

CHAPTER

5

**Coordinating the care of
dual-eligible beneficiaries**

Coordinating the care of dual-eligible beneficiaries

Chapter summary

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have higher medical expenses than other beneficiaries. While they make up disproportionate shares of Medicare and Medicaid spending relative to their enrollment, neither program assumes full responsibility for coordinating all of their care. The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality.

Within the dual-eligible population, there are distinct groups of beneficiaries with widely different care needs. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized. Many have multiple chronic conditions that make care coordination especially important. Other duals have no or one physical impairment and no chronic conditions. Reflecting this wide range in care needs, spending varies by a factor of four according to physical and cognitive impairment. Likewise, spending on specific types of services differs by subgroup, with some having higher spending on nursing home or hospital services than others. Care coordination activities, and the need for them, should reflect these differences, tailoring specific activities to each beneficiary.

In this chapter

- Characteristics of dual-eligible beneficiaries
- Conflicting incentives of Medicare and Medicaid
- Approaches to integrate the care of dual-eligible beneficiaries
- Challenges to expanding enrollment in integrated care
- Concluding observations

Improving the care for dual-eligible beneficiaries requires two fundamental changes in financing and delivering care to them. First, the financing streams need to be more integrated so that the current conflicting incentives between Medicaid and Medicare no longer undermine care coordination. Second, an integrated approach to care delivery is needed to ensure quality care for this complex population. An integrated approach could involve a single entity at financial risk for the care furnished to beneficiaries with the responsibility for coordination of all care furnished to dual-eligible beneficiaries.

In integrated approaches, beneficiaries are regularly assessed for their risk for hospitalization or institutionalization and a multidisciplinary team manages a beneficiary's care according to an individualized care plan. Entities that furnish integrated care need to be evaluated by using outcome measures such as risk-adjusted per capita costs, potentially avoidable hospitalization rates, rates of institutionalization, and emergency room use. In addition, condition-specific quality measures and indicators that reflect the level and success of care integration need to be gathered so that the success of care integration for different subgroups of duals can be assessed.

Two approaches currently in use—managed care programs implemented through Medicare Advantage special needs plans that contract with states and the Program of All-Inclusive Care for the Elderly—offer more fully integrated care. These programs combine funding streams so that the conflicting financial incentives of Medicare and Medicaid are mitigated. Entities are also at full financial risk for all (or most) services, including long-term care, and provide care management services. Given the diversity of the care needs of the dual-eligible population, a common approach to full integration and care coordination may not be best suited for all beneficiaries.

While integrated approaches have the potential to be successful, they are few in number and enrollment in some programs is low. Numerous challenges inhibit expanding their numbers and enrollment. Challenges include a lack of experience managing long-term care, stakeholder resistance (from beneficiaries and their advocates, and from providers), the costly initial program investments and uncertain financial viability, and the separate Medicare and Medicaid administrative rules and procedures. Also, by statute Medicare beneficiaries must have the freedom to choose their providers and cannot be required to enroll in a health plan that could integrate care. However, several states have successfully implemented fully integrated care programs, illustrating that it is possible to overcome these obstacles. ■

Dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid) have, on average, higher medical expenses than other beneficiaries and the care they receive is likely to be uncoordinated. They make up 16 percent of Medicare's enrollment but one-quarter of its spending (Medicare Payment Advisory Commission 2009a). On the Medicaid side, they make up 18 percent of Medicaid enrollment but almost half (46 percent) of its spending (Lyons and O'Malley 2009). However, there are distinct groups of beneficiaries with widely different care needs. Given the multiple chronic conditions of many dual-eligible beneficiaries, care coordination is paramount but often lacking.

The Medicare and Medicaid programs often work at cross-purposes in ways that impede the coordination of care for dual-eligible beneficiaries. Conflicting program incentives in Medicare and Medicaid encourage providers to avoid costs rather than coordinate care, and poor coordination can raise total federal spending and lower quality. Neither program assumes full responsibility for coordinating the care furnished to dual-eligible beneficiaries.

This chapter describes the dual-eligible beneficiaries and spending on them. It then describes examples of fully integrated programs in which an entity receives revenue from Medicaid and Medicare, assumes full (or most of the) financial risk for the enrollees, and manages all the services furnished to them. It discusses performance measures that would be relevant to the dual-eligible population, which are particularly important if enrollment in integrated plans is to expand.

The chapter discusses approaches being used to coordinate the care for dual-eligible beneficiaries—Medicare Advantage (MA) special needs plans (SNPs) that contract with the state Medicaid agencies to provide integrated managed care programs, and the Program of All-Inclusive Care for the Elderly (PACE). These programs make two fundamental changes to the financing and delivery of care to dual-eligible beneficiaries. First, entities are at financial risk for all (or most) of the care furnished to duals, so that the current conflicting incentives no longer undermine care coordination. Second, a single entity takes responsibility for care coordination. Few beneficiaries are enrolled in these programs and the last section discusses the challenges to expanding their enrollment.

Background

Dual-eligible beneficiaries are people who receive health care coverage through both Medicare and Medicaid. In 2005, approximately 16 percent of Medicare beneficiaries were also enrolled in Medicaid. Of these dual-eligible beneficiaries, almost two-thirds were aged 65 or older and one-third were disabled and under age 65 (Medicare Payment Advisory Commission 2008). Many beneficiaries who would otherwise qualify for Medicaid do not enroll in the program.¹ Most dual-eligible beneficiaries remain eligible for state coverage over time because they typically do not experience large changes in assets or income. About 5 percent of dual-eligible beneficiaries lose their eligibility each year; about 40 percent of them reenroll within a year (Stuart and Singhal 2006).

Within the dual-eligible population, there are different levels of assistance through what are called Medicare Savings Programs. Most “duals” (almost 80 percent) qualify for full Medicaid benefits, including long-term care (often referred to as “full benefit duals”). Medicaid also pays their Medicare premiums and cost-sharing expenses. Medicare beneficiaries with higher incomes (often referred to as “partial duals”) do not receive Medicaid benefits other than assistance with Medicare premiums and cost sharing.²

Medicare is considered the primary payer for dual-eligible beneficiaries and pays for all Medicare-covered services (such as hospital and physician services; see Table 5-1, p. 132). For Medicaid, all states are required to cover certain services, including nursing home care, Medicare cost sharing (the Part A and Part B deductibles, the Part B premiums, and the Part B coinsurance), coverage for inpatient hospital and skilled nursing facility services when Part A coverage is exhausted, and home health care for those dual-eligible beneficiaries who would otherwise qualify for nursing home services. States have the option to cover other services—such as dental, vision, and hearing; home- and community-based services; personal care services; and home health care (for those duals who do not qualify as needing nursing home services). Not surprisingly, there is considerable variation across states in the services covered and in eligibility rules, resulting in different benefits for duals, depending on where they live. States can cap their payments for Part B cost sharing to what they would pay for the service if the beneficiary had only Medicaid coverage.³ As a result, most states do

**TABLE
5-1****Services paid for by Medicare and Medicaid for dual-eligible beneficiaries**

Medicare	Medicaid
<ul style="list-style-type: none">• Acute care (hospital) services• Outpatient, physician, and other supplier services• Skilled nursing facility services• Home health care• Dialysis• Prescription drugs• Durable medical equipment• Hospice	<ul style="list-style-type: none">• Medicare cost sharing (Part A and Part B deductibles, Part B premiums and coinsurance)• Coverage for hospital and skilled nursing facility services if Part A benefits are exhausted• A portion of the cost of prescription drugs• Nursing home care• Home health care not covered by Medicare when the beneficiary qualifies as needing nursing home care• Transportation to medical appointments• Optional services: dental, vision, hearing, home- and community-based services, personal care, and home health care (when the beneficiary does not qualify for Medicare and does not need nursing home care)• Durable medical equipment not covered by Medicare

not, in effect, pay for cost-sharing expenses (Mitchell and Haber 2004).

Over the last three decades, programs delivering home- and community-based services (HCBS) such as home health care and personal care have become an attractive alternative to institutional care for persons who require long-term care. Between 1995 and 2007, Medicaid spending on HCBS as a percentage of its total long-term care obligations has more than doubled from 19 percent to 41 percent (Kaiser Family Foundation 2009b). Demand is high because many beneficiaries prefer to remain at home and receive support services that allow them to avoid being institutionalized. States fund such programs because they believe the services will reduce facility-based expenditures on long-term care, which is the single largest spending item for Medicaid, constituting a third of its total spending (Kaiser Family Foundation 2009a). Differences in state policies to fund these services contribute to the considerable variation in average per capita HCBS spending. In 2006, per capita spending on HCBS ranged from \$5,407 in Texas to \$33,862 in Rhode Island (Kaiser Family Foundation 2009b).

Although Medicaid is a state-run program, there is considerable federal support. The federal government contributes to each state's Medicaid program based on a formula that yields higher matching funds for poorer states. The average "match rate" is 57 percent, but it ranges from 50 to 76 percent. To provide short-term fiscal relief to states, the Congress included a provision in the American Recovery and Reinvestment Act of 2009

that temporarily (through 2010) raised the minimum match rate to 65 percent and the maximum to 83 percent (Department of Health and Human Services 2009).

Characteristics of dual-eligible beneficiaries

On average, dual-eligible beneficiaries differ from other beneficiaries. They are more likely to be young and disabled and to have multiple chronic conditions. But the dual-eligible population is not homogeneous. Duals differ considerably in their physical and cognitive impairments, their abilities to perform activities of daily living, and whether they are institutionalized. Some duals have multiple chronic conditions that will raise their spending year after year. Others—the essentially well duals—have minimal care needs. These factors will shape the amount and type of services that need to be coordinated and the opportunities and benefits of integration.

Dual-eligible beneficiaries differ from other beneficiaries

To qualify for Medicaid, dual-eligible beneficiaries must have low incomes. More than half of duals have incomes below the poverty line (in 2006, poverty was defined as \$10,294 for an individual and \$13,167 for married couples) compared with 8 percent of non-dual-eligible beneficiaries. Their poverty shapes their basic living needs. If they have inadequate housing or cannot afford heat and food, they cannot focus on and manage their health care

TABLE 5-2**Demographic differences between dual-eligible beneficiaries and non-dual-eligible beneficiaries**

Characteristic	Percent of beneficiaries	
	Dual eligible	Non-dual eligible
Disabled	41%	11%
Report poor health status	20	7
Race		
White, non-Hispanic	58	82
African American	18	7
Hispanic	15	6
Other	9	4
Limitations in ADLs		
No ADLs	49	71
1-2 ADLs	23	19
3-6 ADLs	29	10
Living arrangement		
In an institution	19	3
With a spouse	17	55
Education		
No high school diploma	54	22
High school diploma only	24	31
Some college or more	18	45

Note: ADLs (activities of daily living). Totals may not sum to 100 percent due to rounding and the exclusion of an "other" category.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2006.

needs. For example, the lack of adequate heating can delay recovery from illness.

