectiveness of the Medicaid program. They were also asked to describe the most effective levers for improving efficiency and quality and innovations that have been successful.

The suggestions discussed in this paper do not necessarily reflect the opinions of all key informants. Also, the suggestions are not represented as consensus conclusions by all key informants.

This paper is organized around four major categories of responses:

- 1) remove the institutional bias in Medicaid;
- 2) improve coordination of care for dual eligibles;
- 3) improve chronic care management; and
- 4) reduce demand for the Medicaid program.

Many comments could have been assigned to more than one category, but these four areas capture the full range of comments. The four areas can be summarized as:

### **Remove the Institutional Bias in Medicaid**

- Create Comprehensive Systems That Create a Level Playing Field:
  - Allow states to replace the complex array of Medicaid eligibility categories with a single category based on a percentage of the federal poverty level.
  - Allow states to presume financial eligibility for Medicaid.
  - Remove disincentives to expand Medicaid eligibility that were created by the Medicare Part D “clawback” requirements.
  - Provide additional incentives for states to remove asset tests from Qualified Medicare Beneficiary/Special Low Income Medicare Beneficiary (QMB/SLMB) categories.
- Improve Medicaid’s Non-Institutional Services:
  - Make home and community-based services (HCBS) a mandatory service under the Medicaid state plan.
  - Modify the DRA to allow states to replace HCBS waivers with an optional program under the Medicaid state plan.
  - Provide an enhanced matching rate for home and community-based services to create incentives for states to expand community options.
  - Consider reforms to make housing in the community more affordable.

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<sup>5</sup> More than 28 names are listed at the end of this document as “key informants” because in some cases more than one person participated in a single interview.

## **Improve Coordination of Care for Dual Eligibles**

- Improve Coordination at the Operational Level:
  - Federalize the financing of coverage for duals.
  - Require Medicaid and Medicare to share beneficiary-level data.
- Create Financial Incentives for Coordination:
  - Allow Medicaid to benefit from savings to Medicare.
  - Create episode-based capitation for certain conditions.
  - Better integrate dual eligibles in current full capitation model.
  - Monitor the growth of Medicare Special Needs Plans serving dual eligibles.
  - Consider options for encouraging enrollment in managed care.

## **Improve Chronic Care Management**

- Improve Medicaid fee-for-service's ability to pay for promising approaches.
- Provide grant funds for states to test chronic care management approaches.
- Change the Medicaid Upper Payment Limit (UPL) payment disincentive.

## **Reduce the Burden on Medicaid**

- Provide long-term care coverage based on a social insurance model.
- Create incentives for the purchase of private long-term care insurance:
  - Provide tax incentives or subsidies for the purchase of long-term care insurance.
  - Support the DRA's expansion of the Long-Term Care Partnership.
- Support people with chronic conditions and disabilities at work and protect access to comprehensive employer-based health insurance coverage.

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# REMOVE THE INSTITUTIONAL BIAS IN MEDICAID

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## Background

Medicaid is the nation's largest payer for long-term care services.<sup>6</sup> Medicaid accounts for 42 percent of the nation's long-term care spending and 43 percent of expenditures for nursing home care.<sup>7</sup> Nearly one-third of total Medicaid spending (31.4 percent) is for long-term care services.<sup>8</sup>

Most of Medicaid's spending on long-term care pays for care in a nursing home. Nearly two-thirds (63 percent) of Medicaid long-term care expenditures are for institutional care, while the balance is for home and community-based services (HCBS).<sup>9</sup> However, nursing home care is shrinking as a share of Medicaid long term-care spending and home and community-based care is growing (See Table 1).

**Table 1 Medicaid Spending Growth (in billions of dollars)**

Category	FY 2000	FY 2005	Percent change
Total Medicaid spending	\$194	\$300	35%
Total LTC	\$68.6	\$94.5	27%
Nursing home	\$39.6	\$47.2	16%
ICF/MR	\$9.9	\$12.1	18%
HCBS waivers	\$12.8	\$22.7	44%
Personal care	\$3.8	\$8.6	56%
Home health	\$2.3	\$3.6	36%

While elders make up the majority (63 percent) of people who rely on Medicaid for long-term care services, most (75 percent) of Medicaid's spending on home and community-based care has supported services for people with mental retardation and developmental disabilities, and not the elderly.<sup>10</sup> Most (62 percent) of the care provided to individuals with mental retardation or developmental disabilities is delivered in the community; while little (27 percent) of the care provided to elders and adults with physical disabilities is provided in community settings.<sup>11</sup> Only a small fraction (.2%) of Medicaid's spending on home and community-based care has supported services for people with mental illness or children with serious emotional disturbances.<sup>12</sup>

While most Medicaid-funded long-term care is provided in an institution, most Americans in need of long-term care services receive these services in the community. Almost 10 million Americans need assistance with daily activities such as bathing, dressing, eating, mobility,

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<sup>6</sup> Robert Friedland, "Long-Term Care: Are American's Prepared?," Testimony for the Special Commission on Aging, March 9, 2006. Figure 3.

<sup>7</sup> Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Long-term Care Services," *Medicaid Facts*, (July 2006).

<sup>8</sup> Ibid. Note, based on 2001 MSIS data only 3.4 percent of all Medicaid enrollees received institutional care.

<sup>9</sup> Steve Eiken, Brian Burwell, and Becky Selig, *Medicaid HCBS Waiver Expenditures FY 2000- 2005. Memorandum* (The Thomson Group, July 6, 2006).

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

and toileting.<sup>13</sup> The vast majority of these people (83 percent) live in the community and only a small fraction (17 percent) live in nursing homes.<sup>14</sup>

## The Challenge

Since its inception, Medicaid has favored institutional care. Care in a nursing home is a mandatory Medicaid service and all beneficiaries who meet the income and admission criteria must be covered for this benefit. Nursing homes have an important role for people who need short-term, rehabilitative care, or have advanced dementia and other conditions that may make it difficult to provide care in the community.

By contrast, most of the care provided in the community is currently covered through Medicaid waivers.<sup>15</sup> Home and community-based services can be offered in limited areas of the state to a limited number of individuals. And, affordable housing and housing supports, particularly for people with serious and persistent mental illness, are often in very short supply.<sup>16</sup> When states reach the number of people they agreed to cover under their waiver, a waiting list may be established. States may cover a narrow or broader list of home and community-based services under their waivers. Further, some individuals who are eligible for Medicaid if they reside in a nursing home may not even be eligible for Medicaid if they reside in the community.

State officials and other experts contend that community care is – on average – less expensive than institutional care. Others claim that expanding home and community-based services options increases aggregate Medicaid spending because individuals who would not enter a nursing home will apply for services if they can obtain them in their own home. Data from the state of Washington show that over a period of ten years, expanding the number of Medicaid beneficiaries served in community led to a significant decline in the number of Medicaid beneficiaries served in institutions. A General Accounting Office (GAO) report that reviewed home and community-based programs in Oregon, Washington, and Wisconsin found that the expansion helped control the overall growth in long-term care spending and these states were able to serve more people with the available funds.<sup>17</sup> Community options reduced the need for and supply of nursing homes.

The U.S. Supreme Court added impetus to reducing the institutional bias in the current system in its ruling that long-term care services must be provided in accordance with the Americans with Disabilities Act “in the most integrated setting appropriate to the needs of

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<sup>13</sup> Kaiser Commission on Medicaid and the Uninsured, “Medicaid and Long-term Care Services,” *Medicaid Facts* (July 2006).

<sup>14</sup> *Ibid.*

<sup>15</sup> In one AARP Survey done in 2003, 87 percent of adults over age 50 with disabilities, said they wanted to be cared for at home. See also *Profiles of Nursing Home Residents on Medicaid*, Kaiser Commission on Medicaid and the Uninsured, July 2006.

