

# Using Shared Savings to Foster Coordinated Care for Dual Eligibles

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There are 9.2 million people who are eligible for both Medicare and Medicaid. They're eligible for both programs either because they are younger than 65 years of age, disabled, and poor or because they are 65 or older and are poor or have exhausted their nonhousing assets paying for health care. These dually eligible program participants make up about 20% of Medicare beneficiaries and about 17% of Medicaid beneficiaries and account for 29% and 39% of Medicare and Medicaid spending, respectively.<sup>1</sup> New federal policy initiatives are promoting organizations that integrate and coordinate care to meet the complex needs of this vulnerable population. The hope is that if beneficiaries are encouraged to enter into such arrangements, costs will fall and quality of care will improve.

From a clinical perspective, dually eligible beneficiaries are more likely than others to have multiple chronic conditions or a severe mental disorder or to have functional limitations and cognitive impairments. Organizing care and support for this population is complicated because they frequently rely on income support, social supports, housing assistance, and long-term care that are administered and paid for by different state and local government agencies.

Financing health care for dually eligible people is also challenging because they require support from the state-run Medicaid program and the federal Medicare

program. These two programs have provisions, payment rules, and regulations that often align poorly with one another, which results in high-cost, low-quality care. For example, a nursing home that cares for a long-stay Medicaid patient is economically advantaged when it transfers one of its residents to an acute care hospital for treatment of, say, a urinary tract infection. When this happens, the nursing home avoids devoting resources to treatment of the infection, it receives a payment from Medicaid to hold the bed for the hospitalized resident, and it gets paid a higher per diem rate by Medicare than it would from Medicaid for a period after the patient returns because he or she qualifies for Medicare-financed post-acute care.

The fragmentation in organization and financing of care for dually eligible people is seen by federal and state policymakers as a problem that can be remedied. Many policymakers believe that greater coordination of care for the dually eligible population that uses a strong care-management system under a unified budget can lead to both savings and improved care. To address this issue, the Affordable Care Act established the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services. The Bowles-Simpson Commission projected that between 2015 and 2020, we could save \$13 billion by moving dually eligible people into managed-care plans. Others have

proposed enrolling dual eligibles in state-designed care coordination entities (CCEs). Such a move was projected to save \$126 billion over 10 years, according to the most optimistic estimate.<sup>2</sup> Twenty-six states are pursuing demonstration projects aimed at better coordinating care for dual eligibles.

Because state Medicaid programs pay for most or all of a dually eligible beneficiary's premiums and cost-sharing obligations, it has been very difficult to lure these beneficiaries away from uncoordinated, fee-for-service arrangements to more structured arrangements of care. To foster the transition, nearly all states are putting in place so-called passive-enrollment methods to expand participation in coordinated-care arrangements.

Passive enrollment involves automatic enrollment of eligible beneficiaries into a CCE with the ability to opt out. The assignment method generally uses information on a beneficiary's needs to match him or her to a CCE's capabilities. Passive-enrollment techniques have gained considerable credence because they have been successful in increasing participation rates in employer-sponsored 401(k) retirement plans. In those cases, natural tendencies toward inertia are exploited to get people to save for retirement. The beneficial effects of passive enrollment are clear: people get financial contributions from their employers toward their retirement. Failure to join a

401(k) plan leaves money on the table and the nonparticipant worse off.

The use of passive enrollment into CCEs would most likely produce higher rates of enrollment, enabling states to establish CCEs for a critical mass of enrollees. For beneficiaries who are dually eligible, however, the benefits may be less apparent. Many of these people may have established a set of relationships with providers so that their care is effectively managed within the fee-for-service system. Since coordinated care under a set global payment (e.g., capitation) or variants of that approach can create incentives to restrict services, there are risks of undertreatment. Some beneficiaries may therefore experience the transition to coordinated care as a loss to them.

How can state policymakers promote self-determination for vulnerable populations and offer them a reason to engage with a new care delivery system with coordinated-care arrangements? Coordinated care for dually eligible people is built on a financing structure known as shared savings, in which three of the parties involved — the federal and state governments and the CCE — share any financial gains from coordinating care. Including patients in shared savings could create a positive reason to engage with a CCE. How might such an approach work? A share of the expected savings could be set aside into an “account” for

each dually eligible person enrolled in a CCE. The funds in the account could be directed by the patient and could be used to purchase supplemental services and supports such as transportation, home modifications, and personal assistance with activities of daily living. Similar types of accounts have been successfully used for some disabled Medicaid beneficiaries.<sup>3</sup>

These accounts are designed to have two aims. First, offering extra benefits creates an incentive for participants to engage with the CCEs in a way that promotes self-determination. Second, the additional funds can be used to compensate for gaps in services offered by CCEs in a way that helps in meeting individual needs (cushioning the risk the participant incurs by joining a CCE). Medicaid’s cash and counseling program, like other self-directed consumer programs, creates “cash-equivalent accounts” for purchasing services and supports. These accounts are overseen by a financial intermediary and provide counseling and help in decision making to support both independence and program integrity. This approach would enable beneficiaries to extend the benefits of Medicare and Medicaid in a personally tailored fashion without increasing their total costs.

One could also couple options for shared savings with an active choice mechanism whereby beneficiaries are forced to choose

among options rather than defaulting into either a CCE or the status quo. Experimental research shows that this approach might also result in greater enrollment in CCEs than an opt-in system would.<sup>4,5</sup> It would mean presenting beneficiaries with an explicit choice, without a no-action default, in which the CCE option would entail sharing in savings. It is important to advance program designs that have the potential to improve care and save money, but we need to do so in a way that promotes self-determination and the exercise of real options.

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