NACDEP
National Coalition for Dually Eligible People
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DUALLY ELIGIBLE PEOPLE WITH MEDICARE AND MEDICAID

PART 1

"SECOND – CLASS MEDICARE"

Separate but Unequal Medical Care for
Dually Eligible People with Medicare and Medicaid
Is Unethical, Violates Civil Rights, and
Decreases Access to Health Care.

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SUMMARY

Dually eligible people have both Medicare and Medicaid benefits. They worked and earned the right to Medicare, and they receive it when they become elderly or disabled. They also have Medicaid because they are still so poor that they qualify for their state's Medicaid program for the needy.

Medicare payment rates are significantly higher than the rates paid by Medicaid, which often result in Medicaid patients having difficulty finding physicians to treat them. After the patient pays an annual $100 deductible, Medicare will pay 80% of its "allowed amount", and the patient is responsible for paying the remaining 20% coinsurance of the bill. In the past, the portion of the Medicare deductible and coinsurance that was not paid by Medicare, was paid by Medicaid when the dually eligible patient's claim was "crossed-over" and sent from Medicare to Medicaid for payment.

The Balanced Budget Act of 1997 (BBA) enabled Louisiana and other states across the country to essentially abolish crossover payments for dually eligible patients. The BBA created significant geographical inequities and perpetuates discrimination. It is, therefore, in violation of both the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990.

By eliminating Medicaid crossover payments for patients who are dually eligible for Medicare and Medicaid, the State of Louisiana and the Louisiana Department of Health and Hospitals (DHH) are engaging in harmful discrimination. Because of this budget cut several well-defined groups, including the elderly, the poor, African Americans and other minorities, women, and mentally and physically disabled persons who reside in New Orleans, cannot fully access their Medicare benefits.

By eliminating Medicaid crossover payments, Louisiana has imposed a "geriatric penalty" on the oldest, poorest, sickest, and most disabled people in our state, and has created a new underclass of inadequately insured people in Louisiana. These dually eligible people now have what I refer to as "Second-Class Medicare," and are permanently reimbursed through a second-class payment schedule that hovers between the Medicare payment rate and the Medicaid payment rate. The result is a *discriminatory, two-tiered benefit system* for dually eligible people who are disproportionately minorities, female, elderly and disabled. This doctrine of "separate but unequal" makes it difficult for these frail people to gain medical access, and violates both the Civil Rights Act of 1964 and the Americans with Disabilities Act.

The Civil Rights Act of 1964 states that indirect, or "disparate discrimination" — which is discrimination affecting one group of people disproportionately more than another group of people — is illegal, even if it is unintentional. It is, therefore, illegal even if the State of Louisiana is unaware that its seemingly neutral budgetary cut has had an indirect discriminatory effect on several protected groups of Louisiana citizens.

The Americans with Disabilities Act prohibits any public program or agency from discriminating against persons with disabilities. In the landmark 1999 *Olmstead v. L.C.*

decision, the Supreme Court said the ADA required "reasonable modifications" in a state's Medicaid program in order to avoid "unnecessary institutionalization and segregation of persons with disabilities." This provision is important to dually eligible Medicare-Medicaid patients (most of whom are elderly) because *the ADA has no age limit.* Elderly patients frequently have multiple ADA-listed impairments, limited life activities, or illnesses, and are therefore "qualified disabled persons" who are protected by the ADA rules. In addition, *any* Medicare beneficiary younger than 65 who has been declared "disabled" by the Social Security disability program has already proven that he or she meets the more lenient ADA disability requirements and thus is covered by the ADA legislation.

The elimination of crossover payments is a particular problem for *mentally disabled* dually eligible people who now have decreased psychiatric access because physicians who treat them can only receive *50% payment* for their services. This decreased access may lead to psychiatric decompensation and institutionalization — issues that the *Olmstead* ruling said were illegal according to the ADA.

The total cost of these crossover payments is $23.5 million. Louisiana's share is less than $7 million, and the federal government's share is $16.5 million. For Louisiana to spend $7 million dollars of its own money (in addition to the federal government's money) to restore these crossover payments is not a "fundamental alteration" in its Medicaid program

There were six million dually eligible people in the U.S. in 1995. This number will double by 2030. They are only 17% of the Medicare and Medicaid population, yet they use almost 35% of all Medicare and Medicaid money. In 1995 the cost of caring for these patients totaled *$106 billion.* (See Figure 1, page 29.) Their healthcare costs are so high because the medical problems associated with being old or disabled are multiplied by the social problems of being poor. The "old-old" and the "non-elderly disabled" are the fastest growing segments of the Medicare and the dually eligible population. As we decrease their medical access, their expenses will continue to climb, and they will consume an increasingly large percentage of our nation's healthcare resources.

Prior to the passage of the Balanced Budget Act of 1997, 31 states reported paying crossover payments at the full Medicare rate. In the first two years following passage of the BBA, 15 of these states stopped paying crossover payments for dually eligible people. The elimination of crossover payments in these 15 states affected *almost two million dually eligible people* — approximately one-third of the entire dually eligible population in the United States.

The dually eligible Medicare-Medicaid population is largely an older, poor, female population with a large percentage of minorities. They frequently live alone, have few educational skills, poor vision and hearing, are generally in poor health, and have difficulty performing their activities of daily living. Dually eligible beneficiaries are in much worse health than Medicare-only beneficiaries. One-quarter of the dually eligible population live in long-term care facilities.

Since Medicaid crossover payments were eliminated in 2000, a physician who performs a 45-minute new patient office visit for an elderly dually eligible patient with multiple medical problems *would lose 73%* of the Medicare allowed charge if the patient's Medicare deductible was not met, and *would lose 20%* of the payment if the deductible was met. *Insurance reimbursement affects patient access to medical care*. Dually eligible patients whose care is only reimbursed at 27% of the Medicare allowed charges cannot get equal access to medical care. The larger the number of dually eligible patients in a physician's practice, the larger the physician's loss. A pediatrician or obstetrician may lose little, but a geriatrician may lose thousands of dollars each year.

This geriatric penalty decreases medical access and discourages the practice of geriatric medicine. As a result of the elimination of crossover payments, I have been forced to decrease two parts of my geriatric practice. My first change was to stop making home visits to new dually eligible patients because, by eliminating crossover payments, Louisiana *cut the reimbursement for a home visit by 81%.* I can no longer provide this service and stay in business. By cutting 81% of the reimbursement for a home visit Medicaid makes it necessary for these patients to be seen in the emergency room where the costs will be multiplied.

The second change was to decrease my geriatric clinic office hours by 10%. For one day out of each two-week period, I no longer see geriatric (i.e., dually eligible) patients in my office. Instead, I do other medical work for which the financial reimbursement is better. Because of the demographic makeup of the dually eligible population in New Orleans, stopping my home visit services and decreasing my geriatric office hours by 10% affects primarily old, poor, African-American women, and the mentally and physically disabled. Other physicians in our Orleans Parish Medical Society have indicated they have also decreased services to dually eligible patients.

I have been practicing internal medicine and geriatrics in New Orleans for 25 years. Seventy-two percent of my Medicare patients have Medicaid and are dually eligible — a far cry from the national 16% dually eligible Medicare population. Seventy-nine percent of these patients are women and 21% are men. Thirty-four percent of my dually eligible patients are under the age of 65 and disabled — a higher number than the 28% of disabled dually eligible patients nationally.

Of all the elderly and disabled dually eligible patients in my practice, 89% were African American and 11% were White. Of all my *elderly* dually eligible Medicare-Medicaid patients, 96% are elderly African Americans, and only 3% are elderly Whites. African Americans are less than 10% of the national Medicare population but are one-quarter of the national dually eligible population. The extreme 89% preponderance of African-American dually eligible patients in my practice reflects the demographics of the New Orleans neighborhoods that I serve.

For the two-year period prior to the elimination of crossover payments, 100% of my home visits to dually eligible patients were to the homes of African-American patients. Although most of these home visits were to *elderly* African-American patients,

100% of them were also disabled, as defined by the ADA, because they were all bed-bound and/or homebound due to severe medical problems.

Women, minorities, the elderly and disabled people are over-represented in the ranks of the dually eligible because dual eligibility is a marker for poverty. If *any* physician in New Orleans who treats dually eligible people is forced to decrease access to geriatric patients, the majority of people whose access will be injured will be these protected groups. I regret having to stop this part of my practice, but shifting the focus of my practice away from complicated, time-consuming dually eligible patients seems the best way to stem my losses.

Although the national percentage of African Americans is 12%, African-American communities are not evenly dispersed across the country. They are heavily concentrated throughout the Southeastern United States, forming the "Southern Black Belt," a large and poor area of our country. (See Figure 4, page 59.) Louisiana, which forms part of the Southern Black Belt, has an African-American population of 33%, and New Orleans has an African-American population of 67%. The vast majority of my elderly dually eligible practice focuses on *treating elderly African-American grandmothers and great-grandmothers***.** Similarly, 45% of dually eligible people in Georgia — which also forms part of the Southern Black Belt — are African American, compared with just 6% in Colorado, "reflecting differences in the racial composition of these states' dually eligible populations."

"Redlining" is "an arbitrary practice by which banks limit or refuse to grant mortgage loans for properties in blighted urban areas." The term originates from the practice of circling such areas on a map with a red pencil. Likewise, by eliminating crossover payments Louisiana has drawn a line around New Orleans and these dually eligible citizens. By force of law, Louisiana has made it impossible for large segments of protected New Orleans' populations to receive their rightfully earned Medicare benefits.

There is what I refer to as a "Southern Disability Belt" in the United States. (See Figure 5, page 62.) Although the national disability rate may be 19%, there is a large clustering of states where the percentage of non-elderly people with disabilities is "25% and over." This clustering of states is again across the Southeastern United States, and is the same area of our country as the Southern Black Belt. As with the Southern Black Belt, New Orleans and Louisiana sit within this Southern Disability Belt and carry a large disability burden.

New Orleans has a higher percentage of disabled persons than the rest of Louisiana, and Louisiana has a higher percentage of disabled persons than the rest of the United States. If Louisiana citizens carry an extra burden of disability, then the State of Louisiana should at least provide adequate medical access for these citizens, and allow the physicians of Louisiana a chance to care for them.

These issues were apparently not analyzed in detail before the budget cut was implemented. Officials at Louisiana DHH as well as the Bureau of Health Services Financing have indicated that Louisiana was essentially in an emergency situation and

had to take quick action to shore up its budgetary shortfall. Hemodialysis and transplant services, however, were excluded from the Medicaid crossover elimination because state officials "felt that *it was inappropriate to limit access* to these services [emphasis added]."

Louisiana leads the United States in poverty, and in southern Louisiana poor people are concentrated in the New Orleans area. According to David Hood, Secretary of Louisiana DHH, "Louisiana's elderly are among the poorest and the most vulnerable in the country." One factor contributing to Louisiana's poor health is "a continued lack of access to primary care." The problems of dually eligible people have deep roots in Louisiana's poverty. The decrease in medical reimbursement for our elderly and disabled poor resulting from the elimination of crossover payments will only worsen our medical access problems.

Any city or rural area containing a large number of poor and disabled minority citizens may experience discrimination and "medical redlining" of their dually eligible citizens, similar to the New Orleans experience. Although Connecticut has an 82% White majority, Hartford is 72% African American, Hispanic and other minorities. The elimination of Connecticut's crossover payments in 1999 led to decreased geriatric and medical access and difficulty obtaining care for frail nursing home patients. A survey by The Fairfield County Medical Association in Connecticut demonstrated that 42% of their physicians had reduced medical access for dually eligible patients.

The number of frail, elderly patients is increasing at almost three times the rate of our national population. We will need a large number of geriatricians to care for these people. Geriatrics, as it stands today, is an ailing specialty. There is a shortage of geriatricians, and the major reason is poor Medicare reimbursement. Medicare "currently provides a disincentive for physicians to care for Medicare beneficiaries who are frail and chronically ill." Louisiana has the lowest number of physicians with Certification in Geriatric Medicine, with only 45 out of the thousands of geriatricians certified nationally.

There is no possible increase in the Medicare fee schedule that can undo the damage that the elimination of crossover payments is doing to dually eligible patients, and to the practice of geriatrics. No matter how high the Medicare payment ceiling is raised, geriatricians would always be losing a minimum of 20% compared to physicians who do not treat these dually eligible patients. Medical students who leave medical school with the burden of student loans are less likely to choose a geriatrics career where he or she is laboring under a minimum 20% penalty compared to all other specialties. Geriatricians may shun states such as Louisiana that have this geriatric penalty in favor of states that do not have this geriatric penalty.

The elimination of crossover payments for dually eligible persons was estimated to save $23.5 million, or seven tenths of one percent (0.7%) of the entire $3.384 billion Louisiana Medicaid budget. This amount pales when compared to the $504 million, or 15% of the total Louisiana Medicaid budget, spent on poorly utilized nursing homes. Cutting down this nursing home expense by only 5% would more than pay for the complete restoration of Louisiana crossover payments.

In general, Medicare pays for *acute medical care* in the physician's office, in the hospital, and through home health. Medicaid, on the other hand, pays the bulk of *chronic long-term care* expenses. (See Figure 6, page 80.) Louisiana must strive to *maximize* the amount of money spent by Medicare in the physician's office, hospital and through home health, while at the same time *minimizing* the amount of money spent by Medicaid in the long-term nursing facility. Louisiana must keep people in the *Medicare-sponsored* community and out of *Medicaid-sponsored* nursing homes. Louisiana can do this, but in order to be successful, Louisiana must enlist the aid of its physician base — the very same group of physicians upon whom Louisiana imposed a geriatric penalty.

Without the physicians' attention, vulnerable dually eligible patients are left without their best patient advocate. If a geriatric physician decreases his or her geriatric (i.e., dually eligible) office practice or stops making home visits to these frail patients, dually eligible people will have less access to timely medical care. These patients must then wait for medical care until they become sicker and more vulnerable to hospital admission and nursing home placement.

Louisiana citizens already visit our state's emergency rooms 36% more than the national average, and are admitted to our state's hospitals 29% more than the national average. As access to physicians' services decreases, emergency room visits, hospitalizations and expensive nursing home placements will further increase as a result of the elimination of crossover payments. In 1995, 85% of all national Medicaid money spent on dually eligible people went to pay for their nursing home care.

It seems impossible that the 104,110 dually eligible persons in Louisiana, as well as the multitude of dually eligible persons nationwide, could be *so invisible* that so few people would object to our state's poorly reasoned attempt to save money by decreasing medical access for this neediest and most expensive population group.

In 1965, the United States Congress made a pact with our nation's elderly and disabled citizens and established Medicare. By eliminating Medicare-Medicaid crossover payments for its dually eligible population, Louisiana has broken this 37-year-old promise and has injured our elderly and disabled patients as well as the physicians who serve them.

The 2002 Medicare budget contained a 5.4% cut for all Medicare patients, which include many healthy and wealthy seniors throughout our country, and drew an angry and impassioned response from organized medicine. If this recently proposed budget cut of 5.4% looks bad because it "will have immediate negative consequences for patient access to physician services," then consider how dire the consequences will be of an additional 20% to 80% reduction in Medicare payments for dually eligible people. Everyone should join forces behind this issue, because by working together *we can stop* Second-Class Medicare, and we can make a difference in the health care for our neediest citizens.

STATEMENT OF PURPOSE

This monograph on the problems of dually eligible people was written:

1. To restore Medicare-Medicaid crossover payments for dually eligible patients,

2. To begin a debate about health care for the dually eligible population by presenting information about this group, and

3. To provide increased visibility and purpose for the specialty of geriatrics.

COMPLAINT 1: THE CIVIL RIGHTS ACT COMPLAINT

Complaint 1a

The State of Louisiana and the Louisiana Department of Health and Hospitals (DHH), both recipients of federal funding, are medically redlining New Orleans and are in violation of the Civil Rights Act of 1964.

By eliminating Medicaid crossover payments* for dually eligible persons with Medicare and Medicaid, the State of Louisiana and Louisiana DHH are promoting "disparate discrimination" of several protected classes of citizens, including African-Americans, women, the elderly, the poor, and the physically and mentally disabled. The State of Louisiana and Louisiana DHH are preventing these groups of citizens from accessing the full benefits of their federally mandated Medicare health insurance and are preventing these groups of citizens from enjoying full access to medical care.

Complaint 1b

The Congressional Balanced Budget Act of 1997 enabled Louisiana and many other states across the country to essentially abolish these Medicare-Medicaid crossover payments for dually eligible people. Therefore, that section of the Balanced Budget Act also violates the Civil Rights Act of 1964.

* Technically, Louisiana DHH is not allowed to "eliminate" crossover payments for dually eligible people. DHH's final rule, which appeared in the Louisiana Register on October 20, 2000, states that DHH will compare the actual Medicare payment (without the Medicare deductible and 20% coinsurance) to the Medicaid payment rate. If the Medicare payment exceeds the Medicaid payment rate, the claim is adjudicated as a fully paid claim with a zero Medicaid payment — which means a minimum loss of 20% of the Medicare fee. If the Medicaid rate exceeds the Medicare payment (e.g., if Medicare pays little or zero because the Medicare deductible has not been met), the claim is reimbursed at the lesser of the actual Medicare payment amount or up to the Medicaid maximum payment — a loss which may exceed 80% of the Medicare fee. The patient and Louisiana DHH have no further legal or financial liability to make payment for the service. The net effect of this complicated rule — which was sanctioned by the Balanced Budget Act of 1997 — is that crossover payments for dually eligible people have been essentially eliminated.

