

An hourglass-shaped graphic with a globe inside. The top bulb is dark blue, and the bottom bulb is light blue. The globe is centered in the narrow neck of the hourglass. The top bulb is filled with a dark blue color, and the bottom bulb is filled with a light blue color. The globe is centered in the narrow neck of the hourglass.

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*Federal and State Initiatives to Integrate Acute and
Long-Term Care*

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Abstract. This report characterizes the dually eligible population and describes the problems associated with meeting their health and social service needs. It describes federal and state programs that seek to integrate acute and long-term care services for this population. Policy implications are also discussed.

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Federal and State Initiatives to Integrate Acute and Long-Term Care

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Summary

Congress has considered many approaches to improve the financing and delivery of long-term care services to vulnerable populations. These approaches have included ways to improve the delivery of care to persons who qualify for both Medicare and Medicaid acute and long-term care services, or “dual eligibles.” Because persons who are dual eligibles are especially vulnerable and costly, both the federal and state governments are interested in finding more effective ways of serving them. This report characterizes the dually eligible population and describes the problems associated with meeting their health and social service needs. It briefly describes federal and state programs that seek to integrate acute and long-term care services for this population. Policy implications are also discussed. This report summarizes the more in-depth CRS Report RL30813, *Federal and State Initiatives to Integrate Acute and Long-Term Care: Issues & Profiles* and will not be updated.

Dual Eligibles Defined

Over the past two decades, Congress has considered a variety of proposals to improve the financing and delivery of long-term care. One such approach is to better coordinate the acute and long-term care services needed by many of the 7 million Medicare beneficiaries who also qualify for Medicaid (i.e., the “dual eligibles”). Compared to other beneficiaries, dual eligibles are especially vulnerable and costly to serve. Not only are they disproportionately poor, but they are more likely than other Medicare beneficiaries to be age 85 or older, disabled, non-white, female, living alone, in only fair or poor health, cognitively and functionally impaired, and/or suffering from many chronic ailments and diseases (see **Table 1**).

Not surprisingly, dual eligibles use a disproportionate share of resources relative to their numbers. Although they constituted only 16% of Medicare beneficiaries in 1995, dual eligibles accounted for approximately 30% of total Medicare expenditures (\$53

billion).¹ Although only 17% of Medicaid recipients, dual eligibles accounted for approximately 35% of Medicaid expenditures (\$53 billion). Overall, the \$106 billion consumed by this population was *one-third of total spending* by both the Medicare and Medicaid programs combined in 1995. Based on demographic projections that indicate significant growth among the “oldest old,” those 85 years and older, and growing ranks of the population that will be chronically ill and disabled, Medicare and Medicaid expenditures for long-term care services *for the elderly* are projected to double between 2000 and 2025.² It is likely that an increasingly disproportionate share of these resources will be consumed by dually eligible individuals, since they are more likely to be among the populations requiring long-term care.

Table 1. Comparison of Medicare Beneficiaries by Dual Eligibility Status, 1998

Characteristics	Duals	Non-Duals
Total beneficiaries	7.0 million	39.8 million
Income less than \$10,000	73.8%	18.3%
Age 85 and older	18.1%	9.9%
Under Age 65 but disabled	28.8%	9.4%
Non-White (Hispanic, Black, other)	38.5%	14.1%
Female	63.2%	54.6%
Living alone if in community	39.4%	29.2%
Fair/poor self-reported health	53.4%	25.1%
One or more ADL or IADL limitations	76.4%	42.9%
Mobility limitation	68.8%	42.7%
Urinary incontinence	33.6%	20.5%
Multiple chronic conditions	81.3%	70.5%
Pulmonary disease	19.4%	13.2%
Stroke	14.8%	10.0%
Alzheimer's disease	12.0%	2.8%

Source: HCFA (now Center for Medicare and Medicaid Management (CMS)). Analysis of the 1998 Medicare Current Beneficiary Survey

IADL=Instrumental Activity of Daily Living (e.g., shopping, housework, telephoning)

ADL=Activity of Daily Living (e.g., bathing, dressing, eating, toileting, transferring from bed to chair)

Serving Dual Eligibles: Separate Systems

Given their disproportionate share of disease and disability, dual eligibles often require a continuum of acute and long-term care services that meet their changing health and social service needs, including services delivered in the home and the community. The Pepper Commission defined long-term care as “an array of services needed by individuals

¹ Health Care Financing Administration (HCFA). (Now the Center for Medicare and Medicaid Management, (CMS)). *A Profile of Dually Eligible Beneficiaries*. Prepared for the National Health Policy Forum, May 6, 1997.

