

Dual eligible beneficiaries: Managing their care to overcome conflicting Medicare and Medicaid incentives

Carol Carter

November 5, 2009

Roadmap

- Conflicting incentives between Medicare and Medicaid
- Managed care initiatives to coordinate care
- Spending differences across dual eligible beneficiaries
- Implications for care coordination

Conflicting incentives between Medicare and Medicaid

- Incentives for providers to transfer patients to other settings
- Lowers spending for one program but raises it for the other
- No incentive to consider long run costs, service provision, or care coordination

Example: Hospitalization of nursing home residents

- Nursing homes have financial incentive to transfer residents to hospitals
- Hospitalizations lower state spending on nursing homes but raises Medicare spending on hospitals

Fee-for-service payment methods encourage cost shifting

- Per unit payments do not encourage providers to consider the costs for other providers or programs
- No payment policies to discourage transfers
- Bundling Medicare payments would not address conflicting incentives between Medicare and Medicaid that can raise combined spending

Conflicting incentives may lower quality of care

- Multiple patient transitions increase the risk of:
 - Fragmented care
 - Medication mismanagement
 - Medical errors
 - Poor patient follow up
- Unnecessary hospitalizations expose beneficiaries to hospital-acquired illness
- Multiple sources of coverage may result in poorly coordinated care

Managed care initiatives to coordinate care

For the entity

- Contracts with both programs
- At risk for total spending
- Manages and coordinates care *and* benefits

For the beneficiary:

- One membership card
- Combined set of benefits
- Coordinated care
- Single point of inquiry

Issues to resolve

- Adequate number of entities to ensure access
- Overcoming beneficiary reluctance to enroll in a managed care entity and comply with its rules
- Countering the incentive to stint on service provision
- Lack of entity's expertise in coordinating unfamiliar services

Characteristics of dual eligible beneficiaries that will influence care coordination strategies

Compared to other beneficiaries, dual eligible beneficiaries are more likely to:

- Be younger and disabled
- Have 3+ limitations in their ADLs
- Live in an institution
- Have less education
- Be mentally impaired

Subgroups examined

Disabled under 65

Developmentally disabled (7%)

Dementia (1%)

Mentally ill (17%)

Physically impaired (<1%)

Not physically impaired (13%)

Aged

Developmentally disabled (1%)

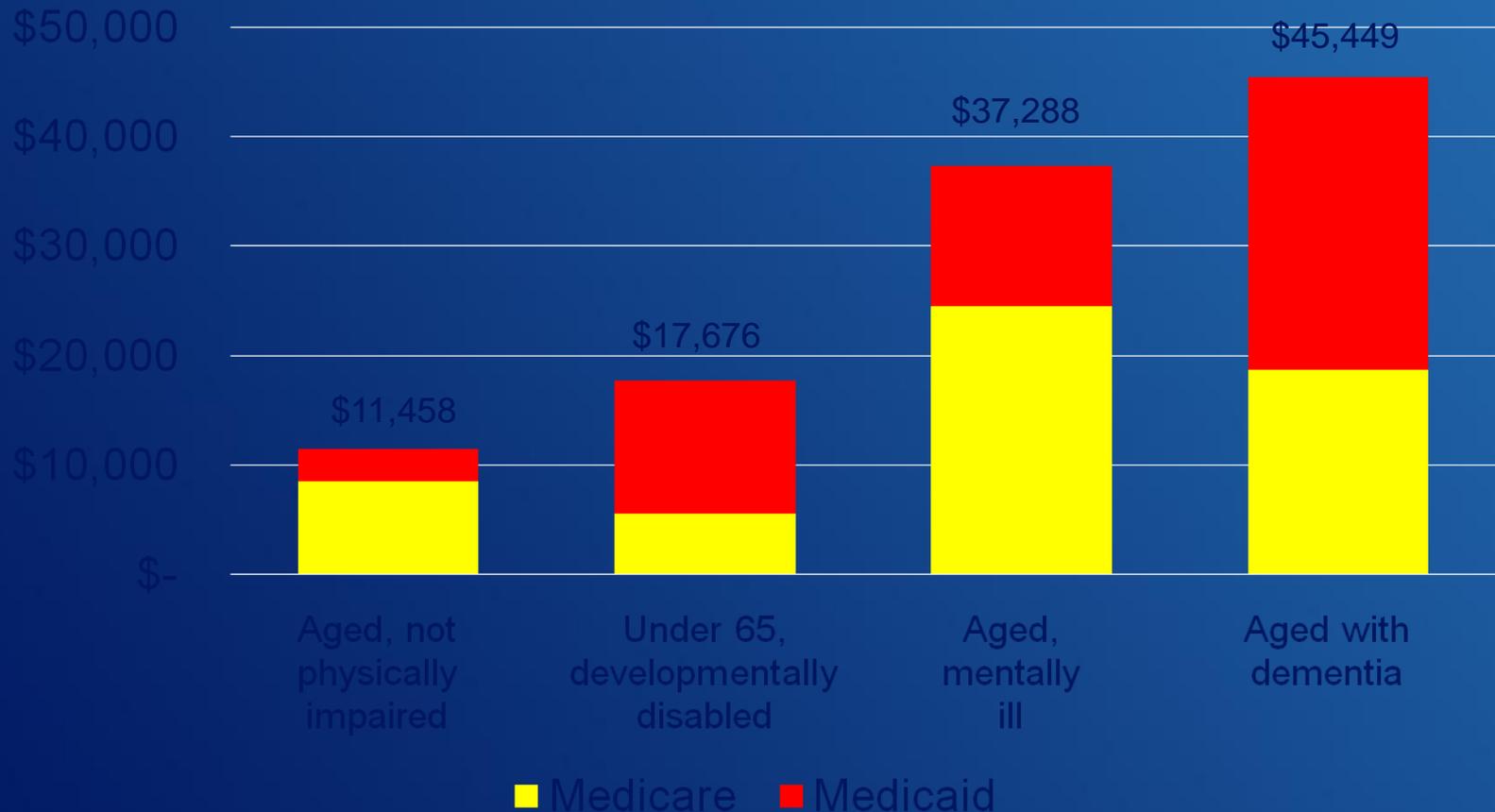
Dementia (10%)

