

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building  
International Trade Center  
Horizon Ballroom  
1300 13th Street, N.W.  
Washington, D.C.

**Thursday, January 15, 2004**  
**9:15 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
AUTRY O.V. "PETE" DeBUSK  
NANCY-ANN DePARLE  
DAVID F. DURENBERGER  
ALLEN FEEZOR  
ALAN R. NELSON, M.D.  
JOSEPH P. NEWHOUSE, Ph.D.  
CAROL RAPHAEL  
ALICE ROSENBLATT  
JOHN W. ROWE, M.D.  
DAVID A. SMITH  
RAY A. STOWERS, D.O.  
MARY K. WAKEFIELD, Ph.D.  
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

**Dual eligible beneficiaries: eligibility, coverage,  
and payment policy -- Anne Mutti, Sarah Lowery**

MS. MUTTI: This presentation introduces our work plan and initial work on the dual eligible population. And that's those beneficiaries that are eligible for both Medicare and Medicaid coverage.

In addition to the briefing materials we sent you in advance of this meeting, back November -- and I'm not sure if you're going to remember this -- we did give you a preview of our work plan. So you've had some materials to get an idea of what our thoughts were on this topic.

I just want to take a moment first to talk about the reasons we felt that it was important to focus on this population. First, as many of you probably have noticed in numerous of our discussions on different payment policies, questions have arisen about how dual eligibles are paid for, what their care patterns look like, what their coverage is. And we're hoping that this agenda for work will answer many of those and probably raise others.

Secondly, the very nature of this population motivates us to put it on our agenda. These are a vulnerable and costly group of beneficiaries. In terms of vulnerability, by definition they are poor. They tend to be more likely to be living alone, living in nursing homes, be disabled, have more chronic conditions.

In terms of costliness, they account for about 17 percent of Medicare beneficiaries but 24 percent of spending. In terms of total costs, they are about twice as costly as Medicare beneficiaries.

We also thought it was important because there's been a variety of policy changes that have been enacted in the last few years that may particularly impact this population, be it PPS's for post-acute care services, a prescription drug benefit, changes in how Medicaid is supposed to pay for Medicare cost sharing. All of these are important. And while we may not have the resources right now to examine each of these specifically, I think collectively we felt that they warranted closer attention to this population.

Lastly, there's a number of other issues that we're looking into, the implementation issues of the prescription drug benefit, disease management proposals, and both of those have implications for dual eligibles. And certainly going over some of the basics of this population, who they are, how they are paid for, what their care patterns are, should help facilitate those discussions, also.

The work plan is up on the screen. The first two items, eligibility requirements and coverage and payment policies, we will be talking about today and we'll identify some of the issues that we've found so far in our look at that.

In the future, we plan -- and this is supposedly this spring -- we're going to be looking at the demographic characteristics

of this population. We're particularly interested in teasing out the subpopulations within duals because it can be a somewhat diverse group. We'd like to look at their cost and use of care and compare that to other beneficiaries, and also look at access to care. And we're hoping to use MCBS and CAHPS data, if not some other sources to specifically look at responses by dual eligibles.

At this point, I'm going to turn it over to Sarah, who's going to talk about eligibility requirements and issues. Then I'll come back and talk about coverage and payment policy. And then we look forward to getting your comments, both on the agenda and the content of this presentation.

MS. LOWERY: About 90 percent of dual eligible beneficiaries qualify to receive full Medicaid benefits such as nursing homes or other institutional care, home care, or dental care in addition to their Medicare benefits. Beneficiaries can qualify for these benefits either by also qualifying for Supplemental Security Income, SSI, and meeting other asset requirements, or by being medically needy.

A beneficiary is considered medically needy if after deducting their medical expenses from their income they meet a state-specified level. Medically needy beneficiaries would not otherwise qualify for Medicaid since their income and assets are above the requirements, but they are essentially allowed to spend down their income to qualify. And they're also often called spend-down beneficiaries.

Medically needy beneficiaries often cycle into and out of the Medicaid program since their eligibility may change frequently. 39 states have medically needy programs through which states have the option of paying the Part B premium, in addition to providing full Medicaid benefits.