<sup>16</sup> American Academy of Clinical Psychology, *Position Statement on Housing options for People with Serious and Persistent Mental Illness*. Viewed at <http://www.com.psych.pitt.edu/finds/Housing-Revised.htm>

<sup>17</sup> General Accounting Office, *Medicaid Long-term Care, Successful State Services* (Washington, DC: HEHS-94-167, July 1994).

qualified individuals with disabilities.” Compliance with the *Olmstead* decision has framed much of state long-term care policy over the last decade.

## **Ideas for Removing the Institutional Bias in Medicaid**

Informants’ ideas for creating greater choice and balance fell into two general themes:

- allowing for the right eligibility at the right, time and
- improving non-institutional service options.

### **Create comprehensive systems that create a level playing field**

Eliminating institutional bias requires a long-term care system that offers a comprehensive array of in-home, residential, and institutional services; access to service options through a single point of contact; streamlined, expedited eligibility; options counseling for individuals entering a nursing home; and nursing home transition opportunities for residents who are interested in relocating to the community. Expanding HCBS alone is not sufficient. As access to HCBS expands, Medicaid nursing home utilization should remain stable or decline. Declines can be expected as states offer options counseling, case management for nursing home residents, and an array of community options. States will need incentives and resources to create the infrastructure for a comprehensive point of entry system.

#### *Allow states to replace the complex array of Medicaid eligibility categories with a single category based on a percentage of the federal poverty level*

The federal Medicaid statute currently includes 28 mandatory and 20 optional eligibility groups. The array of eligibility groups creates confusion and delays for applicants and the staff that process them. Under current federal eligibility rules, many people living in the community would be eligible for Medicaid in a nursing home but are not eligible in the community. They do not receive needed services that could prevent institutionalization because they do not have sufficient income to pay for home and community-based services on their own. Others who are institutionalized would lose Medicaid eligibility if they moved back into the community.

Eliminating the categorical design of the program and tying eligibility solely to income would allow states to serve people in the most cost-effective setting. It could also expand access to individuals living in the community who would qualify for Medicaid but may not enter an institution in the short term. Experience in Washington and other states indicates that 2 or 3 people can be served in the community for every person who transitions from or is diverted from an institution.<sup>18</sup>

#### *Allow states to presume financial eligibility for Medicaid*

Delays in establishing an individual’s financial eligibility for Medicaid home and community-based services often lead to nursing home admissions because community agencies cannot assume the risk of non-payment, and applicants who need services to stay at home often cannot wait for the official process to be completed. Current law does not allow states to receive federal

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<sup>18</sup> Washington Aging and Disability Services Administration, Personal Communication.

reimbursement for services provided to applicants who are found ineligible when the application process is completed.

Presumptive eligibility is a means of establishing immediate eligibility for Medicaid. The state or an independent entity (not a direct service provider) would examine, but not necessarily verify, the financial and other information provided by the individual while in the hospital. The individual could then return to the community (instead of entering a nursing home) if Medicaid services were available. Applicants who are presumed eligible could receive HCBS for a temporary period, such as 60 days, until their information was verified. During this 60-day period, the federal government and the state would both pay for these services, even if the individual were later found ineligible for the services. States currently have the option to presume eligibility for children and pregnant women, and many states have taken up this option.

#### *Remove disincentives to expand Medicaid eligibility that were created by the Part D “clawback” requirements*

The clawback provisions associated with Medicare Part D create a disincentive for states to expand eligibility for long-term care services. States must contribute a share of the funds that would have been spent on prescription drugs for Medicaid beneficiaries in the absence of Part D based on the number of Medicaid beneficiaries in a given year. A state’s monthly payment is intended to reflect a percentage (beginning at 90% and declining to 75% by 2015 and thereafter) of the expenditures a state would have made from its own funds had it continued to pay for outpatient prescription drugs for dual eligibles through Medicaid.<sup>19</sup> The total state clawback payment for 2006 was \$6.6 billion.<sup>20</sup>

When a state expands eligibility, for example to everyone with income below poverty, it incurs increased liability for the so-called “clawback” payment. Each new dual eligible a state decides to cover costs the state an average of \$1,076.28 per year in clawback payments.<sup>21</sup> Reducing or removing this penalty would remove one barrier to raising eligibility and would allow individuals with chronic conditions and functional impairments to access Medicaid home and community-based services. This might be accomplished by omitting the expanded eligibility groups from the clawback formula.

#### *Provide additional incentives to states to remove asset tests from QMB/SLMB categories*

One informant suggested removing the asset test from the Qualified Medicare Beneficiary (QMB) and Special Low Income Medicare Beneficiary (SLMB) programs that allows individuals to have greater access to Part D and can also enroll in Medicare Special Needs Plans (SNPs). The Federal Eligibility Criteria for QMB/SLMB are \$4,000 for an individual and \$6,000 for a couple. States can either increase these limits or disregard all assets in determining eligibility, which in effect, “eliminates” the asset test under 1902(r)(2).

Removing the asset test might produce cost savings in Medicaid in two ways. First, it can reduce the state administrative costs associated with documentation collection, verification, and

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<sup>19</sup> Kaiser Commission on Medicaid and the Uninsured, *An Update on The Clawback* (March 2006).

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

eligibility determination. One state found that by eliminating the administrative costs involved in the asset verification process, it could expand eligibility to hundreds of beneficiaries at a total cost of only \$75,000 per year.<sup>22</sup> Second, enrollees having access to Part D subsidized drugs and SNPs may have better health care outcomes and will be less likely to need full Medicaid – particularly nursing home care – in the future.

### **Improve Medicaid’s non-institutional services**

Another consistent message was that people should have the same access to home and community-based services and supports as they do to nursing home care. There were many suggestions about how to make home and community-based services more available.

#### *Make HCBS a mandatory service under the Medicaid state plan*

Currently, home and community-based services are not a mandatory service in Medicaid. A 2004 study of Medicaid HCBS programs found that more than 206,000 individuals were on waiting lists for services.<sup>23</sup> More than 110,000 on waiting lists were elderly or adults with physical disabilities. More than 93,000 were individuals with mental retardation or developmental disabilities. Due in part to these wait-lists, some people end up in an institution and are never able to return to the community, and others forego needed services at home and rely on family and friends for limited assistance.

Further, for people with mental illness, waivers have provided limited assistance. Under current Medicaid rules, states cannot count toward meeting budget neutrality requirements the funding for children whose mental health services are provided in psychiatric residential treatment or for adults whose services are provided in psychiatric hospitals. As of 2003, enrollment in three state’s waiver programs that specifically targeted mental health needs represented less than 1 percent of total enrollment in 1915(c) waivers.<sup>24</sup>

One approach would be to make HCBS a mandatory Medicaid service, providing HCBS to all Medicaid-eligible individuals on the waiting list for these services, and increasing state and federal spending on these services. HCBS could be offered as a “program” or bundle of services (similar to the Program of All-Inclusive Care for the Elderly or PACE) and include a full array of in-home, community, and residential services, including mental health-related services. Under this option, states could no longer cap enrollment and maintain waiting lists for HCBS services. It was clear from informants that states are concerned about the increased cost of making HCBS a mandatory service and feel that capping enrollment is a useful cost-containment tool.

#### *Modify the DRA to allow states to replace HCBS waivers with an optional program under the Medicaid state plan.*

The Deficit Reduction Act of 2005 created a new option for states to cover a limited array of home and community-based services under a state plan amendment. This new option allows

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<sup>22</sup> Tiedemann and Fox, “Promising Strategies for Enrollment in Medicare Savings Programs,” *State Solutions, An Initiative to Improve Enrollment in Medicare Savings Programs*.

<sup>23</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid 1915 (c) Home and Community Based Service Programs: Data Update* (July 2005).

<sup>24</sup> Diane Rowland et al. “Accomplishments and Challenges in Medicaid Mental Health,” *Health Affairs* (2003).

states to set functional eligibility levels that are less restrictive than those required for admission to a nursing home. Currently, home and community-based service programs provided under waivers are limited to individuals who meet the nursing home admission criteria.

