dual-eligible reform
a step toward population health management

By improving care coordination for patients who receive full benefits under both Medicare and Medicaid, the healthcare industry could save up to $20 billion a year while improving quality of care and outcomes.

“Dual eligibles”—beneficiaries of Medicare and Medicaid who receive full benefits under both programs—account for about $320 billion in healthcare costs annually. The majority of dual eligibles receive care in uncoordinated systems, resulting in poor quality or costly care, the Medicare-Medicaid Coordination Office of the Centers for Medicare & Medicaid Services (CMS) observed in a July 2011 letter to state Medicaid directors (“Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees,” July 8, 2011).

It has been estimated that as much as $20 billion a year could be saved by better integrating and coordinating primary, acute, behavioral, and long-term care services for dual eligibles and thereby eliminating duplicative or unnecessary hospital and nursing home services and enhancing quality of care (Thorpe, K., “Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligibles,” America’s Health Insurance Plans, September 2011). Some observers have described dual eligibles as the “last untapped market”—a multibillion-dollar opportunity to reduce costs by improving care management. There is growing commercial interest in the dual-eligible market from companies that specialize in the management of Medicare and Medicaid programs for dual-eligible populations.

The size and costs associated with dual eligibles are difficult to measure exactly—various estimates of these statistics do not agree. By any estimate, however, one thing is clear: These individuals account for a significant portion of total spending for Medicare and Medicaid.

AT A GLANCE

> Improved care coordination for dual eligibles has the potential to reduce hospitalizations and eliminate duplicative services.
> Finding common ground on program design for dual eligibles has proved difficult, and for some programs to date, the cost of care management has balanced out savings achieved.
> Partnering with an experienced Medicaid managed care plan could be the best strategy for market entry for all but the most experienced integrated delivery systems and health systems.
In California, a dual eligible who has multiple chronic conditions will see, on average, 14 physicians and fill 50 different prescriptions a year. For example, according to the Medicare Payment Advisory Commission (MedPAC), despite constituting only 16 percent of the Medicare population and 18 percent of the Medicaid population, dual-eligible enrollees account for 25 percent and 46 percent of total spending for Medicare and Medicaid, respectively (A Data Book: Health Spending and the Medicare Program, MedPAC, June 2010). In an October 2012 report, the Kaiser Family Foundation cites similar statistics, finding that dual eligibles account for 31 percent of total Medicare costs and 39 percent of total Medicaid costs, yet constitute just 21 percent of the Medicare population and 15 percent of the Medicaid population (Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries, Kaiser Family Foundation, Oct. 1, 2012). Medicare is the primary source of health insurance for dual eligibles, while Medicaid, which supplements Medicare, pays for long-term care and Medicare’s premium and cost-sharing requirements.

Because the average amount Medicare and Medicaid spend on dual eligibles is more than twice the average amount the programs spend on other beneficiaries, and has been growing twice as quickly as the latter, the market appears ripe for the introduction of integrated care delivery coordination and coordinated benefit payments.

A Complex and Diverse Population

Dual eligibles are a complex patient population. They are more likely than other Medicare beneficiaries to be frail, have multiple chronic conditions, and have functional and cognitive impairments. They have a higher hospitalization rate than other Medicare beneficiaries—26 percent, compared with 18 percent for other beneficiaries—and are almost twice as likely to be readmitted (11 percent readmission rate, compared with a 6 percent readmission rate for other beneficiaries).

With the bulk of their care provided by fee-for-service providers, dual-eligible beneficiaries are among the highest users of healthcare services—and their higher hospitalization and readmission rates suggest they are not efficiently treated. The California Department of Health Care Services, for example, reports that in California, a dual eligible who has multiple chronic conditions will see, on average, 14 physicians and fill 50 different prescriptions a year (Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Beneficiaries, Proposal to the Center for Medicare and Medicaid Innovation, May 31, 2012).

But dual eligibles also are a diverse group that may be particularly good candidates for managed care:

> Nearly 40 percent are younger than 65.
> Approximately 75 percent have no hospital admissions.
> About 87 percent still live at home rather than in a facility.

The risks of adverse selection in enrolling dual-eligible beneficiaries are real:

> Nearly half of dual eligibles also have some form of mental impairment or dementia.
> Roughly 35 percent of dual eligibles have four or more chronic conditions, which pose a challenge for integrated care delivery and treatment planning under either capitated or fee-for-service care management programs.

In the Crosshairs of Reform

Dual eligibles have been a focus of reform since the Affordable Care Act became law. In July 2011, CMS announced “State Demonstrations to Integrate Care for Dual Eligible Individuals,” a national effort to integrate care and coordinate benefit payments for dual eligibles in partnership with the states. The previously cited letter issued by CMS’s Medicare-Medicaid Coordination Office to state Medicaid directors at that time was intended to provide guidance regarding this project. In the letter, CMS notes states’ potential
under the demonstrations to enroll some 2 million beneficiaries in a capitated managed care or managed fee-for-service program. This massive effort therefore could affect approximately 25 percent of dual eligibles.