Compared with other Medicare beneficiaries, dual-eligible beneficiaries are, on average, more likely to be young and disabled, report poor health status, and be a member of a racial or ethnic minority group (Table 5-2). Dual-eligible beneficiaries are almost three times more likely than other beneficiaries to have three or more limitations in their activities of daily living (such as dressing, bathing, and eating), with 29 percent reporting this level of physical impairment. Dual-eligible beneficiaries are more than six times more likely to be living in an institution, with 19 percent living in one compared with 3 percent of other beneficiaries. Compared with other beneficiaries, duals

are much less likely to live with a spouse. More than half of dual-eligible beneficiaries did not complete high school, compared with fewer than one-quarter of other beneficiaries.

The disabled group make up about one-third of dual-eligible beneficiaries. Among them, 44 percent are mentally ill, one-third have one or no physical impairment, and 18 percent are developmentally disabled (Table 5-3). A small share have dementia, reflecting their younger age.

The group of beneficiaries entitled based on their age make up about two-thirds of dual-eligible beneficiaries. Among them, more than half have one or no physical impairment, 26 percent are mentally ill, and 16 percent have dementia. A small fraction of the aged dual-eligible beneficiaries have two or more physical impairments.

Beneficiaries in these impairment groups vary considerably in what share are institutionalized, which will have a large impact on per capita spending. High proportions of aged duals with dementia or with at least two physical impairments are institutionalized (Figure 5-1, p. 134).⁴ But only a small fraction (2 percent) of those with no or one physical impairment are institutionalized. The rates of institutionalization among the other groups—the mentally ill, the developmentally disabled, and the disabled with

TABLE 5-3**Physical and cognitive impairments vary considerably among dual-eligible beneficiaries**

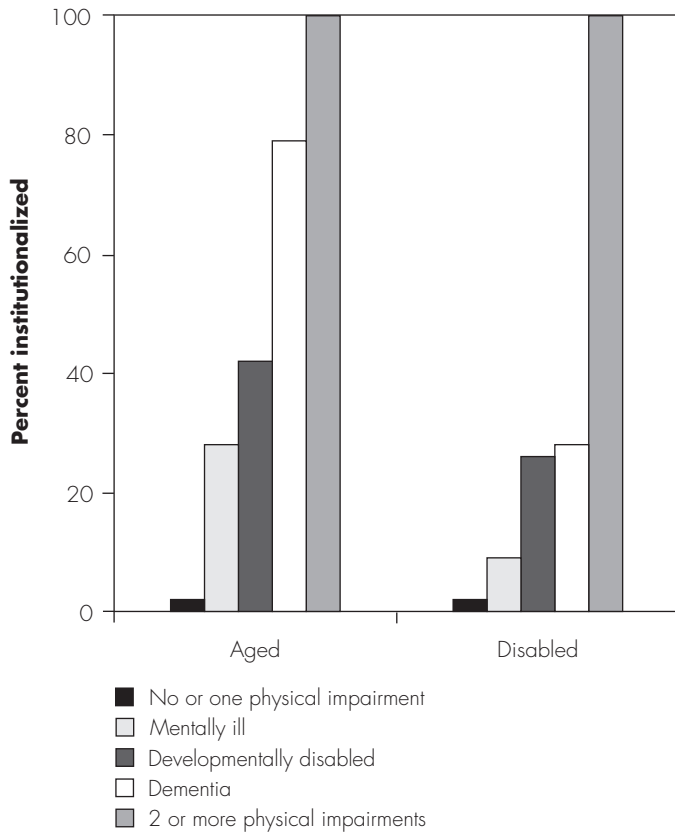
Dual-eligible group	Aged	Disabled
Mentally ill	26%	44%
Dementia	16	3
Developmentally disabled	2	18
One or no physical impairments	54	33
Two or more physical impairments	3	3

Note: Beneficiaries were grouped into the "aged" and "disabled" groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004-2006.

FIGURE 5-1

Rate of institutionalization varies by group of dual-eligible beneficiaries



Note: Beneficiaries were grouped into the “aged” and “disabled” groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a cognitive impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a cognitive impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

dementia—are more variable, ranging from 9 percent to 42 percent. In general, aged duals are more likely to be institutionalized than disabled duals.

Using CMS’s chronic conditions warehouse data, we found that many dual-eligible beneficiaries have three or more chronic conditions—41 percent of duals who do not have end-stage renal disease (ESRD) and 74 percent of those who do. The most common chronic conditions include cardiovascular, diabetes, Alzheimer’s and related disorders, rheumatoid arthritis or osteoarthritis, and depression (Mathematica Policy Research 2010).

The frequency of chronic conditions varied considerably among the disabled and the aged groups (Table 5-4). More than one-quarter of the aged dual-eligible beneficiaries had the five most frequent chronic conditions— ischemic heart disease, heart failure, Alzheimer’s and related conditions, diabetes, and rheumatoid arthritis or osteoarthritis. Except for diabetes, many fewer of the under 65 and disabled dual-eligible population had these conditions. For example, only 17 percent had ischemic heart disease, compared with 43 percent of the aged dual-eligible beneficiaries. Among those under 65 and disabled, only two conditions—depression and diabetes—were as prevalent (at least 20 percent of duals had the condition). It is likely that the under 65 and disabled population has other conditions not included in the Chronic Conditions Warehouse (CCW), such as schizophrenia, other psychosis, serious neurosis, and substance abuse, which are not captured in the data. The vast majority of dual-eligible beneficiaries admitted to inpatient psychiatric hospitals had a diagnosis of psychosis (see Chapter 6). The unreported conditions will understate the prevalence of mental illness among duals.

TABLE 5-4

Five most frequent chronic conditions vary among the aged and the under 65 and disabled dual-eligible beneficiaries

Chronic condition	Percent of group with the condition	
	Aged	Under 65 and disabled
Alzheimer’s and related conditions	30%	5%
Chronic obstructive pulmonary disease	18	10
Depression	18	28
Diabetes	36	23
Heart failure	33	11
Ischemic heart disease	43	17
Rheumatoid arthritis/osteoarthritis	31	13

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Duals also vary in the number of chronic conditions they have (Figure 5-2). While 19 percent had five or more chronic conditions, a large share (38 percent) had none or one. Half of the 22 percent with dementia also had four other chronic conditions.

Dual-eligible beneficiaries' health status characteristics—whether they are aged or disabled, their physical and cognitive impairments, and their chronic conditions—shape the amount of care coordination they require, the mix of providers serving them, and their inclination and ability to seek timely care. Those with minimal physical impairments are likely to require much less support than dual-eligible beneficiaries with serious impairments. Care needs will also vary according to the chronic condition. Beneficiaries with conditions particularly at risk for hospitalization, such as heart failure and chronic obstructive pulmonary disease, should be closely monitored to avert unnecessary hospitalization. Beneficiaries who live alone are at risk for institutionalization, which HCBS may be able to delay or avoid.

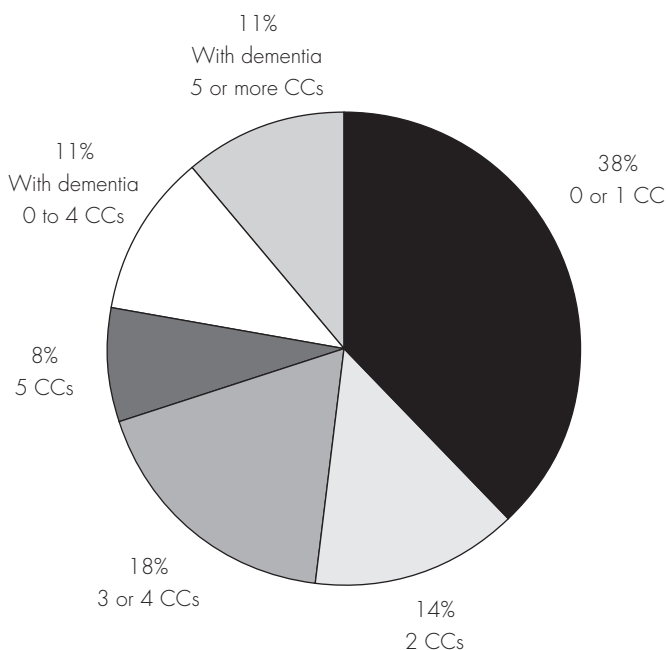
Mentally ill and cognitively impaired dual-eligible beneficiaries are typically limited in their abilities to understand instructions and adhere to them. In addition, although mental health care providers often serve as the central health care resource for mentally ill beneficiaries, they may not routinely screen their patients for general health problems or adequately monitor health effects of medications that are frequently prescribed. Furthermore, the network of mental health care providers treating a dual-eligible beneficiary is often separate from that furnishing general health care, requiring mentally ill duals to navigate yet another system of care. This landscape should shape care coordination activities for this group of dual-eligible beneficiaries.

Per capita spending on dual-eligible beneficiaries varies by subgroup

The variation in health status, cognitive and physical impairments, and living arrangements across dual-eligible beneficiaries is reflected in the large differences in per capita spending across these beneficiaries' subgroups. A large factor is whether the beneficiary is institutionalized, which affects Medicaid spending and combined program spending. Chronic conditions also contribute to higher spending levels, particularly for patients with dementia, as do cognitive and physical impairments.⁵

FIGURE 5-2

Number of chronic conditions and presence of dementia vary considerably among dual-eligible beneficiaries



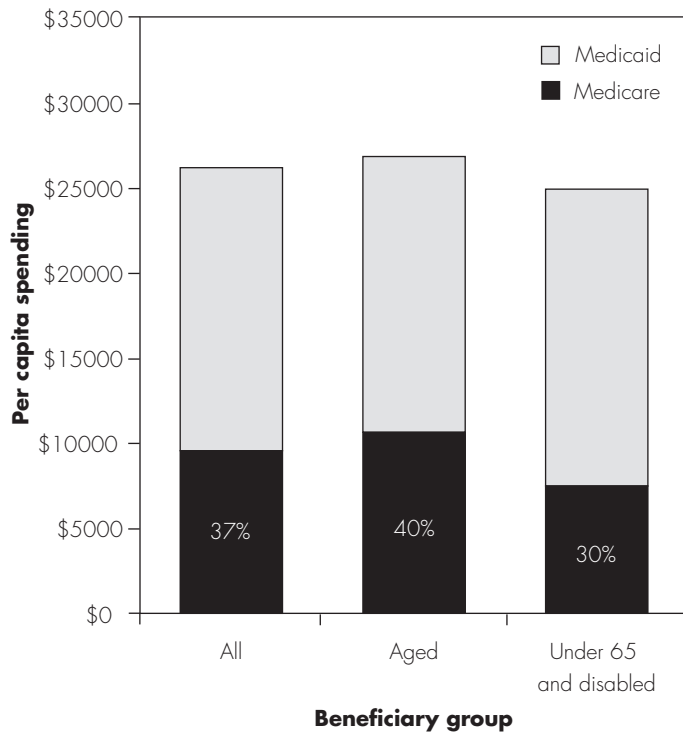
Note: CC (chronic condition). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Medicaid and Medicare per capita spending on dual-eligible beneficiaries totaled \$26,185 in 2005, with Medicare spending accounting for 37 percent of the total (Figure 5-3, p. 136). Combined per capita spending was slightly higher (3 percent) than average for the aged dual-eligible beneficiaries, while per capita spending for the under 65 and disabled was 5 percent less than the average. Medicare's share of the combined varied from 30 percent (under 65 and disabled) to 40 percent (aged), largely reflecting the share of beneficiaries receiving Medicaid-financed long-term care and prescription drugs. These data predate the implementation of Medicare's drug benefit, so prescription drug spending is included in Medicaid's spending.