Before the DRA, states operated HCBS programs exclusively under waiver authority. A growing number of states are interested in expanding community-based, long-term care services. However, most states plan to expand care through additional waivers and not through the new DRA option. In FY 2006, over half of states enhanced home and community-based services by adopting new or expanding waivers or adding services.<sup>25</sup> In FY 2007, 38 states plan to adopt expansions of HCBS, including 13 states that plan to implement or expand a Program of All-Inclusive Care for the Elderly (PACE) program.<sup>26</sup> Many of these states will continue to use waivers to expand care, because waivers allow states to provide a broader array of services and to extend eligibility up to 300 percent of the federal poverty level (FPL).

The DRA HCBS option takes a step in the right direction, but it is limited in two important ways. First, the new option is available only to Medicaid beneficiaries whose income is less than 150 percent of the federal poverty level (\$1,225 a month in 2006). The waiver program allows states to service people up to 300 percent of the federal SSI benefit (\$1,809 a month in 2006). Second, the new option does not allow states to provide the full array of home and community-based services available under waiver programs.<sup>27</sup>

The DRA should be changed in order to give meaning to the concept embodied in the DRA – that states should have meaningful options to provide home and community-based services through a state plan rather than through a waiver. First, eligibility should be changed to allow states to serve all eligibility groups that are currently eligible for 1915 (c) waiver services. Services provided under waivers that would not be allowed under the DRA option include home modifications, assistive technology, assisted living/residential settings, personal emergency response, transportation, home delivered meals, nutrition supplements, communication services, companion, special medical equipment, independent living skills training, and transition services. In addition, Medicaid financial eligibility should be the same in the community as it is in the institution. As in the current DRA option, states could continue to limit participation for the program by capping enrollment.

*Provide an enhanced matching rate for home and community-based services to create incentives for states to expand community options*

The Federal Medicaid Assistance Percentages (FMAP) or the percentages of federal matching funds each state gets for its Medicaid Program ranged from 50 percent to 76 percent in fiscal

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<sup>25</sup> Kaiser Commission on Medicaid and the Uninsured, *Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007* (October 2006).

<sup>26</sup> Ibid.

<sup>27</sup> Services provided under waivers include home modifications, assistive technology, assisted living/residential settings, personal emergency response, transportation, home delivered meals, nutrition supplements, communication services, companion, special medical equipment, independent living skills training, transition services.

year 2006.<sup>28</sup> This percentage is currently the same for both community-based and institutional services.

One way to entice states to provide more home and community-based services is to provide a greater federal reimbursement for these services. An enhanced match could be based on half of difference between the state's current match and 100 percent. For example, in a state with a 70 percent match rate, the state would get an enhanced match of half the difference between 70 percent and 100 percent, or an enhanced match rate of 85 percent. There is a precedent for providing this type of enhanced match in the Money Follow the Person Provisions of the DRA. This approach would reward states currently providing home and community-based services, provide additional funding for expansions, and encourage a shift in spending from institutional to community and residential services.

The enhanced match could be conditioned on a state having a comprehensive system that meets federal guidelines for access points, service array, information and assistance, assessment and eligibility determination, and service coordination.

*Consider reforms that make housing in the community more affordable*

Medicaid covers "housing" costs in a nursing home but not in the community. Informants noted that this contributes to the institutional bias because the Supplemental Security Income (SSI) community payment standard is only 74 percent of the federal poverty level and is not sufficient to pay for rental housing in many communities across the country. Some proponents suggest that Medicaid should cover the housing component of the cost in assisted living facilities and allow beneficiaries to exclude the cost of rental housing from income in determining Medicaid eligibility. Another approach would allow medically needy applicants to exempt income that is used to pay for housing costs (or to allow rent to count toward the "spend down"). Expenses for housing-related costs are allowed in an institution and should be allowed in the community in order to reduce institutional bias. A third option would be to raise the federal SSI benefit to 100 percent of the federal poverty level and to expand the supply of subsidized housing.

Covering the housing component in assisted living shifts costs from SSI to Medicaid and increases the net cost to states. Allowing medically needy applicants to exempt income used to pay for housing is helpful only in medically needy states, and could increase costs for states if it cannot be targeted to beneficiaries who would otherwise enter an institution. Since SSI is federally funded, raising the benefit to 100 percent of the federal poverty level would increase federal expenditures. Creating a separate living arrangement for individuals who receive long-term care services would reduce the increase, but it would create inequities for beneficiaries who do not receive long-term care services.

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<sup>28</sup> Congressional Research Service report, <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2126203012005.pdf>.

## IMPROVE COORDINATION OF CARE FOR DUAL ELIGIBLES

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### Background

Dual eligibles are low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. Although dual eligibles make up only a small portion of Medicaid beneficiaries (14 percent), they account for a very large share (40 percent) of total Medicaid spending. Dual eligibles also represent nearly a quarter of Medicare spending (24 percent).<sup>29</sup> Most dual eligibles have very low incomes and substantial health needs.<sup>30</sup> Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, and more likely to have chronic health conditions and to need institutional care.

By definition, dual eligibles rely on both Medicaid and Medicare to finance their health-care needs. Medicare covers their basic health services, such as physician and hospital care. Medicaid pays Medicare premiums, cost-sharing, and benefits and services not provided by Medicare such as long-term care, and vision and dental care. The majority of Medicaid expenditures (66 percent) for dual eligibles are for long-term care services.<sup>31</sup> Since the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 in January 2006, dual eligibles receive their drug coverage through Medicare, but states must pay a “clawback” payment that roughly reflects the expenditures a state would make if it continued to pay for outpatient prescription drugs for duals through Medicaid.

### The Challenge

Because dual eligibles receive benefits from both Medicare and Medicaid, many care coordination challenges arise in delivering high-quality, cost-effective, and comprehensive benefits across the two programs. Fifty-eight percent of dual eligibles needing help with activities of daily living reported unmet needs, and 56 percent of those suffered at least one serious consequence – such as being unable to bath or dress themselves, falling out of bed or a chair, wetting or soiling themselves, or going hungry – because they did not receive assistance.<sup>32</sup> Many of these problems continue to exist even after the implementation of the Medicare Modernization Act’s prescription drug benefit.

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<sup>29</sup> Melanie Bella presentation at NASHP conference, October 15, 2006.

<sup>30</sup> Kaiser Family Foundation, *Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries* (February 2006). (73 percent of dual eligibles have annual income below \$10,000. Data cited are from 2002 and 2003).

<sup>31</sup> Kaiser Family Foundation, *Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries* (February 2006). The data are from FY2003, Urban Institute Estimates for KCMU, based on MSIS and Financial Management Reports (Form 64).

<sup>32</sup> National Academy of Social Insurance, based on Komisar, Feder and Kasper, “Unmet Long-term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles,” *Inquiry* (42:171-182).

## Two Scenarios that Illustrate Care Coordination Challenges for Dual Eligibles<sup>33</sup>

**Scenario 1: Medicaid meets a dual too late** – A nursing home stay covered by Medicaid began as a post-acute admission following a hospital stay that was covered by Medicare. The hospital stay led to a nursing facility admission for short-term rehabilitation services (also covered by Medicare), but when the Medicare coverage ended, the resident was not discharged, and she spent down her assets until Medicaid became the payer. Medicare served as the gateway to the nursing facility admission, and Medicaid, which might have been able to offer HCBS, could not have diverted the person into HCBS services because it only learned of the person’s eligibility for Medicaid long after the admission to the nursing facility occurred. The interaction of Medicare and Medicaid makes it difficult to promote community-based care.

**Scenario 2: Medicare pays for hospital entry after institutionalization** – Medicare inpatient services may be triggered when individuals receive poor care in a Medicaid-paid nursing home covered by Medicaid. For example, the poor quality of care may lead to falls or pressure sores that require inpatient hospital care paid by Medicare. Better quality nursing home care helps the Medicare program avoid unnecessary hospitalizations. Under the current system, it is less likely that one entity manages care across settings.