COMPLAINT 2: THE AMERICANS WITH DISABILITIES ACT COMPLAINT

Complaint 2a

The State of Louisiana and the Louisiana Department of Health and Hospitals (DHH), both recipients of federal funding, are discriminating against disabled dually eligible patients and are in violation of the Americans with Disabilities Act (ADA) of 1990.

By eliminating Medicaid crossover payments for dually eligible persons with Medicare and Medicaid, the State of Louisiana and Louisiana DHH are promoting discrimination of dually eligible "qualified individuals with disabilities." The dually eligible population has a large number of young and elderly disabled persons, as defined by the ADA. The State of Louisiana and Louisiana DHH are preventing these groups of citizens from accessing the full benefits of their federally mandated Medicare health insurance. They are preventing these groups of citizens from enjoying full access to medical care and to their Medicare benefits, which, in many cases they earned solely because they were disabled in the first place.

Complaint 2b

The Congressional Balanced Budget Act of 1997 enabled Louisiana and many other states across the country to essentially abolish these Medicare-Medicaid crossover payments for dually eligible people. Therefore, that section of the Balanced Budget Act also violates the Americans with Disabilities Act.

HCFA'S CIVIL RIGHTS STANDARDS

In 1998 Nancy-Ann Min DeParle, the Administrator of the Health Care Financing Administration (HCFA) — now renamed the Centers for Medicare & Medicaid Services (CMS) — issued the "HCFA Civil Rights Compliance Policy Statement". The purpose of this Compliance Statement was to ensure there would be no discrimination in any HCFA healthcare program. She stated the agency's goal was to see

> that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all HCFA program operations and activities. . . . These laws include: Title VI of the Civil Rights Act . . . the Rehabilitation Act . . . the Age Discrimination Act . . . [and] the Americans with Disabilities Act . . . .
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> To achieve its civil rights goals, HCFA will continue to incorporate civil rights concerns into the culture of our agency and its programs . . . [and will be] collecting data on access to, and the participation of, minority and disabled persons in our programs . . . [and will] allocate financial resources to . . . ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability. . . .
>
> HCFA's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries . . . . We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.[1]

The elimination of Medicare-Medicaid crossover payments is contrary to HCFA's mission of assuring "equal access" for all Medicare and Medicaid beneficiaries and is harmful for dually eligible persons.

[1] DeParle, Nancy-Ann Min. Health Care Financing Administration (HCFA) Civil Rights Compliance Policy Statement. HCFA. Aug. 3, 1998. 8 Aug. 2001 <http://www.hcfa.gov/medicaid/smd8398.htm>.

POSITION STATEMENT

> The problems of the chronically-ill and dually eligible populations pose tremendous challenges to consumers, providers, payors and policy makers. A significant barrier to addressing the needs of the chronically-ill is lack of education among policy makers regarding the magnitude of the problem and the issues faced by those with chronic conditions and disabilities.[2]

One such barrier to adequately caring for our nation's most vulnerable citizens is our state and federal governments' decision to eliminate the Medicaid portion of crossover payments for people who are dually eligible for Medicare and Medicaid. In an attempt to save money, many states stopped paying for these crossover payments, without fully studying the issues. The elimination of these payments decreases access to medical care for our elderly and disabled dually eligible citizens.

Many physicians and policymakers believe the elimination of Medicare-Medicaid crossover payments for dually eligible people is a Medicaid issue. The real problem, however, is not a problem with Medicaid. It is actually a problem with the *unfulfilled promise of Medicare*. (See the chapter titled, "'Second-Class Medicare': How Do Medicare-Medicaid 'Crossovers' Work?")

By eliminating crossover payments for patients who are dually eligible for both Medicare and Medicaid, several well-defined minority groups, including the elderly, the poor, African Americans, women, and the mentally and physically disabled that reside in New Orleans, cannot fully access their Medicare benefits. This results in a discriminatory, two-tiered benefit system that violates several federal laws.

The State of Louisiana should correct this discriminatory practice and restore these eliminated crossover payments. But the pattern of well-demarcated areas of disadvantaged populations also occurs in other cities and rural areas across the nation whose demographic map mirrors New Orleans. (See the chapters titled, "'Medical Redlining' of Dually Eligible Persons in New Orleans" and "'Medical Redlining' Elsewhere".) The federal government should correct this national discriminatory practice and void that section of the Balanced Budget Act of 1997, which allowed the elimination of Medicare-Medicaid crossover payments in the first place.

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[2] Feldman, Eli. Hearing on Issues Relating to Coordinated Care Systems Under Medicare. US Cong. House. Subcommittee on Health of the House Committee on Ways and Means. Apr. 29, 1997. 19 July 2001 <http://waysandmeans.house.gov/health/105cong/4-29-97/4-29feld.htm>.

OVERVIEW OF THE CIVIL RIGHTS ACT COMPLAINT

1.

This complaint centers on Medicare, as opposed to previous challenges, which centered on Medicaid. The Medicaid health insurance program consists of over 50 separate entitlement programs for the poor. Medicare, on the other hand, was established so that our elderly citizens could have access to first-class medical treatment at an affordable cost. It is a single nationwide promise given by the federal government to all citizens who worked and paid payroll taxes into the Social Security – Medicare system. As such, it is not an entitlement program like Medicaid, but rather it is an earned benefit with one set of national rules and equal benefits for everyone in the United States. (See the chapter titled, "The Medicare and the Medicaid Programs.")

2.

Dually eligible people have both Medicare and Medicaid benefits. They worked and earned the right to Medicare, and they receive it when they become elderly or disabled. These dually eligible people also have Medicaid because they are still so poor that they qualify for their state's Medicaid program for the needy. Dually eligible patients are the oldest, poorest, sickest and most disabled group of people in the country. They also have the highest Medicare and Medicaid expenditures. (See the chapter titled, "Dually Eligible People.") Dually eligible persons, in New Orleans and elsewhere, are disproportionately old, poor, minorities, female and disabled. (See the chapter titled, "Dual Eligibility Statistics from My Medical Practice.") The unifying characteristic of all of these dually eligible groups is poverty. (See the chapter titled, "Dual Eligibility as a Marker for Poverty.")

3.

In order to ride on the "healthcare bus" everyone needs a ticket. It costs $1.00 to ride in a first-class seat on the healthcare bus. Medicare gives every beneficiary a first-class ticket to ride at the front of the healthcare bus, without regard to age, sex, race, income, or disability status. Medicare, however, does not pay for the entire bus ticket. Medicare only pays 80 cents of the $1.00 ticket and the patient, or his or her secondary insurance, is supposed to pay the remaining 20 cents, thus ensuring a complete first-class ride at the front of the bus.

In the case of a dually eligible patient, Medicare still pays 80 cents towards the first-class bus ticket, and Medicaid is supposed to pay the remaining 20 cents. However, in order to save money for the states, the Congressional Balanced Budget Act of 1997 (BBA) allowed each state the option of not paying the full portion of the Medicare bill that crossed-over to Medicaid. These "crossover payments" consist of a $100 yearly deductible and a 20% coinsurance, or copayment. (See the chapter titled, "Crossover Payments and the Balanced Budget Act of 1997.")

Since Louisiana eliminated these crossover payments for dually eligible persons in 2000, Louisiana has assured these patients that forever, they can only expect to receive

a maximum of 80 cents to ride on the healthcare bus. If the State of Louisiana refuses to pay the remaining 20 cents, and physicians are precluded from billing the patient under penalty of law, then this group of patients is once again relegated to "sit at the back of the bus" because they can never purchase the complete $1.00 first-class seat on the healthcare bus.

To make matters worse, at the beginning of each year, before the patient's annual Medicare deductible has been met, Medicaid may only provide a 20- or 30-cent ticket to ride on the bus. This shortfall results from the elimination of crossover payments for the Medicare deductible, and pushes these vulnerable people even further to the back of the healthcare bus. (See the chapters titled, "'Second-Class Medicare': How Do Medicare-Medicaid 'Crossovers' Work?" and "My Response to This 'Geriatric Penalty'".)

By eliminating Medicare-Medicaid crossover payments, the State of Louisiana is preventing several well-defined population groups with long histories of discrimination from *ever* accessing their full Medicare benefits and access to first-class health care. By eliminating these Medicaid crossover payments Louisiana has imposed a "geriatric penalty" on the oldest, poorest and sickest patients in our state, and has succeeded in creating a new underclass of medically insured patients.

These dually eligible patients now have Second-Class Medicare. These patients' medical services are now reimbursed on a fee schedule that hovers permanently between the Medicare payment rate and Medicaid payment rate. (See the chapter titled, "'Second-Class Medicare': How do Medicare-Medicaid 'Crossovers' Work?") Instead of receiving the full amount of these patients' Medicare payment for their services, all physicians in Louisiana who treat these frail patients will only receive 80 cents out of every dollar that the federal government says each service is worth. And, for patients with psychiatric disability, physicians may only receive *a cap of 50 cents out of every dollar*. (See the chapter titled, "The 'Rule of 62s' and Psychiatric Care for Dually Eligible Persons.")

4.

This doctrine of "separate but unequal" is discriminatory, creates difficulty with medical access for these frail patients, and means that dually eligible patients can never enjoy the full 100% benefits of the Medicare program for which they have worked all of their lives. The BBA allowed each state to decide the fate of its Medicaid crossover payments. Although the BBA may appear to be a relatively neutral regulation, in practice it creates significant geographical inequities and perpetuates racial discrimination.

Many states including Louisiana have large, geographically well-defined pockets of poor minority citizens — such as the New Orleans area. States that have eliminated crossover payments are "medically redlining" the poor, elderly, minority, female and disabled populations that live in these impoverished, minority neighborhoods. This is particularly relevant throughout the "Southern Black Belt" of eleven states in the southeastern United States extending from Virginia through Texas.[3] (See the chapter

[3] McMurray, Jeffrey. "Coalition seeks a boost for 'Black Belt.'" The Times-Picayune [New Orleans] 18 Aug. 2001: A4.

titled, "'Medical Redlining' of Dually Eligible Persons in New Orleans.") This medical redlining also occurs in many northern states, which have wealthy White suburbs but poverty stricken inner cities populated mostly by minorities. (See the chapter titled, "'Medical Redlining' Elsewhere.")

According to the Title VI Legal Manual of the Civil Rights Division of the U.S. Department of Justice**,** the Civil Rights Act of 1964 specifically states that this indirect, or disparate discrimination is illegal, even if it is unintentional.[4] (See the chapter titled, "The Civil Rights Act and 'Disparate Discrimination'".)

5.

New Orleans is a city with an African-American majority population. In my own geriatric practice, which draws patients from many predominantly poor African-American neighborhoods, almost three-quarters of my Medicare patients are dually eligible for both Medicare and Medicaid. Of these dually eligible patients, 89% are African American, 79% are female, and 34% are disabled. (See the chapter titled, "Dual Eligibility Statistics from My Medical Practice.") All of these groups are protected groups according to our Civil Rights laws.

Because the State of Louisiana has eliminated Medicaid crossover payments, all of these protected groups, which reside in well-demarcated geographic areas in New Orleans and elsewhere, cannot obtain access to the same medical care as Medicare recipients who do not *also* have Medicaid insurance. These protected dually eligible population groups can never receive the full $1.00 first-class ticket to ride on the healthcare bus.

As a direct result of Louisiana's Medicaid budget cuts, I have been forced to stop accepting new dually eligible homebound patients into my geriatric practice, and no longer make house calls to any new dually eligible patient. Also, because of these budget cuts I have been forced to decrease my geriatric clinic hours by 10% in order to do more profitable medical work. (See the chapter titled, "My Response to This 'Geriatric Penalty'".) In our limited Orleans Parish Medical Society poll, other physicians indicated they will also decrease the number of dually eligible patients they are willing to treat.

Because geriatric medical practice in New Orleans is so heavily weighted with dually eligible patients who are old, poor, female, African American and disabled, these groups of protected citizens are being injured by decreasing their access to geriatric medical practices, *solely* because of the Louisiana's budget decision. These dually eligible patients now have reduced access to Medicare's first-class medical care — a violation of the Civil Rights Act of 1964.

6.

[4] United States. Dept. of Justice. Civil Rights Division. Title VI Legal Manual. Washington: Sept. 1998. 15 Aug. 2001 <http://www.usdoj.gov/crt/grants_statutes/legalman.html>.

Any city or rural area containing a large number of poor minority citizens will also contain a disproportionate number of old, poor, African American and/or Hispanic, female and disabled citizens. Although the wealthy State of Connecticut has an 82% White majority, the city of Hartford is only 28% White and 72% African American, Hispanic and other minorities.[5]

The Fairfield County Medical Association in Connecticut conducted a survey of its members to determine the impact on patient access following Connecticut's withdrawal of Medicaid crossover funding for dually eligible patients. Of the nearly 500 responses, 42% of the physicians stated they had reduced medical access for new dually eligible patients.[6] (See "'Medical Redlining' Elsewhere.") Because of Hartford's population demographics, many of the dually eligible patients affected by Connecticut's Medicaid crossover cuts were probably minorities, females or disabled persons, all protected groups under the Civil Rights Act.

7.

In summary, the seemingly neutral decision by the State of Louisiana (or the State of Connecticut, etc.) to eliminate Medicaid funding for Medicare-Medicaid crossover payments results in "disparate" or disproportionate discrimination of several protected groups of citizens in New Orleans and probably in many similar demographic areas across the United States. By never allowing these protected citizen groups to enjoy their full Medicare benefits the State of Louisiana is engaging in medical redlining, which violates the Civil Rights Act of 1964. Since the Balanced Budget Act of 1997 allows states all across the United States to eliminate Medicaid funding for crossover payments, that section of the Balanced Budget Act is also in violation of the Civil Rights Act.

[5] United States. Census Bureau. Quick Tables. QT-P3. Race and Hispanic or Latino: 2000. Census 2000 Summary File. Geographic Area: Hartford city, Connecticut. 2000. 5 Sept. 2001 <http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF1_U_QTP3_geo_id=16000US0937000.html>.

[6] Fairfield County Medical Association. Fairfield County Medical Association Releases Crossover Survey Results. Press release. Mar. 21, 2001. 13 Aug. 2001 <http://www.fcma.org/webpages/crossover-survey.asp>.

THE CIVIL RIGHTS ACT AND "DISPARATE DISCRIMINATION"

Title VI of the Civil Rights Act of 1964 states:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In calling for its enactment, President John F. Kennedy identified "simple justice" as the justification for the Civil Rights Act:

> Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion, which encourages, entrenches, subsidizes, or results in racial discrimination. Direct discrimination by federal, state, or local governments is prohibited by the Constitution. But indirect [or disparate] discrimination, through the use of federal funds, is just as invidious . . . .

According to the U.S. Justice Department's Title VI Legal Manual, the Civil Rights Act of 1964, in addition to barring intentional discrimination, specifically states that *indirect*, or disparate discrimination is illegal:

> The Supreme Court has held that . . . regulations may validly prohibit practices having a disparate impact on protected groups, even if the actions or practices are not intentionally discriminatory. . . .
>
> A recipient [of federal funds, such as the State of Louisiana] . . . may not, directly or through contractual or other arrangements, utilize criteria or methods of administration *which have the effect* of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin. . . .
>
> In a disparate impact case, the focus . . . concerns the consequences of the recipient's [the State of Louisiana and DHH's] practices, rather than the recipient's intent. . . . To establish liability under a disparate impact scheme, the investigating agency must first ascertain whether the recipient utilized a facially neutral practice that had a disproportionate impact on a group protected by Title VI [of the Civil Rights Act].[7]

After an investigating agency determines this discrimination complaint is valid, the second stage of the disparate impact analysis would begin. This second stage requires the investigating agency to "determine whether the recipient [the State of Louisiana and DHH] can articulate a 'substantial legitimate justification' for the challenged practice,"

[7] United States. Dept. of Justice. Civil Rights Division. Title VI Legal Manual.

which is the elimination of the Louisiana Medicaid portion of crossover payments for dually eligible patients. In answer to this justification challenge, the State of Louisiana and DHH would correctly state that Louisiana was in a budgetary crisis, and cutting the crossover payments helped lessen Louisiana's budgetary problems.

According to David Hood, Secretary of Louisiana DHH, "This department does not practice, nor do we tolerate racial discrimination." However, he further states, "We do not keep expenditure statistics based on race. Neither do we budget according to race."[8] Therefore, Louisiana DHH may not be aware that their seemingly neutral budgetary cut has had a harmful disparate effect on several protected groups of Louisiana citizens, all of whom reside within the readily identified geographic boundaries of the City of New Orleans.

Once Louisiana DHH establishes its "legitimate justification" defense, the third and last stage of this disparate impact analysis would begin. The third stage requires a demonstration that a less discriminatory alternative does exist. There are other, more equitable choices for the State of Louisiana and DHH to accomplish its goals of providing good health care to its poorest citizens, without jeopardizing its Medicaid budget, and without discriminating against vulnerable populations in our state. To fulfill this final complaint requirement, we must begin a debate about how to best serve all of our citizens' medical needs, in an efficient, cost-effective manner. This includes the needs of our vulnerable dually eligible patients.