FIGURE 5-3

Medicare and Medicaid per capita spending on dual-eligible beneficiaries in 2005



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Spending on prescription drugs is included in Medicaid spending (the data predate Part D). Percents are Medicare share of combined spending.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

Per capita spending varies by nursing home use

The differences in per capita spending for the aged and the under 65 and disabled groups of dual-eligible beneficiaries were more pronounced once we controlled for nursing home use (Table 5-5). For duals with no nursing home spending (i.e., living in the community), combined Medicare and Medicaid per capita spending for the under 65 and disabled was one-third higher (\$22,530) than that for the aged (\$16,916). For duals with the highest nursing home spending (those in the 20th percentile of nursing home spending), the difference between the groups was smaller. Combined per capita spending was 13 percent

higher for the under 65 and disabled group (\$84,339) than the spending for the aged group (\$74,439).

Nursing home use has a large impact on total combined spending. Combined per capita spending for dual-eligible beneficiaries with the highest per capita nursing home spending was about four times that of duals with no nursing home spending.

Impact of chronic conditions on per capita spending

Considerable differences in combined per capita spending also exist by category of chronic condition (Table 5-6 and online Appendix 5-A, available at <http://www.medpac.gov>). Among the most frequent conditions, combined per capita spending ranged from 20 percent higher than average for dual-eligible beneficiaries with diabetes or with rheumatoid arthritis or osteoarthritis to 80 percent higher than average for duals with Alzheimer’s disease and related conditions. Per capita spending for duals with five or more chronic conditions was almost double the per capita spending for all duals. Because beneficiaries can have more than one chronic condition, the differences reported here are not the additional spending associated with the condition alone. For example, many beneficiaries in the diabetes group have other chronic conditions that raise program spending. Twenty percent of duals had none of the chronic conditions recorded in the CCW.

Dementia plays a key role in per capita spending differences. Across the most prevalent chronic conditions, combined per capita spending for dual-eligible beneficiaries with dementia was 30 percent to 60 percent higher than for duals without it.

Spending also varied considerably by the number of chronic conditions the beneficiary had (Figure 5-4, p. 138). Combined per capita spending for duals with one chronic condition was just over \$16,000 but with dementia it increased to more than \$31,000. Spending for duals with five or more chronic conditions was \$43,000; combined spending on those with dementia was more than \$55,000.

Physical and mental impairments influence per capita spending

To examine spending differences by physical and mental impairments, we examined Medicare Current Beneficiary Survey data and used a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Then, it assigned beneficiaries first into cognitive impairment groups and then, if not already

**TABLE
5-5****Controlling for nursing home use, per capita spending for under 65 and disabled duals is higher than for aged duals, 2005**

	Total	No nursing home spending	Top nursing home spending
All dual eligibles	\$26,185	\$19,171	\$75,469
Aged	26,841	16,916	74,439
Under 65 and disabled	24,924	22,530	84,339

Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans. Top nursing home spending includes the top 20th percentile of spending for beneficiaries who used nursing home services.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

assigned, into physical impairment groups. A beneficiary with both types of impairments is assigned to a mental impairment group.⁶

Within the aged and disabled groups, Medicare and Medicaid per capita spending ranged by a factor of four (Figure 5-5). In both the disabled and aged groups, spending on duals with no or one impairment was about half of the average; in contrast, the highest spending groups (those with two or more physical impairments and

those with dementia) were about double the average. Other differences were difficult to discern. Groups with high rates of institutionalization tended to have high spending, but not always. For example, while spending was about twice the average for duals with two or more physical impairments (groups with high institutionalization rates, see Figure 5-1), spending was about 20 percent above average for the developmentally disabled aged group (a group in which fewer than half were institutionalized). For any given impairment group, spending for the aged groups

**TABLE
5-6****Total Medicare and Medicaid per capita spending for dual-eligible beneficiaries varied for most frequent chronic conditions**

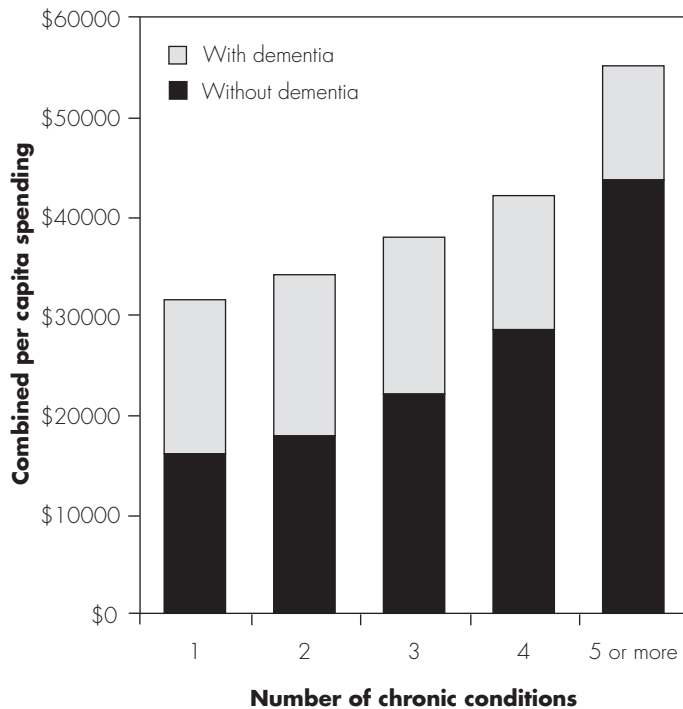
Select chronic condition	Share of all duals with condition	Medicare and Medicaid spending	Spending relative to average
All dual-eligible beneficiaries	100%	\$26,185	1.0
Alzheimer's and related conditions	22	46,578	1.8
COPD	15	40,645	1.6
Depression	21	38,829	1.5
Diabetes	32	32,188	1.2
Heart failure	26	40,632	1.6
Ischemic heart disease	34	34,568	1.3
Rheumatoid arthritis & osteoarthritis	25	31,864	1.2
4 or more chronic conditions	30	43,986	1.7
5 or more chronic conditions	19	50,278	1.9

Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

FIGURE 5-4

Combined per capita spending increases with dementia and number of chronic conditions



Note: The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

tended to be higher than for the disabled groups, but not always. Spending was higher for the aged groups with cognitive impairments, but the disabled group with two or more physical impairments had higher spending than its aged counterpart.

Mix of service spending varies by clinical condition

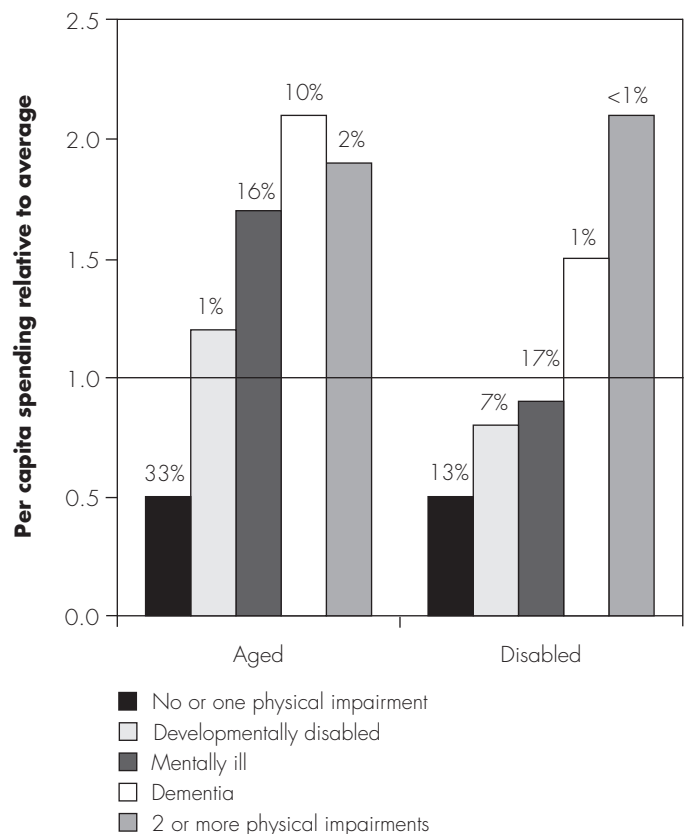
The impairments and chronic conditions shape the mix of services beneficiaries use. Dual-eligible beneficiaries who are institutionalized have a high proportion of combined per capita spending on nursing home services. Those with minimal impairments, living at home, and without a hospitalization are likely to have a greater share of combined program spending on physician and other community-based services. Those with conditions that are

susceptible to frequent hospitalizations, such as chronic obstructive pulmonary disease (COPD) and heart failure, have a high share of combined spending on hospital services.

Among the most prevalent chronic conditions, the share of total per capita spending devoted to nursing home services ranged from 20 percent for dual beneficiaries with heart failure or COPD to 45 percent for duals with Alzheimer’s disease and related conditions (Figure 5-6 and online Appendix 5-A, available at <http://www.medpac.gov>). Per