## Managed care as a tool to improve coordination

After almost a decade of rapid growth, Medicaid’s reliance upon managed care has leveled off in recent years. As of 2004, 60.7 percent of Medicaid enrollees obtained some or all of their care in managed care – only a marginally higher proportion than the 53.6 percent in managed care six years earlier.<sup>34</sup> States routinely use managed care for non-disabled children and their parents, who tend to have similar health needs to commercially insured populations. Use of managed care, particularly capitated managed care, has generally been much more limited among higher-cost and more complex disabled and elderly enrollees, but it is beginning to gain steam.

Medicaid is currently providing managed long-term care in eight states: Arizona, Florida, Massachusetts, Minnesota, New York, Texas, Wisconsin, and Washington. Several states are planning to operate managed long-term care in the near future: California, Hawaii, Maryland, Michigan, and Vermont. Medicaid managed long-term care generally has been shown to reduce the use of higher cost services such as emergency rooms, hospitals, and nursing homes, while it has had mixed results in trying to control Medicaid costs overall.<sup>35</sup> However, in some states, savings have been dramatic. Savings in Arizona’s Long-term Care System early on were 16 percent of a comparable fee for service program and resulted in a high percentage of participants receiving services in community settings rather than in an institution.<sup>36</sup> Savings to Medicaid in

<sup>33</sup> National Academy for State Health Policy, “Medicare and Medicaid Dual Eligibles,” *Issue Brief #6, Making Medicaid Work in the 21<sup>st</sup> Century* (Portland, ME: December 2004).

<sup>34</sup> “CMS 2004 Medicaid Managed Care Enrollment Report,” accessed at <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer04.pdf> on December 26, 2005

<sup>35</sup> AARP Public Policy Institute, *Medicaid Managed Long-term Care* (American Association of Retired Persons, 2005).

<sup>36</sup> Nelda McCall, “Lessons from Arizona’s Medicaid Managed Care Program,” *Health Affairs* (July 1997).

Wisconsin's Family Care program – a waiver program that provides pre-paid managed care services to people needing Medicaid long-term care services – were roughly \$452 per member per month: services were less expensive and people stayed healthier than people in the control group.<sup>37</sup>

The first programs to provide managed long-term care services specifically to dual eligibles were in Minnesota and Wisconsin. An early evaluation of these programs – Minnesota Senior Health Options and the Wisconsin Partnership Program – showed mixed results.<sup>38</sup> There were some modest positive results in terms of enrollee and family satisfaction, and there were lower rates of preventable hospital admissions and emergency room visits, but there was little if any improvement in mortality rates. However, at the early evaluation, there were no cost savings, but this may be due to rate setting procedures during the evaluation period, which have since been changed. State officials indicate that cost savings have increased over time.

In addition, the Program of All-Inclusive Care for the Elderly (PACE) covers an integrated set of Medicare and Medicaid services including both acute and long-term care. PACE began as a demonstration in 1986, but the BBA of 1997 established PACE as a permanent option under Medicaid and Medicare.<sup>39</sup> Unlike other programs, PACE operates under a coordinated set of rules and requirements outlined in federal Medicare and Medicaid law.

As of November 2005, there were 34 PACE sites nationwide enrolling about 11,200 individuals. PACE serves people 55 or older who live in a PACE service area and meet the state's nursing home admission criteria. PACE combines Medicaid and Medicare funds for services that include adult day care, medical care from program providers, and home health and personal care. Because PACE enrollees regularly attend adult day care centers where PACE services are provided, most sites are generally in urban areas and enrollment is limited to a few hundred individuals at each site.<sup>40</sup>

Many informants had a positive impression of the PACE programs, but generally felt they were currently small programs and it would be difficult to serve large numbers of participants as well as to operate PACE programs in rural areas. The DRA established a grant program for up to 15 pilot PACE programs in rural areas.

## **Ideas for Improving Care for Dual Eligibles**

Ideas that would improve care coordination for dual eligibles fell into two main categories:

- improving care coordination at the operational level, and
- creating financial incentives for coordination.

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<sup>37</sup> APS Healthcare, Inc., *Family Care Independent Assessment: An Evaluation of Access, Quality and Cost-Effectiveness for Calendar Year 2003-2004* (October 7, 2005).

<sup>38</sup> Robert Kane, "Multi-State Evaluation of Dual Eligibles Demonstration," July 2004, Revised August 2004.

<sup>39</sup> CRS Report for Congress, "Integrating Medicare and Medicaid Services Through Managed Care," June 27, 2006.

<sup>40</sup> Ibid.

## **Improve coordination at the operational level**

### *Federalize the financing of coverage for dual eligibles*

A major focus of the National Governors Association (NGA) and others leading up to the enactment of the Medicare Modernization Act was the notion of federalizing the financing of coverage for dual eligibles. By eliminating the problems due to two separate payers of care, federalization has the potential to improve coordination of care by assigning responsibility for all services to one entity.

Different versions of this approach have been discussed, including the federal government paying for all the costs associated with the dual eligibles, or a portion of the costs currently paid by Medicaid, such as Medicare premiums, prescription drugs not covered by Medicare, or long-term care. Federalized financing would eliminate incentives to shift costs between payers. Some informants felt strongly that since CMS has had no direct role in developing, contracting, and overseeing the long-term care delivery system, it would be critical for states to retain their role in this area.

### *Require Medicaid and Medicare to share beneficiary-level data*

Medicaid and Medicare do not share beneficiary-level data on health services received, prescription drugs, or diagnoses. This problem was recently aggravated when the dual eligibles moved from Medicaid to Medicare for their prescription drug benefits, and state Medicaid agencies lost access to most data on their drug use.<sup>41</sup> Shared data is a valuable tool for monitoring quality, access, and costs and is a mechanism for catching waste, fraud, and abuse in the program. For example, a dual eligible could be using a lot of Medicaid services (like home and community-based services or home health services) in order to stay out of the hospital, but Medicaid could not estimate the extent of cost savings because it would not have access to the hospital data.

Solving this problem would involve developing data-sharing arrangements in order to transmit information on a timely basis from Medicare to state Medicaid agencies and vice versa. Informants noted that data sharing arrangements would need to include confidentiality protocols, common files and interfaces, and common fields.

## **Create financial incentives for coordination**

Informants' suggestions in this section ranged from allowing Medicaid to benefit from savings to Medicare, to creating a new episode-based capitation payment, to improving the integration of dual eligibles in managed care.

### *Allow Medicaid to benefit from savings to Medicare*

States have little incentive to improve care coordination for dual eligibles, because they often do not benefit from the savings. For example, if a state spends additional funds on case management with the effect of reducing hospitalizations, the costs are borne by Medicaid but the savings accrue to Medicare.

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<sup>41</sup> States even lost drug data for dual eligibles who are enrolled in a single managed care plan.

One respondent noted that savings to the Medicaid program in fully integrated managed care programs for dual eligibles do not usually emerge during the first few years of the program. The median savings average about 26 percent, and most of these savings are due to reduced Medicare utilization.<sup>42</sup> The most generous approach for Medicaid would allow Medicare savings to be shared with Medicaid dollar for dollar. A second option would at least allow states to count Medicare savings toward budget neutrality requirements in waiver programs.

### *Create episode-based capitation for certain conditions*

One idea to consider is creating episode-based capitation or bundled payments for hospital and nursing home or rehabilitative services. One informant focused on changing the Medicare payment structure for hospitals. Currently, if a hospital readmits a person, even on the same day as his or her discharge, Medicare pays the hospital an additional Diagnosis Related Group (DRG) payment as if the patient had not just been in the hospital. A possible change would be that hospitals would be paid differently for patients with designated ambulatory care sensitive-conditions.<sup>43</sup> For any related readmissions within 90 days of discharge, the hospital would not get the full payment. The hospital would instead get a bonus for *not* readmitting a patient within a certain time after discharge.

