

Mandatory Managed Care for Dual Eligibles Could Harm Patients and Stifle Innovation

Many new initiatives around dual eligible policy hold the promise of improving care and reducing costs. But requiring dual eligibles to enroll in private Medicare and Medicaid managed care plans is a one-size-fits-all solution that would take us down the wrong path.

Dual eligibles are the most vulnerable people in the health care system.¹

- Dual eligibles qualify for Medicare because of age or disability and qualify for Medicaid because they are low-income.
- Two-thirds have three or more chronic conditions and three-fifths have cognitive impairments.
- Over 85 percent have incomes below 150 percent of the poverty level.
- Sixteen percent of dual eligibles live in long-term care settings, such as nursing homes, because of functional limitations and/or cognitive/mental impairments.
- Changes to coverage can be devastating, as few can afford to pay out-of-pocket or experience disruptions in their care.

Mandatory private managed care is not a silver bullet to address cost and quality for dual eligibles.

- Quantifiable, scoreable CBO savings will be minimal until we learn what works well.
- Requiring dual eligibles to enroll in private Medicare and Medicaid managed care plans is only one of many models of care that could improve care and reduce costs.
- Other models of care coordination work better in some states. Many states lack the managed care infrastructure to serve dual eligibles adequately, and those managed care companies that are present lack experience caring for this population.
- Most Medicaid managed care plans have never before been tasked with providing long term services and supports, a key issue for the dually eligible population. Doing so requires expertise in evaluating not just the medical needs, but also the social needs of the person, an approach the existing, medical managed care model cannot provide.
- The track record of dual eligible Medicare Special Needs Plans is mixed at best. Many plans have been unable to demonstrate any improvements in quality. Few plans coordinate with Medicaid or have adequate networks of Medicaid providers. Most plans will not describe the model of care that makes their plan special.²
- The innovations in care supposedly provided by managed care plans (case management, counseling, care coordination) can also be provided, sometimes more cheaply, through other models such as primary care case management, health homes, and Accountable Care Organizations.
- Managed care plans in Medicare have historically cost more, not less, than the traditional system.
- Medicaid managed care does not always reduce costs and in some cases may cost more than fee-for-service Medicaid.³

Better care for dual eligibles should be the primary policy goal. Over time, improving care should reduce costs.

- Better coordinated care and early interventions can reduce undesirable and costly outcomes. Examples: better discharge planning and transitional care reduces avoidable re-hospitalizations; better medication management can prevent dangerous drug interactions; increased home and community based supports can prevent unnecessary institutionalization. Policy should focus on getting people the care they need when they need it, keeping people in a setting that best

meets their needs, guaranteeing access to all covered benefits, and ensuring Medicare and Medicaid work well together.

- Developing effective models of care for dual eligibles takes an intensive, long-term commitment from providers, payers, and people receiving services. It cannot be mandated from above.

Current policy provides states with appropriate flexibility to innovate.

- The Affordable Care Act has catalyzed a wave of innovation around dual eligible policy. The Medicare-Medicaid Coordination Office and Innovation Center have launched multiple innovations, using both managed care plans and other alternative models.
- Thirty-seven states are planning to participate in dual eligible initiatives, including but not limited to private managed care.
- Fifteen states are already developing new models of care for dual eligibles under contract with the CMS Innovation Center.
- Legislation that mandates any one particular model, such as managed care through private plans, will tie the hands of states that are pursuing alternative models and prevent the further development of alternative models that demonstrate promise for better quality care at a reduced cost to both Medicare and Medicaid.
- The ongoing efforts will inform future policy. They must be allowed to work.

All dual eligible policy initiatives must provide key consumer protections.

- People's right to choose how, where, and from whom they receive care.
- Access to all services covered by Medicaid and Medicare, as well as enhanced benefits, especially those designed to keep individuals living at home and in the community.
- Continuity of care allowing access to current providers and services, treatments and drug regimes during a transition process.
- The ability to appeal decisions and to file complaints about problems encountered in dealing with the program.
- Meaningful notices and other communications to inform about, for example, enrollment rights and options, plan benefits and rules and care plan elements.
- Culturally and linguistically appropriate and physically accessible services.
- Access to the right providers who are able to serve the unique needs of dual eligibles.
- Strong accountability and oversight of the delivery of all services.
- Payment structures to promote delivery of optimal care, and not reward the denial of needed services.
- Build on existing structures and delivery systems.

¹ Kaiser Family Foundation Program on Medicare Policy, *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid* (Menlo Park, CA: Kaiser Family Foundation, January 2011), available online at <http://www.kff.org/medicare/upload/8138.pdf>.

² Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Delivery System* (Washington: MedPAC, June 2011), chapter 5.

³ Mark Duggan and Tamara Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates*, (Cambridge, MA: National Bureau of Economic Research, July 2011), available online at <http://www.nber.org/papers/w17236>.