On the other hand, states must pay the Part B premium and cost-sharing for beneficiaries who qualify through SSI, in addition to the full Medicaid benefits.

Additional programs, often called the Medicare Savings Programs, created four other categories of dual eligible beneficiaries. Qualified Medicare beneficiaries, QMBs, specified low income beneficiaries, SLMBs, qualifying individuals, QIs, and qualified disabled and working individuals.

QMBs, which make up 6 percent of dual eligible beneficiaries have incomes up to 100 percent of poverty and a higher asset level than SSI recipients and states pay their Part B premiums and cost-sharing.

3 percent of duals are SLMBs, who have incomes between 100 and 120 percent of poverty with the same asset requirements and states pay the Part B premiums.

QIs must have incomes between 120 and 135 percent of poverty, again the same asset requirements, and states pay some or all of their Part B premiums.

DR. NELSON: [off microphone.] Is an owned home excluded in the assets?

MS. LOWERY: Yes. Yes.

States pay Part A premiums for qualified disabled and working individuals if they purchase Part A after they return to

work and have incomes less than 200 percent of poverty but don't qualify for any other Medicaid assistance.

MS. DePARLE: Alan was asking me about the assets test and you answered one of the questions, but can you go back to that chart?

This may be too complicated, but how do the assets test under these various categories compare with what's in the DIMA for the subsidies for low income people? Are the asset tests the same, or do you know?

DR. BERNSTEIN: [off microphone.] States have different asset tests and some of those are similar to DIMA and some of them are significantly lower. Some of them are higher. They're all over the place.

MS. DePARLE: For DIMA it will be a nationwide assets test. So the state may have its own asset test for this purpose.

DR. BERNSTEIN: Right.

MS. DePARLE: And then also do the other one.

DR. BERNSTEIN: [off microphone.] They do set floors for -- the state's program has floors. But for full Medicaid benefits there are different assets tests that vary by state.

DR. STOWERS: Another thing, usually Alan, if they go into a long-term care facility, a nursing home or whatever, then they only get to keep their home for one year to be sure they're not going to get back out. But at the end of the year, the house has to be sold. And that asset goes into helping pay for their nursing home care, in most states.

MS. LOWERY: Eligibility and benefits offered to Medicare beneficiaries through Medicaid can vary greatly by state, as you just talked about. For example, states have the option to extend full Medicaid benefits to beneficiaries with incomes up to 100 percent of poverty. Some states do this and some do not.

Also, even if a beneficiary is eligible for Medicaid benefits, they may not be enrolled in the program because of various barriers to program participation or they simply may choose not to enroll. Outreach to beneficiaries, simply educating them about the programs may not be effective and welfare workers, Social Security employees, and community-based organizations often don't have extensive knowledge about the programs.

The enrollment process itself can be long and complicated and often requires long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets that could deter beneficiaries from enrolling, as well as difficulties with language and transportation.

Beneficiaries may choose not to enroll if the state has Medicaid state recovery requirements and there's also a stigma associated with being on Medicaid which may prevent beneficiaries from enrolling.

Enrollment in Medicaid and the Medicare savings programs is often documented at significantly less than 100 percent of eligibles. For example, only about 16 percent of those eligible for the SLMB program are enrolled and estimates of beneficiaries who qualify for the QMB program range from 55 to 78 percent.

The differences that we have described in eligibility and

enrollment translate to differences in health care benefits which can affect access to needed care.

Now Anne will move on to coverage.

MS. MUTTI: By definition, dual beneficiaries have both Medicare and Medicaid coverage but one of key questions is which program covers which service. Medicare is primary, and by that I mean it pays first for the services that it covers in its benefit package. While that may sound somewhat straightforward, it really gets a lot more complicated because there's many dimensions to coverage.

For example, for a Medicare service to be covered it has to be provided by a Medicare approved provider, it has to be deemed to be medically necessary, it has to meet certain coverage criteria that certain services have like a three-day hospital stay prior to a SNF-covered benefit. Or the beneficiary has to be homebound before being covered by the Medicare home health benefit.

These examples raise the issue that there's a lot of gray area, that we are guided by statute, and a lot by judgment, too, on intermediaries, on their part. And then if these decisions are appealed administrative law judges can get involved and then their judgment pertains here, also.