Episode-based capitation would emphasize that a hospital's responsibility for a patient does not end with discharge. It would create both short-term and also long-term cost savings for Medicaid. In the short-term, fewer people may be discharged from the hospital in need of nursing home care paid for by Medicaid. In the long-term, if hospitals improve the quality of their care the health status of the population will improve and reduce the overall incidence of disability. This type of approach might also lessen medical errors. Medicare would not provide full payment if a patient were readmitted because of a mistake or if it involved a hospital-acquired infection.

### *Better integrate dual eligibles in the current full capitation model*

One informant felt very strongly that managed care could ultimately provide a mechanism for integrating the care of Medicare- and Medicaid-provided primary/preventive, acute, long-term, and behavioral services. Managed care would have the potential to integrate Medicare premiums and cost-sharing, non-covered Part D drugs, case management, institutional, residential, and in-home services and supports that are generally covered by Medicaid.<sup>44</sup> However, Medicare and Medicaid have inconsistent procedures that need to be consolidated to make the programs seamless. There should be a single enrollment form and process for Medicare and Medicaid. The enrollment date should be the same for both programs. One single set of marketing materials and one member handbook should be developed. State Medicaid agencies should be allowed to review the marketing materials that apply to dual eligibles. A single set of notices and letters should be designed to ensure that consistent information is provided. Multiple reporting requirements should be integrated (HEDIS, CAHPs, Performance Improvement Projects).

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<sup>42</sup> Informant interview.

<sup>43</sup> Robert Berenson, *Challenging the Status Quo in Chronic Disease Care: Seven Case Studies*, California HealthCare Foundation, September 2006.

<sup>44</sup> Melanie Bella, "Chronic Care Management, the Next Generation," presentation at NASHP Annual Conference, October 16, 2006.

Finally, the disease management/chronic care management program priorities for Medicare and Medicaid should be consistent.

*Monitor the growth of Medicare Special Needs Plans serving dual eligibles*

A new avenue for integrating acute and long-term care for dual eligibles is available through contracts with Medicare Special Needs Plans (SNPs). SNPs were authorized by the Medicare Modernization Act of 2003. They are the first Medicare advantage plans that can restrict enrollment for certain categories of special needs beneficiaries, such as dual eligibles, people in institutions, and people with severe or disabling chronic conditions. SNPs cover only Medicare services, but can provide services tailored to a target group and can also contract with states to cover Medicaid services for dual eligibles. As of July 2006, most (226 out of 273) of the SNPs were approved to service dual eligibles.

Although the SNPs are new and we do not yet know whether they will improve care coordination, some informants already had early thoughts about how to improve them. One informant suggested that guaranteeing a state's seat at the table might improve the quality of care provided to dual eligibles in SNPs. Under new CMS policy for contract year 2008, SNPs may target enrollment of dual eligibles to "subsets" of dual eligibles based on receipt of Medicaid.<sup>45</sup> For example, if a state Medicaid agency contracts with a plan for Medicaid wraparound services for certain dual eligibles (such as people with disabilities) and the plan also contracts as an SNP, the SNP may limit enrollment to that subset of dual eligibles.

*Consider options for encouraging enrollment in managed care*

Informants recommended changing requirements involving enrollment and retention in managed care plans. Currently, dual eligibles' enrollment in managed care is voluntary. Enrollment in Medicaid managed care is mandatory for some populations in some states. However, Medicare requires freedom of choice, which allows beneficiaries to be able to choose their providers.

Informants felt that freedom of choice in Medicare is unlikely to be waived and mandatory managed care enrollment for dual eligibles is controversial. One middle ground idea might be to require that dually eligible beneficiaries who enroll in a managed care plan must remain in the plan for one year to receive Medicare benefits. Another possibility is to allow a demonstration project that would allow a state to enroll dual eligibles in a mandatory managed care program that covers both Medicaid and Medicare benefits. A third option is to create incentives to use network providers. States could be given the authority to deny payment of the Medicare cost sharing amounts to providers who are not part of the Medicaid plan's network.

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<sup>45</sup> Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter, August 11, 2006.

# IMPROVE CHRONIC CARE MANAGEMENT

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## Background

In 2005, 133 million Americans had one or more chronic conditions, most commonly hypertension, arthritis, respiratory diseases, cholesterol disorders, and chronic mental conditions.<sup>46</sup> Almost half of these Americans have multiple chronic conditions and 25 percent have limitations in activities of daily living. This group of people accounts for 83 percent of all health care spending. The number of Americans with chronic conditions is expected to grow to 171 million by 2030.<sup>47</sup>

Nearly half (40 percent) of the non-institutionalized people enrolled in Medicaid have at least one chronic condition.<sup>48</sup> Most of Medicaid spending (83 percent) is paying for services for people with chronic conditions. A higher percentage (83 percent) of Medicaid enrollees have a chronic condition than those who are privately insured (75 percent).<sup>49</sup>

Low-income Medicaid beneficiaries with multiple chronic conditions often fall between the cracks. Programs that address needs in all areas are the exception, not the rule. Care is often fragmented with little communication across settings and providers. People with multiple illnesses have to navigate a system that requires them to coordinate several disparate financing and delivery systems themselves, making it more difficult to obtain the full range of appropriate services. People who need supportive services often delay seeking care until some acute exacerbation of their condition occurs, a crisis that may have been avoided if the individual had sought care earlier or if care coordination had been available.<sup>50</sup>

For example, a recent study showed that people with serious mental illness die on average 25 years earlier than the general population, largely due to preventable conditions such as cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza), and infectious disease.<sup>51</sup> These deaths could be prevented with better integration of primary care and mental health services.

## Traditional Disease Management and Care Management

Care management refers to a broad range of activities designed to reduce the need for services among the Medicaid population. In the 1980s and 1990s, states moved a large share of their Medicaid enrollees into risk-based managed care plans and primary care case management

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<sup>46</sup> “Chronic Conditions: Making the Case for Ongoing Care,” Partnership for Solutions, September 2004 Update (data projection by Rand corp), other data from 2001 MEPS.

<sup>47</sup> Ibid.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid.

<sup>50</sup> Robert Mollica, “Care Coordination for People with Chronic Conditions,” NASHP, Prepared for Partnership for Solutions, Johns Hopkins University, January 2003. Available at [http://www.partnershipforsolutions.org/DMS/files/Care\\_coordination.pdf](http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf) See also, *Coordinating Care for the Chronically Ill, How Do We Get There From Here*, NASHP’s Flood Tide Forum IV, February 2003.

<sup>51</sup> Barbara Mauer, et al, *Morbidity and Mortality in People with Serious Mental Illness* (National Association of State Mental Health Program Directors Medical Directors Council, October 2006).

(PCCM) programs. In the former, a health plan agrees to provide all necessary and covered services to a patient population for a fixed monthly payment. The plan decides on the precise mechanisms it uses to contain costs, but these generally include rate negotiations, utilization controls, and provider selection. In PCCM programs, enrollee care is coordinated by primary care physicians, who are paid monthly management fees, while other services are provided on a fee-for-service basis.

Care management can save money by preventing adverse drug reactions and hospitalizations. For example, a care coordinator can review all the medications a patient is taking to identify which may produce adverse drug-to-drug side effects and then coordinate with the appropriate physicians to revise the patient's drug regimen and avoid the problem. Care management can also prevent avoidable hospitalizations by monitoring nursing home care and providing information about alternatives when a beneficiary is discharged from a hospital.

Other, more limited versions of care management include disease management, case management, and high-cost case management – programs that supplement traditional care delivery and focus on subgroups of the covered population, such as people with diabetes or asthma. The services are generally provided by a vendor that contracts directly with the state. Twenty-six states were using one of these approaches in 2005, and 25 states say that they will begin new programs or expand existing ones in 2006.<sup>52</sup>

## Emerging Consensus about Chronic Care Management

Among informants, there was a strong consensus that chronic care management rather than disease management is the approach that works best. Traditional disease management programs often manage a single chronic condition despite the need to manage the “whole person” with multiple conditions. Within care management, one informant also stressed that Medicaid should move away from a traditional care model that included risk-based managed care and disease management, and toward an emerging care management model that includes an accountable medical home, patient-centered care, accountability, performance measurement, and financial incentives.<sup>53</sup> The American Academy of Pediatrics (AAP) characterizes the medical home as being “accessible, continuous, comprehensive, family-centered, coordinated and culturally effective.”<sup>54</sup> One informant said that an “accountable” medical home would include an explicit, ongoing connection with a Medicaid beneficiary and the health care system and be responsible for cost and quality, but might have different levels of financial risk.