If we can demonstrate how the State of Louisiana can save money in its treatment of the frail elderly, then the demonstration of a "less discriminatory alternative" to the current disparate discrimination will be achieved. I will present several ideas to help this elderly, disabled, dually eligible population later in this paper. (See the chapters titled, "The Medicare-Medicaid Payment Seesaw and Our Nursing Home Budget," and "Suggestions to Improve Medical Access in Louisiana," and "Suggestions to Improve Medical Access for Our Nation's Elderly.")

[8] Hood, David. Letter to the author. 2 July 2001.

THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD VS L.C.*

The Americans with Disabilities Act (ADA) of 1990 prohibits any public program or agency from discriminating against persons with disabilities. The ADA requires public agencies to make "reasonable modifications" in order to avoid discrimination, as long as the modifications do not amount to "fundamental alterations" in the basic structure of the public program.

As described by Sara Rosenbaum, whom the AARP calls a "nationally recognized Medicaid scholar,"[9] the Supreme Court's 1999 decision in *Olmstead v. L.C.* arose under the Americans with Disabilities Act. In this case two Georgia plaintiffs, who had mental retardation and mental illness, were kept in institutions long after their conditions had stabilized because the state did not fund enough community services for the plaintiffs to be discharged to a community placement program. The Supreme Court decided that the ADA prohibited the state's action and required "reasonable alterations in the existing design [of a state's program] where unnecessary institutionalization and segregation of persons with disabilities are present."

Ms. Rosenbaum states this ruling has broad implications for persons with disabilities. The *Olmstead* decision "is not confined to a particular type of disability or institution." Any community-dwelling person who is at risk of institutionalization unless he or she receives proper medical care is protected by the *Olmstead* decision. This court decision "directly affects Medicaid" because the anti-discrimination requirements of the ADA apply to all public programs, including Medicaid. The *Olmstead* ruling "focuses on the obligations of states toward persons with disabilities under the ADA — in relation to the entire fabric of state health and welfare programs and structure of state health budgets." It also focuses attention on how states use the Medicaid program to provide appropriate community care for its disabled persons.

The *Olmstead* ruling implies that "states have a Medicaid obligation that parallels the ADA to ensure that individuals are not being inappropriately placed in institutions." This provision is of prime importance to dually eligible Medicare-Medicaid patients (most of whom are elderly) because *the ADA has no age limit.*

There is only *one* path to Medicaid eligibility — being poor. But a person who has worked has *two* paths to Medicare eligibility — through age or through disability. The less common path is for a person who is younger than 65-years-old to be declared disabled by the Social Security disability program — the "non-elderly disabled." Title II of the ADA states that a "disabled" person is someone who has

> a physical or mental impairment that substantially limits one or more major life activities . . . such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working

[9] Rosenbaum, Sara. *Olmstead v L.C.*: Implications for Older Persons with Mental and Physical Disabilities. AARP Public Policy Institute. Washington: Nov. 2000. <http://research.aarp.org>.

> . . . [or has] orthopedic, visual, speech, and hearing impairments . . . [or has] cancer, heart disease, diabetes [as well as] mental retardation, [or] emotional illness . . . .[10]

Any person who has been declared disabled by the Social Security disability program has already proven that he or she meets the generally more lenient ADA disability requirements and is therefore covered by the ADA legislation.

The more common path to Medicare benefits is simply to grow old enough to be considered elderly. Elderly patients frequently have several of these ADA-listed impairments, limited major life activities, or named illnesses, and are therefore "qualified disabled persons" who are protected by the ADA rules. Ms. Rosenbaum states that "dementia and Alzheimer's disease," illnesses common in the elderly nursing home population, would also "fall within the general categories of impairments listed above." According to a report prepared for the Kaiser Commission on Medicaid and the Uninsured, "43% [of dually eligible people] are cognitively impaired . . . . [and] dual beneficiaries constitute 69% of Medicare beneficiaries with mental retardation and nearly half of beneficiaries with mental disorders or Alzheimer's disease."[11]

Dually eligible persons are poor, elderly or disabled, and have significantly more impairments, limited activities and illnesses than other Medicare beneficiaries have. (See the chapter titled, "Dually Eligible People.") Therefore, dually eligible patients qualify for even *greater* ADA protection than other Medicare patients who are not dually eligible. By eliminating crossover payments Louisiana and DHH are discriminating against a large portion of the elderly dually eligible population who meet the ADA definition of disabled. Louisiana and DHH are also discriminating against the *entire* dually eligible population who qualified for their Medicare benefits on the basis of being previously declared mentally or physically disabled by the Social Security disability program.

The elimination of crossovers means that any disabled dually eligible person, be they young or old, can only expect to get 80 cents out of every $1.00 of their medical providers' bills paid, as compared to similar patients who are not dually eligible. Medical providers who treat non-dually eligible Medicare patients are allowed to receive 100% of the Medicare "allowed charges" because non-dually eligible patients pay their medical providers the additional 20% coinsurance not covered by Medicare. The State of Louisiana, however, has refused to pay this 20% Medicare coinsurance for dually eligible patients and has made it *illegal* for medical providers to bill dually eligible patients for this coinsurance. The State of Louisiana and DHH have forever relegated all dually eligible disabled persons who have Medicare on the basis of age or disability to an 80-cent, second-class ticket to ride the healthcare bus.

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[10] United States. Americans with Disabilities Act. Title II Regulations. 10 July 2002 <http://janweb.icdi.wvu.edu/kinder/pages/TitleIIReg.htm>.

[11] O'Brien, Ellen, Diane Rowland and Patricia Keenan. Medicare and Medicaid for the Elderly and Disabled Poor. Kaiser Commission on Medicaid and the Uninsured. Washington: Kaiser Family Foundation, May 1999. 5 May 2002 <http://www.kff.org/content/archive/2132/poor.pdf>.

The *oldest* Medicare beneficiaries along with beneficiaries who are the *most physically or mentally disabled* are most likely to be poor, have Medicaid, and be dually eligible. Therefore, in a perversion of social justice and logic, both of these large, dually eligible, disabled populations which meet the ADA disability requirements and are most in need of protection from the ADA in healthcare matters, are in Louisiana the very same populations that are forbidden to have full access to their Medicare benefits.

According to the AARP, over 4% of the 1997 US population age 65 and older resided in nursing homes. "Nearly three-fourths of these residents were women, and about one-half were age 85 and older." Most nursing home residents are dually eligible people with multiple disabilities and qualify for protection under the ADA. Seventy-five percent of all nursing home residents age 65 and older need help performing at least three activities of daily living, which included "bathing, dressing, eating, transferring from bed to chair, and using the toilet. About 42% of nursing home residents were diagnosed with dementia, and 12% had other psychiatric conditions, such as schizophrenia and mood disorders."[12]

The most egregious example of this discrimination is the disabled dually eligible Medicare-Medicaid patient who is receiving his or her Medicare benefits on the basis of a *mental impairment*. If Medicare assures all beneficiaries a $1.00 first-class ticket, and the elimination of Medicare-Medicaid crossover payments by our state Medicaid program means that many disabled beneficiaries can only get a Medicare 80-cent, second-class ticket, then surely it is a travesty to have mentally disabled dually eligible patients only get a *50-cent ticket* to ride way in the back of the bus.

A Medicare regulation, the "rule of 62s," states the most Medicare will pay a physician for his or her follow-up services to a Medicare beneficiary with a psychiatric diagnosis is 50% of the allowed charge. (See the chapter titled, "The 'Rule of 62s' and Psychiatric Care for Dually Eligible Persons.") This is in contrast to the 80% reimbursement a provider will receive for a patient with a non-psychiatric diagnosis. Medical providers who treat non-dually eligible Medicare patients are allowed to receive 100% of the Medicare allowed charge for their psychiatric services because non-dually eligible Medicare patients pay the medical provider the remaining 50% of the Medicare allowed charges. This is in contrast to a dually eligible patient with a psychiatric diagnosis whose physician can only receive 50% of the total Medicare allowable charge because the State of Louisiana and DHH refuse to pay the remaining 50%, and the physician is again *forbidden by law* to bill the patient.

The irony of this situation is that these very patients, the "mentally disabled" dually eligible patients, who need their full Medicare benefit to allow them to get appropriate medical and psychiatric care, are the *least* likely patients to receive the full benefits of their Medicare insurance. Because psychiatry is a non-procedural medical

[12] Pandya, Sheel. Nursing Homes. AARP Public Policy Institute. Public Affairs. Washington: Feb. 2001. 9 Sept. 2001 <http://www.research.aarp.org/health/fs10r_nursing.html>.

specialty, the most valuable psychiatric asset is the physician's time. Few psychiatric or medical physicians can afford to accept a large number of patients whose insurance reimbursement can only total 50% of what Medicare says their services are worth and still stay in business. To expect disabled patients who receive only 50% total reimbursement to have the same access to our healthcare system as patients who receive 100% reimbursement is simply unrealistic.

If these mentally disabled dually eligible patients earned their Medicare benefits solely because they were mentally disabled, then the problem is compounded because the program's administration has been turned upside down, with the *most needy* patients, these dually eligible mentally disabled patients, getting the *least medical access*. This 50-cent, third-class healthcare bus ticket can lead to difficulty with psychiatric or medical access, to difficulty obtaining mental health prescriptions, and eventually to psychiatric decompensation and institutionalization. Just having a diagnosis of schizophrenia, depression, bipolar disorder or psychosis should not relegate anyone to third-class seating. This is discrimination against the dually eligible disabled and is illegal under the ADA provisions, as extended by the *Olmstead* ruling.

Title II of the ADA is a "broadly conceived remedial law that is designed to reach all public programs." It states that public agencies should operate in an equally effective, non-discriminatory manner, and must make "reasonable modifications" in order to avoid discrimination as long as these modifications are not "fundamental alterations" in the basic structure of a state's program for disabled persons. The fact that a state may spend more money on the disabled population in order to implement these modifications "would not appear to be an alteration that changes the basic structure of the state's programs."[13]

Recent court cases dealing with the *Olmstead* decision have demonstrated that spending more money on Medicaid services (e.g. restoring crossover payments) is not a "fundamental alteration" in a state program's structure. "The mere fact that a state might have to spend an additional amount" of money to restore equal access to the physician's office in order to avert institutionalization and nursing home placement for disabled dually eligible people is not a fundamental alteration to the state's Medicaid program. These court cases imply that a state must fund benefits and services "up to reasonable coverage levels . . . . [A] state cannot refuse to spend more than a flat, fixed amount per individual for covered services and claim that such additional expenditures up to a [more] reasonable coverage level [would] amount to a fundamental alteration."[14]

The total amount of Louisiana treasury money that our state hopes to save by eliminating Medicare-Medicaid crossover payments for all dually eligible patients, including disabled persons, is less than $7 million dollars for the entire year for all Louisiana physicians. Although the total cost of these crossover payments is $23.5 million, the federal government contributes 70% of the money to pay for our state's Medicaid program and would give Louisiana the additional $16.5 million from the

[13] Rosenbaum.
[14] Rosenbaum.

federal government's treasury to help pay for these crossover payments.[15] Without Louisiana's $7 million share, however, dually eligible patients with multiple disabilities have less access to medical care and are at risk of being "institutionalized" in nursing homes. This violates the ADA, as defined in the *Olmstead* case.

To fully fund these crossover payments for dually eligible patients is a "reasonable modification," as defined in the ADA. For Louisiana DHH to spend $7 million dollars of its own money (in addition to $16.5 million of the federal government's money) does not amount to a "fundamental alteration" in its Medicaid program. It would, however, allow its disabled dually eligible citizens, as well as all other dually eligible citizens, full access to their Medicare benefits, and would allow Louisiana to correct its current discriminatory practices.

[15] Louisiana. Office of the State Register. Louisiana Register. "Notice of Intent. Professional Services—Medicare Part B Claims." Vol. 26 May 20, 2000. 1156-57.

THE MEDICARE AND THE MEDICAID PROGRAMS

The United States Congress created the Medicare and the Medicaid programs in 1965 to ensure access to our healthcare system for our most vulnerable citizens. Although established at the same time, these two programs differ significantly and serve two different populations.

Medicare is a federal health insurance program that provides benefits to persons aged 65 and older, disabled workers and persons with end-stage renal disease. Individuals usually earn their Medicare benefits by working and paying payroll taxes into the Social Security – Medicare system. Medicare Part A, which has no monthly premium, covers inpatient hospitalization, some home health visits, and some post-hospital care (either for a short-term stay in a skilled nursing facility or a rehabilitation center). Medicare Part B requires a monthly premium and covers physician and outpatient services, some home health visits, and other medical services. Medicare covers all persons who qualify for it, regardless of age, medical condition or ability to pay.[16]

Most Medicare payment is for acute care, ambulatory care and rehabilitation services. Only a small percentage of Medicare dollars is spent for long-term, or nursing home care. Medicare is a nationwide promise made by the federal government of one set of rules and equal benefits for everyone. Medicare is the great "healthcare equalizer" and provides a first-class ticket for access to our healthcare system for the elderly and disabled. In fiscal year 1996, Medicare covered an estimated 38 million beneficiaries at a cost of $197 billion.

Unlike Medicare, which is an earned benefit, Medicaid is an entitlement program based solely on an individual's financial resources and serves the medical needs of the poor. Whereas Medicare is a single program administered by one federal agency having one set of rules, the Medicaid program consists of 56 separate entitlement programs for the poor — one for each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories.[17] Each Medicaid program has its own regulations, payment schedules, eligibility requirements and bureaucracies.

Medicaid is a jointly funded federal-state program. The size of the federal government's portion depends upon each state's per capita income and poverty rate. The federal government's share of the Louisiana Medicaid program is approximately 70%, and the state treasury's share is the remaining 30%.[18] In 1996, the federal government paid 57% of the aggregate national Medicaid costs of $160 billion, which provided healthcare coverage for 37 million beneficiaries.[19]

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[16] Gross, David J., and Normandy Brangan. The Medicare Program. AARP Public Policy Institute. Washington: Apr. 1998. 9 Sept. 2001 <http://www.research.aarp.org/health/fs45r_medicare.html>.
[17] Scanlon, William J. Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues. US Cong. Senate. Special Committee on Aging. Washington: GAO, Apr. 29, 1997.
[18] Boyd, Curtis. Louisiana's Medicaid Program. Annual Report. State Fiscal Year 1998/99. Louisiana DHH. Baton Rouge: 1999. <http://www.dhh.state.la.us/OMF/PDF/AR_98.pdf>.
[19] Scanlon.

In addition to paying for acute and ambulatory care services, Medicaid also pays for services that Medicare does not fund, including outpatient prescription drugs, and the majority of long-term care and nursing home bills. "Medicaid finances care for over two-thirds of the nation's nursing home residents, and pays nearly half of nursing home costs in the nation."[20] In addition, each state may also choose to fund other "personal care items" such as eyeglasses, dentures, etc.

In general, Medicare provides coverage for acute medical care in the physician's office, hospital or rehab setting, or through home health. It does not usually cover chronic medical care, the type of care that is increasing in the United States today. Medicaid, on the other hand, pays a smaller amount for acute medical care, but pays the bulk of chronic long-term care.

[20] Kaiser Family Foundation. Medicaid's Role for Low-Income Medicare Beneficiaries. Feb. 2001. 25 Apr. 2002 <http://www.kff.org/content/2001/2237/2237.pdf>.

DUALLY ELIGIBLE PEOPLE

Dually eligible people have both Medicare and Medicaid benefits. They live in the intersection where Medicare's elderly and disabled world overlaps with Medicaid's world of poverty. If we were to take all of the medical and socioeconomic problems associated with growing old or being disabled, and multiply them by all of the socioeconomic problems that come with being poor, we would have a working idea of what it means to be dually eligible for both of these programs.

Dually eligible people with Medicare and Medicaid are the group of old, poor, frail or disabled persons who are at greatest risk of becoming ill and requiring long-term nursing care:

> In 1995, there were approximately 6 million [dually eligible people] in the U.S. and this number is expected to double by 2030. . . . The nonelderly disabled and elderly persons aged 85 and older are the fastest growing segments of the dual eligible population. The dual eligible population experience significant physical and cognitive health problems, and are much more likely to become chronically ill than non-dual eligibles. . . . Close to 60% of the 85 plus population are disabled and likely to need some type of support or assistance with activities of daily living. . . . Dual eligibles are eight times as likely to be living in an institution.[21]

Dually eligible people are the oldest, the poorest, and the sickest group of people in the country. Senator John Breaux, in his opening statement before the Senate Special Committee on Aging in April 1997, stated:

> Any serious attempt to hold down Medicare and Medicaid costs must take the needs of the dually eligible — the elderly and disabled poor — into account. They are the most expensive of the Medicare and Medicaid beneficiaries. They account for a disproportionately large share of spending in both Medicare and Medicaid. As 16% of the Medicare population, they account for 30% of its expenditures. As 17% of the Medicaid population, they consume 35% of its payments. Overall, $106 billion was spent in 1995 on dual eligibles. This amounts to nine times more money than was spent nationally on medical research.
>
> As only 2% of the nation's population, they account for 10% of the country's health care spending. They are also the two fastest growing segments of the Medicare population. These groups — the nonelderly disabled and individuals 85 years and older — are the two groups most likely to be dually eligible.[22]

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[21] Feldman.