An analysis of initial proposals indicates that states will change their service delivery models to various forms of managed care, including risk-based and non-risk-based contracts. State proposals have included development of accountable care organizations (ACOs), integrated care networks, and/or primary care case management involving risk capitation. The focus of such proposals is generally focused on the 6 million Medicare-Medicaid enrollees who are eligible for full benefits from both programs.

**Managed Care Market Opportunity**
The Kaiser Family Foundation’s October 2012 report notes that approximately 20 percent of dual eligibles are enrolled in Medicare Advantage plans, compared with 23 percent of other beneficiaries. Indeed, in approximately 30 states where Medicare Advantage enrollment is below national averages, there is very little care coordination for dual eligibles at all.

There is no shortage of models for Medicaid managed care. More than 70 percent of Medicaid beneficiaries in 48 states are now enrolled in either risk-based managed care organizations (26 million beneficiaries) or in primary care case management (8.8 million). About half of Medicaid managed care is provided by for-profit corporations, and two-thirds of Medicaid managed care providers serve only Medicaid beneficiaries. However, very few of these programs have specifically targeted dual-eligible beneficiaries, who tend to be more costly and difficult to treat because of their complex range of personal and health problems.

Under the capitated model, participating health plans will receive a prospective, blended payment to provide the full continuum of benefits for Medicare-Medicaid beneficiaries. Because this rate will likely be higher than current Medicaid managed care rates, the demonstrations provide an immediate opportunity for Medicaid plans that already play in the government market to score large one-time enrollment gains.

To date, 26 states have submitted proposals; 18 are pursuing capitated, gainsharing models; five are pursuing managed fee-for-service models; and three are pursuing both models. So far, only two states have been approved by CMS: Massachusetts, which was approved for a capitated program covering all 109,000 dual eligibles ages 21 to 64 in the state, and Washington, which has been approved for a managed fee-for-service program for dual-eligible beneficiaries in rural areas.

Other states have publicly announced their plans to launch programs in 2013 and 2014, and their proposals are still under CMS review. Illinois, for example, which faces a huge deficit in its Medicaid budget, announced it has selected eight managed care companies to coordinate the health care of 137,000 dual eligibles, mainly in the Chicago metropolitan area and Springfield. On the West Coast, the California Coordinated Care initiative—the state’s dual-eligible demonstration program—will be launched in 2013 with “passive enrollment” of approximately 560,000 Medicare dual eligibles in the Bay Area and southern California in participating managed care plans.

Texas, which has to date voted against participating in the Medicaid expansion, has submitted an ambitious capitated model to enroll 214,000 of the state’s 323,000 dual-eligible beneficiaries in participating managed care plans in 2014.

Simply put, the federal government will pay all of the healthcare costs in a demonstration program’s budget, while states will pick up the long-term costs of care. The majority of these demonstrations will provide for shared savings with the state if the program beats the prospective budget once a 2 percent minimum threshold has been met. This is similar to the requirements for ACOs participating in the Medicare Shared Savings Program. It is interesting to note that although only 26 out of the 50 states have submitted proposals to participate in demonstration
programs. 40 of the 50 largest cities in the nation are located in those states. Dual-eligible beneficiaries not only account for a disproportionate amount of Medicare-Medicaid spending, but also are concentrated in the states that are participating in the demonstration programs.

**Policy Differences Cloud Reform**

Although the overriding goals of improved care management for dual eligibles are clear, finding common ground on program design is proving more difficult.

For example, there is a culture clash between proponents of Medicare demonstration programs for dual-eligibles versus Medicaid waivers. There also is the issue of Medicare freedom of choice, an option advocated by CMS, versus limited choice and mandatory managed care enrollment for all beneficiaries, approaches that are preferred by state governments. Then there is the practical issue of whether Medicare or Medicaid should be responsible for the administration of benefits for dual eligibles, or whether it is preferable to simply create a new uniform program. This issue is complicated by the fact that dual eligibles are high-cost patients in both programs—but for different reasons, since only a fraction of beneficiaries are high spenders under both programs (Weil, A., “Policy Alternatives for Dual Eligibles,” National Academy of State Health Policy, October 2012).

**‘Traditional Providers’ Still Key**

Private physicians in solo fee–for–service practice or small, independent physician practices are still the major providers of dual–eligible medical care in many urban areas. In Los Angeles County, for example, there are 374,000 dual–eligible residents who are concentrated in communities with high Medi-Cal enrollment. Both the Medicare and Medi-Cal patients are heavily dependent on “traditional providers”—private physicians practicing alone or in small, independent physician practices—for their care. The fee–for–service revenue provides “life support” for many of these physicians’ incomes (Flores, H., California’s Dual Eligible Pilot: Impact on IPAs and Private Practice Physicians, October 2012).

Thus, the use of massive “passive enrollment” procedures to assign dual–eligible beneficiaries to managed care plans is seen by community advocates as a threat to the continuity of care for the sickest and most vulnerable patients in society—even with the opt-out provisions and beneficiary protections specified in the states’ proposals.