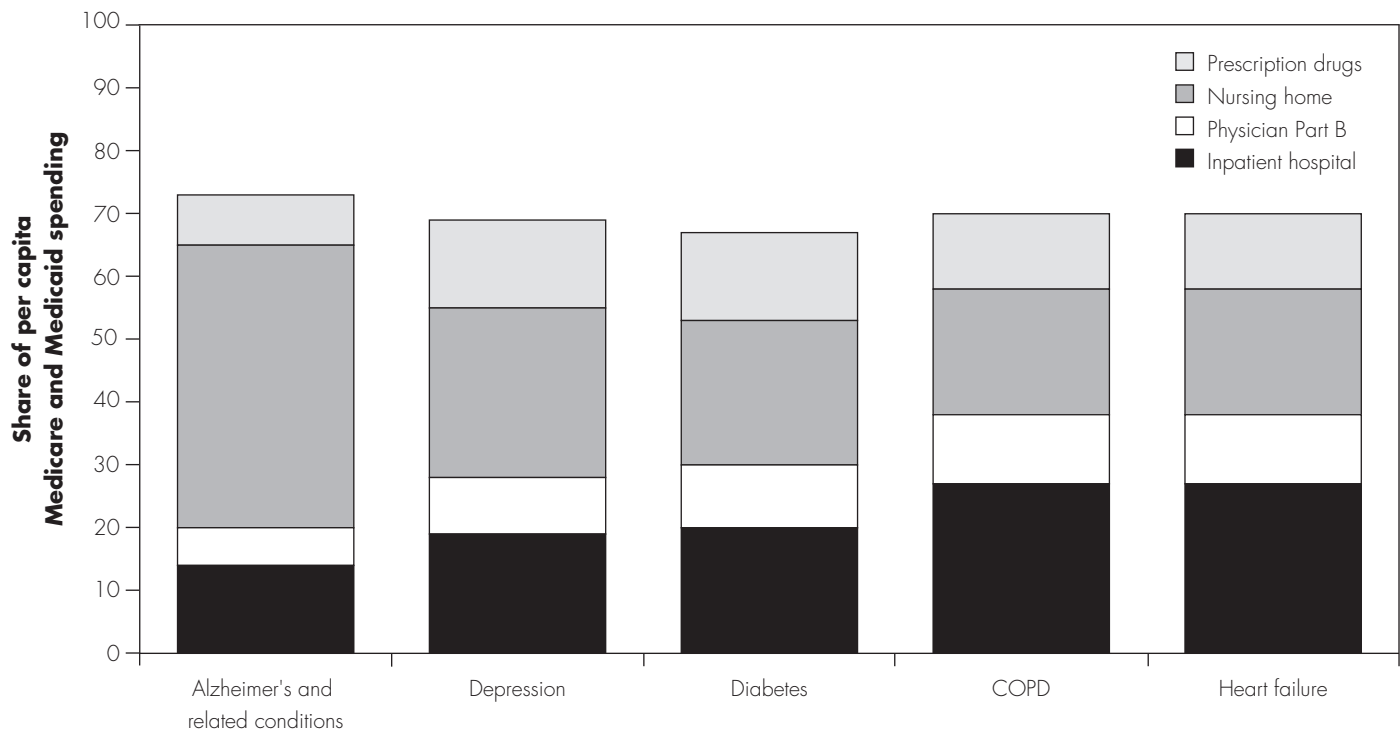
FIGURE 5-5

Per capita spending by cognitive and physical impairment group



Note: Beneficiaries were grouped into the “aged” and “disabled” groups based on how they qualified for Medicare coverage. The grouping uses a hierarchy that first divides dual-eligible beneficiaries by their original eligibility into the Medicare program. Beneficiaries are then assigned to a mental impairment group and, if none, are assigned to a physical impairment group (a beneficiary with both would be assigned to a mental impairment group). Physical impairment refers to a limitation to perform activities of daily living such as bathing, dressing, or eating. The percentages represent the share of all duals included in the group. Beneficiaries with end-stage renal disease were excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 2004–2006.

FIGURE 5-6**Differences in per capita spending by select chronic condition**

Note: COPD (chronic obstructive pulmonary disease). The analysis includes duals who were eligible for full Medicaid benefits and were enrolled during all 12 months of the year or were enrolled from January through their date of death. Data from Maine were incomplete and were excluded. Analysis excludes beneficiaries with end-stage renal disease and beneficiaries enrolled in Medicare Advantage plans or Medicaid managed care plans.

Source: Mathematica Policy Research 2010; CMS merged Medicaid (MAX) and Medicare summary spending files for 2005.

capita spending for inpatient services was more concentrated (27 percent of per capita spending) for duals with heart failure or COPD compared with duals with any chronic condition (17 percent of per capita spending). Across the most common chronic conditions, per capita spending on prescription drugs ranged from 8 percent (Alzheimer's disease and related conditions) to 14 percent (depression and diabetes). Per capita spending on physician and other Part B services ranged from 6 percent (Alzheimer's disease and related conditions) to 11 percent (COPD, heart failure, ischemic heart disease, and rheumatoid arthritis and osteoarthritis).

Implications for coordinating care

The design and targeting of care coordination approaches could be tailored to match the care needs of different groups of dual-eligible beneficiaries. Given the variation in the level and mix of spending, a uniform way to coordinate care for all dual-eligible beneficiaries is

unlikely to be as effective as more targeted approaches for individual subgroups. For example, coordinating the care for dual-eligible beneficiaries living in the community will require managing services across a wide array of providers, especially for beneficiaries with multiple chronic conditions. In contrast, for beneficiaries residing in nursing homes, care coordination might be best based at the facility. It might be possible to avoid premature institutionalization of some dual-eligible beneficiaries with minimal care needs if they are managed appropriately.

Beneficiaries with certain clinical conditions are at greater risk of hospitalization than others. Care management approaches that emphasize preventing unnecessary hospitalizations would avoid the unnecessary spending and care transitions that undermine good quality of care. Such techniques would differ for community-dwelling and institutionalized beneficiaries. In addition, specific medication management approaches

could be used for beneficiaries with high spending on prescription drugs or with certain diagnoses, similar to the medication therapy management programs that prescription drug plans and Medicare Advantage–Prescription Drug plans are required to implement for high-risk beneficiaries. There has been considerable variation in how these programs were implemented and CMS strengthened plan requirements for 2010 (Medicare Payment Advisory Commission 2009b, Medicare Payment Advisory Commission 2010).

Conflicting incentives of Medicare and Medicaid

Care coordination is hampered by the conflicting incentives of Medicare and Medicaid. The two programs can work at cross-purposes that undermine cost control and good patient care. At the payer level, Medicaid and Medicare have incentives to minimize their financial liability by avoiding costs through coverage rules. Medicare covers services that are restorative or improve a beneficiary’s functional status, denying payment for services that are considered “maintenance.” In contrast, Medicaid may pay for services that prevent further deterioration. At times there is ambiguity about whether a service helps maintain the status quo or is restorative.

Examples of these conflicting incentives include the financial incentive to hospitalize nursing home residents, shift costs to the next provider (“downstream”) in an episode of care, and shift coverage for home health care from one program to another (see text box on conflicting incentives). States’ longstanding use of “Medicare maximization” strategies—raising a state’s federal match dollars through illusory financial arrangements—underlines the importance of designing financially integrated approaches that successfully balance state flexibility with adequate fiscal controls and the need for carefully specified policies.

Fee-for-service payment methods discourage care coordination

Medicare and Medicaid pay for post-acute care (PAC) by using fee-for-service (FFS) payment methods that typically limit spending per visit, day, or episode. These payment methods create incentives to hospitalize patients with above-average costs rather than invest in the resources (such as skilled nursing staff) to manage patients in-house. Estimates of the rates of potentially avoidable

rehospitalizations vary from 18 percent to 40 percent, depending on the PAC setting, the risk adjustment method, and the clinical conditions considered (Grabowski et al. 2007, Medicare Payment Advisory Commission 2010, Saliba et al. 2000).

Hospitalization rates appear to be sensitive to the level of payments. One study of nursing homes found that for every additional \$10 in Medicaid daily payment above the mean, the likelihood of hospitalization declined 5 percent (Intrator et al. 2007). Another nursing home study found that Medicaid residents were more likely than other higher payment patients to be rehospitalized, with risk-adjusted hospitalization rates that were 15 percent lower for Medicare and private pay patients (Konetzka et al. 2004).

As a result of the FFS payment methods, providers typically have no incentive to take into account the impacts of their own practices on total spending over time. What may be in a provider’s own financial interest in the short term may result in higher federal spending over the longer term. Medicare’s PAC transfer policy under the hospital inpatient prospective payment system counters the financial incentive to prematurely discharge inpatients to PAC settings. However, PAC settings do not have transfer penalties. PAC providers can lower their own costs by shifting patients to other PAC settings or to the community. Although bundling Medicare payments for hospital and PAC services could encourage more efficient use of Medicare resources, it would not address the incentive to shift costs to another program.

Further discouraging care coordination is the lack of a care coordination benefit in Medicare. Although care coordination per se is not covered, certain providers are required to conduct some of these activities, such as discharge planning by hospitals. Because MA plans are required to provide only those services covered in FFS, they are not required to furnish care coordination. However, these activities may improve a plan’s quality indicators and its financial performance, particularly plans that enroll high-cost beneficiaries. Plans enrolling an essentially well mix of beneficiaries may have little financial incentive to offer care coordination activities.

Conflicting incentives may lower quality of care

Because Medicaid and Medicare have no incentive to improve overall efficiency and care coordination for duals, each program focuses on minimizing its own payments instead of investing in initiatives that would lower overall

Examples of conflicting incentives

Three examples illustrate how providers and states can shift the responsibility for beneficiaries from one program to another and, at the same time, raise total federal spending (Grabowski 2007).

- *Nursing home transfer to hospitals*—Transferring dual-eligible beneficiaries receiving long-term care in nursing homes to hospitals is financially advantageous to facilities and states but raises Medicare spending. A nursing home benefits first by avoiding the high costs associated with care the hospital had to provide. State bed-hold policies that pay nursing homes a daily amount while a resident is in the hospital can also affect hospitalization rates. States with bed-hold policies had hospitalization rates that were 36 percent higher than states without them (Intrator et al. 2007). Second, the facility may qualify for a higher payment under Medicare when the beneficiary is readmitted and requires skilled nursing facility (SNF) services.⁷ The state also benefits when beneficiaries qualify for Medicare-covered SNF stays because its financial liability is to pay only for the copayments and deductibles for Medicare-covered services.
- *Hospital transfer to nursing home*—Hospitals do not have a financial incentive to consider the “downstream” costs of long-term care. Rather, their financial incentive is to lower their own costs by transferring patients to nursing facilities, which increases state and federal spending.
- *Home health care*—As a result of a 1988 U.S. Supreme Court decision, Medicare broadened the coverage guidelines for home health care.⁸ Medicare’s home health benefit expanded from covering mostly short-term, post-acute care to one that can cover patients over longer periods of time (Government Accountability Office 2000). Because Medicare and Medicaid home health care coverage can be ambiguous (does the patient qualify for skilled care, is the patient homebound), Medicare and Medicaid can jockey to avoid paying for care by asserting the beneficiary does or does not meet Medicare’s criteria for coverage (being homebound, requiring skilled care, or receiving part-time or intermittent services).⁹ ■

spending and improve quality. States are more inclined to invest in programs to lower their long-term care spending than in programs that avoid unnecessary hospitalizations because these benefits accrue to Medicare. Reflecting the ambivalence to lower rehospitalization rates, none of the four state nursing home pay-for-performance programs (Iowa, Kansas, Minnesota, and Ohio) uses hospital readmissions as a performance measure (Grabowski 2007).

The patterns of care that result from shifting patients for financial, rather than clinical, reasons can lead to suboptimal care for beneficiaries. Nursing homes have little incentive to provide preventive care and avoid acute flare-ups of chronic conditions if their efforts raise their costs. Moreover, to the patient’s detriment, unnecessary hospitalizations expose beneficiaries to hospital-acquired disease that can delay patients’ recovery or erode their health status. We found that dual-eligible beneficiaries

make up the majority of beneficiaries with repeat hospitalizations (four or more within two years). Multiple transitions between settings increase the likelihood that a patient will experience fragmented care, medical errors, medication mismanagement, and poor follow-up care. The Health and Human Services Office of Inspector General found that more than one-third of episodes of patients with multiple hospital skilled nursing facility stays were associated with quality-of-care problems (Office of Inspector General 2007).

Care can also be fragmented when dual-eligible beneficiaries are enrolled in multiple plans for their health care coverage. Some dual-eligible beneficiaries are enrolled in different Medicaid and Medicare managed care plans or in a managed care plan under one program and FFS in the other, in addition to a separate plan for prescription drug coverage. Duals in these circumstances do not have a single person or entity taking responsibility

for their care. Such fragmentation can lead to medication mismanagement, poor coordination of treatment plans, and low patient adherence to medical instructions.