[22] Breaux, John. Torn Between Two Systems: Improving Chronic Care in Medicare and Medicaid. US Cong. Senate. Special Committee on Aging. Apr. 29, 1997. 19 Aug. 2001 <http://www.senate.gov/~aging/hr3jb.htm>.

Dually eligible people are expensive to care for because they are frail and require many costly medical services. A report in the Robert Wood Johnson 2000 Anthology states they "use more Medicare services across the board — hospital, skilled nursing facility and home health care." Thirty-three percent of dually eligible people use the emergency room each year, compared with 18% of non-dually eligible Medicare beneficiaries.[23] The medical expenses of dually eligible people with Medicare *and* Medicaid are approximately *twice* the expenditures of non-dually eligible Medicare *or* Medicaid beneficiaries. (See Figure 1.)

Dually eligible persons are a unique population. In a 1998 presentation at the HCFA National Committee on Vital and Health Statistics, Chris Murtaugh of the Center for Home Care Policy and Research in New York pointed to a

> difference between people who are dually eligible and the rest of the Medicare . . . population. . . . [D]ual eligibility is a marker . . . for people who have been ill, chronically ill for a long time and have exhausted their financial resources . . . it is picking up on measured frailty, and . . . [is] a marker, of course, for people who have always been poor, and maybe it tells you something especially in the home care arena about the environment that they live in, maybe not only their own individual housing, but, also, the supply of services, [and] the type of physicians who might or might not be available in the community in which they are living.
>
> So . . . some caution in applying a single system across the board to both dual eligibles as well as people who are just eligible for Medicare might be appropriate.[24]

Dually eligible persons in the New Orleans area are disproportionately old, poor, African American, female and disabled. (See the chapter titled, "Dual Eligibility Statistics from My Practice.") Some of these people have problems brought about by long-standing racial discrimination and poverty, which become magnified when they become old or disabled. (See the chapter titled, "Medical Discrimination Results in Unsatisfactory Medical Outcomes.") The AARP agrees that "the status and resources of many minority older persons reflect social and economic discrimination experienced earlier in life."[25]

A 1999 HCFA Summary Report on the Dual-Eligible Medicare/Medicaid Population described the socioeconomic aspects of being dually eligible. Although the

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[23] Alper, Joseph, and Rosemary Gibson. "Integrating Acute and Long-Term Care for the Elderly." Robert Wood Johnson 2000 Anthology. 2000. Chapter 5. <http://www.rwjf.org/app/rw_publications_and_links/publicationsPdfs/anthology2001/chapt5.htm>.

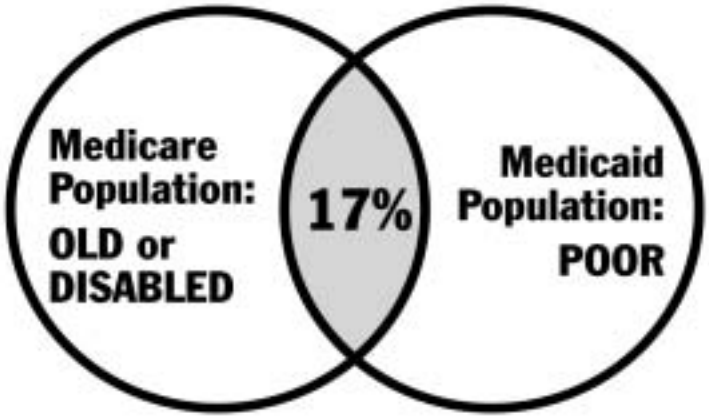
[24] Murtaugh, Chris. HCFA. National Committee on Vital and Health Statistics. Joint Meeting of Subcommittees on: Population-Specific Issues and Health Data Needs, Standards, and Security. Hearings. Morning sess. Maryland: March 2, 1998.

[25] Bacon, Carrie, project manager. Portrait of Older Minorities. AARP Minority Affairs. [Washington]: Nov. 1995. 18 Feb. 2001 <http://research.aarp.org/general/portmino.html>.

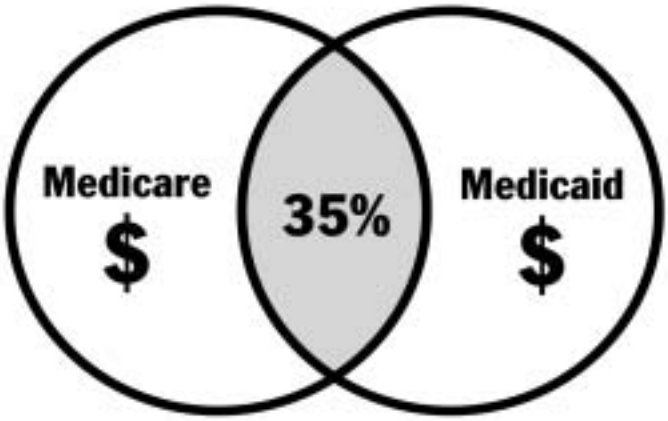
Figure 1.

Dually Eligible Patients are Expensive

1. Dually Eligible Patients comprise only 17% of the Medicare and Medicaid population.



2. Yet these same patients use almost 35% of all Medicare and Medicaid money.



3. The cost of caring for these patients totalled $106 Billion in 1995.

Source: Breaux, John. Torn Between Two Systems.

dually eligible population is generally only slightly older than the general Medicare population,

> 1. The largest difference occurs in the oldest cohort, where almost 13% of dual eligibles are 85 years old or older compared with 9% of the general elderly Medicare population.
>
> 2. The dual eligible population has a much larger share of minorities than does the general Medicare population. . . . The proportion of African American, Hispanic and beneficiaries of other races/ethnicities in the dual eligible population is three to four times that of beneficiaries in general.

Population statistics vary. In this report African Americans represented 8% of the total elderly Medicare population, but represented 23% of the dual eligible Medicare population.[26] A different report on Medicare stated that 18% of dually eligible persons are 85 years of age or older, and minorities in general "comprised only 14% of the non-dually eligible population, [but] made up 38% of the dually eligible population."[27]

Additionally, the racial composition of the dually eligible population "varied "considerably across states. For example, 45% of [dually eligible people] in Georgia and 29% of those in Michigan were African American, compared with just 6% in Colorado and 5% in Washington, reflecting differences in the racial composition of the dual-eligible populations of those states."[28]

The 1999 HCFA Summary Report on the Dual-Eligible continued:

> 3. [T]he percentage of women who are dually eligible is substantially higher than in the general Medicare population (74% vs. 58%, respectively).
>
> 4. Much like the general Medicare population, many more dually eligible people live in urban areas than in rural areas (68% vs. 32%, respectively). However, a somewhat larger percentage of this population live in rural areas (32%) compared with the general Medicare population (25%).
>
> 5. Compared to the general Medicare population, a substantially greater proportion of dually eligible people live alone (30% [for the total Medicare population] and 46% [for dually eligible people] respectively).

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[26] Edder, Margaret. Increasing Medicare Beneficiary Knowledge Through Improved Communications: Summary Report on the Dual-Eligible Medicare/Medicaid Population. Barents Group. Maryland: HCFA, March 5, 1999.

[27] United States. Dept. of Health and Human Services. HCFA. Characteristics and Perceptions of the Medicare Population: Data from the 1997 Medicare Current Beneficiary Survey. 3 Sept. 2001 <http://www.hcfa.gov/surveys/mcbs/PubCNP97.htm>.

[28] Schore, Jennifer, and Randall Brown. State Variation in Medicaid Pharmacy Benefit Use Among Dual-Eligible Beneficiaries. Mathematica Policy Research, Inc. Washington: Kaiser Family Foundation, Mar. 2002. 5 May 2002 <http://www.kff.org/content/2002/6016/6016rv.pdf>.

> Only 20% of dually eligible people lived with a spouse in 1996, while 56% of the general Medicare population lived with a spouse. Dually eligible patients were also more likely to live with their children or with other relatives or non-relatives compared with the general Medicare population.
>
> 6. As would be expected, the largest difference between the dually eligible population and the general Medicare population is in their economic characteristics. . . . [A]lmost 99% of dual eligibles have an annual income of $15,000 or less, compared to 42% of the general Medicare population.
>
> 7. The dually eligible population is also much less educated than the general elderly Medicare population. . . . 30% of them completed only fifth grade or less compared to about 7% of the general Medicare population. . . . [W]hile almost one-third of beneficiaries in the general Medicare population had some post-high school education, only 7.4% of dually eligible persons reported this.
>
> 8. The dually eligible population is generally less healthy than the general Medicare population. Forty-two percent of them reported being in fair to poor health compared to only 21% of the general Medicare population.
>
> 9. About 54% of dually eligible patients . . . had . . . trouble with their vision. . . . compared with the general Medicare population (38%).
>
> 10. Nearly 48% of dually eligible patients . . . [have] problems with their hearing, compared with 42% of beneficiaries in the general Medicare population.
>
> 11. As beneficiaries move through the normal aging process, they tend to become more limited in their activities of daily living (ADLs). ADLs are activities related to personal care and include bathing or showering, dressing, getting in and out of bed or a chair, using the toilet, and eating. Dually eligible patients tend to have more problems conducting their activities of daily living without help than do the general Medicare population, and this is an increasing trend as dually eligible people age . . . .

Indeed, 13% of dually eligible persons have difficulty performing *one* ADL as opposed to 8% of all Medicare beneficiaries. This gap widens as a person's disability increases so that 3% of all dually eligible people have difficulty performing *five* ADLs as opposed to only 1% of the general Medicare population. In addition, "a much larger proportion of dually eligible people also reported knowing little about how to stay healthy compared to the general Medicare population. . . . "[29]

[29] Edder.

Thus, the picture of the dually eligible Medicare-Medicaid population is largely an older, poor, female population with a large percentage of minorities. These people frequently live alone, have few educational skills, poor vision and hearing, are generally in poor health, and have difficulty performing their ADLs. Many of these characteristics meet the definition of a "qualified individual with disabilities" described in the Americans with Disabilities Act.

William Scanlon, Director of Health Financing and Systems Issues of the Health, Education, and Human Services Division, testified in 1997 before the Senate's Special Committee on Aging and agreed that dually eligible people are vulnerable and poor:

> [M]any [dually eligible people] are in poor health, with over 20% residing in nursing homes. . . . Dual eligibles are among the most vulnerable Medicare beneficiaries. . . . By definition dual eligibles are poor: About 20% have annual income of less than $5,000 a year, 80% have an annual income of less than $10,000.
>
> Compared with Medicare-only beneficiaries dual eligibles are more likely to:
> 1. Live in a nursing home or live alone;
> 2. Have a serious and chronic condition, and physical or cognitive impairment; and
> 3. Have less access to a regular source of care and preventative services, and higher use of emergency room care.[30]

In his testimony before the Senate Committee on Finance in 1999, Massachusetts Governor Argeo Celluci confirmed that dually eligible patients are an expensive population:

> Government officials project that Medicare spending will surge over the next quarter century from 12% of federal expenditures to more than 25%. . . . Dually eligible beneficiaries are . . . an expensive population . . . Medicare and Medicaid spend about the same amount for dually eligible beneficiaries. In 1997 Medicare spending for dual eligible beneficiaries totaled $62 billion. That same year Medicaid spending for this population totaled $58 billion. Combined Medicare and Medicaid spending for dually eligible beneficiaries averages over $20,000 per person.[31]

A Profile of Dually Eligible Seniors in Massachusetts in 1995 described Massachusetts' experience with dually eligible people:

> Nearly two-thirds (64%) of dually eligible seniors reside in the community, with the remainder in a nursing facility or other long-term

[30] Scanlon.
[31] Cellucci, Argeo. Financing Medicare. US Cong. Senate. Committee on Finance. May 5, 1999. 19 July 2001 <http://finance.senate.gov/5-5cell.htm>.

institutional setting. . . . [T]he overwhelming majority of dually eligible seniors are women (78%) . . . [A] much higher percentage of elderly, dually eligible women (35%) than men (20%) are age 85 and above.

Consistent with national data . . . dually eligible beneficiaries are in much worse health than Medicare-only beneficiaries. Compared to other Medicare seniors dually eligible seniors [in Massachusetts] are:

1. 10-50% more likely to have diagnosis of acute myocardial infarction, arthritis, asthma, bronchitis, enteritis/colitis, esophageal disease, gastrointestinal bleed, ischemic heart disease, liver disease or osteoporosis.
2. 51-100% more likely to have a diagnosis of cardiovascular disease/stroke, chronic obstructive pulmonary disease, chronic renal failure, diabetes, digestive disorder or ulcer;
3. Two to three times more likely to have a diagnosis of alcohol/drug disease, chronic heart failure, depression, hip fracture, paralysis or Parkinson's Disease;
4. Three to five times more likely to have a diagnosis of Alzheimer's disease, amputation, epilepsy or psychosis; and
5. Greater than five times more likely to have a diagnosis of dementia, mental retardation, or schizophrenia.

Differences in disease prevalence rates between dually eligible seniors and other Medicare seniors are, in large part, related to Medicaid eligibility criteria [i.e., being poor]. While many seniors are eligible for Medicaid because their incomes do not exceed a specified threshold ('the income eligible'), many others do not become eligible for Medicaid until they become sick and incur high out-of-pocket medical expenses, and spend-down their income and assets to specified standards (the 'medically needy' or 'spend-down' population). This spend-down process generally does not occur until after admission to a nursing facility, where out-of-pocket costs can quickly exhaust a beneficiary's savings. Consequently, prevalence rates for diseases frequently associated with the need for institutional care, such as Alzheimer's disease, are likely to be higher for dually eligible seniors than for Medicare-only population. Conditions that are more common among seniors age 85 and over, who are more likely to need institutional care than other seniors, will also be more prevalent among the dually eligible population. . . .

Differences in service use between dually eligible Medicare beneficiaries and Medicare-only beneficiaries generally reflect the differences in the health status . . . . Compared to other Medicare beneficiaries, dually eligible beneficiaries have:

1. 10 to 50% more visits to a nephrologist, neurologist, and physical medicine and rehabilitation specialist; and units of outpatient lab and diagnostic radiology services.
2. 50 to 100% more days of Medicare home health, inpatient acute care and outpatient emergency services; and visits to a primary care physician and multi-group practice;
3. Two to three times more days of inpatient emergency care and Medicare hospice services; and
4. Greater than three times more days of Medicare SNF [Skilled Nursing Facility] services, Medicare-covered long-term care hospital services, and inpatient psychiatric services; and visits to a geriatrician, optometrist, podiatrist, a psychiatrist and outpatient therapy.

> In 1995, combined fee-for-service Medicare and Medicaid spending for dually eligible seniors totaled over $2.1 billion [in Massachusetts alone]. The largest share of this spending (45%) was for Medicaid-covered nursing facility services [as opposed to 4.2% which was spent on physicians' services] . . . . Total Medicare and Medicaid spending in 1995 for all dually eligible seniors averaged $1,983 [per person, per month, or $23,796 per person, per year].[32]

The theme that emerges from Massachusetts' experience is that dually eligible persons are a large population with multiple medical problems and illnesses. Many of these patients meet or exceed the impairment definitions of "qualified individuals with disabilities" described in the Americans with Disabilities Act.

Similar demographic and financial data are found in other states that have studied the dual eligibility issue. Pamela Parker, of the Minnesota Department of Human Services, stated:

> People who are dually eligible for Medicare and Medicaid comprise only about 18% of Minnesota's Medicaid enrollees, but they account for as much as 50% of Minnesota's Medicaid costs. 60% of Minnesota's dually eligible seniors reside in nursing homes, and Medicaid is the largest payor of their healthcare costs. . . . In addition, Medicaid acts as a kind of Medigap policy for dual eligibles, paying for the [Medicare] Part B premium and coinsurance and deductibles not covered by Medicare.[33]

The medical costs for dually eligible patients may vary across the states, but the costs are always high. In four New England states, dually eligible beneficiaries comprise only 13% of all elderly and disabled beneficiaries, but account for 41% of combined Medicare and Medicaid spending. "On average, each dually eligible elderly beneficiary

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[32] Perrone, Christopher, and Daniel Gilden. Profile of Dually Eligible Seniors in Massachusetts 1995. Massachusetts Division of Medical Assistance and JEN Associates. Mar. 1999.