Medicaid is generally secondary. I just would note that there are some dual beneficiaries who actually have other sources of coverage and in that case they would be secondary. But for the vast majority, Medicaid is secondary.

It covers three types of health care costs. Medicare cost-sharing, and I'm going to come back to that in a moment because I will qualify that. Benefits that have been exhausted under Medicare or are not covered because of a certain characteristic is not met. And that may be hospital stay, the episode has been exhausted, or a SNF stay of 100 days in an episode has been exhausted. And thirdly, benefits not covered by Medicare, and this would include long-term care services, most of those, as well as at the moment outpatient prescription drugs. In 2006 Medicare will have its own prescription drug benefit and at that point Medicare will be primary on that. And certainly implementation of that drug benefit raises a lot of issues for dual eligibles. And actually my colleague, fortunately, Joan, will be coming back to you to talk through some of those with you.

But at this point I thought it might just be useful to note that the benefit design of this prescription drug benefit is really quite a departure from other benefits in the Medicare package because it's the first time -- that we know of anyway -- that the generosity of the benefit varies by income of the beneficiary. So that the cost-sharing requirements for dual eligibles are quite a bit less than the cost-sharing requirements for higher income beneficiaries.

We'd also note that coverage issues are somewhat more complicated when duals are in M+C plans because these plans have different benefit and cost-sharing structures than under fee-for-service. These plans, the cost sharing structure varies by plan and the plans are increasingly charging premiums that are in

addition to the Part B premium. And this raises some payment issues that I will come back to as we talk about payment in M+C.

Turning to payment for beneficiaries who are in fee-for-service Medicare. When a service is covered by fee-for-service Medicare pays the provider the Medicare payment rate, just as it would for any other beneficiary. Historically, most Medicaid programs have paid the Medicare co-insurance. But do to a clarification in the BBA, the state program can opt to pay a portion or none of that coinsurance if their Medicaid rate is lower than the Medicare payment. In other words, states are now required only to fill in the Medicare cost-sharing up to their Medicaid payment rate.

So I'll give you a quick example. You've probably heard this one before if you've gone through this before.

If the Medicare total payment rate is \$100 and Medicare pays 80 percent, we pay \$80. The remaining coinsurance is \$20. If the Medicaid payment rate for that service is \$90, Medicaid would pay \$10 of that coinsurance to the Medicare provider. If the Medicaid payment rate were \$70, and it was stated in their state plan that they would only pay up to the Medicaid rate, they would pay no coinsurance to the Medicare provider for that service.

In general, beneficiaries cannot be charged for this uncollected cost-sharing, but the impact of this policy is that the providers will not get paid as much for delivering that service to a dual beneficial than most of its other patients that it may see, assuming that they have supplemental coverage that pays for this, and usually it does.

Facility-based providers, however, can offset some of this loss because they can claim it as bad debt and it is reimbursed by Medicare.

Somewhat different rules apply for outpatient mental health services. I think I'll try using a similar example. If the Medicare payment amount is \$100, Medicare is only required to pay \$50, 50 percent of that. Medicaid, at most, is required to pay only 12.5 percent or \$12.50 of that cost-sharing. The beneficiary can be charged for the remaining \$37.50. So there are some different rules for that type of service.

For beneficiaries enrolled in M+C plans, Medicare pays a capitated rate to the health plan, just as it would for any other beneficiary. However, because dual beneficiaries are often sicker than other beneficiaries, the risk adjustment formula produces a higher payment for them.

For certain specialized plans, such as PACE plans, the normal risk adjustment calculation is paired with a frailty adjuster which pays plans a higher rate assuming that most of their beneficiaries have limitations in their activities of daily living.

Medicaid is the secondary payer and, in theory, is responsible for the cost sharing. This doesn't always happen. It's somewhat inconsistent, as some case studies have shown. The issues that are cited in this is often that the plans don't have information that these beneficiaries are dually eligible. They do not even know to go look for that money from Medicaid. We've seen a number of studies point to the fact that states have a

hard time getting reliable and timely information to plans.

