

ON MEDICAID'S MOST COMPLEX AND COSTLY

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The American health care delivery system is in need of fundamental change. Common chronic conditions should serve as a starting point for the restructuring of it. — Institute of Medicine.

Ultimately, success in the "longitudinal" management of populations with chronic illness will depend on the integration of care across various sectors, acute hospitals, primary care, nursing home care, home health care, and hospice care. It will depend on a financing strategy that promotes the rational allocation of resources among the sectors of care.



Improving payment and performance for high-risk beneficiaries

FRAIL ELDERLY, ADULT DISABLED, AND THE DUALY ELIGIBLE



Historically, states have addressed problems of growing Medicaid expenditures by reducing enrollment, benefits and/or provider payments; increasing co-pays; taxing providers; or through creative inter-governmental transfers. Recently, the federal government has sought to provide States increased flexibility in making these decisions as a companion effort to broader Medicaid reform designed to save \$10 billion dollars over 5 years. While temporarily stemming the tide of budget shortfalls, none of these actions address the root cause of escalating Medicaid costs.

The starting point for meaningful Medicaid reform is recognizing that: a) the aging of America is already here, b) the nature of health care is changing from acute to chronic, and c) Medicare and Medicaid are highly interdependent programs.

This projected growth in the elderly population, a proportional increase in the complexity of chronic conditions, and escalating health care costs in excess of retirement savings will result in significant increased demand for public financing.

- ❖ Four-fifths (82 percent) of projected Medicaid expenditure growth reflects increases in the cost of caring for aged, blind and disabled Medicaid beneficiaries (Center on Budget and Policy Priorities).
- ❖ 20 percent of people 65 and older have five or more chronic conditions and account for 68 percent of Medicare spending (Partnership for Solutions).

While Medicare and Medicaid remain separate federal programs, they both provide support for a common high-risk population of frail elders and adults with disabilities.

- ❖ Approximately 42% of Medicaid dollars are for care of Medicare

beneficiaries. Medicare and Medicaid spending for the dually eligible will exceed \$200 billion in 2005.

As Americans retire and age, the cost burden of serving a high-cost/high-need population will only become more severe.

- ❖ From 2000 to 2050, the population 75 years and over will increase from 6 to 12 percent. By 2040, the 75 and over population will exceed the population 65-74 years of age. The rate of hospital, nursing home and pharmacy use increases significantly with age. (Health, United States, 2004.)

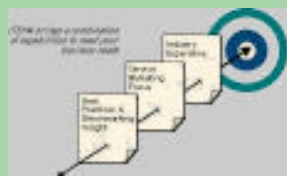
Unfortunately, current health policy, payment methods and regulations are rooted in antiquated acute care methods and silo-based structures that *cause* significant and unnecessary stress, confusion, medical complications and costs.

- ❖ Medicare beneficiaries with four or more chronic conditions are 99 times more likely to incur a hospitalization that could have been prevented with appropriate primary care.
- ❖ Millions of dollars are spent each year in administering duplicative and conflicting requirements, with adverse market incentives for *total* cost and quality improvement.

Stabilizing Medicaid financing over the long-term requires that public officials take into account the expensive, complex and ongoing care needs of frail elders, adults with disabilities and other high-risk beneficiaries, and the pervasive interdependence between Medicare and Medicaid in meeting their needs. It requires a person-centered, system-oriented approach that is both compassionate and fiscally responsible. Our current approach to serving our most vulnerable population is neither.

A BLUEPRINT FOR CHANGE

Change is upon us, and we can neither run nor hide. The only answer is to create new—nimble businesses capable of adroitly responding to the chaotic conditions produced by constant change. It won't be easy, but it won't be dull or unrewarding either. — Daryl R. Conner.