[33] Parker, Pamela. States Face Major Obstacles in Integrating Financing and Service Delivery for Persons Dually Eligible for Medicare and Medicaid. US Cong. Senate Special Committee on Aging. Apr. 29, 1997. 18 July 2001 <http://aging.senate.gov/hr3pp.htm>.

costs the federal government nearly four times as much as each Medicare-only elderly beneficiary." Long-term care, or nursing home care, accounts for one-half of the combined Medicare and Medicaid costs for these states' dually eligible elderly population, and one-quarter of the combined costs for dually eligible adults with disabilities.[34] Also, in 1995, "Texas paid more than $83 million in Medicare deductibles and copayments for dually eligible Medicare-Medicaid recipients."[35]

HCFA has acknowledged that the healthcare costs of dually eligible persons are more than double the healthcare costs of non-dually eligible persons. Their costs are so "inflated because almost one-third of them were part- or full-year nursing home residents." However, if all dually eligible nursing home residents were excluded from this cost analysis, the per capita healthcare spending for dually eligible persons in 1995 was still 56% higher than the per capita spending for non-dually eligible Medicare beneficiaries.[36]

The basic mission of home health care has changed from short-term, post-hospital convalescent care, to a program that cares for many vulnerable, chronically ill patients in a long-term home setting, as opposed to a nursing home setting. Because many of these patients are elderly and chronically ill, home health agencies deal with large populations of dually eligible patients. According to HCFA, "Dual eligibles accounted for 36% of Medicare's . . . home health care services."[37] This is one reason program costs for home health services have soared.

Similar to other healthcare arenas, the same medical, socioeconomic, and demographic dual eligibility issues repeat themselves in the area of home health care. Compared to Medicare-only beneficiaries, dually eligible patients who receive home health services are more likely to be poor women who live in poor communities, and who are in poor physical and psychological health. They are more likely to be "ethnic/racial minorities" and are on multiple medications. They are more likely to "be referred from and discharged to an inpatient setting." Dually eligible patients receive "significantly more skilled nursing and home health aide services. In addition, the dually eligible patient appeared to rely more heavily on formal rather than informal caregivers."[38]

In addition to the elderly, Medicare is also awarded to persons who are disabled. In 1995, 14% of all Medicare beneficiaries were under age 65 and were disabled, or had

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[34] Bratesman, Stuart, and Bill Brooke. Dually Eligible Beneficiaries in New England. New England States Consortium, Oct. 26, 1999. 13 Aug. 2001 <http://nesc.muskie.usm.maine.edu/chrtbook.htm>.

[35] Texas. Texas Comptroller of Public Accounts. Texas Performance Review. FR3: Reduce Medicaid Overpayments. Austin: [1997?]. 22 July 2001 <http://www.window.state.tx.us/tpr/tpr4/c6.fr/c603.html>.

[36] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population: Data from the 1995 Medicare Current Beneficiary Survey. <http://www.hcfa.gov/surveys/mcbs/PubHHC95.htm>.

[37] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

[38] Spriggs, Aubrey, Maryam Navaie-Waliser and Timothy Peng. Dually-Eligible vs. Medicare-Only Home Health Care Recipients: A Comparative Study of Characteristics and Needs. American Public Health Association. 129th Annual Meeting. Atlanta: Oct. 24, 2001. Poster board. 21 Aug. 2001 <http://apha.confex.com/apha/129am/techprogram/paper_25173.htm>.

end-stage renal disease.[39] A large number of disabled beneficiaries are dually eligible. According to HCFA, in 1997 only 9% of all *non-dually* eligible persons received their Medicare on the basis of being disabled, as opposed to 28% of *dually eligible* persons who were under 65 and received Medicare benefits because of a disability. Nearly one-quarter of dually eligible persons lived in nursing facilities as opposed to only 2% of non-dually eligible persons.[40] Future growth in Medicare is most likely to occur in this disabled group, as well as the "old-old" population group.

Many dual eligibility themes have been documented and unchanged for 20 years. A report focusing on elderly, dually eligible people in 1978 found similar population patterns. In 1978 dually eligible people were older than non-dually eligible Medicare beneficiaries, and 71% of dually eligible people were women. It also demonstrated that "the proportion of persons of minority races was four times as great as the proportion in the remaining population." The study indicated "that the death rate was 50% higher for dually entitled [i.e. dually eligible]" persons. The report ends by musing, "Perhaps the excess morbidity and mortality of the poor as they enter their senior years, reflect a lifetime of poor nutrition, housing, and other non-medical factors that are believed to influence health status."[41] This is as true today as it was in 1978.

HCFA has recognized that "the dual [eligible] population exhibits many characteristics that are either direct indicators or correlates of low socioeconomic status, and high morbidity and mortality rates."[42] Their health problems are tightly commingled with the socioeconomic problems of the world in which they live. Their healthcare costs are so great because their medical problems are multiplied by the social problems of being poor. Liu, Long and Aragon summarized this issue by stating, "The vast majority of the higher Medicare costs of dually eligible beneficiaries relative to other Medicare enrollees were attributable to demographic, health, and disability characteristics."[43]

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[39] Gage, Barbara, Marilyn Moon and Sang Chi. "State-Level Variation in Medicare Spending." Health Care Financing Review 21 (1999): 85-98.

[40] United States. Dept. of Health and Human Services. HCFA. Characteristics and Perceptions of the Medicare Population.

[41] McMillan, Alma, et al. "A Study of the 'Crossover Population': Aged Persons Entitled to Both Medicare and Medicaid." Health Care Financing Review 4 (1983): 19-46.

[42] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

[43] Liu, Korbin, Sharon K. Long and Cynthia Aragon. "Does Health Status Explain Higher Medicare Costs of Medicaid Enrollees?" Health Care Financing Review 20 (1998): 39-54. Abstract. AARP AgeLine Database Accession #79315, Record #63403. 9 Sept. 2001 <http://research.aarp.org/cgi-bin/starfinder/9709/ageweb.txt>.

"SECOND-CLASS MEDICARE"
HOW DO MEDICARE–MEDICAID "CROSSOVERS" WORK?

For dually eligible patients with both Medicare and Medicaid benefits, Medicare is always the "first payer" and sets the payment rates. A claim for medical services first goes to Medicare, who then tells the physician, the patient and each state's Medicaid department what it calculates each service is worth using its own Relative Value Scale.

Medicare is an earned benefit. Although Medicare payment rates are generally lower than private insurance payment rates, the Medicare payment schedule is a workable standard to pay physicians for their work — a standard by which patients can get the care they need and by which physicians can still keep their doors open and pay their staff. In contrast, the significantly lower rates paid by Medicaid often result in patients having difficulty finding physicians to accept them as patients.

Medicare rarely pays the patient's entire bill. After the patient pays an annual $100 deductible, Medicare will pay 80% of its allowed amount, and the patient is responsible for paying the remaining 20% coinsurance of the bill. In the past, the portion of the Medicare deductible and coinsurance that was not paid by Medicare, was paid by Medicaid when the dually eligible patient's claim was crossed-over and sent from Medicare to Medicaid for payment.

Figure 2 shows the January 2000 pre-budget cut situation — *with crossovers*. In this example an 80-year-old dually eligible woman with diabetes, hypertension, arthritis and Alzheimer's disease comes to see a physician as a new patient in January 2000. This is a 45-minute, new patient, level 4 office visit, CPT code 99204. Medicare says that this 45-minute office visit has an allowed amount of $126. Medicare pays its portion first, then the medical claim is automatically crossed over to Louisiana Medicaid, which pays the rest of the patient's Medicare deductible and coinsurance. In this January 2000 situation the total payment of $126 is exactly the same amount that Medicare said it should be because of the Medicare-Medicaid crossover program. In this situation all Medicare beneficiaries, whether they are dually eligible or not, are able to receive the same 100% of their promised Medicare benefits.

Figure 3 shows an entirely different situation. Here it is one month later, in February 2000, after the *crossovers have been eliminated*. Here is the same 45-minute new patient office visit. Medicare still "allows" $126 for this service. On the left of Figure 3, with the "Medicare Deductible NOT Met," Medicare first subtracts the $100 yearly deductible from the $126 allowed amount, and then pays 80% of the remaining $26, for a payment to the physician of $20.80. The claim is then sent to Louisiana Medicaid to pay its portion of the remaining balance of $105.20. This time, however, Medicaid says in essence, "I don't care if Medicare says this physician service which takes 45 minutes should be paid $126. We are going to pay this service as if this dually eligible patient had *only* Medicaid insurance and not *both* Medicare and Medicaid. Therefore, the maximum Medicaid payment for this service, including the money Medicare has already paid to you, the physician, is $34."

Figure 2.

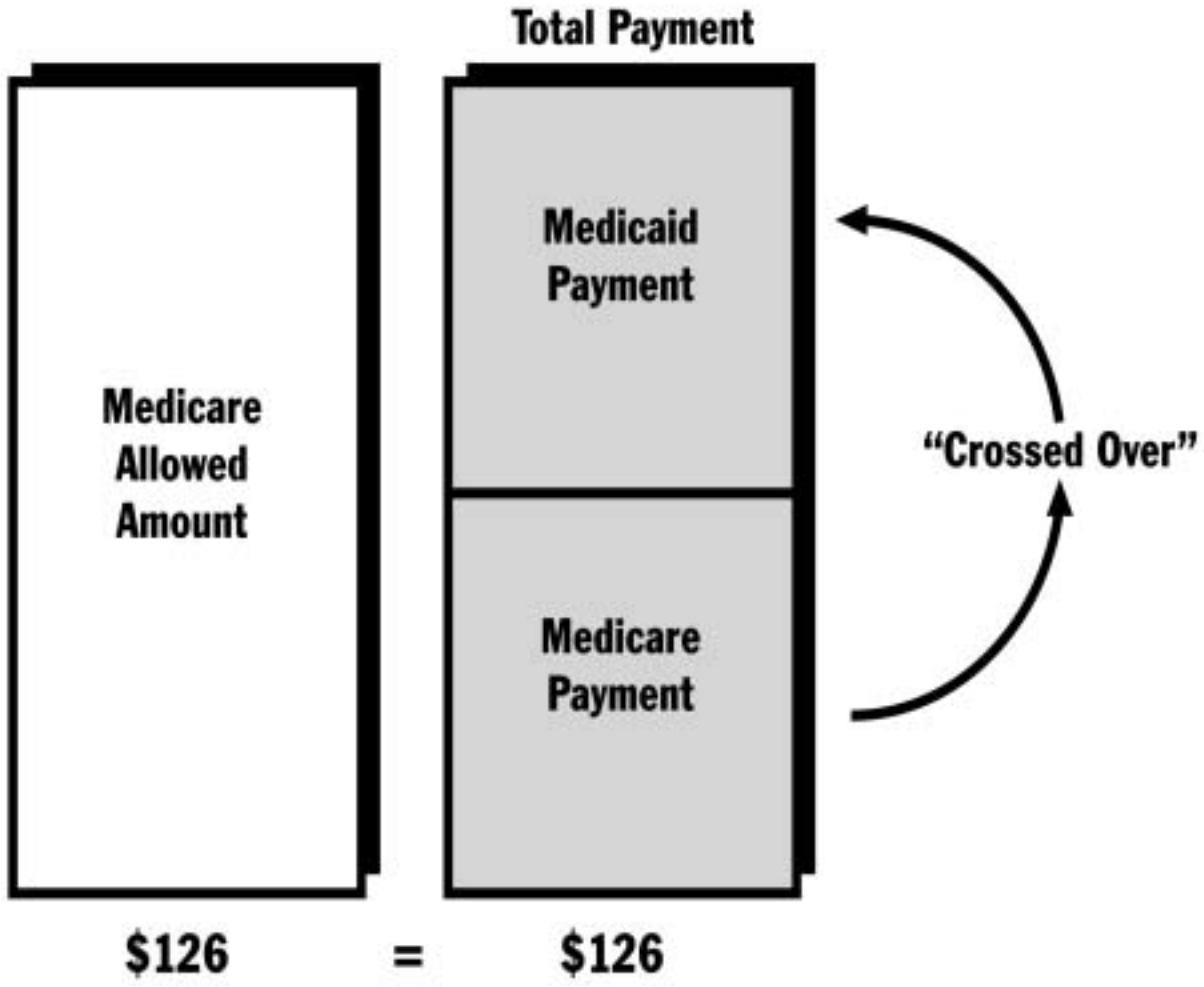
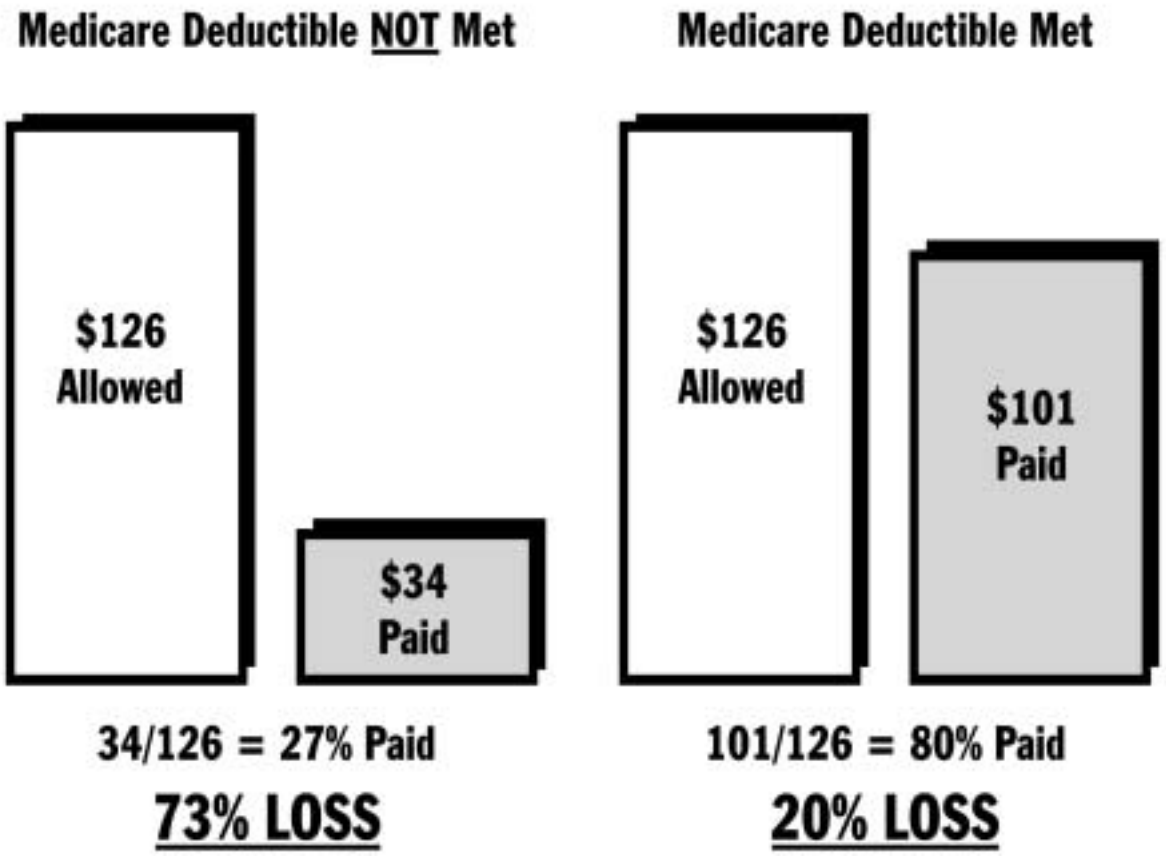

How Crossovers Work:
January 2000–With Crossovers
80-Year-Old Woman
Diabetes, Hypertension, Arthritis, Alzheimer's Disease
New Patient – 45-minute Office Visit – Level 4
Total Payment
Medicaid Payment
Medicare Payment
Medicare Allowed Amount
"Crossed Over"
$126
=
$126

Figure 3.

How Crossovers Work: February 2000–Without Crossovers

45-minute Office Visit for the Same New Patient as in Figure 2.



In this instance, instead of the $126 that the physician and the patient were promised by Medicare, the physician is receiving only $34 or 27% of what he or she had received only one month earlier. Because the State of Louisiana has stopped paying for the crossover payments, and the physician is forbidden by law to bill the patient for this amount, this loss of $92 or 73% of the Medicare allowed charge can never be recovered. Is it any wonder that a physician may now want to screen all new dually eligible patients to see if their deductible for the year has been met before deciding to accept them as new patients? *Insurance reimbursement does affect patient access to medical care*. Dually eligible patients whose care is only reimbursed at 27% of the Medicare allowed charges simply cannot get equal access to medical care.

On the right of Figure 3, with the "Medicare Deductible Met", Medicare pays 80% of the $126 allowed amount, which is $100.80. The claim is then sent to Medicaid who then says essentially, "Since you have already received $100.80, which is more than the $34 you would have received if the patient was a Medicaid-only patient, I'm not paying you anything more." In this instance, with the deductible already met, the physician would be receiving 80% of the amount he or she had received one month earlier. Although certainly better than losing 73% of the payment, having the patient's deductible met still amounts to a minimum loss of 20% on every dually eligible patient the physician sees for the remainder of the calendar year.

This 20% to 73% loss on most geriatric services will have varying effects on physicians' practices. The larger the number of dually eligible patients in a physician's practice, the larger the loss the physician, and the physician's patients will suffer. A pediatrician or obstetrician who does not treat many dually eligible patients may lose close to zero. A geriatrician, or any physician, who deals with large numbers of frail, dually eligible patients, will be more adversely affected. A geriatrician with a large nursing home practice may lose thousands of dollars each year, because 70% of his or her patients in nursing homes may be dually eligible.