M+C providers may also not be Medicaid providers and therefore have a difficult time billing Medicaid for the coinsurance. It's also possible that Medicaid would claim that the M+C plan payment to the provider was sufficient and exceeded the Medicaid rate and therefore they do owe any additional cost-sharing, similar to the fee-for-service provision.

In addition, I wanted to point out that Medicaid is not required to pay Medicare plans premiums and particularly as more plans are charging premiums this ends up being perhaps a more significant issue.

Some states have opted to pay these premiums because the additional coverage the premium buys, say for example outpatient prescription drug coverage, offsets what Medicaid would have had to spend otherwise for this benefit. But in other cases, states do not pay the premiums and beneficiaries are restricted in their enrollment in M+C plans. Plans, if they do not receive their premiums for three consecutive months, are permitted to disenroll the beneficiary.

There are some innovative approaches out there to integrating Medicare and Medicaid financing that address many of these coordination of benefit issues, and perhaps more importantly align incentives and improve the quality of care that is delivered to this population.

I won't go into detail on these programs now but I just wanted to point them out and note that they serve relatively a small portion of dual beneficiaries. The thing that unifies these programs is that they receive an integrated payment for Medicare and Medicaid services. Both are capitated payments for each program services. They include PACE, which serves primarily a frail elderly population, has a care model that is very specific. It is a nationwide program but is currently operating in about 14 states. Minnesota and Wisconsin each have state waivers and have had several years of experience now with integrating the payments and service delivery there.

And then other states have launched other programs that just capitate the Medicaid acute and long-term care services and put particular emphasis on coordinating with Medicare benefits. They may have designated people who are designed to work with Medicare providers to facilitate coordination of care.

Let me go on though to the issues and implications that emerge from these coverage and payment policies. First, we would note that spending for each program is affected by the other program. And as a result there is an incentive for cost shifting between the two programs. For example, I talk about this a little bit more in the paper, if a state Medicaid program is successful in challenging Medicare denial of home health claims, Medicare will pay those claims and spend more money. This will relieve Medicaid from paying those claims and they will save money.

This budgetary tension can also undermine coordination of care. For example, Medicaid programs may not invest in services such as care coordination that reduces hospitalization because the payoff for that investment is accrued to Medicare. They

cover the hospitalizations, they will get the savings.

Similarly, at a provider level nursing homes have a financial incentive to hospitalized patients for a three-day stay. So that upon discharge back to the nursing home a Medicare SNF covered stay would be triggered. Medicare payment rates are generally higher than Medicaid and so the Medicare covered stay is financially preferable. This incentive is tempered by data that's being collected on rehospitalization rates but nevertheless the financial incentive is in place.

These incentives for inefficiency and also the bureaucratic wrangling over who pays for what service likely increase total costs.

Then we just go to the impact of access and note, just following up on our discussion before about the limited cost-sharing provision that limit that amount of payment, some providers may be less inclined to take dual eligible beneficiaries. In fact, CMS did contract for a study that looked into this question in nine states and did find that there was a reduction in utilization that correlated with a reduction in payment. And this was particularly noted for outpatient mental health services.

It is difficult to pinpoint the total impact of this policy at this point. That study looked at nine states. We don't know what's happening in all the states. We don't know how much lower their Medicaid payment rates are. And we don't know for what services they've decided to this for because they can choose to have different policies for different services.

Access to care could also be threatened on the M+C side to the extent that beneficiaries are avoiding care because they are being charged for it and they actually shouldn't have been charged for it, and the fact that Medicaid is not required to pay the premiums may be a discouragement to these beneficiaries for enrolling in this type of plan. That may be of concern if you feel that this kind of plan would actually benefit these beneficiaries who have a lot of health care needs.

I would also note that recent legislation, DIMA, did have a provision that allowed specialized plans to focus on dual eligible populations, as well as other vulnerable populations. And if they were focusing on them they would be relieved of certain regulatory requirements. And that may enable them to enroll more dual beneficiaries. Of course, we don't know how that will actually play out. And it does seem that it's limited. It doesn't necessarily apply to those M+C plans that are serving a much more diverse population and haven't chosen to just focus on duals.