Not surprisingly, some are concerned that a potential unforeseen consequence of the CMS demonstrations will be the potential destabilization of the healthcare provider network in underserved areas, driving physicians out of private practice and into employed positions with providers that do not serve these urban communities.

**Pilot Programs Have Mixed Results**

A variety of program interventions targeted dual–eligible and other high–risk Medicare beneficiaries before the large–scale CMS state demonstrations were announced. The results of all the studies indicate the importance of establishing targeted subsets of dual eligibles, given the diversity of the population, to reduce hospital and nursing home utilization. Segmenting dual eligibles by the type of care needed and the appropriate setting for care delivery appears to be the most effective approach to targeting (Brown, R., and Mann, D., Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence, Mathematica Policy Research and Kaiser Family Foundation, October 2012).

To date, the results have been mixed:

- **PACE:** The Program of All–Inclusive Care for the Elderly, a capitated program in 29 states serving 27,000 frail Medicare and Medicaid beneficiaries, has reduced hospitalization by 30 percent, but has not saved money overall due to high capitation rates.
- **Minnesota Senior Health Options and the Wisconsin Partnership Program** both reduced preventable hospital admissions, but did not save money compared with Medicare fee for service.
- **Evercare,** a hospice and palliative care organization that focuses on long–stay nursing homes, lowered hospitalizations by increasing acute
services provided by nursing homes, but did not save money because the capitated payments were set higher than the amount Medicare would have paid under the regular fee-for-service program.

Only two of the nine capitated programs that were reviewed by researchers for the Kaiser Family Foundation’s October 2012 report actually reduced hospitalization and spending: the Commonwealth Care Alliance Disability Program in Massachusetts and the SCAN Health Plan in San Diego. The researchers thought that neither of these programs could be applied generally, however, because one had a relatively narrow geography (11 counties served by SCAN in Southern California with very high Medicare fee-for-service rates) and the other had a narrow program focus (Medicare recipients using wheelchairs).

Howard Kahn, CEO of LA Care, the nation’s largest public Medicaid Managed Care Plan and a leader in California’s effort to improve dual-eligible care coordination, also cautions that current experience dealing with dual eligibles shows mixed results and little evidence, as yet, of large savings (Kahn, H., LA’s Dual Demonstration: Bringing Coordination to a Fragmented System, LA Care Health Plan, National Dual Eligible Summit, October 2012). Kahn suggests that potential participants in the dual-eligible market should ensure they have several key capabilities in place before getting started:

- Targeting and specialization capabilities
- Strong IT systems
- Data to understand patients and historic providers
- Early outreach to patients and providers with clear messaging
- Ability to match care provided to care needed
- Experience in the design and implementation of care coordination initiatives
- Publicly available data to support tracking and potential policy debates
- Well-designed integration initiatives
- Appropriate rate setting to avoid adverse selection

**Relevance for Health Systems and Networks**

CMS’s dual-eligible demonstration is another arrow in the quiver of reform and a step down the road to population health management. The demonstration programs’ roll-out initiatives in 2013 and 2014 will have greatest interest to Medicare and Medicaid managed care plans, with existing provider networks and experience working with low-income communities where dual-eligible beneficiaries tend to be concentrated. Most big-city providers also will want to pay close attention to the potential impact of dual-eligible demonstrations in their markets, because eliminating unnecessary hospital admissions and readmissions is a primary objective of most state programs. It will be important for health systems and clinically integrated networks in urban markets to “cast a weather eye” on what impact the likely reduction in admissions will have on revenues. They also should try to determine what, if any, effect the switch from fee-for-service to capitation may have on medical staff income, as a substantial number of fee-for-service Medicare recipients will be enrolled in new, capitated care management plans.

The pilot capitation programs set care coordination fees at between $150 to $195 per month per enrollee. The experience of these programs suggests that generating net savings at this cost requires a reduction of at least 15 hospitalizations per 100 enrollees.

Special needs programs report that the cost per dual-eligible beneficiary for basic Medicare services exceeds that of fee-for-service programs for similar beneficiaries. This experience raises questions about any state proposals that assume large-scale savings for Medicare for enrolling duals in either capitated or managed fee-for-service programs at premiums below the rate currently paid to special needs programs. Although there appears to be no shortage of plans willing to do business with states, given the cost associated with care coordination, setting unrealistically low rates could make it difficult for plans to stay in business in all but the markets with the highest fee-for-service costs. The only clear winners at
this point may be existing Medicaid managed care programs with clinically integrated systems already in place in markets where dual eligibles are concentrated.

The experience of pilot programs indicates that large savings for more coordinated care for dual eligibles have so far been hard to come by, and that the cost of care management for this complex population has balanced out savings achieved through reduced hospitalization. Care for dual eligibles should be addressed in any comprehensive population health management plan, but the evidence to date has not shown any significant cost improvement in capitated programs over existing fee-for-service arrangements. Partnering with an experienced Medicaid managed care plan would appear to be the best strategy for market entry for all but the most experienced integrated delivery systems and health systems. ●

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