A recent paper describes one emerging view of chronic care management based on the chronic care model.<sup>55</sup>

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<sup>52</sup> Vern Smith et al., *Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005 and 2006: Results from a 50-State Survey*, (Kaiser Commission on Medicaid and the Uninsured, October 2005).

<sup>53</sup> Melanie Bella, “Chronic Care Management, the Next Generation,” presentation at NASHP Annual Conference, October 16, 2006.

<sup>54</sup> The National Center for Medical Homes Initiatives for Children with Special Health Care Needs, The American Academy of Pediatrics.

<sup>55</sup> Robert Berenson, *Challenging the Status Quo in Chronic Disease Care: Seven Case Studies* (California HealthCare Foundation, September 2006).

The fully implemented Chronic Care Model relies on multidisciplinary teams of professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic conditions. Individually tailored evidence-based treatment plans guide clinical decision making and the recommended frequency of patient visits. Patients are charged with undertaking lifestyle and behavioral changes to manage their conditions responsibly. Health information technology is a care component of practice redesign, which also includes the use of disease registries that permit outreach to all patients with a certain condition, not just those who present for care. [It] also calls for greater involvement of non-physician professionals, and the team establishes links with community resources to help address the non-clinical needs that many patients with chronic conditions have.

## **Ideas for Improving Chronic Care Management**

Informants' ideas for improving chronic care management ranged from ways to improve Medicaid fee-for-service's ability to pay for promising approaches, to providing grant funding for states to test new approaches, to changing the UPL payment disincentive in managed care. The topic of chronic care management includes both the populations of dual eligibles and people in need of long-term care services discussed earlier, but for organization purposes, it is discussed as a separate topic in this paper.

### **Improve Medicaid fee-for-service's ability to pay for promising approaches**

Current federal policy defining which services are eligible for federal Medicaid assistance percentage (FMAP) and which are only eligible for administrative match may limit a state's interest in fostering chronic care management. CMS has provided guidance to states on payment for some of these types of services. Currently, Medicaid allows providers to bill for "disease management" as a medical service if it includes direct services by licensed practitioners such as nurses, pharmacists, or physicians who provide services directly to beneficiaries.<sup>56</sup> Medicaid can bill for these disease management services by contracting with disease management organizations, an enhanced PCCM program, or individual providers through changes to a state plan amendment or a waiver, and be billed at the state's FMAP. However, under Medicaid, some services are considered "administrative," such as providing feedback on beneficiary utilization of services, improving provider-patient communication skills, adherence to evidence-based guidelines, and other activities where there is no face-to-face contact with the beneficiary. These "administrative" activities are only eligible for a 50 percent administrative match.<sup>57</sup>

Medicaid programs may want to adjust physician reimbursement to reflect services delivered outside a traditional office visit, such as phone calls, e-mail, conferences with other professionals, and other activities. Funding streams that would allow providers to be paid for consultation and coordination, other services such as a referral to a care coordination program, team conferences with patients and families to discuss care options, or home visit approaches with

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<sup>56</sup> Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter #04-002, February 25, 2004.

<sup>57</sup> Ibid.

additional allowances for provider's travel time, would give providers more of a reason to engage in these activities.<sup>58</sup>

Another related issue important for dual eligibles is that Medicare has difficulty supporting the chronic care model because of its reliance on fee-for-service models and its specific rules about which providers can be paid and under what circumstances.<sup>59</sup>

Some promising care management practices that informants highlighted are:

### *Pediatric care teams*

In 2004, a program in Wisconsin with only 46 children enrolled saved \$5 million (even when including the cost of the team) when hospital charges decreased substantially.<sup>60</sup> The children had uncertain or multiple diagnoses involving five or more subspecialties, required multiple services, and had frequent hospitalizations. Each child was assigned a team (the program employed four nurses, two part-time physicians, a program coordinator, and one part-time administrative assistant) on the hospital payroll and which co-managed the children's care. The team worked together to make sure the specialists were in agreement about the children's care and arbitrated divergent opinions.

### *Predictive modeling*

A few informants suggested that Medicaid needs to implement chronic care predictive modeling programs that focus attention on managing the care of those who actually need it. Predictive modeling uses data to identify beneficiaries who are at high risk of using more resources over time. It is the "process of forecasting future health care expenditures, resource utilization, or adverse clinical events (such as inpatient admits) based on differences in individuals' health status."<sup>61</sup> For example, most diabetics do not need care coordination, but those that have intense needs would benefit from it.

### *Home visits*

Key informants described successful home visit programs that reduce hospitalizations. Washington Hospital Center's Medical House Calls Program, which began in 1999, assists about 150 to 170 patients weekly. A staff of 17 physicians and social workers travel within a 10 mile radius of the hospital to treat elderly patients and address emotional issues. The program estimates that the house calls cost \$35,000 annually per patient, compared with \$75,000 for a patient who might require transportation to a hospital for the same treatment.<sup>62</sup> Another program

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<sup>58</sup> Robert Berenson, *Challenging the Status Quo in Chronic Disease Care: Seven Case Studies* (California Health Care Foundation, September 2006).

<sup>59</sup> Robert Berenson and Jane Horvath. "Confronting the Barriers to Chronic Care Management in Medicare," *Health Affairs*. Web exclusive, 2003, W3-37.

<sup>60</sup> Federal Expert Work Group on Pediatric Subspecialty Capacity, *Promising Approaches for Strengthening the Interface Between Primary and Specialty Pediatric Care* (March 2006).

<sup>61</sup> Disease Management Association of America's Dictionary of Disease Management Terminology, in *For The Record*, February 14, 2005. Viewed on Nov. 2, 2006.

[http://www.medai.com/publications/pdf/2005\\_02\\_14\\_for\\_the\\_record\\_full.pdf](http://www.medai.com/publications/pdf/2005_02_14_for_the_record_full.pdf).

<sup>62</sup> "Hospital House Call Program Provides Care for Elderly Residents," Kaiser Daily Reports, October 2005. A case study of this program is also provided in Robert Berenson, *Challenging the Status Quo in Chronic Disease Care: Seven Case Studies*, California Health Care Foundation, September 2006.

at the University of Pennsylvania is nurse-based, and Johns Hopkins has a geriatrician-based program. The common component is identifying beneficiaries at risk and providing services that identify factors that eventually require more intensive services if they are not addressed.<sup>63</sup>

### *Prescription drug management*

One informant analyzed prescription patterns of Medicaid beneficiaries with mental health conditions in the state and notified doctors when they were inconsistent with best practices (whether due to overuse or underuse) to allow them to modify treatment. The informant reported that this effort saved \$7 to \$8 million in the first year of operation. Prescriptions decreased on average by 2 prescriptions per month for people on psychiatric drugs and 1 prescription per month on other medications, and hospitalization decreased as well.

### *Training for non-clinicians*

One state is funding clinical practitioners to practice in day care centers around the state. Rather than providing one-on-one consultation, the clinician mostly teaches behavior-management to day care providers and parents, which may help children stay out of the residential system in the long run.