Lastly, we would note that there has been some inconsistency in the way that conflicts between the two programs rules have been resolved. For example, as Medicaid programs begin mandating enrollment in managed care plans, dual eligibles were exempted from this requirement on the grounds that they were Medicare beneficiaries first, and that as Medicare beneficiaries they had freedom of choice. But as we see in the cost-sharing provisions, that Medicaid payment is now adequate for these beneficiaries. And in that case, it seems that they're Medicaid beneficiaries



first, Medicare beneficiaries second.

I think with all those words, that concludes our summary of payment and coverage.

I just would note what our next steps are. I think we have a little bit more work to do on this area and we look forward to getting your comments and out some of the facts and implications. And then we want to move on to the other areas that I mentioned before the demographic characteristics, cost and use of care, and access to care.

We're hoping to get this into shape for a June report chapter. And we look forward to your comments on the content and tone, and anything we might have missed so far.

MR. DURENBERGER: I'll be brief.

I just want to thank you, Mr. Chairman, and Mark, and obviously both of you for the quality of this work. I think, as I listened to you go through this, it's so much easier to understand than dealing with the aggregates of all of the hospitals in America, and so forth, because we're finally concentrating on looking at this as people.

I laughed as you were going through the presentation and I wish Sheila had been here, because we're the people that are responsible for doing all this sort of thing and creating all of these kinds of things, which only reflects on the critical importance of finding a way to undo it, is much harder. But we can't do that unless we understand what it is. And that's why the importance of this contribution to our work, I think, is enormous.

I was looking at page 10 on the separate payment systems and clearly this does not only apply to low income dual eligibles. This applies to the whole system, all of this, promotes cost shifting, undermines coordination of care, increases total cost. This whole list is the American health care system. So this is an incredibly valuable insight, certainly for me and hopefully for a lot of others.

One of the things that's a distinction here maybe more than in other places though is the population that's involved. And to that end, when you go back to the beginning of the work product, I'd appreciate it very much if we could spend a little time researching the language that is used. And I put it under information, education, communication.

Any of us who have ever been through the system, either as providers or consumers, understand nothing about the "benefit" or the enrollment. All of this stuff is just totally confusing.

I really think, since we're going into this new Republican world now with HSAs and MAs and all that sort of stuff, and everybody's going to be walking around with money to buy into the system, we really need to focus on how do we communicate what it is that is the most appropriate benefit, access, all these other issues.

So to that end, and I know this maybe just be another project rather than a project here, anyone who is familiar with that part of the system knows that you cannot put all of this into any kind of a one-pager or a two-pager or anything else that will adequately present a family faced with a particular

situation or an individual faced with a new crises with the kind of information they need.

Just this little interchange here about is a home deductible and all that sort of thing, I recall going through this process with mother. She's just living longer than anybody expected. But I got 11 languages to deal with, and that's only on the English side. And then we move on to all of the other languages in my community.

All of the information in the system, including 1-800-Medicare, with on all due respect, is unintelligible to the average American. And so if, in fact, we are moving to getting the consumer, the family, whatever it is, much more involved we really do need to spend some amount of time helping the policymakers and implementers focus on language and focus on what it is we are trying to present them with in terms of alternatives.

In addition to that, we have to get rid of things like this is not a bill, and all the rest of those things that confuse. But the most important part is language and is communication.

And I would stress that in this population, because across America -- and you know the data better than I would -- but across America, including North Dakota, Minnesota, Montana, places like that, the cultural change in America in just the last 10 years is enormous. And the way in which different people from different backgrounds and different families are confronted with the need to come into this system at the level that we're talking about here, dual eligibles and so forth, is enormous. And the way they think about it, the way they react to information, the way they use that information in a particular community, the way providers have to react to that, is also an enormous challenge.

So I probably haven't put my finger on the right phrase to use here, but in terms of what is the work effort, if it is possible to put some time into at least outlining the problem for policymakers, I think it would be helpful.

MR. HACKBARTH: I think you're absolutely right about how well or poorly we communicate these things, although in this area in particular I think an important part of the problem is that the underlying policy isn't coherent. So you can spend forever trying to state it clearly and make it sound better, but it's hard to change the underlying reality.

