DUAL ELIGIBLES

Financial Risk Shifts To More Providers

By JADE GONG, M.B.A., RN, and KATHLEEN M. GRIFFIN, Ph.D.

In the ideal world, poor elders with debilitating chronic diseases and functional limitations would have easy and immediate access to a network of high-quality care and supportive services that allow them to live well and safely in their homes and communities. The network would be person-centered so that their needs and preferences would be honored, and all services and venues would be integrated and connected. The elders would be fully engaged with care providers in managing their chronic conditions. The per-person costs of care would be less than it is today, as fragmented care and duplication of services disappear.

Transformational changes now being proposed in the health care delivery system for Medicare and Medicaid dual eligibles are breathtaking in scope and scale. However, long before policymakers began to focus on our fragmented and uncoordinated care delivery, Catholic health care providers had shown an unwavering commitment to caring for those who are poor and elderly or disabled and eligible for both Medicare and Medicaid payments. Catholic hospitals and health systems operate nursing homes, low-income housing, home care and a variety of other programs offering medical care and long-term services and supports to this population.

The growth of the dual-eligible population and the upward spiral in costs of care have prompted federal and state policymakers to create demonstration programs that attempt to improve care coordination while shifting the financial risk inherent in these delivery and financing models to providers and managed-care organizations. In order to achieve the goals set for such demonstrations, Catholic health care providers must accept the risk and proceed to develop and implement new delivery models in their communities.

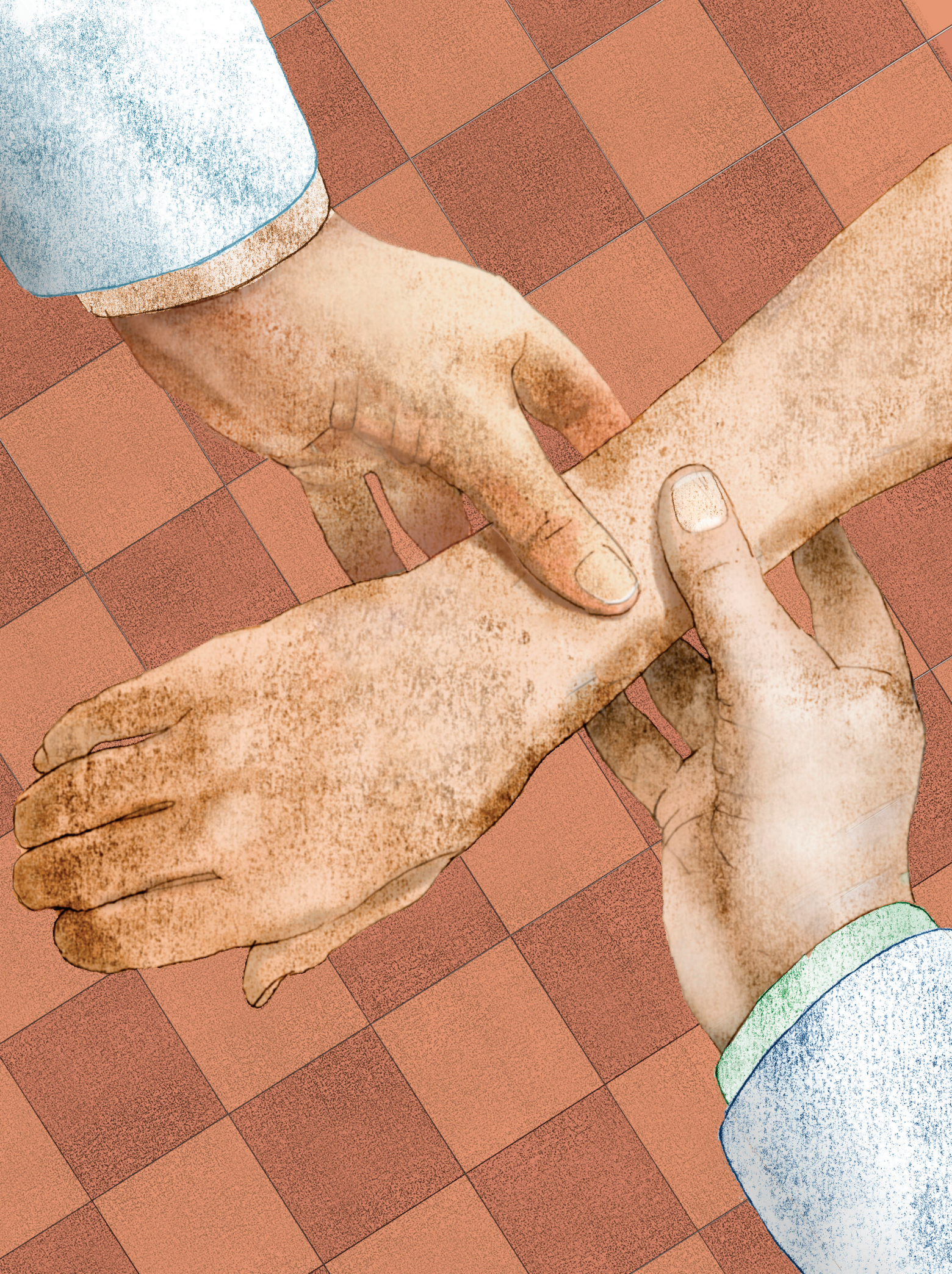
WHO ARE THE DUAL ELIGIBLES?