## **Provide grant funds for states and providers to test chronic care management approaches**

States and providers should be able to test new chronic care management approaches without the constraints of current fee for service or managed care funding streams. Grants with longer time spans may also be needed to show that investments in chronic care management pay off. It will likely take states and providers longer than a 12-month budget cycle to demonstrate the savings of these types of investments. Federal grants could be provided to states or directly to providers that serve a large portion of Medicaid patients. Grants could provide funding for infrastructure and support that would allow providers to

- teach patients self-management;
- communicate more often with patients outside of face-to-face office visits;
- manage their medications;
- coordinate care among many other professionals and providers to avoid redundancy and errors; and
- develop and maintain more appropriate medical information summaries.<sup>64</sup>

## **Change the UPL payment disincentive**

One barrier to expanding chronic care management programs provided through Medicaid managed care is the Medicaid Upper Payment Limit (UPL).

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<sup>63</sup> While Medicare covers physician home visits, rates are lower than the rate for a home health aide. The rate does include compensation for transportation, follow-up calls, and back office work.

<sup>64</sup> Berenson, "The Medicare Chronic Care Improvement Program," Testimony, May 11, 2004, viewed at <http://www.urban.org/url.cfm?ID=900714>.

Under the Medicaid program, states have broad flexibility in determining the payment rates for Medicaid providers; however, the total payments to hospitals and nursing facilities cannot exceed an upper payment limit (UPL), which is the rate Medicare would have paid. Under a managed care program, states and/or providers must forego the additional federal Medicaid dollars generated through UPL funding arrangements. The loss of federal funding provides a significant disincentive to states and providers to develop or participate in managed care programs.<sup>65</sup> One option to ameliorate this problem would be to treat UPL revenues like Disproportionate Share Hospital (DSH) payments.

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<sup>65</sup> For more information, see, “Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action,” Congressional Research Service, Report RL32101.

## REDUCE THE BURDEN ON MEDICAID

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### Background

Demand for long-term support services is likely to increase in the coming years due to the aging of America and the large number of people with chronic conditions. The Congressional Budget Office reports that expenditures for long-term care for elders totaled \$135 billion in 2004.<sup>66</sup> The aging baby boom generation is expected to expand demand for long-term care services. Some estimates project that spending for long-term care for the elderly could nearly quadruple by 2050.<sup>67</sup>

The cost of paid care far exceeds even most middle class families' ability to pay. In 2005, the average annual cost of nursing home care was nearly \$75,000 and of home care was estimated at \$19 per hour. The need for extensive, paid, long-term care is a catastrophic expense. When families provide care in the community, it also comes at a cost – to employment, health status, and quality of life – and it may also fail to meet the individual's needs.<sup>68</sup>

Consideration of new programs outside of Medicaid to provide long-term care services and supports were not the major focus of our work, but they could potentially have a large impact on Medicaid. As mentioned earlier, Medicaid is a major source of financing for long-term care, and currently accounts for 42 percent of all long-term care spending and 43 percent of all expenditures for nursing home care.<sup>69</sup>

### Ideas for Reducing the Burden on Medicaid

#### Provide long-term care coverage based on a social insurance model

There are different social insurance models for providing long-term care coverage.<sup>70</sup> One approach would be modeled on Social Security and would provide everyone access to a basic, limited long-term care benefit, supplemented by private insurance for the better-off and enhanced public protection for the low-income population. A second approach could be means-tested, establishing a national floor of income and asset protection that would reform or replace Medicaid's coverage of long-term care. People could then purchase private long-term care insurance to protect a larger amount of assets.<sup>71</sup>

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<sup>66</sup> Congressional Budget Office, *Financing Long-term Care for the Elderly* (April 2004). Available at: <http://www.cbo.gov/showdoc.cfm?index=5400&sequence=1&from=0>

<sup>67</sup> General Accounting Office, *Long-term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets* (Washington, DC: GAO-02-544T, March 21, 2002).

<sup>68</sup> Metlife Mature market Institute, *Metlife Market Survey of Nursing Home and Home Care Costs* (Sept. 2005).

<sup>69</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts: Medicaid and Long-term Care Services* (July 2006).

<sup>70</sup> National Academy for Social Insurance, *Developing a Better Long-term Care Policy: A Vision and Strategy for American's Future* (November 2005).

<sup>71</sup> Ibid.

One more limited step in this direction suggested by an informant is the CLASS Act (Community Living Assistance Services and Supports), which has been proposed in Congress. It would establish a national insurance program to be financed by a voluntary payroll deduction to provide benefits to adults who become severely functionally impaired. To qualify for benefits, individuals must be 18 years old and have contributed to the program at least 5 years (contributions would be voluntary). All working adults would be automatically enrolled in the program, unless they choose not to be. There would be two benefit tiers: Tier 1 benefits (\$50/day) will be payable to eligible individuals who have 2 or more impairments of Activities of Daily Living (ADL) or the equivalent cognitive impairments. Tier 2 benefits (\$100/day) will be payable to individuals who have 4 or more ADLs or the equivalent cognitive impairment.<sup>72</sup> They would be able to purchase any service that meet the person's functional needs. This approach is more flexible than a menu of services and allows the options that substitute for services listed on a menu. For example, purchasing a microwave may be approved in place of having a homemaker or personal care attendant visit to prepare meals. This type of proposal could reduce reliance on Medicaid and spread the responsibility for financing long-term care across a broader base on contributors.

If structured properly, the availability of additional financing mechanisms for long-term care could lesson Medicaid's burden by creating a uniform national needs-based eligibility threshold. They could also expand access to services in states with limited financial eligibility criteria and higher nursing home admission criteria.

### **Create incentives for the purchase of private long-term care insurance**

Currently, only 10 percent of long-term care is paid for by private insurance.<sup>73</sup> Several people suggested that incentives to purchase private long-term care insurance, such as tax incentives or increased use of the Medicaid long-term care partnership were needed to relieve fiscal pressure on Medicaid. Currently, private long-term care insurance policies are a limited means of spreading long-term risk because private long-term care insurance is: 1) not available to people who already have long-term needs; 2) is not designed to meet the needs of younger people who are also at risk of needing long-term care; 3) is not affordable to a substantial segment of older people with low and modest incomes.<sup>74</sup> Informants suggested two major ways of doing this: one through tax incentives or publicly-financed subsidies, or through expansion of the Long-Term Care Partnership program which was authorized by the Deficit Reduction Act of 2005.

#### *Provide tax incentives or subsidies for the purchase of long-term care insurance*

Currently, benefit payments made by an employer for a qualified long-term care insurance policy are already tax-free (like benefit payments under a health-insurance policy). However, the

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<sup>72</sup> Summary of the DeWine-Kennedy CLASS Act of 2005, Community Living Assistance Services and Supports Act, Provided by Senator Kennedy's staff, February 2006. Available at [http://www.easterseals.com/site/PageServer?pagename=OPA\\_Class\\_Act\\_Summary](http://www.easterseals.com/site/PageServer?pagename=OPA_Class_Act_Summary)

<sup>73</sup> Komisar, H & Thompson, L, *Who pays for long-term care? Fact Sheet* (The Georgetown University Long-term Care Financing Project, Updated July 2004).

<sup>74</sup> Judith Feder, "Long-term Care and Medicaid" Spiraling Costs and the Need for Reform," Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 27, 2005.

amount an employee pays is deductible, subject to age-based restrictions, only if itemized medical expenses exceed 7.5 percent of annual income.<sup>75</sup>

There are different approaches for providing tax incentives for long-term care. One informant suggested enacting a new tax incentive program like a 401(k) but for long-term care insurance where pre-tax dollars were automatically deducted from payroll. There have also been bills in Congress that would allow a deduction for qualified long-term care insurance premiums; and payment for LTC insurance through "cafeteria" plans and flexible spending arrangements. Alternatively, there could be refundable tax credits based on income that would include people who owe little or no federal income tax.