For cognitively impaired dual-eligible beneficiaries, efforts to effectively coordinate care are further complicated. Focus groups have revealed that dual eligibles often do not understand their benefits and coverage (Ryan and Super 2003). This complexity of coverage can result in discontinuities in care, involuntary disenrollment, and inappropriate charges for cost sharing. These experiences were echoed in focus groups on prescription drug coverage conducted by the Commission in 2009. We found that some low-income beneficiaries were confused about coverage of the various programs they were enrolled in.

Fragmentation can occur even when beneficiaries are enrolled in SNPs, the MA plans that focus on special needs populations, including dual-eligible beneficiaries. Until 2010, SNPs were not required to contract with states to provide Medicaid benefits and most did not. In 2008, the Commission recommended that the Secretary require SNPs to contract with the states of their service areas (Medicare Payment Advisory Commission 2008). The Medicare Improvements for Patients and Providers Act of 2008 required SNPs to contract with states to provide Medicaid benefits (for a summary of the legislative changes to SNP provisions, see online Appendix 5-B, available at <http://www.medpac.gov>).

Approaches to integrate the care of dual-eligible beneficiaries

There are approaches to coordinate the care for dual-eligible beneficiaries that combine the financing of Medicare and Medicaid and make a single entity (such as a provider or managed care plan) responsible for coordinating all services. Two approaches are being used to integrate the care for dual-eligible beneficiaries: Medicare Advantage special needs plans (SNPs) that contract with the state Medicaid agencies to provide all services and PACE. These approaches shift the current silos of financing and care delivery to one entity that is responsible for all services and at full financial risk. While the models integrate the financing and care coordination, they differ in whether the entity is acting essentially as an insurer (managed care plans) or primarily as a set of providers assuming risk (PACE). They also vary

considerably in their target populations and enrollment, the services they manage, and how they organize and integrate services.

Some policy analysts have proposed approaches that integrate the financing of the two programs (but do not coordinate the care) as a way to help overcome the programs' conflicting incentives. Financial integration approaches include giving block grants to the states or shifting the responsibility of dual-eligible beneficiaries to the Medicare program. In block grants, a state would be given a funding allotment each year (a block grant) to pay for all services covered by Medicaid and Medicare.¹⁰ If a state's spending is less than the block grant, the state would keep the difference; if spending exceeds the grant amount, the state would be financially liable. Block grants would require enforcement to ensure that state programs maintained beneficiary access to services and that states funded the intended services.¹¹ Financial integration could also be achieved if Medicare assumed primary administrative responsibility for the services furnished to the dual-eligible population (Bruen and Holahan 2003, Government Accountability Office 1995, Holahan et al. 2009, Moon 2003). Although approaches to financially integrate Medicaid and Medicare would mitigate the conflicting incentives of the programs, they would not, by themselves, result in coordinated care.

Features of a fully integrated model of care

Fully integrated models of care manage both Medicare and Medicaid services and benefits. Many other efforts manage either Medicaid or Medicare services (but not both), and those that manage only Medicaid services typically exclude long-term care. However, given the incentives to shift costs between the programs, fully integrated models of care should consider including both programs and extend to all services.

Integrated care has the potential to offer enrollees enhanced, patient-centered, and coordinated services that target the unique needs of the dual-eligible enrollees (Table 5-7). Case management, individualized care plans, assistance with accessing community services, and care transition services are intended to lower total program costs by averting hospitalizations, institutional care, medication mismanagement, and duplicative care.

Care coordination begins by assessing patients to identify their level of risk and matching coordination efforts to the person's needs. Then, a multidisciplinary team develops a patient-specific plan of care that is regularly updated

**TABLE
5-7****Sample activities of an integrated model of care**

Feature	Coordinated care activity
Assess patient and assign to a risk group	<ul style="list-style-type: none"> • Use protocols, service use (e.g., hospital and SNF admissions, ER and specific prescription drugs), referrals from community service and medical care providers, and predictive models to identify high-risk beneficiaries • Care coordination plan reflects the patient's level of risk
Devise and update individualized care plan	<ul style="list-style-type: none"> • Design a plan of care for each beneficiary; share plan with patient and all providers; update plan periodically to reflect changes in health status or service provision • Educate patients about their prescription drugs and how to manage their disease • Visit at home those patients who are at risk for falls; identify and coordinate installation of safety measures • Socially isolated beneficiaries may be enrolled in adult day care • Adapt patient education and counseling activities for cognitively impaired beneficiaries so that patient/family member recognizes warning signs of the need for prompt medical attention
Assist beneficiary in negotiating health care and community services systems	<ul style="list-style-type: none"> • Schedule appointments • Arrange for prescriptions, DME, and transportation • Link beneficiary to community services (such as heating assistance programs) that could undermine medical regimen if left unattended
Manage nursing home use	<ul style="list-style-type: none"> • Visit patients in nursing homes to monitor and treat conditions that if left untreated could result in hospitalization
Coordinate behavioral and primary health care	<ul style="list-style-type: none"> • Clinical social workers may screen patient population for mental health care needs • Behavioral health providers update primary care physicians on a quarterly basis
Multidisciplinary teams manage care	<ul style="list-style-type: none"> • Teams may consist of primary care physician, clinical social worker, pharmacist, behavioral health provider, and medical assistant

Note: SNF (skilled nursing facility), ER (emergency room), DME (durable medical equipment).

Source: Lukens et al. 2007.

so that it remains a current map of the care each patient should receive. A comprehensive provider network ensures that patients have access to the full spectrum of services that address the special care needs of dual-eligible patients. Ideally, a beneficiary would have one plan card with one set of rules for Part A, Part B, and Part D coverage. Data are shared across providers so that all participants know the care plan, the services furnished to beneficiaries, and the outcomes and results so that care can be optimally managed.

Performance measures for fully integrated care

Performance measures for fully integrated plans should include outcome-based measures of quality that span all providers over an episode of care as well as metrics

specific to the clinical conditions prevalent among the dual-eligible population. In addition, measures should gauge the level and success of care coordination and case management. Tying providers' performance on these types of measures to payments can give them an incentive to collaborate.

One set of outcome measures could be used to gauge the overall performance of all types of fully integrated programs, which would allow for comparison of plans along comparable dimensions of care. Quality measures for managed care plans (such as MA plans) currently assess the extent to which patients receive appropriate preventive care, medication, and acute care and also assess patient satisfaction. In addition, outcome measures could include hospital readmission rates, rates of hospital

admissions for ambulatory-care-sensitive conditions, potentially preventable emergency department visits, and mortality rates for specific conditions. Changes over time in functional and cognitive status may also be appropriate measures for the dual-eligible population. For all outcome measures, it is important to use risk adjustment as much as technically feasible to control for patient characteristics that can affect outcomes but are beyond the providers' influence.

Furthermore, some metrics should be tailored to the care needs of the relevant population, defined by specific factors such as diagnoses, cognitive state, disability status, and institutional status. For example:

- *Nursing home residents:* Although publicly reported Nursing Home Compare measures report on many aspects of institutional long-term care, they do not assess the appropriateness of the admission, medication errors, or rates of potentially avoidable hospitalizations. Ideally, quality measures would detect, for example, if patients were prematurely institutionalized or if their medical condition or functioning deteriorated more quickly than expected once they were institutionalized. In addition to measures for the elderly, measures should include those specifically designed to gauge the quality of care furnished to beneficiaries with physical or cognitive disabilities.
- *Beneficiaries living in the community:* Measures could gauge whether beneficiaries who need supportive care and other social services receive them and the degree of care coordination (e.g., does the patient have a primary care physician who is regularly seen and are medications being managed). CMS established a quality framework for HCBS that included the following categories of measures: beneficiary access, patient-centered service planning and delivery, provider capacity and capabilities, beneficiary safeguards, patient rights and responsibilities, outcomes and patient satisfaction, and system performance.¹² Because a large fraction of the disabled live in the community, measures specifically designed for adults with disabilities would need to be able to gauge the quality of care furnished to this population.
- *Duals with significant mental health care needs:* Given the chronic nature of some severe mental illness, outcome measures for many duals will be hard to develop (see Chapter 6). In the interim, process measures could gauge whether the care coordination

identifies persons needing mental health services, ensures beneficiaries receive care in a timely manner, checks that patients' medications are reconciled periodically and every time they transition from one care setting to another and that the medications are being taken, and facilitates communication between a beneficiary's mental health professional and his or her primary care physician. Hospitalization rates for selected psychiatric conditions would provide feedback on the success of managing beneficiaries on an outpatient basis.

Fully integrated care programs should also assess the degree of care coordination and care management provided. As of 2009, SNPs are required to report on structure and process measures of case management, care transitions, and dual-eligible integration. For example, one measure looks at how frequently an organization identifies members who need case management services, while another measure counts how many processes focused on reducing unplanned transitions. Regarding Medicare–Medicaid coordination, SNPs must report whether they have, or are working toward, an agreement with the relevant state Medicaid agency. An inherent shortcoming of these structure and process measures is that they do not assess the effectiveness of these care coordination efforts. Patient and physician surveys on care transitions and case management efforts may be helpful in assessing how much managed care programs facilitate patient understanding of postdischarge plans and improve provider collaboration.

Examples of fully integrated care programs

There are two main types of fully integrated care programs: state–SNP integrated managed care programs and PACE. These programs receive capitated Medicare and Medicaid payments to cover all Medicare and Medicaid services including all or some long-term care services. The programs are at full financial risk for all (or most) of the services they cover. This risk structure gives the programs the incentive to coordinate the Medicare and Medicaid services they offer to reduce unnecessary utilization or high-cost services that programs would otherwise have to pay for.

The type of entity that receives the capitated payments and manages the benefits differs in the two approaches. In the state–SNP programs, the integration is through a managed care plan; under PACE, these functions are carried out by a PACE provider. All the state–SNP programs and PACE target dual-eligible beneficiaries, although the specific subgroups of dual-eligible beneficiaries that

are targeted for enrollment differ across programs. In addition, while the intensity of care coordination varies across programs, this variation may reflect the level of needs of the programs' target population. For example, the PACE program offers an intense care management structure with frequent monitoring and management of participants; however, PACE serves the frail elderly living in the community who require this level of care. A program serving a healthier dual-eligible population may require a less intense form of care management than PACE provides.

A number of states are considering other models to improve care coordination for the dual-eligible population. These alternative models include state-administered managed care plans and medical homes. Each has the potential to improve the care coordination for the dual-eligible population but, for different reasons, may have limited success and one model could raise significant concerns about adequate fiscal controls and accountability (see text box, p. 147).

State-SNP integrated managed care programs

To date, at least eight states—Arizona, Massachusetts, Minnesota, New Mexico, New York, Texas, Wisconsin, and Washington—have fully integrated Medicare and Medicaid programs for dual-eligible beneficiaries through SNPs (all of which are MA plans) or through MA plans that are not SNPs (see text box on SNPs, p. 148). Under these programs, a managed care organization, often operating in MA as a SNP, receives capitated payments from both Medicare and Medicaid. The plans are then responsible for establishing provider networks and implementing the model of care, including care coordination or case management services. An estimated 120,000 dual-eligible beneficiaries nationwide are enrolled in fully integrated managed care programs (Center for Health Care Strategies 2009). These individuals represent less than 1.5 percent of the dual-eligible population and about 8 percent of the dual-eligible beneficiaries enrolled in MA plans (SNP and non-SNP MA plans) (Center for Health Care Strategies 2010).¹³

Integrated managed care programs through SNPs could be an option for all subgroups of the dual-eligible beneficiaries—the nonfrail aged, the nursing-home certifiable, the institutionalized, the physically disabled, and the mentally retarded and developmentally disabled. Currently, programs exist to serve these individual subgroups, but few programs serve all subgroups in the same program.