Dual eligibles typically are low-income seniors and people with disabilities who qualify to be enrolled in both Medicare and Medicaid. Dual eligibles are disproportionately costly to both programs, representing $229 billion in expenditures in 2007, the latest data available. Nationally that year, Medicare-Medicaid enrollees were 20 percent of the Medicare population and represented 32 percent of Medicare expenditures. They comprised 15 percent of the Medicaid population and 35 percent of Medicaid expenditures.[1]

Full-benefit Medicare-Medicaid enrollees were more likely than Medicare-only enrollees to use every type of Medicare health service. This data underscores the potential benefits of a dual-eligible program. However, dual eligibles differ in terms of age, where they reside, the number of their chronic conditions and the presence of behavioral health issues. Improving the care delivered to this diverse population will require different approaches for different groups.

The separate nature of the Medicare and Medicaid programs presents conflicting financial incentives that result in less than optimal coordinated care for enrollees and in undesired outcomes. Nowhere are the conflicting incentives more apparent than in the structure of Medicaid programs — they make nursing-home care widely available in every state as an entitlement, but they make it difficult to create and fund robust home and community-based delivery systems for persons who are eligible for Medicaid nursing-home care.

Coordinated care could lead to improved health outcomes, greater satisfaction with care and lower costs to



federal and state governments. Two areas of cost savings, for example, are by reducing hospitalizations of dual eligibles from Medicare and Medicaid nursing facilities and by reducing overall the number of long-term nursing-home placements.

Given the magnitude of the problem, and the huge opportunity to reduce care-related costs, the Centers for Medicare and Medicaid Services (CMS) and the newly created Federal Office for Medicare and Medicaid Coordination presented states with a novel opportunity to transform their care delivery systems for dual eligibles. In 2011, CMS outlined two models for states interested in pursuing integration of primary, acute, behavioral health and long-term services and supports (LTSS) for their full-benefit Medicare-Medicaid enrollees. Both models offer the opportunity to share in costs savings, and 25 states have submitted requests to CMS to participate in one or both three-year demonstration projects:

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- **Capitated Model:** An entity, typically a health plan, receives a capitated rate for providing both Medicare and Medicaid benefits to dual eligibles and is thus at financial risk for delivering the required services for less than the capitated rate. Assuming the payment rate is below what the state and federal governments now pay for this care, savings will ensue. At present, only Massachusetts has been approved by CMS to deliver this model of care.
- **Managed Fee-for-Service Model:** States take responsibility for coordinating care that is paid for on a fee-for-service basis. Under this model, states could qualify for performance payments if they meet quality and Medicare savings targets.

Unlike most demonstration projects, which will occur on a small scale, these projects are currently projected to have an impact on the care that is delivered to almost three million dual eligibles who could be enrolled. However, enrollment brings its own challenge because of different Medicaid and Medicare statutes.

As part of the capitated approach, many states are turning to health plans — mostly operated by national for-profit companies — in order to scale up quickly and get the dual-eligible population enrolled. In order to facilitate widespread enrollment, many states are mandating participation in the Medicaid portion of the managed-care program. (See article on page 22.)

But on the Medicare side, federal statute prohibits states from mandating participation in managed-care programs. An eligible individual must either choose to enroll in the dual-eligible, managed-care program or, if the state automatically enrolls him or her, the individual must be allowed to decide whether to stay in the Medicare managed-care program. Thus the full potential of integrated and coordinated care will only occur if a substantial proportion of dual eligibles opt in or, if they are auto-enrolled, they then do not opt out of the Medicare managed-care program.

HOW ARE THE CAPITATED MODELS OF CARE BEING STRUCTURED?

A closer look at the specific proposals that participating states submitted to CMS offers insight into how they intend to work with health plans and other capitated entities to achieve their goals. The proposals offer details into the entities that will be at risk for the care, how they will be paid, the quality metrics that will be used and the resultant opportunities for the provider community to participate in achieving the goals of the demonstrations.