Because long-term care insurance is so expensive, additional tax preferences that are not large-scale refundable tax credits or subsidies are likely to benefit those who would have purchased long-term care insurance even in the absence of credits, thus substituting private for public dollars.<sup>76</sup>

### *Support the DRA's expansion of the long-term care partnership*

Another approach to expand the use of private long-term care insurance has been "the long-term care partnership," an effort to provide state-approved insurance protection against impoverishment from the costs of LTC. Consumers who buy qualified LTC policies receive coverage for a selected amount of time. If the private policy is exhausted, they can continue their LTC under Medicaid without spending close to all of their assets, as is usually required by Medicaid. Four states (CA, CT, IN, NY) have established explicit partnerships with insurance companies to sell a policy that if purchased changes the resource test used for Medicaid eligibility. The DRA now allows all states to participate in the partnership provided that the partnership program adopt NAIC model standards and most states are planning to do so.<sup>77</sup>

Proponents of these approaches hope that through the safeguard of Medicaid coverage under the partnership, people will be more likely to buy private long-term care insurance. State policy makers comment that increasing purchase rates reduces potential reliance on Medicaid. However, many seniors have very low incomes and the partnership programs and LTC coverage in general are generally unavailable to people with low and moderate incomes. An additional problem is that LTC Partnership policies and other private LTC insurance is generally not available to people with disabilities or people who already require LTC services and supports. Experience with the policies in the four original states produced only limited purchases, mostly among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending.<sup>78</sup>

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<sup>75</sup> Prudential's Long-term Care Insurance Tax Guide, [http://www.longtermcarelink.net/pru\\_ltc.pdf](http://www.longtermcarelink.net/pru_ltc.pdf).

<sup>76</sup> Judith Feder, "Long-term Care and Medicaid" Spiraling Costs and the Need for Reform," Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 27, 2005.

<sup>77</sup> Jeff Crowley, *Medicaid Long-term Services Reform in the Deficit Reduction Act* (Kaiser Family Foundation, April 2006).

<sup>78</sup> Judith Feder, "Long-term Care and Medicaid" Spiraling Costs and the Need for Reform," Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 27, 2005.

## **Support people with chronic conditions and disabilities at work and protect access to comprehensive employer-sponsored health insurance**

It is also important to provide support in the current system outside of Medicaid, to avoid costs being shifted to Medicaid. The largest number of people with chronic conditions are of working age and are privately insured.<sup>79</sup> Seventy-eight million people with chronic conditions have private insurance coverage and their care accounts for about 74 percent of private insurance spending.<sup>80</sup>

Many informants mentioned that providing employment and training opportunities for people with disabilities would save Medicaid money in the long run as people both gained income and possibly relied on private insurance to meet some of their health needs. Informants noted that Medicaid's rehabilitation option is an important tool to provide a range of services for people with mental health conditions; the option allows them to move toward self-sufficiency.

Informants also mentioned that Medicaid benefit offerings are usually more generous than those in private insurance. Because private insurance will often not provide access or not pay for many of the needed services, people often migrate to Medicaid to receive care.

Mental health coverage is an area of particular concern. Despite federal mental health parity legislation and state parity laws, gaps persist in private insurance coverage of mental health services. One survey found that only about two-thirds of private plans covered intensive nonresidential care, and slightly more than a third covered non-hospital residential care.<sup>81</sup> Workers with employer sponsored insurance often face limits on mental health benefits, with almost a third having a limit of twenty or fewer outpatient visits and half having a limit of thirty days or fewer for outpatient care.<sup>82</sup> The Government Accounting Office found that parents placed more than 12,000 children into the child welfare or juvenile justice systems solely to obtain mental health services.<sup>83</sup>

Providing more equal benefit design between Medicaid and private insurance would help alleviate this problem. In addition, providing advocacy and counseling for families to make sure they maximize their private health insurance benefits before they turn to Medicaid may also help.

Changes at the federal level that would require health plans to provide certain benefits or require states to regulate self-insured health plans are extremely controversial. A very limited number of benefits and services are currently required under federal law (such as hospital stays after childbirth under the Newborns' and Mothers' Health Protection Act of 1996) and adding additional services involves amending the Employee Retirement Income Security Act (ERISA). However, states often require that people covered by private health insurance have access to a range of preventive services and benefits. For example, seven states require employers to provide

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<sup>79</sup> "Chronic Conditions: Making the Case for Ongoing Care," Partnership for Solutions, September 2004 Update (data projection by Rand corp), other data from 2001 MEPS.

<sup>80</sup> Ibid.

<sup>81</sup> Diane Rowland, et al. "Accomplishments and Challenges in Medicaid Mental Health," *Health Affairs*, 2003.

<sup>82</sup> Ibid.

<sup>83</sup> General Accounting Office, *Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services* (Washington, DC: April 2003). Data from FY 2001.

early intervention services for children birth to age three.<sup>84</sup> These laws can help improve some children’s access to private coverage for early intervention services and also can alleviate Medicaid’s need to pay for these services. However, under ERISA, these state “mandated benefits” only apply to coverage offered by “fully-insured” employers, and do not apply to coverage offered by medium and large companies that are “self-insured” and pay for employees’ health care costs directly (more than half of people with employer-sponsored coverage are currently enrolled in self-insured plans). Allowing state mandated benefits to apply to self-insured plans also involves a controversial change to ERISA at the federal level.

## **Strengthen Early Intervention Services**

Providing services to young children who have a disabling condition or other special need that may affect their development can also reduce the burden on Medicaid in the long term. Early intervention services range from identification – such as through hospital or school screening and referrals – to diagnostic and direct intervention programs. These programs and services can begin any time between birth and school age and are funded by a variety of sources, including Medicaid. They may focus on the child alone or on the child and family together, and they take place in various settings: a center, the child’s home, a hospital, or a combination of settings.

Informants noted that early intervention could be better supported if parents had improved access to services for their own needs. A common problem is that Medicaid funds mental health services for the child, and may also fund family therapy to address the needs of the child. However, parents may need separate treatment for their own mental health or substance abuse challenges in order to foster the development of a healthy child. In many states, low-income children are eligible for Medicaid, but their parents are uninsured, making it difficult for parents to receive treatment.

Although early intervention services are often, on a short-term basis, more costly than traditional school-aged service delivery models, they often provide significant long-term cost savings. Early intervention has been shown to result in the child needing fewer special education and rehabilitative services later in life, and being more likely to be self-sufficient and find employment.<sup>85</sup>

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<sup>84</sup> Council for Affordable Health Insurance, *Health Insurance Mandates in the States* (2006).

<sup>85</sup> The Global Intervention Network, *Why Intervene Early?* Retrieved Jan. 16, 2007.  
<http://www.dac.neu.edu/cp/ei/usdept1.html>.

## CONCLUSION

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As the dominant payer for long-term care services, states have experimented with many models of delivering care through their Medicaid programs. Most state innovations have never been subject to formal evaluation, thereby preventing precise statements about the effects of these innovations. Yet, there is substantial consensus among our key informants about the most promising mechanisms for improving quality and controlling costs for the highest-cost Medicaid enrollees.

Our informants had ideas that focused on four main categories:

- rebalancing long-term care,
- coordinating care for dual eligibles,
- improving chronic care management, and
- reducing the burden on Medicaid.

Some suggestions were small while others were quite bold. All shared the goal of improving the Medicaid program's ability to get the right care to people at the right time. Some informants focused on specific delivery models; others focused on financial incentives designed to encourage enrollees, providers, and/or health plans to adopt better models of care delivery. Financial incentives include paying directly for important services, rewarding better outcomes, enhancing payments to states for certain activities, and capping payments to systems so they can benefit from savings they generate through better delivery of care.<sup>86</sup>

Chronic care is driving the cost of the Medicaid program, and the future of insurance coverage for low-income families and children depends upon success in meeting the needs of those with chronic conditions at a cost society can afford. This paper tallies the suggestions made by a group of informants who have given substantial thought to how Medicaid can achieve this goal. We hope it represents a helpful contribution to ongoing efforts to meet the needs of the most vulnerable Americans.

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<sup>86</sup> One informant proposed a block grant to states for the Medicaid program as a mechanism for providing strong incentives for savings while also providing maximum flexibility regarding the methods for achieving those savings. The block grant suggestion was not included among the identified options because it is silent as to the methods, and this paper was designed to provide readers with a realistic possible set of methods.

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