MS. DePARLE: You just made my point. I agree, Senator Durenberger, with everything you said about communication. But whenever I return to the subject, and you did a great job of outlining the issues and the current state of the program, I'm reminded of how crazy it is to have all these different categories, QMB, SLMB, QI, DWI, QDWI, whatever it is.

What does that community do to people except a mess with all the different tests? Clearly what makes most sense is if we had a separate thing that was Medicare Plus or Medicare something for people who were very low income.

I worry that the new DIMA provisions, while well intentioned to help people who have the greatest burden in trying to meet the costs of a new prescription drug benefit, is only going to add to the complication. I don't know whether that's anything that we

could ever have an effect on but certainly I think that's a big part of the problem.

MR. DURENBERGER: You're making my point in so does the Chairman. Our message has to be to policymakers that -- because most of these people who are here in this town understand nothing about the policy that they're dealing with, in all reality. There's a few people that understand the difference between a QMB and a SLMB, but most of them don't understand Medicare versus Medicaid.

So they have to be presented with the challenge you faced as the administrator in a different way, in a context which goes back to their district and to the people that come into their offices and complain about language and not understanding this and how come I have to give up my home and things like that.

So I don't disagree that policy is the problem. But I think we have to -- we should play a role in putting a way to educate these policymakers on the consequences and what are the alternatives. Thank you very much.

MS. DePARLE: Yes, and the challenge that I faced as the administrator was not this. I'm not proud of that, but for every one call or letter I ever received about any of these people, there were 500 about which hospital fit into this or that category and wage adjustment.

So we're not talking about -- I think the point that Anne made at the beginning, is we're not talking about 20 percent of our beneficiary population who fall into this category. And whatever the reasons have been before that we haven't focused on it, we have to start focusing on them.

One thing that would help me, Anne, and I don't want to add to your burden in trying to get this done by June, but if there's a way to construct an average -- there probably isn't, but an average dual eligible to sort of give us a little more flavor for here's what the person might look like. This is the kind of spending they would have. They've been in a nursing home in a given year or whatever.

Because we tend to look at things here in stovepipes of services. This has come up repeatedly over the last year, maybe those are duals. Is that who that is, the high spending people in that category or the ones where the nursing home is having trouble covering them.

It would help me to see that. And maybe even a low end and a high end. I don't know if that's possible but I think that would help me to get a better sense of who these people are.

MS. MUTTI: Absolutely. That was part of our plan in our cost and user of services and also in our demographic analysis, too. And maybe there's an average dual beneficiary out there, but maybe there's not. Maybe it would be helpful also to provide with you're going to see there's three major types of dual beneficiaries and their health care needs actually vary quite a lot from each other. And this is what each of those categories -- if we can do that, that's our goal because I think it would help tease out what some of the real issues here are, where the access problems are going to be, who specifically would face those, if there are any.

DR. WAKEFIELD: Some of the thoughts that I had in reaction to this chapter have already been expressed.

I'd say when I was reading it, the further I got into the draft the more I started to reflect on, there was some TV program that was something like good pets gone bad. This is like a good program, God love you for creating it, whatever role you had, gone bad. That's just the sense I had.

The complexity here and the disservice and the dissimilarities in a population that is, I think, unarguably the most vulnerable of the population we care about, really starts to come through here. I think most of us would have recognized that in the back of our minds. But you did an exceptional job of beginning to tell the story. So that's my first comment.

And I'd say stay the course because this might be one of places where we as MedPAC could make one of our best contributions to the extent we can perform -- help first educate and then secondly inform people's thinking about this in order to drive hopefully some meaningful change over time. I can't think of a better cause, personally, than really drilling down in this area.

So you start to do that, at least you did it for me when I was reading this. And I think it's a really good use of our time and resources and so on. So that's the first comment.

The second comment is I don't know that -- for example, it was jarring reading about the mental health coverage and that particular section as an example. I don't know that you would ever have access to or we could find anything that would tell us about whether or not these people just sort of fall off in terms of being able to access services. That is, we know utilization drops but is there anything else that happens? Do we see a bump up someplace else like in emergency room visits or in hospital utilization when those benefits start to slide down? I don't know that we've got data that tells us that. What we know is that there's fewer utilization, I think it was of inpatient mental health services perhaps, or outpatient it was.