Most players see their job as “managing their position” in isolation from the rest of the system. What is required is to see how their position interacts with the larger system ... everyone shares responsibility for problems generated by a system. — peter Senge

Current Medicare and Medicaid administration, financing and care policies contain incentives for plans and providers to sub-optimize costs around isolated care segments and maintain antiquated acute care practices in serving beneficiaries with severe or disabling chronic conditions. They limit the ability of plans and providers to transform their operations in response to 21st century demands. They create unnecessary conflict between state and federal governments and restrict the government's ability to effectively address the cost and care needs of healthcare's highest-cost and fastest growing service group—the frail elderly, adults with disabilities and other high-risk beneficiaries.

To resolve the pending Medicaid crisis, federal and state leaders must work together around a common blueprint for change. They should:

1. ADVANCE USE OF SPECIAL NEEDS PLANS

Section 231 of the Medicare Modernization Act established a new class of Medicare Advantage Plans, called Special Needs Plans (SNPs). The provisions lay a foundation for plans to specialize in care of high-risk beneficiaries, including a) persons dually eligible for Medicare and Medicaid, 2) persons living in institutions or in the community with similar needs, and 3) persons with serious or disabling chronic conditions, such as ESRD and AIDS. The number of applications for SNP certification has far exceeded everyone's expectation—over 150 applications for 2005 and 2006 contract years.

This overwhelming market response offers a practical foundation for evolving specialized care for healthcare's most costly and needy population. To optimize their chances for success, CMS and/or Congress should—

- ❖ Allow national demonstrations with the most experience in serving a high-risk population to maintain all existing waivers through the period of waiver authority as they transition to SNP status.
- ❖ Apply the learning from these integration and dually eligible demonstrations in streamlining administrative oversight and facilitating use of integrated financing and management structures for other

SNPs serving high-risk beneficiaries.

- ❖ Allow states to establish methods for integrating Medicare and Medicaid through the state plan amendment process rather than through waivers.
- ❖ Eliminate the sunset provision for SNPs to ensure stability of the SNP program.

2. ESTABLISH MORE APPROPRIATE MARKET INCENTIVES FOR HIGH-RISK BENEFICIARIES

Medicaid waiver opportunities and the Supreme Court's *Olmstead* decision have emboldened states to strengthen their home care service capabilities. Some have developed special programs for the dually eligible. Federal and state officials should—

- ❖ Immediately apply a frailty adjuster to SNP payments, thus eliminating adverse market incentives to target and serve high-risk beneficiaries.
- ❖ Adopt a common risk-adjusted payment methodology for serving persons dually eligible for Medicare and Medicaid.
- ❖ Allow SNPs serving the dually eligible to receive funds from both programs under a uniform payment structure.
- ❖ Combine costs of Medicare and Medicaid in defining budget neutrality and cost effectiveness.
- ❖ Give states greater flexibility in the financing of home and community-based services as an alternative to nursing home care.
- ❖ Monitor total costs in serving the dually eligible and strengthen pay-for-performance in meeting *cumulative* quality and cost objectives.
- ❖ Stabilize financial participation between states and the federal government to decrease cost shifting and optimize total public cost savings.
- ❖ Create incentives for principal care physicians to target and serve high-risk patients using more appropriate care management methods.

A BLUEPRINT FOR CHANGE (CONTINUED)

3. ESTABLISH NEW QUALITY MEASURES

Medicare and Medicaid programs must move away from measuring quality around narrow, predefined programs and isolated treatment methods. Instead, CMS should—

- ❖ Define “total quality” measures to monitor *cumulative* cost and quality effects in serving high-risk beneficiaries as their needs evolve over time and across care settings.
- ❖ Define new quality measures for serving frail elders, adults with disabilities, and persons with co-morbid illness that take into account the limitations of single disease-state and provider-specific guidelines.
- ❖ Give more importance to quality of life and customer satisfaction indicators.
- ❖ Create measures to empower continuous quality improvement rather than incent providers to gravitate to the lowest common denominator.
- ❖ Delay the report to Congress on the quality and cost effectiveness of SNPs until 12/31/09 to provide an appropriate timeframe to develop appropriate quality measures for evaluating their performance.