The state programs vary in their eligibility requirements (their target populations), their enrollment, covered services, risk structures, and models of care. There is also variability in results, if any, to date. The key characteristics and differences across state-SNP integrated managed care programs are discussed below (Table 5-8). A brief description of each state-SNP integrated managed care program is provided in a text box (see text box on state-SNP integrated managed care program descriptions, pp. 150-151).

Eligibility While the programs vary in the subgroups of dual-eligible beneficiaries they serve, the two broadest groups of dual-eligible beneficiaries—the aged and disabled—are eligible to enroll in almost all of the programs. Six of the programs (Arizona, New Mexico, New York, Texas, Wisconsin, and Washington) enroll the aged and disabled in the same program. Minnesota has separate programs for the aged and disabled. Some programs exclude large subgroups of duals, such as the non-nursing home certifiable (beneficiaries who are healthy or not frail enough to require a nursing home level of care), institutionalized duals, or the mentally retarded and developmentally disabled. The programs that do not restrict eligibility to the nursing home certifiable can enroll both beneficiaries who are healthy or not frail enough to require nursing home services and frail dual-eligible beneficiaries who require a nursing home level of care.

Fully integrated state-SNP programs appear to more selectively target subgroups of the disabled duals compared with the aged duals. Regarding the disabled populations, some programs exclude the non-nursing home certifiable and institutionalized disabled, while others restrict eligibility to the physically disabled, thus excluding the mentally retarded and developmentally disabled population. Regarding the aged, the non-nursing home certifiable is the most common subgroup of the aged duals that is excluded from these programs, and one program also excludes the institutionalized aged. These restrictions may be indicative of the challenges in designing and implementing multiple models of care in a single program to serve the distinct subgroups of dual-eligible beneficiaries.

Enrollment Most states with strong enrollment in their integrated care programs had statewide Medicaid managed care programs in place before adding the integrated programs. Other states' programs, such as the one in New York, struggled with enrolling large numbers of eligible duals. In New York, voluntary program enrollment and

**TABLE
5-8**

Characteristics of fully integrated care programs

State	Program name	Eligible population		
		Aged	Disabled	Mandatory or voluntary enrollment
Arizona	Arizona Long-Term Care System (ALTCS)	Nursing home certifiable only	Nursing home certifiable only	Mandatory enrollment in ALTCS for Medicaid long-term care services, but voluntary enrollment in a Medicare managed care plan
Massachusetts	Massachusetts Senior Care Options	Yes	No	Voluntary
Minnesota	Minnesota Senior Health Options (MSHO)	Yes	No	Voluntary for MSHO, but mandatory for aged Medicaid beneficiaries to enroll in a managed care plan. MSHO is one of the managed care options.
	Special Needs Basic Care	No	Yes	Voluntary; disabled are not required to enroll in a managed care plan
New Mexico	Coordination of Long-Term Services	Yes	Yes, but excludes beneficiaries with developmental disabilities who are enrolled in a 1915(c) waiver	Mandatory
New York	Medicaid Advantage Plus	Nursing home certifiable only	Nursing home certifiable only	Voluntary
Texas	Texas Star+Plus	Yes, except for beneficiaries residing in nursing facilities	Yes, except for beneficiaries residing in intermediate care facilities for the mentally retarded	Mandatory
Washington	Washington Medicaid Integration Partnership	Yes	Yes	Voluntary
Wisconsin	Wisconsin Partnership Program	Nursing home certifiable only	Physically disabled only	Voluntary

Source: Center for Health Care Strategies 2010, Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Frye 2007, Korb and McCall 2008, and Osberg 2009.

competition from nonintegrated SNPs contributed to the program’s low enrollment (Korb and McCall 2008). In addition, most programs operate in select regions within each state rather than across the entire state, which can also limit enrollment.

Covered services and risk structure The nine state–SNP fully integrated programs cover Medicare acute care benefits, Medicaid acute care wraparound benefits, and Medicaid long-term care services. Most also cover

behavioral health services. A few of these programs, however, place limits on the amount or type of long-term care services that are covered. For example, Minnesota’s programs, Minnesota Senior Health Options (MSHO) and Special Needs Basic Care, cover nursing home utilization up through 180 days and 100 days, respectively. Any nursing home utilization incurred after these limits is paid through Medicaid FFS although enrollees remain in the program. New York’s Medicaid Advantage Plus program also caps

Alternative models may be limited in their ability to effectively control spending and coordinate care

Some states are considering other ways to improve the care coordination for dual-eligible beneficiaries, including state-administered managed care plans and medical homes. In state-administered managed care plans, a state entity would receive special needs plan–like payments from Medicare and Medicaid and would be responsible for all health care benefits for dual-eligible beneficiaries. One model considers state-administered Medicaid Advantage plans in which participating states contract with competing health plans to manage the care for dual-eligible beneficiaries (Turner and Helms 2009). The state would have the option of managing the care itself, if its state capacities were sufficiently developed, or contracting with private health plans. Each state could tailor benefit packages to target specific groups of dual-eligible beneficiaries, use performance-based payments, and encourage plans to engage in active care management.

This model may have potential in some states but may not result in adequate beneficiary access to care and proper use of federal spending in every state. Policymakers should note a long history of state financial strategies to maximize federal support while minimizing the state’s own contributions. Such strategies generated considerable controversy because the higher federal spending did not always expand coverage or get used to furnish or improve health care (Coughlin and Zuckerman 2002). The strategies underline the importance of adequate fiscal controls and accountability to ensure that spending remains focused on target populations and services.

A number of states are considering the use of medical homes to manage care for dual-eligible beneficiaries. In this model, primary care practitioners are paid (typically on a per member per month basis) to coordinate care for patients between visits and across providers. In 2008, the Commission recommended that Medicare establish a pilot program for medical homes that pays qualified medical practices to coordinate the care of beneficiaries with multiple chronic conditions.

In January 2010, the North Carolina Community Care Networks, an existing medical home and shared savings program serving the Medicaid population, began providing dual-eligible beneficiaries with care management in return for a portion of the savings that may eventually accrue. Any Medicare savings beyond a certain threshold will be reinvested in other services, including home-based services, health information technology, and coverage expansions (Community Care of North Carolina 2009). According to CMS, at least half of the shared savings payments will be contingent on those providers meeting certain quality goals.

Under current payment policies, because medical homes do not assume full risk for their patients’ care, their effectiveness at controlling spending will be limited. Medical homes operate within the context of fee-for-service (FFS) medicine and their ability to control total spending will be limited by the portion of payments attached to performance measures. That said, medical homes represent a potentially effective way to bridge the unmanaged world of FFS and more fully integrated care. ■

covered nursing home utilization at 100 days. Texas’s program covers community-based long-term care services but not institutional nursing home care (Center for Health Care Strategies 2010, Edwards et al. 2009, Osberg 2009, Texas Health and Human Services Commission 2010b).

Model of care for state–SNP programs The state–SNP programs manage the Medicare medical services and Medicaid medical and support services for the dual-eligible beneficiaries. For example, in addition

to managing the Medicare and Medicaid medical services, care coordinators typically consider the need for nonmedical services and supports that facilitate beneficiaries living in the community. These services include HCBS, transportation, heating, food, and housing-related supports; they can help beneficiaries function at home so they can more effectively seek medical attention and adhere to treatment regimens, resulting in appropriate service use.

Special needs plans

Special needs plans (SNPs) are Medicare Advantage (MA) plans that target enrollment to certain groups of Medicare beneficiaries. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized SNPs to target enrollment to the following types of beneficiaries with special needs: those dually eligible for Medicare and Medicaid services, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs were originally authorized through December 2008; first extended through 2009 by the Medicare, Medicaid, and SCHIP Extension Act of 2007; extended again through 2010 by the Medicare Improvements for Patients and Providers Act of 2008; and again through 2013 by the Patient Protection and Affordable Care Act (H.R. 3590).

SNPs receive capitated payments from Medicare to offer Part A and Part B services as well as prescription drug coverage under Part D. Medicare pays SNPs through the same payment method as other MA plans. Payments are risk adjusted for factors that include dual-eligibility status, health condition, disability

status, and residence in an institution. SNP per capita payments tend to be higher than payments to other MA plans in the same geographic area because of the risk-adjustment factors and the populations SNPs enroll.

SNPs can also contract with states to receive Medicaid payments to offer Medicaid benefits for dual-eligible beneficiaries. Beginning in 2010, new and expanding dual-eligible SNPs are required to have contracts with states; however, existing dual-eligible SNPs that are not expanding have until January 1, 2013, to establish state contracts (see summary of main legislative changes in online Appendix 5-B, available at <http://www.medpac.gov>). SNPs can offer a range of Medicaid services for the dual-eligible beneficiaries including coverage of Medicare cost sharing, supplemental acute care services that are not offered by Medicare (such as vision, dental, and transportation), and institutional and community-based long-term care services and supports. SNPs that offer all Medicare and Medicaid acute and long-term care services are considered fully integrated programs. More information on SNPs is available in online Appendix 5-B, available at <http://www.medpac.gov>. ■

Source: Saucier et al. 2009, Verdier 2006

Each program has a single care coordinator or a care management team to oversee the enrollee's care. For example, in Minnesota's MSHO program for the aged, enrollees are assigned a care coordinator who works with the enrollee's primary care physician and coordinates the enrollee's health care and social services. In the Massachusetts Senior Care Options program for the aged, care management teams coordinate the care for enrollees and authorize the services that enrollees can receive. Similarly, in the Wisconsin Partnership Program, which enrolls both the nursing home certifiable aged and physically disabled adults, the managed care plans employ staff who work together as care coordination teams and nurse practitioners who are responsible for overseeing enrollees' care (Centers for Medicare & Medicaid Services 2007).

Programs also include other coordination activities in their models of care. Arizona's program, for example, focuses on rebalancing nursing home- and community-based long-

term care. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007). Some integrated care programs have adopted elements of the Evercare Nursing Home Program, a model of managing Medicare benefits for long-stay nursing home patients. The goal of the program is to provide better Medicare primary care services in order to lower Medicare spending by reducing hospitalizations and emergency services. The health plans employ nurse practitioners who work with nursing home residents' primary care physicians to provide enhanced primary care, care coordination, and customized care planning.

Results Outcomes research on the integrated programs is limited; however, analyses of some of the programs demonstrate their ability to reduce institutional and inpatient utilization. The Massachusetts Senior Care Options and Minnesota Senior Health Options program reduced nursing home utilization. Specifically, the

Massachusetts program reduced the number of nursing home admissions and nursing home lengths of stay. Under the Minnesota program, nursing facility utilization declined over a recent five-year period by 22 percent and the number of seniors receiving HCBS increased by 48 percent (JEN Associates 2009, Osberg 2009). An analysis of Evercare demonstration sites found that patients had a lower incidence of hospitalizations, fewer preventable hospitalizations, and less emergency room utilization compared with two control groups (Kane et al. 2002).