Several themes emerge:

- Most of the state plans submitted thus far mandate auto-enrollment in the Medicaid managed-care program in order to achieve substantial numbers. As mentioned earlier, however, Medicare beneficiaries must be permitted to remain in the Medicare fee-for-service program if that is their choice.
- States are targeting populations that have not been previously enrolled in managed-care plans — that is, individuals who need long-term supportive services, including those residing in nursing homes and persons with mental health problems. CMS has supported extensive analysis of Medicare and Medicaid utilization data to show that these populations incur the greatest costs, thus have the most to gain from more coordinated care funded by Medicare and Medicaid. Therefore, states are now enrolling, rather than excluding, these high-cost populations and seeking new

models of care that address their identified needs.

- States are embracing stratified care coordination models based upon an enrollee's level of need ranging from low-intensity to high-intensity.
- States are working to avert nursing home placements whenever possible and increasing options for home and community-based services. For example, many state plans direct care coordinators to actively and regularly determine if dual eligibles residing in nursing homes are interested in placement in the community if that is achievable.

Across states and the entities that receive the capitation, Ohio is allowing only selected health plans to accept risk for these populations. Approved health plans have proposed a variety of innovative models for achieving the goals that allow providers to accept risk to create new models of care.

Michigan is defining a new entity called integrated care organizations (ICOs) that will provide care to dual eligibles. While health plans would clearly qualify as ICOs, it appears likely that some providers will also meet ICO requirements. The state has not yet issued its request for proposal detailing the ICO requirements.

New York is building upon its long-standing managed-care infrastructure by creating managed long-term care programs (MLTCs). Under the state's plan, these may be health plans as well as provider organizations that are willing to accept risk and meet MLTC requirements.

These state proposals for creating a managed-care infrastructure to care for dual eligibles have inherent challenges to assuring quality care, enrollee satisfaction and reduced per-capita costs. Among them:

- Do the states' plans have the experience with effective models of care that can meet the diverse needs of the dual-eligible populations, such as nursing-home-eligible populations and behavioral health populations? Health plans traditionally have served children and younger adults with fewer health care needs and not dual-eligible populations.
- Will health plans be able to develop the robust networks necessary to meet the needs of these populations for long-term supportive services? Most health plans do not currently operate networks that include home and community-based services and behavioral health providers.
- Can cost savings actually be achieved within this time frame and will states count on cost savings that will not ultimately materialize? The Congressional Budget Office's recent evaluations of the Medicare Coordinated Care Demonstrations found that in most cases, little or no savings were achieved.

A number of Catholic providers already are leaders in managing the care of dual-eligible persons through at-risk payment plans. Some Catholic health systems, like Catholic Health East (CHE), have embraced the Program of All-inclusive Care for the Elderly (PACE) as a model of care that achieves the triple aim of improved outcomes, reduced per-capita cost and greater patient satisfaction.

Other Catholic health care providers are forming Medicare accountable care organizations (ACOs) and applying for the Medicare Shared Savings Program (MSSP) so that they can share in savings achieved by improved care coordination. By using skills and experience gained from years of caring for poor elders and new skills gained from shared risk programs such as PACE and MSSP, Catholic providers can become the natural leaders in assuring that state plans for dual eligibles continue to provide optimal care that respects consumer preferences.

In states that allow a provider to serve as the entity accepting risk, Catholic health systems can organize a delivery system that meets the state's requirements and directly accepts the payment and risk associated with delivering care to dual eligibles. This would require an effective care management system that is well integrated with patient-centered medical homes to directly enroll dual eligibles. Michigan's dual-eligible plan will offer an opportunity for providers to become integrated care organizations. New York's dual-eligible plan allows PACE providers and other provider-based entities to become licensed as a managed long-term care plan and directly enroll dual eligibles.

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direct risk and enroll dual eligibles, Catholic providers may choose to partner with health plans to develop and implement new models of care. Examples include accepting a shared risk arrangement to provide primary, acute and long-term care for a subset of the dual-eligible population and accepting a shared risk arrangement to provide home and community-based services to enrollees transitioning from the nursing home to a community-based setting.

Many Catholic providers offer low-income housing to dual-eligible populations. Health plans will face a growing need for housing options for these populations if they are to be served in the community rather than in nursing homes. Catholic providers may consider options such as creating fee-based care management programs to be implemented in the senior housing community with a share of savings if quality metrics like reduced hospitalizations/rehospitalizations and reduced emergency room visits are achieved; or partnering with area agencies on aging and local municipalities to develop tax credits and other municipality-funded, low-income housing for dual-eligible populations.

Relying on their long experience and fundamental mission in providing care for society's most vulnerable, Catholic providers are well-positioned to bridge the gap between today's less desirable system of care for dual eligibles and tomorrow's ideal.

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NOTE

1. Centers for Medicare and Medicaid Services, *Medicare-Medicaid Enrollee State Profile: The National Summary* (Washington, D.C.: U.S. Dept. of Health and Human Services, 2012).

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