4. RE-ENGINEER OVERSIGHT

Separate Medicare and Medicaid program requirements promote cost shifting and reinforce fragmented, antiquated care delivery. To reduce cost and improve quality across settings and over time, government officials should—

- ❖ Consolidate program oversight for the dually eligible under a single senior-level CMS administrative authority.
- ❖ Immediately replace current waivers with statutory authority and stabilize matching requirements and intergovernmental transfer payments.
- ❖ Eliminate regulatory disparities between Medicare and Medicaid in serving the dually eligible and for persons requiring care across the continuum of primary, acute and long-term care providers.
- ❖ Establish continuity of care requirements for providers serving the same person, either at the same time or in sequence to one another, and for simplifying and

improving the safety of persons moving from one care setting to another.

5. ESTABLISH A SINGLE FEDERAL PROGRAM FOR THE DUALLY ELIGIBLE

Most Medicare and Medicaid costs relate to persons with complex chronic conditions who require a full continuum of primary, acute and long-term care. Current health policy contains incentives for plans and providers to sub-optimize costs using antiquate care management methods, without regard for their cumulative adverse effects. To achieve long-term cost and quality improvement requires that Congress establish a single authority for the dually eligible, with an integrated financing and regulatory structure. Congress should develop and approve legislation that—

- ❖ Identifies a timetable for establishing a single administrative authority for the dually eligible, using an integrated financing and regulatory structure.
- ❖ Establishes a negotiated rulemaking Committee to resolve key differences between state and federal governments.
- ❖ Where there are inconsistencies, the Committee should defer to whichever rule that currently provides the greatest protection for program recipients.

6. REENGINEER THE HEALTH CARE INFRASTRUCTURE

Training and information technology is rooted in acute care and component-based structures inappropriate for serving frail elders, adults with disabilities and other high-risk beneficiaries. Congress should—

- ❖ Advance training for all health care providers in geriatric medicine, disability care and inter-provider collaboration.
- ❖ Advance information technology to enable providers to use a common care plan as a person's needs evolve over time and across care setting.
- ❖ Require that patients and caregivers be more fully involved in care decisions.
- ❖ Enhance self-care capabilities and caregiver support.

Corporate control systems must be built that can manage both to control operations and increase the rate of creative destruction. Control what you must, not what you can. — Richard Foster and Sarah Kaplan

We tend to focus on snapshots of isolated parts of the system and wonder why our deepest problems never seem to get solved.” —Peter Senge

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*Improving payment and
performance for high-risk
beneficiaries*

THE TIME TO ACT IS NOW!

Historically, tax policy and budget policy have become *the* means for making health policy decisions, including those related to the Medicaid program. This year, Congress is seeking to cut 10 billion dollars from the Medicaid budget and provide states with greater flexibility for reducing costs.

Public officials must recognize that the emerging growth in Medicaid spending is heavily related to the aging of America, the transformation of healthcare from acute to chronic, and the interdependence between Medicare and Medicaid. There is increasing evidence that our fragmented, acute care approach to health policy actually *causes* significant and unnecessary confusion, administrative duplication, cost shifting, medical complications and costs in serving dually eligible beneficiaries.

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To minimize costs and maintain quality over the long-term, require a non-traditional bipartisan approach that brings together federal and state officials around a common Medicaid reform agenda. It requires a person-centered, system-oriented approach that takes into account the multidimensional, interdependent and ongoing nature of care in serving frail elders, adults with disabilities, and other persons with volatile, complex, comorbid, disabling chronic conditions.

Current health policy and financing methods are neither efficient nor effective. Cost reduction without re-engineering the infrastructure for Medicare and Medicaid financing and administration may in fact make matters worse. The time to act is now!

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THE NATIONAL HEALTH POLICY GROUP

The National Health Policy Group (NHPG) is dedicated to improving health policy for people with serious and disabling chronic conditions. The NHPG has experience in addressing the real-world issues of chronic illness care with the commitment and skills necessary to help government, national associations, and plans and provider organizations improve our health care system's overall performance.

The NHPG welcomes the opportunity to work with those interested in establishing new programs and policies to meet the changing care needs of 21st century health care consumers.