Program of All-Inclusive Care for the Elderly

PACE is a Medicare benefit and an optional Medicaid benefit that fully integrates care for the frail elderly, most of whom are dual eligible. To qualify for coverage, beneficiaries must be at least 55 years of age, nursing-home certified, and live in a PACE service area. Enrollees attend an adult health day care center where they receive medical attention from an interdisciplinary team of health care and other professionals. States vary in their licensing requirements for PACE entities—as day care centers, home care providers, outpatient clinics, or some combination of them.

Under capitation with both Medicare and Medicaid, the PACE organization is responsible, and at full risk, for providing all medically necessary care and services, including primary care, occupational and recreation therapy, home health care, and hospital and nursing home care. The interdisciplinary team consists of a physician, registered nurse, social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietician, PACE center manager, home care coordinator, personal care attendants, and drivers. PACE sites directly employ the majority of PACE providers and establish contracts with providers such as hospitals and nursing facilities. If an enrollee needs nursing home care, the PACE program pays for it and continues to coordinate his or her care, even though the beneficiary resides in the facility. Beneficiaries are provided transportation to attend the day care center during the week.

Evaluations of this program have been positive. In its demonstration phase, the program demonstrated higher rates of ambulatory service utilization and significantly lower rates of nursing home utilization and hospitalization relative to those of a comparison group (Chatterji et al. 1998). Concurrently, quality measures were good—enrollees reported better health status and quality of life, and mortality rates were lower. The Balanced Budget Act of 1997 authorized the coverage of PACE benefits in the

Medicare program, and PACE programs began expanding across the country.

Overall enrollment in PACE programs is low, although the number of PACE organizations has more than doubled since 1999. The number of PACE programs grew from 30 in 1999 to 72 in 2009, and as of February 2010, 18,000 beneficiaries in 30 states were enrolled in PACE (National PACE Association 2010).¹⁴ In a survey of PACE program officers and researchers, one study identified a number of barriers to expansion (Lynch et al. 2008). First, many beneficiaries did not find the program appealing, given that they would have to frequently attend the adult day care center and change their existing provider relationships. Second, the program had significant upfront costs that nonprofit entities often could not afford. Third, it is more difficult to make PACE programs financially viable in rural areas. The distances raise transportation costs and place a greater premium on information technology to integrate the care coordination and centralize medical records. Despite these challenges, officials from the National PACE Association mentioned that 14 programs are operating in rural areas. Some of these programs use teleconferencing for team meetings and information technology to facilitate the sharing of medical charts from multiple locations.

The PACE model is not a match for some beneficiaries. The program targets the frail elderly who live in the community and are eligible for nursing home care. Patients who have modest care needs are not appropriate for this level of care.

Challenges to expanding enrollment in integrated care

States and managed care entities have faced a number of challenges when implementing integrated care programs. While some states and entities have overcome these factors, they still remain as challenges to more wide-scale implementation of these programs.

Lack of experience with long-term care

Most states, Medicare managed care plans, and medical homes do not have experience with managed care for long-term care services. Only 10 states had some form of Medicaid managed long-term care by January 2009 (Edwards et al. 2009). The remaining states either do not have Medicaid managed care programs for the aged

State–special needs plan integrated managed care program descriptions

Arizona Long-Term Care System

The Arizona Long-Term Care System (ALTCS) program is an example of a mandatory Medicaid managed care program in which the state contracts with managed care plans to also offer enrollees Medicare benefits. It is one of the programs within the Arizona Health Care Cost Containment System—a statewide mandatory 1115 waiver demonstration program for Medicaid beneficiaries. ALTCS provides long-term care services. Participation in ALTCS is mandatory for the elderly and disabled who are nursing home certifiable; however, enrollees can choose to enroll in one of the Medicare managed care plans or special needs plans (SNPs) for their Medicare benefits or they can receive their Medicare benefits through fee-for-service (FFS). Most ALTCS members reside in the community and receive home- and community-based services (HCBS) such as home health, attendant care, personal care, transportation, adult day care, and homemaker services. Institutionalized enrollees are reassessed every six months to see if they can be placed in the community (Centers for Medicare & Medicaid Services 2007).

Massachusetts Senior Care Options

The Massachusetts Senior Care Options (SCO) program began in 2004 as a demonstration program and converted to SNP authority. All aged Medicaid beneficiaries, both nursing home certifiable and non-nursing home certifiable, are eligible to enroll in the program on a voluntary basis. The program covers all Medicare and Medicaid benefits, including institutional and community-based long-term care services. Care management teams coordinate the care for enrollees and the teams authorize the services that enrollees can receive. An evaluation of SCO published in 2009 found that the program reduced both the number of nursing home admissions and nursing home length of stay (Centers for Medicare & Medicaid Services 2007, JEN Associates 2009).

Minnesota Senior Health Options

Minnesota's program, Minnesota Senior Health Options (MSHO), originally began in 1997 under Medicare demonstration authority. The managed

care plans participating in MSHO are now required to be SNPs. MSHO is a voluntary program for dual-eligible seniors who are nursing home certifiable and non-nursing home certifiable. Although the program is voluntary, it has been mandatory since 1983 for Minnesota's elderly Medicaid population to enroll in a managed care plan for primary and acute Medicaid services, and the elderly Medicaid beneficiaries must choose from MSHO and another plan that offers only Medicaid services. All Medicare and Medicaid acute care services are integrated in MSHO as well as behavioral health and community-based long-term care services and up to 180 days of nursing home care. Nursing home utilization after 180 days is paid for through FFS. Each enrollee has a care coordinator who works closely with the enrollee's primary care physician and coordinates the enrollee's health care and social services. MSHO data show that nursing facility utilization for MSHO members declined by 22 percent from 2004 to 2009 and the number of seniors receiving HCBS increased by 48 percent (Centers for Medicare & Medicaid Services 2007, Edwards et al. 2009, Osberg 2009).

Minnesota Special Needs Basic Care

The Minnesota Special Needs Basic Care program (SNBC), is a voluntary program for all dual-eligible beneficiaries with disabilities. SNBC coordinates all Medicare and Medicaid acute services and Medicaid behavior health services. The program covers the first 100 days of nursing home care, but all other HCBS and long-term care services are FFS (Center for Health Care Strategies 2010, Osberg 2009).

New Mexico Coordination of Long-Term Services

New Mexico's Coordination of Long-Term Services (CoLTS) program began in 2008. CoLTS is a mandatory program for dual-eligible beneficiaries, Medicaid beneficiaries living in nursing facilities, and Medicaid beneficiaries enrolled in New Mexico's disabled and elderly waiver program. The program excludes Medicaid beneficiaries with developmental disabilities who are enrolled in New Mexico's 1915(c) waivers. CoLTS offers all Medicare acute care benefits and

(continued next page)

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Medicaid acute and long-term care services through SNPs (Edwards et al. 2009, Korb and McCall 2008).

New York Medicaid Advantage Plus

The Medicaid Advantage Plus program (MAP) is a Medicare and Medicaid managed care program for dual-eligible beneficiaries who are nursing home certifiable. MAP offers Medicare acute and Medicaid long-term care services, including up to 100 days of care in a nursing home and HCBS such as personal care, case management, adult day care, and social support services. New York contracts with a SNP to offer the program. MAP is voluntary; however, beneficiaries must enroll in the SNP to receive their Medicare benefits before they are permitted to enroll in the SNP for their Medicaid benefits (Edwards et al. 2009).

Texas Star+Plus

Texas Star+Plus is a mandatory program for elderly Medicaid recipients and nonelderly Medicaid beneficiaries with a physical or mental disability who reside in the community. Current nursing home residents, beneficiaries in intermediate care facilities for the mentally retarded, and Star+Plus enrollees who spend more than 120 days in a nursing facility are not allowed to participate in the program. The state contracts with some SNPs to offer both Medicare and Medicaid benefits for the dual-eligible enrollees, and by 2010 contractors will be required to be SNPs. The program covers community-based long-term care but does not cover nursing facility care. Star+Plus health plans are still responsible for members who enter a nursing facility and must work with service coordinators to assess the member at 30 days and 90 days after

admission to determine whether the individual can return to the community. However, nursing facility services are paid by the state directly to the nursing facility and after four months of nursing facility utilization, Star+Plus members are disenrolled from the program and return to Medicaid fee-for-service (Center for Health Care Strategies 2010, Texas Health and Human Services Commission 2010a, Texas Health and Human Services Commission 2010b).

Washington Medicaid Integration Partnership

The Washington Medicaid Integration Partnership (WMIP) is a voluntary pilot project for elderly and nonelderly disabled dual-eligible beneficiaries. The program began in 2005 and operates in one county through a SNP. WMIP offers both Medicare acute and Medicaid acute and long-term care services (Korb and McCall 2008).

Wisconsin Partnership Program

The Wisconsin Partnership Program (WPP) began in 1999 under Medicare demonstration authority and now operates through SNPs. The program is voluntary and targeted to adults with physical disabilities and the nursing home certifiable elderly. WPP covers all Medicare services and all Medicaid acute services, community-based long-term care services, and nursing home services. The managed care plans employ staff to function as care coordination teams for enrollees, and a nurse practitioner is responsible for overseeing each enrollee's care. WPP also integrates the services of independent physicians who participate in the program's network (Centers for Medicare & Medicaid Services 2007, Frye 2007). ■

and disabled or carve long-term care services out of their managed care programs. Although institutional SNPs have relationships with long-term care providers, they offer Medicare benefits to the institutional population and are not required to contract with states for Medicaid long-term care services. All dual-eligible SNPs are required by 2013 to have contracts with states. These contracts are likely to initially cover Medicaid cost-sharing, wraparound, or

supplemental services but not long-term care services. Managed care entities also may not be willing to cover institutional or community-based long-term care services if they lack experience establishing a provider network for those services. Some states are considering various risk-sharing agreements to give plans incentives to include long-term care services in their benefits packages.

Stakeholder resistance

Many states faced resistance from stakeholders during the development of integrated care programs for dual-eligible beneficiaries. In some states, stakeholder opposition has derailed implementation of integrated managed care programs or expansion of these programs to additional dual-eligible populations. Resistance has come from provider groups concerned about payment rates, the loss of clients and autonomy, and dealing with managed care organizations.

Beneficiaries and their advocates are concerned with the impact of the programs on enrollee benefits, freedom of choice, and quality of care (Korb and McCall 2008). In addition, beneficiaries often are not interested in selecting managed care options for their care. They prefer seeing their current set of providers and do not want to switch physicians. Furthermore, because Medicaid currently covers the cost-sharing requirements of Medicare, dual-eligible beneficiaries are not likely to benefit financially (i.e., reduced cost-sharing obligations) by joining a managed care option.

Such resistance could be overcome with program designs that accommodate stakeholder concerns and better understanding of the benefits of the program. For example, in Minnesota and New Mexico, support for these programs grew as the states addressed some of the advocates' concerns through the program design and as advocates understood the benefits of the programs, especially the increased access to community-based long-term care. New Mexico asked for input on program design elements such as enrollment and quality from stakeholder groups including advocates, providers, and Native Americans (Edwards et al. 2009).