This is the opposite of what our society intended. Treating frail, complicated, time-consuming patients should be rewarded, not punished by the imposition of a geriatric penalty. And the more difficult, time-consuming and costly a medical service is, the more income each physician will lose, because this geriatric penalty will take a larger bite out of any medical service that has a larger allowed amount as determined by Medicare.

Prior to Louisiana's recent abolition of Medicare-Medicaid crossover payments there were two general categories of patients receiving government-sponsored insurance coverage. The first category was Medicare, and the second category was Medicaid. By abolishing crossover payments the State of Louisiana has created a new, third category of patients in Louisiana: Second-Class Medicare patients. These are dually eligible patients who have both Medicare and Medicaid insurance, and who are now permanently reimbursed by a second-class payment schedule that lies between the Medicare payment rate and the Medicaid payment rate.

For the first part of each year these patients' insurance payments will be equal to the lower Medicaid payment schedule until their medical bills reach the $100 Medicare deductible level. Until the $100 deductible level is reached, a physician will have a *loss that may exceed 80%* of the Medicare allowable payment, depending on the medical service. (See the chapter titled, "My Response to This 'Geriatric Penalty,'" and Attachment 2: Inability to make house call letter.) The beginning of each calendar year is financially a difficult time for physicians treating these patients because Louisiana has effectively turned all of these Medicare patients into Medicaid patients.

Turning dually eligible Medicare patients into Medicaid patients means that at the beginning of each year these patients may experience the same difficulty obtaining access to health care as Medicaid-only patients, because many physicians find the Medicaid payment schedule inadequate and do not actively participate in the Medicaid program. Although 99% of Louisiana physicians accept Medicare patients and Medicare fee assignment,[44] a much smaller number of physicians accept Medicaid patients and Medicaid fees. The Times-Picayune reported that a study by the Louisiana Hospital Association demonstrated "less than 10% of Louisiana doctors actively participate in the [Medicaid] program."[45]

After the deductible has been met, Louisiana turns these Medicare patients into Second-Class Medicare patients, and the physician loses 20% of the Medicare payments. The physician is expected to absorb these losses without comment, and without altering his medical practice or patient population.

This revenue loss will increase each year as Medicare, but not Medicaid, updates its reimbursement schedule. Unlike Medicaid payments, Medicare payments are adjusted each year to keep pace with the increasing costs of office overhead, malpractice insurance, etc. As the Medicare payments usually increase each year the crossover payments would have increased each year also. In October 2000, HCFA announced that physicians would receive a 4.5% increase in Medicare payments beginning in January 2001. Losing the Medicare-Medicaid crossovers now means that physicians will usually lose more crossover money in the future.

Physicians may lose financially, but dually eligible patients suffer a loss in their access to medical care. Physicians, who must function as businessmen in order to successfully run a medical practice, frequently make decisions about which patients to see in their medical practice based partly on insurance reimbursement. Physicians, such as myself, may be able reluctantly to shift the focus of their practice away from treating poorly paying, time-consuming dually eligible patients who carry this geriatric penalty. As a result, however, these dually eligible patients may have no way to increase their

[44] Kaiser Family Foundation. State Health Facts Online: Louisiana: Medicare Assignment Rates for Physician Services, 1998. 5 May 2002 <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Louisiana&category=Medicare&subcategory=Medicare+Access+to+Services&topic=Medicare+Assignment+Rates>.

[45] Anderson, Ed. "Sales tax losing temporary status." The Times-Picayune [New Orleans] 17 Nov. 2001: A4.

medical access because they can never offer the same 100% insurance reimbursement of non-dually eligible patients, even if they wanted to pay the physician themselves.

The impact of Medicare-Medicaid crossover payments on the financial well-being of a physician's medical practice is difficult to judge unless the physician has a good understanding of his or her billing and payment practices. In a limited Orleans Parish Medical Society poll, our medical society asked if physicians intended to decrease any service or access to dually eligible patients because of the Medicaid crossover budget cuts. One colleague replied that he was upset and as a result would decrease services to younger Medicaid-only patients, but not to the elderly, Medicare and Medicaid patients. This illustrates how difficult this issue is to grasp, because this physician is incorrect. At the same time the State of Louisiana and DHH eliminated the crossover payments for frail, dually eligible persons, they increased the payments for many younger, Medicaid-only patients. It is only frail, dually eligible patients who carry the burden of this geriatric penalty.

Although the loss of crossover payments appears on the surface to be a financial issue, we must all understand that patient access to medical care and physician insurance reimbursement are two sides of the same coin. Patients with poor insurance reimbursement have more difficulty finding physicians to care for them. Paradoxically, these dually eligible Second-Class Medicare patients are the oldest, poorest, sickest, and most disabled citizens of our nation and can least afford any decreased access to efficient, cost-effective medical care.

THE "RULE OF 62S" AND PSYCHIATRIC CARE FOR DUALLY ELIGIBLE PERSONS

Many patients feel stigmatized if they carry a diagnosis of psychiatric illness. This bias against the mentally ill was enacted into law in the Medicare "rule of 62s." It is also embedded in countless other private medical insurance policies that pay less for psychiatric care than for other types of medical care. Ordinarily, Medicare will pay 80% of its allowed amount. However, when it comes to follow-up visits for patients with a psychiatric diagnosis, Medicare invokes its "rule of 62s", which states the 80% of the allowed amount is to be further multiplied by 62.5% (hence the "rule of 62s"). This decreases the Medicare payment to 62.5% of 80%, which equals exactly *50% of the allowed amount.* Because the patient's diagnosis is psychiatric, the patient is responsible for the remaining 50% of the bill. If the diagnosis were non-psychiatric, the patient would only have been responsible for 20% of the bill.

Although psychiatric care under Medicare is more costly to the patient because of the lower Medicare payment rate, all patients including patients with psychiatric illness were still able to access their full benefit by paying a larger share of their bill. Prior to February 2000, dually eligible patients could still receive their 100% Medicare benefit, because Medicaid would pay the remaining 50% of the bill that Medicare did not pay. But since these Medicare-Medicaid crossover payments were eliminated in February 2000, the most that physicians serving these impoverished patients with psychiatric illness can now receive is a 50% payment. The law forbids physicians from billing these patients for the remainder.

In a report on the mental health of minority populations, Dr. David Satcher, the Surgeon General of the United States, stated, "ethnic and racial minorities face large and troubling disparities in mental health care . . . Minorities . . . 'suffer a disproportionate burden of mental illness' because people in those groups often have less access to services than other Americans, [and] receive lower quality care . . . ." As a result of racism and discrimination, patients may receive inaccurate diagnoses or receive inappropriate treatment. African Americans are more likely to receive the incorrect diagnosis of schizophrenia, rather than the correct diagnosis of depression or other mood disorder.[46]

Medicare beneficiaries who are disabled on the basis of *mental* illness are younger, poorer, and more socially isolated than *physically* disabled beneficiaries. They are also more likely to be minorities, and more likely to be dually eligible for Medicare and Medicaid. Medicare beneficiaries who had a mental disability were less likely to have a regular physician and "were less satisfied with the overall quality of care, availability of after-hours care, follow-up care, and coordination of care; and were more likely to report unmet needs, owing in large part to [physician] supply barriers."[47]

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[46] Goode, Erica. "Mental health services for minorities lagging." The Times-Picayune [New Orleans] 27 Aug. 2001: A9.

[47] Rosenbach, Margo. "Access and Satisfaction Within the Disabled Medicare Population." Health Care Financing Review 17 (1995): 147-67.

These people already had difficulty obtaining medical care prior to the recent elimination of crossover payments for mentally and physically disabled dually eligible people. The additional 50% reimbursement loss for Louisiana's dually eligible Medicare patients with psychiatric illness can only aggravate this already worrisome situation.

MY RESPONSE TO THIS "GERIATRIC PENALTY"

The imposition of this "geriatric penalty" has already decreased medical access and discourages the practice of geriatric medicine in this time of unprecedented geriatric population growth. As a direct result of the elimination of Medicare-Medicaid crossover payments, I have been forced to decrease two parts of my geriatric practice. The first change was to stop accepting new dually eligible patients as home patients. I will continue to see them if they can be transported to my office, but I no longer make home visits to new dually eligible patients.

As a geriatrician I have always prided myself on making house calls to my elderly patients. It is a valuable service that helps families stay together and keeps patients out of the emergency room, hospital and nursing home. It is the archetypal geriatric service. It frequently centers on preserving the frail senior's function and comfort, and often includes a family discussion on the case management of the bed-bound senior. (See Attachment 1: "Budget cuts hit doctors hard, putting poorest patients at risk."[48])

According to the American Public Health Association, their Physician House Call Program deals with elderly, homebound patients with multiple chronic medical problems who are unable to travel to the physician's office. Their program improved primary care access in the patient's home and had a "positive impact on patients." The house call program also resulted in "better medication and health management, and provided caregivers with knowledge and empowerment."[49]

This service, however, is the first service that I was forced to curtail now that the budget for these frail patients has been cut. In January 2001, I sent a letter to the daughter of a 95-year-old, bed-bound, dually eligible patient with Alzheimer's disease, stating that I was no longer able to make a house call to see her mother because, by eliminating crossover payments, the State of Louisiana had *cut the reimbursement for this service by 81%*. (See Attachment 2: Inability to make house call letter.) For a 45-minute home visit for a new patient, level 3, CPT code 99343, Medicare has promised the patient and the physician an "allowable amount" of $133. But with this dually eligible patient's deductible not being met in January at the start of the year, instead of receiving the promised $133, Medicaid will insist on paying the physician a total of $25.20, a loss of 81%.

This is a very unattractive situation for a physician. Can I justify getting into my car at the end of my day and driving down to the Industrial Canal or Central City to spend 45 minutes with a patient and their family for $25? Even if I would like to continue this

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[48] Bonura, Chris. "Budget cuts hit doctors hard, putting poorest patients at risk." New Orleans City Business 8 Jan. 2001: 12-13. <http://www.neworleanscitybusiness.com/archives/search_at.asp>

[49] Muramatsu, Naoko, Edward Mensah and Thomas Cornwell. Physician House Call Program: Structure, process and intended/perceived outcomes. American Public Health Association. 129th Annual Meeting. Atlanta: Oct. 24, 2001. Poster board. 3 Sept. 2001 <http://apha.confex.com/apha/129am/techprogram/paper_23101.htm>.

service, I can no longer continue to provide it and stay in business. If the patient's deductible had already been met, the situation might seem a little better because then I would lose 20% of the amount I had been promised instead of 81%. This improvement, however, is still not ideal for the patient or the physician.

Here I am in a no-win situation. I lose either way I go. If I do not see the patient, then I feel I am being a bad doctor. But if I do see the patient, then I feel I am being a bad businessman. I dread receiving telephone calls from bed-bound dually eligible patients who have multiple geriatric problems, who are on multiple medications, and who have no transportation and little family support, asking me to make a house call because they are just not physically able to come to my office. Rather than be caught again in this hopeless no-win situation, I have chosen to just stop accepting any new homebound dually eligible patients into my geriatric practice. Unfortunately, the New Orleans population that my decision affects the most is the same population that makes up the bulk of dually eligible patients in my practice — poor, elderly, African-American females with significant disabilities. (See the chapter titled, "Dual Eligibility Statistics from My Medical Practice.") In this instance they are also bed-bound, and have significant cognitive or physical disabilities. This protected, though now excluded, population easily meets the ADA definition of "qualified individuals with disabilities."

I am frequently able to manage an elderly, bed-bound dually eligible senior at home with the help of a home health agency. The home health agency does the hands-on work, and I supervise the medical care and the case management. This allows the patient to "age in place" for as long as possible, and keeps the patient out of the hospital and out of the nursing home. But in the case of the 95-year-old patient described above, I could not enlist the services of a home health agency. In order for me to order Medicare home health services for a homebound patient, I must have previously seen the patient within the last six months before ordering the service. Because of the elimination of Medicare-Medicaid crossover payments, I am unable to see the patient at home, and so I am also unable to order home health services for this patient.

By cutting back 81% of the reimbursement for a new home visit to this 95-year old, bed-bound patient, Medicaid makes it necessary for this patient to be seen in the emergency room where the costs will be multiplied and the care will be impersonal. From there the patient may be admitted to the hospital and finally wind up in a nursing home at great cost to the patient and her family, and to Louisiana and our nation. The ambulance transportation charge alone is over $200 each way. And, according to Medicare rules, if the patient is not admitted to the hospital, the daughter of this poor, elderly, dually eligible patient who has both Medicare and Medicaid insurance will have to pay for the return trip herself.

The second change I have been forced to make to my geriatric practice, as a direct result of the elimination of Medicare-Medicaid crossover payments, involves the elimination of part of my geriatric office hours. As opposed to home visits, which are only a small part of my practice, the bulk of my geriatric practice consists of ambulatory, or office-based medical and geriatric care. Beginning in January 2001, with the start of the new "deductible year", I decreased my geriatric clinic office hours by 10%. For one

day out of each two-week period, I no longer see geriatric (i.e., dually eligible) patients in my office. Instead, I do other medical work for which the financial reimbursement is better.

On the surface this may not seem like a significant change. But considering the demographic makeup of the dually eligible population in New Orleans, this 10% decrease affects primarily old, poor, African-American women, and the mentally and physically disabled. This is the same group that is affected by my decision to stop making new home visits on dually eligible patients. (See the chapter titled, "Dual Eligibility Statistics from My Practice.") If the physicians next door to me do the same thing, then who is left to treat these frail, vulnerable patients except the local emergency room? And yet, these patients who may not be physically or mentally able to protest these subtle budget cuts, still have two government-sponsored insurances.

This loss of medical access for dually eligible patients must be a statewide concern. Two months after the State of Louisiana eliminated Medicare-Medicaid crossover payments, Medicaid sent a "Provider Update" to all physicians:

> We [the Medicaid department] have begun receiving calls asking if it is acceptable to refuse to accept Medicaid when a patient has both Medicare and Medicaid. [Medicaid then warned that] a provider may not refuse to accept Medicaid in this circumstance. HCFA . . . mandates acceptance of assignment under Medicare for individuals who are eligible for both Medicare and Medicaid. Additionally . . . if a Medicare beneficiary is also a recipient of Medicaid, the provider must accept assignment of claims for services rendered . . . .[50]

How will I respond to future changes in these programs? If the April 2000 President's Health Insurance Proposals offer any guidance, then my future choices will be clear. If these proposals were to become law, I would be forced to decrease my geriatric practice further:

> After Social Security, Medicare and Medicaid are the largest federal entitlement programs. . . . This fiscal year, Medicaid will spend about $115 billion on health care for 43 million low-income people . . . . And Medicare will pay for the health care of some 39 million elderly and disabled people at a gross cost of about $221 billion. . . . Together, these [programs, in addition to the $2 billion SCHIP program for uninsured children,] . . . will account for about 18% of federal outlays in 2000.
>
> CBO [Congressional Budget Office] estimates that total Medicaid enrollment will rise from 43 million in 2000 to almost 51 million by 2010. . . .

[50] Louisiana. Dept. of Health and Hospitals. Louisiana Medicaid Provider Update. Baton Rouge: Vol. 17, Apr. 2000. 2.

> In the decades after 2010, Medicare spending will grow more rapidly, as the baby boomers begin to turn 65. Between 2010 and 2030, the elderly population will increase at a rate three times faster than between 2000 and 2010. Medicare costs are likely to keep growing considerably faster than program enrollment . . . .
>
> [Therefore, the President suggested beneficiaries] pay more for Medicare services by indexing the Part B deductible to inflation and requiring coinsurance payments for clinical laboratory services. . . . Under the President's proposal . . . beginning in 2003 . . . the deductible would be $103, rising to $122 in 2010 . . . . [Also, the President's proposal] would impose the standard [Medicare] Part B deductible and 20% coinsurance requirement on clinical laboratory services . . . .[51]

This proposal would have a disastrous effect on dually eligible patients and their physicians. Any attempt to increase the Medicare deductible without funding crossover payments will result in a further diminution of physicians' already low payment for this groups' medical services. Recall that at the beginning of the year, when the dually eligible patients' deductibles have not been paid, Medicaid pays for their services at the lower Medicaid rate — as opposed to Medicare's higher rate — effectively turning these Medicare patients into Medicaid patients. Increasing the Medicare deductible means that it will take longer for dually eligible patients to meet their deductible. Physicians will receive the lower Medicaid reimbursements and may lose up to 80% of dually eligible patients' payments for a longer time each year, until the higher deductible is met.

Clinical laboratory services are currently exempt from the Medicare deductible and coinsurance requirement. These services are paid in full by Medicare and are not affected by the elimination of crossover payments. If these services are brought under an annual deductible and coinsurance umbrella, then dually eligible patients and their physicians will again suffer a loss. In Louisiana, for example, Medicare reimburses $3 for blood collection. Medicaid pays nothing for this service and pays a lower rate for almost all other clinical laboratory services. If these laboratory services required a deductible and coinsurance, then in the absence of crossover payments physicians would begin to lose up to 100% of blood collection payments and lesser amounts of other clinical laboratory payments.