But is there anything else that's happening that might have a cost implication for the program? Let alone what may happen if we're assuming that this isn't overutilization at the front end?

So if we got that, that might be a helpful piece to toss in as well.

Two other comments. One, you do a nice job of highlighting some of the state demo programs and the PACE program. And you pretty much let the reader know these things are not out there and they're having a relatively small impact in terms of the total population covered. I probably might even try and make that point a little bit more firmly, because for example the PACE program as it's currently constructed, it is extremely hard -- although there are efforts being made -- to try and reorient PACE so that it's viable in rural areas. Historically, it has not been.

So when we start to look at the programs that you're dishing up here as alternatives, they're great. But A, to your point, I think the point needs to be made strongly, not used very much. And in fact, there are some real limitations in terms of where

they can be applied. So that's another point that I wouldn't lose in all of this.

Your implications piece here, we're not teeing this up at the level of recommendations at all when this comes out in the June report. But I do think that to the extent that we can put a road map out there in some fashion, your implications start to move us that way, to really say this is what's happening with coordination of care, of quality implications and access implications.

I think, in addition to educating and informing, without going to the level of saying here are the 15 things obviously that need to be done, if we can't go there, to be as clear as possible in helping the reader understand what next steps might be at least worth considering.

So as much effort as possible on the implications side because the problem is so serious, the challenge is so serious that if we can start help people thinking about what might be some viable alternatives and solutions without saying here are the 10 things that must be done tomorrow, I think that's going to be well worth spending some time, too. Not easy, but well worth spending time. And you've started to do that with your implication section.

So bottom line, really illuminating. I thought the variability that you describe here is jarring on the face of it within the program and I think it's a great piece of work that you've kicked off.

MS. RAPHAEL: There were four points that I just wanted to see emphasized as you move forward. The first is that we actually have 50 Medicaid programs in the United States not one. And I think that really affects a lot of the other issues that we're trying to wrestle with here.

Secondly, I think we need to really interlace this with what we're doing on quality because I think at the consumer level it really does affect quality. I think that this particular group of beneficiaries, because they have greater needs and utilize more services, the fissures and cracks in the system are magnified in their case. And when you look at transitions, the failure to communicate information, the need to move from one payment to another, I think really is very, very important in terms of what happens on quality.

I know in the long-term care system you could prevent rehospitalization but there's no reward or incentive to prevent rehospitalization. That's just one example of many, many other examples of how incentives are not aligned here at all.

A third issue for me, which you made and I think I'd like to see some examples and really some more emphasis, which is this adds to total cost in the system. You mentioned the Medicare maximization programs. I know we're just one of many, many organizations where we've had groups, the state come in, they want claims going back 11 years to rebill to Medicare and say you have to hire 100 people to go and really do the review of thousands upon thousands of claims. And it adds a lot of costs to the system. And there are many, many instances of one payer trying to shift to the other payer and adding costs and

ultimately raising the price that the federal government is paying overall.

Lastly, I would be very interested in seeing if you could pull together something more on managed care because ostensibly this is the group for whom you would want some managed care options. This is a group that really could benefit, whether we call it coordination or managed care, care management.

So I'd like to kind of see right now what is the state of what's happened in managed care, whether it's in M+C or in one of these integrated managed care programs or moving to disease management or chronic care management. And some notion of what we think might be possible in terms of trying to have some real viable managed care options here.

And is it risk-adjustment issues or is it the lack of real clinical models that's impeding work? Or is it ultimately the financing? Because I don't think we're yet laying the groundwork for the next generation of managed care for this particular population.

DR. MILLER: Can I say just one quick thing on your very last point? This is one of the groups that we're going to be talking about in our disease management analysis. So I think some of what you said on your last point could also be dealt with there. But wherever it falls, it falls.

DR. REISCHAUER: Anne and Sarah, I think you've done a really good job and we've started down the right path here. I've groveled around in this literature a good deal over the last few decades and I learned quit a bit from this.

I initially was being motivated to speak because I wanted to disagree with Nancy Ann when she mentioned the word average. And then Carol came in and said what I was going to say on that score.