² *The Long-term Care Financing Model*. Preliminary estimates prepared by the Lewin Group, Inc., for the Office of the Assistant Secretary for Planning and Evaluation, DHHS, 2000.

who have lost some capacity for independence because of a chronic illness or condition. Long-term care consists of assistance with basic activities and routines of daily living such as bathing, dressing, meal preparation, and housekeeping. It may also include skilled and therapeutic care for the treatment and management of chronic conditions.”³

Different programs and levels of government have been assigned primary responsibility for financing, planning, and administering the care that dual eligibles require. Dual eligibles are served by two programs (Medicare and Medicaid), administered under different rules by different authorities (the federal and state governments), that, for these persons, cover different categories of services (acute and long-term care). Delivery of these two basic types of services has been delegated to different organizations and delivery systems. Whereas most acute care services are provided within hospitals and physicians’ offices, most federal and state funded long-term care services are provided by nursing homes and community-based health and social service organizations. Though the Center for Medicare and Medicaid Management (CMS) (formerly the Health Care Financing Administration (HCFA)) administers both programs at the federal level, states have been granted primary administrative responsibility for the Medicaid program. While Medicaid provides coverage for both acute and long-term care services, its coverage of long-term care is especially significant because dual eligibles rely on Medicare as the primary payer for acute care services.

A variety of other federal and state programs also support long-term care services. Federal programs include home and community-based services funded through the Older Americans Act, the Social Services Block Grant, the Department of Veterans Affairs, and various housing programs administered by the Department of Housing and Urban Development. Though not nearly as large as Medicare or Medicaid, these programs play a role in serving the long-term care needs of dual eligibles and others who do not meet the eligibility criteria of Medicare and/or Medicaid. Their varying administrative structures, eligibility requirements, and available services make care coordination even more difficult.

Divided Responsibility: Implications and Reform Goals

Many believe that the bifurcation of responsibility for caring for dual eligibles between Medicare and Medicaid (and sometimes other programs) has helped create a fragmented service delivery system, fraught with administrative inefficiencies, barriers to more effective care, and incentives to shift costs from one payer to the other.

In view of perceived problems in the way acute and long-term care services for Medicare-Medicaid dual eligibles are financed, administered, and delivered, some observers argue that reform of the health care delivery system is required if this population is going to be served more cost-effectively. Among the most commonly articulated goals of reform are to:

³ *A Call for Action, The Pepper Commission: U.S. Bipartisan Commission on Comprehensive Health Care. Final Report*, September 1990. p. 90.

- ! **Eliminate fragmented service delivery**, while promoting enhanced continuity of care and more simplified access to services;
- ! **Develop community-based options** that promote beneficiary independence through the use of the most cost-effective, least restrictive care settings (i.e., reduce institutional care in favor of home and community-based care);
- ! **Make benefits more flexible** and responsive to the diverse and changing needs of individual beneficiaries;
- ! **Promote improvements in care quality** and beneficiary outcomes; and
- ! **Control costs** through greater emphasis on prevention and primary care, reduced incentives to use institutional care, fewer opportunities to cost-shift, streamlined administration and oversight, and less reliance on cost-based reimbursement systems.

Federal and State Initiatives

The federal government and several states have developed a number of pilot initiatives aimed at integrating acute and long-term care services for Medicare-Medicaid dual eligibles. Examples include:

- ! **Federal initiatives** such as the Program for All-inclusive Care of the Elderly (PACE), which uses a managed care approach and capitates⁴ Medicare and Medicaid, as well as the EverCare demonstration and Social Health Maintenance Organization Demonstration (S/HMO) which capitates Medicare only;⁵
- ! **Comprehensive state demonstrations** such as Minnesota Senior Health Options, the Wisconsin Partnership Program, and the Continuing Care Network Demonstration of Monroe County New York, which, like PACE, capitates both Medicare and Medicaid benefits; and
- ! **Capitated state Medicaid demonstrations** such as the Arizona Long-term Care System, Oregon Health Plan, and Florida's Community-Based Diversion Pilot Project, which capitate Medicaid only but actively pursue various Medicare coordination strategies.

Implementation of dual eligible programs such as these require CMS approval of waivers of certain Medicaid and Medicare program rules. A Medicaid waiver, in particular, allows states to waive certain federal requirements in order to operate specific

⁴ "Capitation" refers to the payment of all health and long-term care services under an arrangement where providers are reimbursed for clients served on a pre-set amount per patient. Capitation payments may be adjusted by various factors, such as health and disability status and demographic characteristics of the population to be served, as well as geographic variations in cost of services. In the long-term care context, the purpose of capitating payments to providers is to create an incentive for them to delay or prevent the need for institutional care by maintaining patients in community-based settings, by coordinating health and social services through effective case management, and to use services efficiently.

⁵ The S/HMO program also has the authority to capitate Medicaid covered benefits, though this only occurs in limited circumstances.

kinds of programs. These waivers are usually referred to according to the section of the Social Security Act under which they are authorized. States have traditionally sought waivers of federal law when considering mandatory Medicaid managed care programs and home and community-based service expansion. Those explicitly incorporating Medicare services into their managed care efforts have also sought Medicare waivers which allow them to contract with plans that are not Medicare risk contractors and to alter the way such contractors are paid. Waiver applications are reviewed and approved by CMS.