Initial program investments and program financial viability

Integrated care programs require initial program investments. Managed care plans, for example, have to dedicate resources to managing the care of enrollees and may hire health care professionals to coordinate care. Plans would also have to invest in technology, such as electronic medical record systems. New PACE program sites incur the initial capital costs of establishing a day care and outpatient clinic and of hiring professional staff. Surveys of PACE sites show that lack of start-up capital limited the expansion of existing nonprofit organizations (Lynch et al. 2008).

In addition, there is concern among states about Medicaid program investments generating Medicare program savings. States must secure a waiver from the federal government to implement mandatory Medicaid managed care programs, offer beneficiaries additional services under voluntary or mandatory Medicaid managed care, expand Medicaid eligibility, or test a new payment system. As part of the waiver application, states must demonstrate to the Office of Management and Budget (OMB) that federal Medicaid expenditures under the waiver will be budget neutral. Yet states may incur costs as they invest in care management services designed to lower rehospitalizations, emergency room and skilled nursing facility use, and nursing home placements. Thus, although state Medicaid programs fund care management services (many are not Medicare-covered services), the savings accrue to Medicare. States cannot use expected savings in Medicare to offset any increases in Medicaid spending when demonstrating budget neutrality. These budget-neutrality rules are longstanding OMB policy, not statutory or regulatory requirements (Rosenbaum et al. 2009).

Waiver rules also require that budget neutrality be achieved within two to five years, depending on the waiver. Savings are likely to accrue more quickly from lower hospital, emergency room, and skilled nursing facility use than from averted nursing home admissions. However, under current policies as noted, savings from one program cannot be used to underwrite costs from the other in an integrated managed care program.

Separate Medicare and Medicaid administrative rules and procedures

Medicare and Medicaid have separate and often different procedures for administrative tasks, such as enrollment, disenrollment, eligibility, marketing, appeals, and performance reporting. Navigating and trying to align the two programs' administrative rules and processes is challenging for states, managed care entities, and dual-eligible individuals with limited resources. In addition, states can take many years to obtain federal approval for a Medicare and Medicaid managed care program. Further, each program cannot access health care claims from the other, and lack of data sharing in real time can inhibit care management and coordination between SNPs and states on covered services. SNPs and states can address some of the administrative barriers through close collaboration. For example, all but one of the SNPs participating in Minnesota's integrated care program contract with the state to be responsible for the plans' Medicare enrollment (Edwards et al. 2009).

The Patient Protection and Affordable Care Act established the Federal Coordinated Health Care Office within CMS. The Federal Coordinated Health Care Office goals include simplifying processes for dual-eligible beneficiaries and eliminating regulatory conflicts between Medicare and Medicaid and may help alleviate the administrative burdens of integrated care programs.

Low program enrollment

States can obtain waivers from CMS to mandate enrollment into Medicaid managed care; however, in contrast to states' authority over Medicaid benefits, states cannot require dual-eligible beneficiaries to enroll in a SNP to receive Medicare benefits. Under Medicare, beneficiaries have freedom of choice to select providers. Dual-eligible beneficiaries are permitted to receive their Medicare benefits through any MA plan (and can change plans monthly) or through any FFS provider. Duals may not recognize the advantages of an integrated care program (such as enhanced care coordination) and therefore may not choose to enroll in integrated care programs for their Medicare benefits.

Concluding observations

Approaches to better care coordination for dual-eligible beneficiaries need to combine financing streams and actively manage the care that beneficiaries receive. Without combined finances, an approach will not fully align provider and program incentives. A strategy to coordinate care is also needed. Likewise, care coordination alone would not align financial interests across providers and programs. Conflicting financial incentives could continue to result in unnecessary and fragmented care. Excluding long-term care from any approach will make it difficult to control federal spending for these services and result in less optimal coordinated care.

This review has not concluded whether one or more approaches to care integration are more or less likely to be successful. We have not assessed whether provider-based models (such as PACE) or health plan-based models (such as a state-SNP approach) will have better results. State-SNP arrangements appear to be successful at coordinating care for dual-eligible beneficiaries, but such arrangements were often initiated by states with a history of Medicaid managed care. States vary in their experience with and aversion to managed care and this model will not be equally replicable in all states. Future work will consider

the characteristics of successful fully integrated programs and how enrollment might be expanded.

Care coordination activities should be tailored to patients' characteristics and their relative risk for costly undermanagement—potentially avoidable hospitalizations, medication mismanagement, and premature institutionalization. Beneficiaries at risk for institutionalization will need to be more closely monitored than the essentially well dual-eligible beneficiaries. Approaches for dual-eligible beneficiaries with several chronic conditions will need to emphasize communication and data sharing across the multiple providers and appropriate primary care to avert unnecessary facility-based care. Care management activities for cognitively impaired beneficiaries (a high-spending group) will need to be tailored to their ability to understand and adhere to care plans.

Integrated models of care should, like all beneficiary care, be evaluated with measures that gauge their relative efficiency—such as risk-adjusted hospitalization rates, nursing home use, emergency use, and per capita costs. Other measures should capture the extent to which and how well programs integrate the care dual-eligible beneficiaries receive using measures of care coordination and care transitions. Tying provider payment to these measures will put them at risk for achieving good patient outcomes.

Even if best models are identified, implementing full care integration for all dual-eligible beneficiaries will require a transition from the essentially uncoordinated world to one with active care management. There are multiple ways it could be accomplished. Integration could begin with certain services, such as cost sharing and optional Medicaid services. After successfully integrating these services, the models could be expanded to take on the more difficult (but more important, given the dollars at stake) set of long-term care services. Integration could also start with certain subgroups—either the high cost, those most at risk for costly undermanagement, or those with the most beneficiaries. Partial integration efforts need to be designed with enough flexibility so that other services and groups of beneficiaries can be folded in over time. ■

Endnotes

- 1 One study found that fewer than half of all Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level were enrolled in Medicaid (Pezzin and Kasper 2002). Reasons for low participation rates include welfare stigma, a lack of information about program and eligibility criteria, and cumbersome enrollment processes.
- 2 There are four ways to be eligible for the Medicare Savings Program (MSP). Beneficiaries whose income is less than 100 percent of the federal poverty level (FPL) qualify for the qualified Medicare beneficiaries (QMBs) benefit, and Medicaid pays for their Medicare premiums and cost sharing. Some QMBs do not qualify for full Medicaid benefits (and are referred to as “QMB only”). In some states, higher income beneficiaries do not qualify for cost-sharing benefits but they do qualify for other Medicaid benefits. If their income is between 100 and 120 percent of FPL, then they qualify for the specified low-income Medicare beneficiaries benefit, and Medicaid pays for their Medicare Part B premiums. If their income is between 120 and 135 percent of FPL, then they qualify for the qualifying individuals benefit, and Medicaid pays for their Medicare Part B premium. If beneficiaries are working, disabled individuals with an income up to 200 percent of FPL, then they qualify for the qualified working disabled individuals benefit, and Medicaid pays their Medicare Part A premium. Under the provisions of the Medicare Improvements for Patients and Providers Act of 2008, for all these programs, beneficiary assets cannot exceed twice the Supplemental Security Income limit—\$6,600 for individuals and \$9,910 for couples (Centers for Medicare & Medicaid Services 2009). In 2008, the Commission recommended that the Congress raise the MSP income and asset criteria to those of the low-income drug subsidy criteria, which the Congress adopted beginning in 2010. This alignment updated the criteria (they were last revised in 1989) and will simplify the application process for beneficiaries and lower administrative costs of the programs.
- 3 The Balanced Budget Act of 1997 permitted states to not pay Medicare cost sharing if the Medicare rate minus the cost sharing is higher than the Medicaid rate for those services.
- 4 It is possible that there are community-dwelling duals with two or more physical impairments who, given our hierarchical categories, have been assigned to a cognitive impairment group.
- 5 Dual-eligible beneficiaries with end-stage renal disease (ESRD) were excluded from the analysis. They make up a small share of all dual-eligible beneficiaries (2 percent) and the very high spending on them would distort the underlying picture for the majority of dual-eligible beneficiaries. The average spending for ESRD dual-eligible beneficiaries is about three times that for other duals. In addition, physicians caring for beneficiaries with ESRD receive a monthly fee to manage their patients’ dialysis. Therefore, ESRD patients have, to varying degrees, at least one of their underlying conditions managed by a physician.
- 6 The subgroups draw directly on the approach of Foote and Hogan in their analysis of the Medicare disabled population (Foote and Hogan 2001).
- 7 Most facilities are dually certified for both Medicaid and Medicare. To be covered under Medicare, a skilled nursing facility stay must be preceded by a three-day hospitalization and the patient must require skilled care (such as therapy or skilled nursing services). Medicare Advantage plans may waive the three-day hospital stay requirement and cover skilled care in a nursing facility as a Medicare-covered benefit.
- 8 In *Duggan v. Bowen*, beneficiaries and providers charged that Medicare’s interpretation that services be “part-time or intermittent” was too narrow and denied care to eligible beneficiaries.
- 9 Many states have pursued Medicare maximization strategies to increase federal payments. When coverage for services is ambiguous for some beneficiaries—such as nursing home and home health services—states may require providers to first bill Medicare for services (or to pay the providers directly and then pursue Medicare reimbursement) as a way to have Medicare be the primary payer. States and providers prefer to have Medicare pay the claim: Providers prefer the higher payments generally paid by Medicare, while states can avoid paying for the service. Claims that are rejected by Medicare are then submitted to Medicaid for payments. This back-and-forth between payers can leave beneficiaries with unpaid bills until the coverage is sorted out. Some states have used contingency fee consultants to implement strategies—such as new methods to maximize federal reimbursements, state staff training in the claims submission process, and preparation of claims for federal reimbursement—designed to maximize federal reimbursements to state Medicaid programs (Government Accountability Office 2005).
- 10 Block grants to cover Medicaid services are not a new idea. A proposal to move Medicaid to block grants was made in 1981; they were again proposed in 1995 and 2003. These proposals outlined options for coverage and populations who had to be covered and included federal spending limits and annual increases. Although the limits on federal spending and the expanded state autonomy were attractive, a strong commitment to cover a vulnerable population and concerns about the fiscal impact on states have kept Medicaid as an entitlement program (Lambrew 2005).

- 11 For example, in 2003 the Bush Administration’s block grant proposal included a provision that states show “maintenance of efforts” to receive federal funds—a kind of reverse matching funds (Mann 2004).
- 12 Application to §1915(c) HCBS Waiver Version 3.4. Appendix H. Available from http://www.hcbs.org/browse.php/sby/Date/type_tool/146/Waiver%20templates.
- 13 Commission calculations: estimated number of dual-eligible beneficiaries in integrated care programs and estimated number of dual-eligible beneficiaries in MA plans, including SNPs (Center for Health Care Strategies, Inc. 2009).
- 14 The 30 states with PACE programs are Arizona, California, Colorado, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin. Source for states with PACE programs: MedPAC analysis of CMS, MA enrollment by state/county/contract, March 2010; source for PACE enrollment estimate: MedPAC calculation of CMS MA and Part D contract and enrollment data, February 2010.

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