Although these dollar amounts are small, there is no medical service that a physician can afford to perform indefinitely with no payment in return. If the President's proposals were placed into law, I would have to reevaluate whether or not to keep my small in-office laboratory open. It makes little sense to send all of my dually eligible Medicare-Medicaid patients to the hospital to have their urine or blood sugar checked, or to draw their blood work, when I can easily do this in my office in a matter of minutes. However, receiving no payment for these services, or receiving payment for these

[51] United States. CBO. An Analysis of the President's Budgetary Proposals for Fiscal Year 2001. The President's Health Insurance Proposals. Washington: April 2000. <http://www.cbo.gov/showdoc.cfm?index=1908&sequence=3&from=5>.

services at a reduced Medicaid rate makes even less sense. This would be particularly difficult for dually eligible patients because so many of these patients already have almost insurmountable problems with transportation.

The elimination of crossover payments shows the Law of Unintended Consequences at work. The lack of coordination between the federal Medicare program and the state Medicaid program, which resulted in *changing part of the state Medicaid program, has adversely affected patients in the federal Medicare program.* This damaging lapse was brought about by the Balanced Budget Act of 1997, which allowed states to eliminate crossover payments for dually eligible patients, and would continue with these proposed President's Health Insurance Proposals. Increasing the Medicare deductible or including laboratory services in the deductible and coinsurance calculations will further harm dually eligible patients.

Similarly, Louisiana's attempt to save quick money from its healthcare budget by eliminating crossover payments created a host of complicated problems for many of its most vulnerable citizens. Enacting these new Presidential proposals into law would force me to decrease my geriatric (i.e., dually eligible) office hours further, thereby increasing the disparate discrimination in the current operation of the dually eligible program in Louisiana.

DUAL ELIGIBILITY STATISTICS FROM MY MEDICAL PRACTICE

I have been practicing internal medicine and geriatrics in the Mid-City area of New Orleans for 25 years. I have a large number of old, frail and disabled, dually eligible patients who depend on me for their medical care. I have reviewed my medical practice and patient case mix from January 2000 through December 2000 and will describe the New Orleans population groups that are being harmed by abolishing these crossover payments.

In the medical and geriatric portion of my practice 63% of all my patients had Medicare insurance. Of all these patients with Medicare insurance, 72% or 303 patients had Medicaid and were dually eligible, while 28% of my geriatric practice had Medicare-only insurance. My 72% dually eligible population is a far cry from the national 16% dually eligible Medicare population discussed by Senator Breaux. My geriatric practice is heavily weighted with dually eligible patients who are frail, elderly or disabled persons with multiple medical problems.

Of these 303 dually eligible patients in my practice, 79% are women and 21% are men. This is consistent with previous data showing dually eligible patients are overwhelmingly female.

Of these 303 dually eligible patients in my practice, 34% were under the age of 65 and received their Medicare benefits because they were declared disabled by the Social Security disability program. This is significantly higher than the national 9 - 14% of all Medicare beneficiaries who are under age 65 and are disabled. This number is also higher than the 28% of dually eligible patients nationally who are under 65 and mentally or physically disabled.

Of these 303 dually eligible patients in my practice, 89% were African American and 11% were White. Although previous reports confirmed that minority groups have more dually eligible persons, this number is significantly higher than previously described. African Americans have been reported to be less than 10% of the national Medicare population but represented one-quarter of the dually eligible population. This extreme 89% preponderance of African-American dually eligible patients in my practice probably reflects the demographics of the New Orleans neighborhoods that I serve.

Even more extreme are the racial demographics between the two Medicare populations: the elderly and the disabled. As seen above, only 11% or 32 patients in my Medicare-Medicaid dually eligible practice are White. However, of these 32 White persons, 25 patients are under 65 years of age and receive Medicare benefits because they are disabled, while only seven of my White patients receive Medicare because they are elderly. Therefore, of all my *elderly* dually eligible Medicare-Medicaid patients, 96% are elderly African Americans, and only 3% are elderly Whites.

I stopped accepting new homebound dually eligible patients into my medical practice because crossover payments for these patients were eliminated. For the two-year period from January 1999 through December 2000, I performed 78 home visits to dually

eligible patients. *One hundred percent* of these visits were to the homes of African-American patients. Although most of these home visits were to *elderly* African-American patients, *100% of them were also disabled*, as defined by the ADA, because they were all bed-bound and/or homebound due to severe medical problems. This is one part of my practice that I regret having to stop due to Louisiana's discriminatory actions, but shifting the focus of my practice away from complicated, time-consuming dually eligible patients seems the best way to stem my losses.

My medical practice in the middle of New Orleans has a large number of dually eligible patients who have lost from 20% to 80% of their insurance reimbursement because of this geriatric penalty. This drastic reduction in payment has led, at least in my geriatric practice, to a reduction in access to medical care for our most vulnerable citizens. If *any* physician who treats dually eligible patients is forced to decrease access to geriatric patients in New Orleans, the majority of the people whose access will be injured will be elderly, poor, African-American women, and mentally or physically disabled persons. These people are protected under the Civil Rights Act and the Americans with Disabilities Act, and yet are the populations most affected by the geriatric penalty brought about by the crossover elimination.

DUAL ELIGIBILITY AS A MARKER FOR POVERTY

Women, minorities, the elderly and the disabled are all over-represented in the ranks of dually eligible people in New Orleans. The single unifying theme that underpins these groups' dual eligibility is poverty. In general, as a group's income decreases that group's health problems increase. According to the National Center for Health Statistics, in 1995, Louisiana citizens "in the lowest income group [were] more than seven times as likely to assess their health as poor than those with the highest income."[52]

1. The elderly, dual eligibility, and poverty

According to the Congressional Research Service,[53] the older a Medicare beneficiary was, the more likely that person was dually eligible. In the youngest "elderly Medicare" cohort of 65 to 69 years old, only 10% of all Medicare beneficiaries were dually eligible. This percentage increases with age, until in the oldest Medicare cohort of persons 85 years and older, over 25% of all Medicare beneficiaries were dually eligible. In order to be dually eligible, a patient must be old or disabled, as well as poor and have Medicaid. Since the youngest 65-to-69-year-old cohort already has Medicare, it does not matter if they become older or more disabled because it cannot affect their Medicare insurance. Therefore, the only remaining variables are being poor and having Medicaid.

Is it possible for dually eligible patients who already have Medicaid to simply outlive non-dually eligible Medicare beneficiaries so that the dually eligible population percentages appear greater in "old-old" age? This is doubtful. African Americans, who represent a significant percentage of dually eligible people, frequently die at a younger age than White persons.[54] Also, dually eligible persons in the past had a higher death rate than non-dually eligible persons.[55] The only way this large percentage of 85-year-olds can become dually eligible is to become impoverished and become Medicaid-eligible. Senior citizens, who become poorer with age, become eligible for Medicaid and dual eligibility as they get older.

2. Women and poverty

Dually eligible persons are overwhelming female. Older women outnumber older men and are generally poorer. According to the AARP, older women have more chronic illnesses that limit their activities of daily living and need more expensive medications. Older women also use more nursing home and home health services. "Women, on

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[52] Louisiana Hospital Association. Louisiana Health Care Facts. National Center for Health Statistics. Current Estimates From the National Health Interview Survey, 1995. Baton Rouge: Oct. 30, 1998. 14 Aug. 2001 <http://www.lhaonline.org/la_hc_facts.html>.

[53] United States. Cong. House. Committee on Ways and Means. Medicare and Health Care Chartbook. 105th Cong. Washington: GPO, 1997. 81-132. <home.kosha.net/~h1415c/sec3.pdf>.

[54] McClam, Erin. "Study finds six-year gap in races' life expectancies." The Times-Picayune [New Orleans] 14 Sept. 2001: A5.

[55] McMillan.

average, spend a higher percentage of their incomes on health care than do men. The disparity widens with age."[56]

Older women are poorer and have fewer savings than men because they have worked less in the labor force for smaller wages, and have fewer employment pensions than their male counterparts. In 1999, older women had a higher poverty rate (12%) than older men (7%), with a median income of over $19,000 for men, but less than $11,000 for women.

Because women outlive men, older women are less likely to have a spouse than older men — only 43% of women 65 years of age or older are married, as opposed to 77% of men. There were four times as many widows as there were widowers. The older a woman is, the more likely it is that she will be living alone. In 1998, 58% of older women lived in a family setting, as opposed to 80% of non-institutionalized older men. Of all non-institutionalized older persons, 41% of older women but only 17% of older men lived alone. By the time women are age 85 or older, 60% are living outside of a family setting.[57]

Race, female gender, age, poverty, and marital status are all correlated. Among elderly women, unmarried women have the highest risk of being poor. Although only 6% of elderly, married women are poor, 20% of elderly widows and 47% of elderly, separated women are poor. *Women who are members of minority groups are particularly at risk of being poor*. According to the Center on Budget and Policy Priorities, "women of color are some of the elderly people most vulnerable to poverty." Elderly African-American and Hispanic women had a 34% risk of poverty compared to a 13% risk of poverty for elderly White women. "[E]lderly unmarried African American women face a triple threat. Their race, gender, and marital status increase the possibility that they will be poor."[58]

According to a 1999 study of dually eligible persons in Massachusetts,

> the overwhelming majority of dually eligible seniors are women (78%) reflecting the fact that a greater proportion of women than men have incomes below the federal poverty level, and that more women live to an age when long-term care becomes necessary. . . . [Also] when women become severely functionally or cognitively impaired, they are less likely than men to have a living spouse who can care for them in the home.

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[56] Foley, Lisa A., and Mary Jo Gibson. Older Women's Access to Health Care: Potential Impact of Medicare Reform. Executive Summary. AARP Public Policy Institute. Washington: July 2000. 9 Sept. 2001 <http://www.research.aarp.org/health/2000_08_women_1.html>.

[57] United States. Dept. of Health and Human Services. Administration on Aging. Profile of Older Americans: 2000. Washington: GPO, 2000.

[58] Kijakazi, Kilolo, and Wendel Primus. Options for Reducing Poverty Among Elderly Women by Improving Supplemental Security Income. Center on Budget and Policy Priorities. National Academy of Social Insurance 12th Annual Conference. Jan. 27, 2000. 14 Nov. 2001 <http://www.cbpp.org/1-27-00socsec.htm>.

> Once admitted to a nursing facility, they may quickly spend-down their income and assets, and become eligible for Medicaid.[59]

3. The disabled and poverty

Disabled Medicare beneficiaries (i.e. the Medicare population that is under 65 years old) are over-represented in the worlds of poverty and dual eligibility. According to the Congressional Research Service, 41% of disabled Medicare beneficiaries were dually eligible in 1994, as opposed to 13% of aged Medicare beneficiaries. If dual eligibility is a surrogate marker for poverty, then disabled persons had a rate of poverty *three times* the rate of the larger elderly Medicare population. African Americans are approximately 8% of all Medicare beneficiaries, but represented 18% of the disabled Medicare population

This disabled group represents 12% of the entire Medicare population and is growing rapidly. From 1996 to 2015, the elderly population is expected to grow by 31%, while the disabled population is expected to increase by 77%. The Medicare expenses for a disabled recipient in 1995 were 10% higher than the expenses for an aged recipient, partly because the population with costly end-stage renal disease is included in this category. Among the disabled Medicare population, spending is concentrated in a small proportion of beneficiaries. In 1993, only 1% of beneficiaries accounted for almost one-quarter of spending, and 8% accounted for over two-thirds of all spending for disabled beneficiaries.[60]

4. Minorities and poverty

The U.S. Department of Health and Human Services reported that "between 1999 and 2030, the White population 65+ [years and older] is projected to increase by 81% compared with 219% for older minorities, including Hispanics (328%) [and] African Americans (131%) . . . ."[61]

According to a 1995 AARP study of older minorities, "minority groups in the U.S. have increased risks of poor education, substandard housing, poverty, malnutrition, and generally poor health." The minority older population has grown faster than the White older population. In 1990, only 13% of the 65-years-old or older population were non-White. "By 2025, 25% of the elderly population are projected to be non-White, [and] by 2050, 35% are likely to be non-White."

In 1990, 14% of the total White population was 65-years-old or older, compared to 8% of African Americans, and 5% of Hispanics who were 65-years-old or older. Elderly minorities are particularly concerned with healthcare assistance. "Most minority older persons remain in the community and are cared for by family, friends and relatives."

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[59] Perrone.

[60] United States. Cong. House. Committee on Ways and Means. Medicare and Health Care Chartbook.

[61] United States. Dept. of Health and Human Services. Administration on Aging. Profile of Older Americans: 2000.

Although the sex ratio for African-American older persons of 63 men for every 100 women is the lowest of all minority older persons, "Black older persons formed the fastest growing segment of the Black population." Whereas the total African-American population increased only 13% between 1980 and 1990, the African-American *elderly* population increased 20%. More than 50% of elderly African Americans live in southeastern states (such as Louisiana). The percentage of elderly, African-American men who are divorced or separated is more than twice as large as the percentage of elderly White men, and a smaller percentage of elderly African-American men live with their spouses.

Because elderly African Americans grew up in an era where their access to educational resources were extremely limited, "only 27% completed high school as compared to 56% of White older persons." African-American men "are more likely to have experienced periods of unemployment due to discrimination and other causes." They have "lower levels of lifetime labor force participation than Whites [and] also are more likely to leave the work force earlier."

African Americans and other minorities "are less likely to work in professions or jobs with high benefits." African Americans have less education, worked at less skilled jobs for lower salaries, and have longer periods of unemployment. They are, therefore, "less likely to accumulate income, other assets, and/or benefits and pensions" to be used in their later years, and are more dependent upon Social Security benefits. Elderly African Americans have a lower median income than elderly Whites. The income for elderly African-American men is $7,328, compared to $14,775 for elderly White men. Elderly African-American women have an income of $5,239, compared to $8,297 for elderly White women.

In urban areas, one-third of elderly African Americans live in poverty compared to 10% of older White persons. In non-metropolitan areas almost 50% of elderly African Americans live in poverty. In non-metropolitan areas 46% of elderly African-American women live in or near poverty, compared to 16% of elderly White women.

Older African Americans have higher rates of functional impairment and chronic illness, and are more likely to be sick or disabled than elderly White persons. Although the mortality of African Americans at 65-years of age is higher than the mortality of Whites, "Blacks of extreme old age (75+) have lower mortality rates but higher rates of poverty and illness."

This report concluded, "The status of the older minority members is not likely to improve greatly in the immediate future. The factors which largely determine their quality of life (education, employment, income, and health) will not vary much among the minority populations now approaching retirement age."[62]

Women, minorities, the elderly, and disabled people have lower incomes than other populations in the United States. As these segments of our nation grow older, they

[62] Bacon.

have greater chances of falling into poverty and becoming dually eligible.[63] In order to decrease the rolls of dually eligible persons, our national long-term goal should be to prevent these protected populations from becoming poor. If we cannot prevent poverty, then we should at least be certain that these vulnerable groups are medically protected, and are allowed full access to first-class Medicare healthcare benefits.

[63] United States. Dept. of Health and Human Services. HCFA. Medicare Dually Eligible Population.

"MEDICAL REDLINING" OF DUALLY ELIGIBLE PEOPLE IN NEW ORLEANS

The Random House Dictionary of the English Language defines "redlining" as "an arbitrary practice by which banks limit or refuse to grant mortgage loans for properties in blighted urban areas." The term originates from the practice of circling such areas with a red pencil on a map.[64]

"Medical redlining" is illegal, as illustrated by a case in Connecticut. In 1996, the Office of Civil Rights of the U.S. Department of Health and Human Services,

> entered into a formal settlement agreement with the Connecticut Department of Social Services to ensure that home healthcare providers receiving Medicaid funds will not refuse or limit services based on where a person lives, a practice call 'redlining.'

In this case an African American was refused home health services solely because the patient had moved into a predominately Hispanic and African-American housing complex that the home health agency did not want to serve. In the settlement agreement Connecticut agreed to "implement regulations prohibiting racial discrimination by home healthcare providers. It also will ensure that such agencies do not refuse or limit services to individuals based on where they reside . . . "[65] This settlement agreement is consistent with HCFA's Civil Rights Compliance Policy Statement (See the chapter titled, "HCFA's Civil Rights Standards.") Although this case involved a home health agency, the agreement applies broadly to the delivery of healthcare services to all recipients of federal programs.

Dually eligible people in New Orleans are primarily elderly, African-American women, and mentally or physically disabled persons — all groups protected under the Civil Rights Act and the ADA. According to the 2000 U.S. Census, African Americans represent 12% of the total United States population.[66] However, looking at particular geographic areas such as Louisiana and specifically New Orleans, this statistic is deceiving because African Americans are not evenly dispersed across the country. Over 50% of older African Americans are concentrated in the Southeastern United States, an area which 100 years ago Booker T. Washington called the "Southern Black Belt."