I think averages here are dangerous. In fact, they might describe something that doesn't exist both because, as you pointed out, there are different in a sense flavors of Medicaid beneficiaries, full duals, QMBs, SLMBs, et cetera. But also because the state programs vary so tremendously.

The ramifications thereof are less for the elderly than they are for the non-elderly population. But nevertheless they are significant. And I was hoping what you could do is pick a couple of very different state programs. I think there are some programs that pay quite high to providers and some that pay abysmally low and some that have very rigid eligibility standards or enforce the federal ones, and some that are a little looser and goosier about that. And just sort of give us a flavor for that, rather than the average.

The other thing I was wondering whether it would be possible in the demographic analysis to give a picture for the fully dual eligibles of when and how they come on and how long the stay. I have no idea whether of the fully duals, 80 percent of them come on when they first get Social Security full eligibility at age 65 and stay on until they die, unlike the working population and the Medicaid people. Or whether a very high fraction of them sort of come on as their incomes go down. It's the 75-year-old widow who doesn't get the pension anymore from her spouse who's passed away

and whether we're dealing with that sort of person.

If it's the former it really strikes you as crazy that we do this the way we do it because we have these people, in a sense, in our responsibility for a 20 or 30 year period. So to have them handled the way they're being handled makes no sense.

DR. ROWE: Another category are the ones who are in long-term care facilities and become Medicaid beneficiaries because of the spend-down of their resources. And that is a particular subset that might be particularly interesting to look at with respect to their utilization.

DR. STOWERS: I also thought it was a great chapter.

I wanted to get back a little bit talking access and quality to that copayment issue that you had. I know in my practice our state makes a very strict point to keep below the 80 percent of Medicare payment levels. And I think that's the case in a lot of the states, so physicians are taking care of these individuals at essentially the Medicare rate without the copayment. So that gets to be a problem with access and I think we need to look at access in that group like you're talking.

But in my personal observation the real access problem here becomes in the ones we just talked about in long-term care facilities where the Medicare payment for taking care of nursing home and long-term care patients is extremely low anyway for physicians. And then we turn around and reduce that payment by another 20 percent. And the number of dual eligibles in our nursing home, we may want to bring up also, is a very large percentage of those patients.

So the majority of the nursing home patients end up getting taken care of for a very discounted rate. And therefore, it's very difficult to find physicians that will get into this kind of care and take care of these people where real coordination of care that was mentioned before is really needed. That goes for home health or anything else where we're trying to take care of those individuals.

So I think that would good in this to get the data somewhere along, and you may already have it, of comparing the Medicare payment rate in the states to what the Medicaid payment rate is. And therefore we can really see what physicians are being paid. Are they getting a copay? Are they not getting the copay by state? And maybe that will answer some of our access problems.

But anyway, good chapter.

MS. MUTTI: We don't have that data right now. We'll look for it and see how we do.

MR. SMITH: Thank you. This was terrific stuff and almost everything that my colleagues have said I agree with. Let me just try to quickly underscore three points.

I thought Dave Durenberger's initial reaction was exactly on target, that this chapter ought to cause those of us who have some responsibility for all of this to say oh my God. As we think about what this chapter's purpose is, we ought to see it in the context of a motivational instrument rather than a technically accurate and descriptive one. That's tricky business for us, but I think Dave and Nancy Ann had that exactly right.

Some of the questions that Bob raises about the demographics

of these folks, there are two sets of questions. The take up rates here are low. And is there something important to understand about who accesses this loony movie system and what sort of utilization they are able to therefore make of the health care apparatus. And the slightly larger number of folks, it seems to me, who are eligible but don't access it, and what do their utilization patterns look like.

And related to that, and it's a question that grows out of Carol's observation and a little bit of the work you've already done on the specialized programs, is there anything, whether it's state Medicaid payment rates or access to one of the specialized programs, PACE or Wisconsin or Minnesota, is there anything that we can look at and say this is associated with higher and more appropriate utilization? That might begin to pave some of what a road map might look at. The kind of road map that Nancy Ann talked about.

The answer may well be no, but as we look at variations in utilization, it might be useful to ask ourselves are there any characteristics here which seem to be systematically associated with better utilization, no matter how complex the apparatus is.

MR. HACKBARTH: Okay, well done. Thank you.