Mentally ill (16%)

Physically impaired (2%)

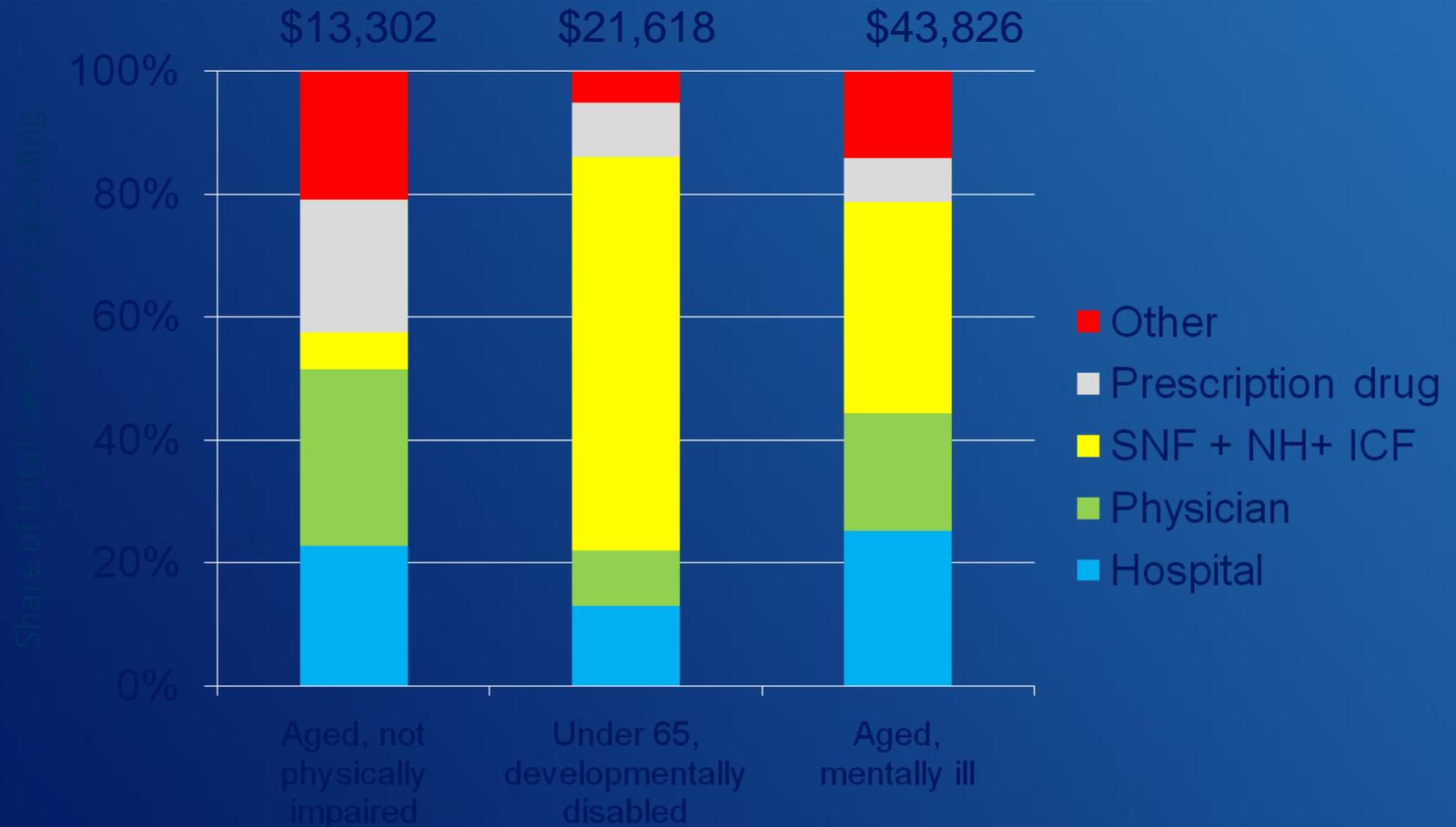
Not physically impaired (33%)

Spending differences: Per capita spending by clinical group of dual eligible beneficiaries



Data are preliminary and subject to change.
Source: MCBS Cost and Use file, 2004-2006.

Spending differences: Mix of service spending by clinical group of dual eligible beneficiaries



Data are preliminary and subject to change.
Source: MCBS Cost and Use file, 2004-2006.

Implications for care coordination: Select certain types of dual eligible beneficiaries?

- High per capita spending—Medicare, Medicaid, or combined
- Numbers of dual eligible beneficiaries
- Potential to lower spending—such as avoidable hospitalizations

Care coordination strategies will differ by dual eligible subgroup

- Range of settings used
- Concentration of spending
- Institution vs community residence

Future work

- Examine Medicare and Medicaid spending by clinical groups
- Review integrated models of care: lessons for designing coordinated care initiatives

Questions for Commissioners

- Should we focus on certain subgroups of dual eligible beneficiaries? If so, which ones?
- Are there specific managed care initiatives we should include in our review?