Though extant initiatives use varying approaches and combinations of waiver authorities, general similarities exist in their strategies for integrating financing and service delivery (see **Table 2**). While financial integration involves capitation of Medicare and/or Medicaid benefits, service delivery integration typically involves comprehensive provider networks, case management, and interdisciplinary teams of providers. Less effort, however, has been made to integrate Medicare and Medicaid administratively.⁶

Table 2. Examples of the Way Programs Pursue Medicare/Medicaid Integration

Program	Financial	Service delivery	Administrative integration
Program for All-Inclusive Care of the Elderly (PACE)	Medicare and Medicaid capitation; Acute and long-term care services	Community organizations; Provider teams	One set of encounter-level ^a data to HCFA
Social HMO (S/HMO) Demonstration	Medicare capitation; Medicaid capitation (where applicable); Acute and some long-term care	HMOs and long-term care organizations; Case managers	-----
EverCare Demonstration	Medicare capitation; Acute care only	HMOs; Provider teams; Case managers	Medicare only
Minnesota Senior Health Options (MSHO) Demonstration	Medicare and Medicaid capitation; Acute and most long-term care	HMOs and Geriatric care systems; Care coordinators	Single contract, enrollment process, and data reporting requirements
Wisconsin Partnership Program Demonstration	Medicare and Medicaid capitation; Acute and long-term care	Community organizations; Provider teams	-----
Continuing Care Network (CCN) Demonstration	Medicare and Medicaid capitation; Acute and long-term care	Integrated network; Provider teams	-----
Arizona Long-term Care System (ALTCS) Demonstration	Medicaid capitation; Long-term care and some acute care	County and private health plans; Case managers	-----
Oregon Health Plan (OHP) Demonstration	Medicaid capitation; Some acute care	Health plans; Care coordinators	-----
Florida's Community-Based Diversion Project	Medicaid capitation; Long-term care and some acute care	HMOs; Case managers	-----

^a Encounter level data refers to diagnoses and service utilization data for a managed care patient visiting a health care provider (comparable to the claims data collected for a fee-for-service patient).

⁶ For more information on these approaches, see CRS Report RL30813, *Federal and State Initiatives to Integrate Acute and Long-Term Care: Issues & Profiles*, by Edward Alan Miller.

Policy Implications

Congress has considered a variety of proposals to improve the financing and delivery of long-term care services, but has primarily taken an incremental approach, including development of federal and state initiatives to integrate acute and long-term care services. Though these programs serve a comparatively small number of the nation's dual eligibles, they provide models that Congress may want to consider when formulating long-term care policy in the future. Before taking action in this area, however, Congress may want to consider a variety of issues, including doubts about managed care's appropriateness for serving vulnerable populations. Many worry that incentives under managed care to control utilization may have deleterious effects on patient welfare and quality—especially for frail recipients. However, there is currently a dearth of evaluation evidence to support or reject this claim definitively. Nevertheless, proponents strongly believe in the efficacy of using managed care to integrate acute and long-term care financing, service delivery, and administration under Medicare and Medicaid. They see managed care as a way to eliminate fragmentation, develop community service options, make benefits more flexible, promote quality of care improvements, and control costs. At the same time, however, they also point to a number of statutory and regulatory requirements inhibiting the development and implementation of these programs.

Given the concerns expressed by both advocates and opponents to using managed care to integrate acute and long-term care for Medicare-Medicaid dual eligibles, congressional action in this area might include an examination of one or more of the following possibilities put forward by various health care experts.

- ! Streamlining or eliminating the CMS waiver approval process;
- ! Allowing all states, and not only a few (Oregon, Arizona, and Minnesota) to limit Medicaid payment of Medicare cost-sharing to dual eligibles who elect to obtain care through their state's Medicaid networks of providers;
- ! Promoting the development of care coordination mechanisms;
- ! Facilitating unified Medicare and Medicaid program administration, including contracting, enrollment, and oversight;
- ! Using alternative payment mechanisms, such as partial capitation, which reduce plan risk, thereby promoting participation in programs targeted toward potentially resource-intensive groups;
- ! Spurring the development of better risk adjustment methodologies to guard against overpayment for healthy beneficiaries and underpayment for frail and disabled beneficiaries;
- ! Developing incentives that encourage health plans to participate in both Medicare+Choice and Medicaid managed care simultaneously;
- ! Continuing and expanding existing federal initiatives such as PACE, S/HMO, and EverCare until more research evidence becomes available;
- ! Directing additional resources toward evaluation of existing programs; and
- ! Supporting the development of Medicare- or Medicaid-based care management options independent of capitation.