According to The Times-Picayune, the "[Southern] Black Belt is an 11-state swath of counties with large Black populations and high poverty rates. . . . stretching across the South from Texas to Virginia." This area, which has been called the "Third World of the United States," has poor physical and social infrastructure, poor employment rates, poor health care access, poor housing, poor educational statistics, and

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[64] "Redlining." The Random House Dictionary of the English Language. The Unabridged Edition. 1979.
[65] United States. Dept. of Justice. Civil Rights Forum Newsletter. Connecticut Agrees to Remedy Title VI Home Health Care "Redlining" Violations. Vol. 10. Washington: 1996. <http://www.usdoj.gov/crt/grants_statutes/forum/winspr96.htm>.
[66] United States. Census Bureau. State and County QuickFacts. Louisiana. July 3, 2001. 20 Aug. 2001 <http://quickfacts.census.gov/qfd/states/22000.html>.

high infant mortality rates. "The Black Belt is one of the most overlooked by the federal government, despite its staggering demographic data. Once home to cotton plantations and slavery, these communities haven't really recovered . . . ."[67]

Within this Southern Black Belt sits Louisiana and New Orleans. (See Figure 4: African-American Population and the "Southern Black Belt."[68]) Although the national percentage of African Americans is 12%, Louisiana, which forms part of the Southern Black Belt, has an African-American population of 33%, and White persons represent 64% of our state's population.[69] In U.S. Congressman William Jefferson's 2nd Congressional District, which includes New Orleans, African Americans are the majority population.[70] And, within the boundaries of the City of New Orleans African Americans are 67% of the city's population, and Whites are only 28% of the city's population, a *reversal of Louisiana's population* statistics.[71]

New Orleans has five City Council Districts numbered A through E, proceeding from west to east across the city. As the Districts go from west to east the percentage of African-American citizens increases almost linearly, while the percentage of White citizens decreases almost linearly. Thus, in City Council District A, which includes several of the city's wealthier areas, the White population is 58% and the African-American population is 39%. Proceeding further east through less affluent sections, the African-American population steadily increases until District E, which contains 84% African-American citizens and only 9% White citizens.[72]

Even in District E with its large preponderance of African Americans, there are areas that stand out demographically. According to The Times-Picayune, Census Tract 9.03 in District E is the "least racially diverse" (i.e., has the most African-American persons) in the city. "With 2,640 residents in the heart of the Lower Ninth Ward, this working-class and virtually all-Black section had the lowest diversity in 2000. . . . The tract's racial breakdown was African American, 2,623 [persons]; White, 3 [persons] . . . ." African Americans accounted for 99.4% of the population and White persons accounted for one tenth of one percent, or 0.1% of this New Orleans' Census Tract's population.[73]

My geriatric practice in Mid-City New Orleans draws patients from several predominantly African-American City Council Districts and neighborhoods and my dually eligible patients are overwhelmingly African American. This Lower Ninth Ward

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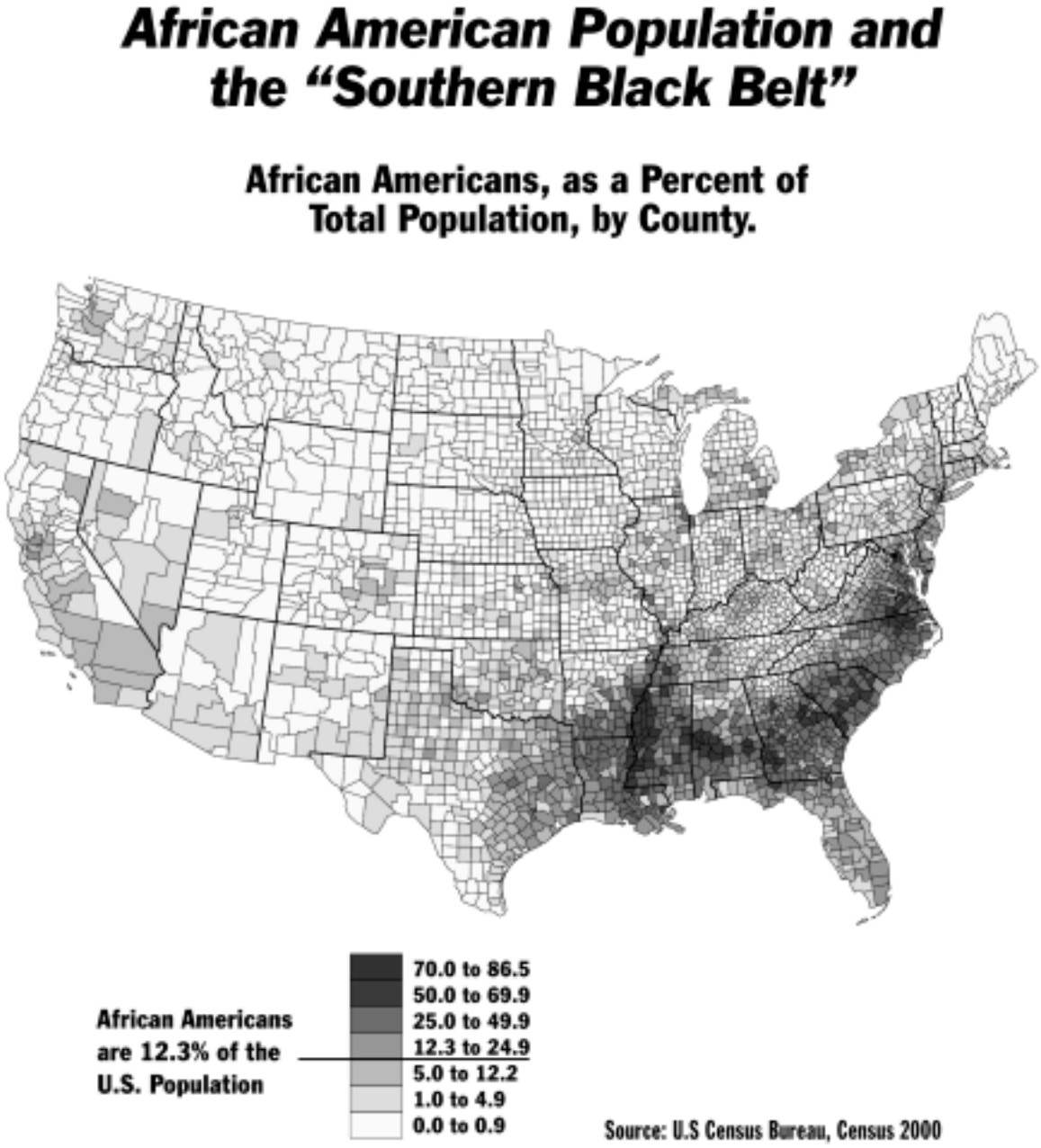
[67] McMurray.
[68] United States. Census Bureau. Mapping Census 2000: The Geography of U.S. Diversity. Percent of Population, 2000. One Race: Black or African American. 2000.
[69] United States. Census Bureau. State and County QuickFacts. Louisiana.
[70] Wardlaw, Jack. "Battle to alter districts fires up." The Times-Picayune [New Orleans] 1 Sept. 2001: A1+.
[71] United States. Census Bureau. Louisiana. Table 5. Population by Race and Hispanic or Latino Origin, for the 15 Largest Parishes. 2000. 3 Sept. 2001 <http://www.doa/state.la.us/census/2000/largestplaces2000.htm>.
[72] "Council redraws its voting districts". The Times-Picayune [New Orleans] 8 Sept. 2001: B1-2.
[73] Warner, Coleman, and Matt Scallan. "Census 2000. Going to Extremes." The Times-Picayune [New Orleans] 3 Sept. 2001: A1+

Figure 4.


African American Population and the "Southern Black Belt"
African Americans, as a Percent of Total Population, by County.
African Americans are 12.3% of the U.S. Population
70.0 to 86.5
50.0 to 69.9
25.0 to 49.9
12.3 to 24.9
5.0 to 12.2
1.0 to 4.9
0.0 to 0.9
Source: U.S Census Bureau, Census 2000

Census Tract 9.03 is an area that feeds my practice and is a neighborhood where I have in the past made home visits to elderly, disabled, bed-bound, African-American patients.

In New Orleans, and throughout Louisiana, 12% of the total population is 65 years of age or older.[74] Although New Orleans is an African-American majority city, as the city's population ages, African Americans lose their numeric advantage because they generally die several years earlier than White persons of the same age, largely through illness and by violence.[75] According to the Orleans Parish Health Profile, of all persons 65 years of age or older living in New Orleans in 1997, 57% of the population was White and 42% of the population was African American. As African Americans tend to have a shorter life expectancy, the percentage of African Americans steadily decreases as the population ages until in the 80-years-and-older group, White persons are 64% and African Americans are 35% of the population, a *reversal of the city's racial makeup* as a whole. Also, because African-American men die younger than African-American women, in the 85-years-and-older African-American population, 73% are female and only 27% are male.[76] Hence, the high concentration of elderly African-American women in the dually eligible population in New Orleans.

My Medicare practice contains almost three-quarters dually eligible patients. These dually eligible patients are 89% African American, 79% women, and 34% disabled. Of my elderly, dually eligible Medicare-Medicaid patients 96% are African American, and of my dually eligible home visit patients 100% were African American. The vast majority of my elderly dually eligible practice focuses on treating that *group of "survivors" — elderly African-American grandmothers and great-grandmothers.* By eliminating crossover payments the State of Louisiana and DHH have drawn a line around New Orleans and these dually eligible citizens and have made it impossible for them to obtain their full Medicare benefits. In other areas of the country where poor and minority populations are more evenly dispersed, giving only some citizens a second-class ticket for health care may spread the pain more evenly and may not affect these protected groups so severely. But here in New Orleans the pain is spread very unevenly.

Looking again at the definition of redlining and changing some of the words, this discrimination case becomes clearer. **This case of medical redlining is about "an arbitrary practice by which the State of Louisiana** ('banks') **limits or refuses to grant full access to Medicare benefits** ('mortgage loans') **for dually eligible citizens** ('properties') **in the New Orleans municipal boundaries** ('blighted urban areas'). . . ."

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[74] United States. Census Bureau. State and County QuickFacts. Orleans Parish, Louisiana. July 3, 2001. 3 Sept. 2001. <http://quickfacts.census.gov/qfd/states/22/22071.html>.
[75] McClam.
[76] Louisiana. Dept. of Health and Hospitals. Office of Public Health. Parish Health Profile 1999: Orleans Parish. New Orleans: 1999. 107-88. <http:www.dhh.state.la.us/oph/php/default.htm>.

DISABILITY ACROSS THE SOUTH

In addition to the elderly, Medicare is awarded to persons who are mentally or physically disabled. Thirty-four percent of my dually eligible patients are under 65 years old and disabled. None of them has end-stage renal disease. This number is 21% higher than the 28% of the national dually eligible population who are under 65 years old and disabled. This population is expected to increase in the future.

According to a Census Bureau report,[77] the overall national disability rate in 1991-1992 was 19%. This disability rate increased with increasing age so that 54% of persons 65-years-old and older had a disability. In the 85-years-old and older group, 84% of all persons had a disability, and 68% of this "old-old" group had a "severe disability."

The statistics on the disabled population are consistent with other statistics on aging, gender, poverty, and dual eligibility:

> The longer life expectancy of women means that women make up a relatively large share of older persons with a disability (64.2% of persons 65 years old and over with a severe disability are women). . . . The presence of a disability is associated with lower levels of income and an increased likelihood of being in poverty. . . . [T]he proportion of persons falling into the below-poverty category was . . . 24.3% among those with a severe disability. . . .
>
> A large proportion of persons receiving public assistance benefits have disabilities. . . . The disability rate was 48.2% among food stamp recipients and 30.7% among those living in public or subsidized housing.

The greater a person's disability, the more likely that person has Medicare and/or Medicaid and is dually eligible.

According to information from the 1999 US Census Disability Data, there is what I refer to as a "Southern Disability Belt" in the United States. Figure 5 is a Census Bureau map illustrating the distribution of non-elderly (i.e., age 16- to 64-years-old) people in the United States who have a disability. Although the national average is 19%, the Census map demonstrates a large clustering of states where the percentage of non-elderly people with disabilities is "25% and over," an increase of *at least 32% above the national average*.

This clustering of states is again across the Southeastern United States, and is *the same area of our country as the Southern Black Belt.* In the age category of 15- to 64-years-old, the national disability rate for African Americans was 18% higher than the disability rate for White persons. The number of disabled African Americans is high in

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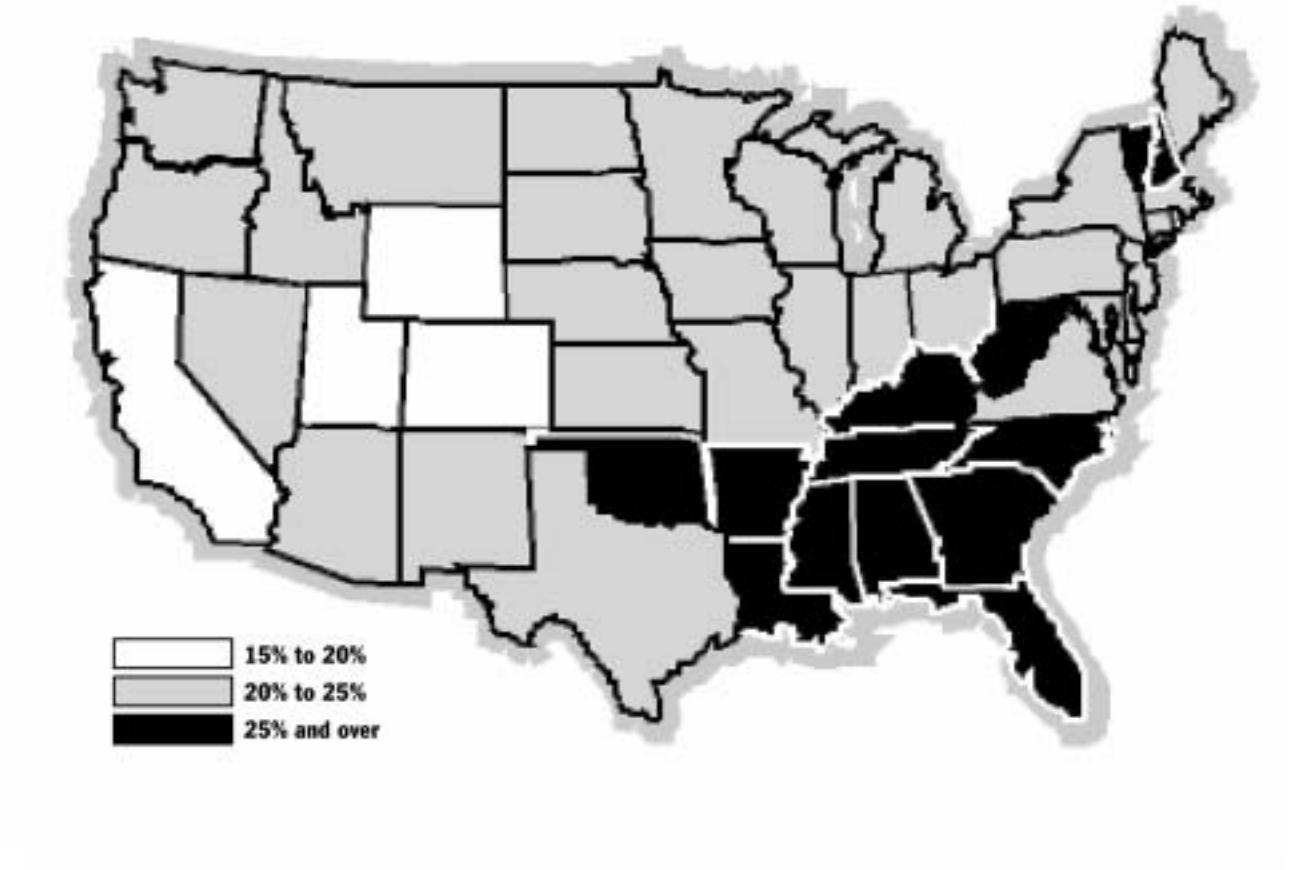
[77] McNeil, John. Disability. US Census Bureau. Population Division and Housing and Household Economic Statistics Division. Jan. 18, 2001. 15 Nov. 2001 <http://www.census.gov/population/www/pop-profile/disabil.html>.

Figure 5.

The "Southern Disability Belt"

Percentage of People with Any Disability, In the 16- to 64-year-old Population, by State, in 1990



Source: U.S. Census Bureau, Census Diability Data, 1999

the Southeastern United States where large numbers of African Americans and disabled persons live.

As with the Southern Black Belt, New Orleans and Louisiana also sit within the Southern Disability Belt and carry a large disability burden. One-third of my dually eligible patients receive Medicare on the basis of being mentally or physically disabled, rather than on the basis of being elderly. This large number is consistent with the demographics of Louisiana's and New Orleans' disabled population. According to Louisiana's Office of Public Health,

> People living with any disability will experience greater medical costs and have more problems with access to care than people without a disability. . . . The U.S. Census Bureau . . . [estimated] that 24.5% (46 million) of persons 16 years old and older in the U.S. had some disability in 1990 . . . . In Louisiana 30.2% (913,041) of people 16 years old and older had a disability of some kind. *In [New] Orleans the estimate was 33.8% percent (122,950).*
>
> Additionally . . . [the] percent of non-institutionalized civilians in . . . [Louisiana] aged 16 to 64 [who] had a disability that prevented them from working . . . [was estimated to be] 5.9% or 149,556 people. *In [New] Orleans it was 6.7% (20,305)* . . .
>
> The number of disabled, mentally ill and elderly in an area is often under-reported. Those populations are usually less visible. . . . For some persons with disabilities, the quality of their lives depends on the prescriptions, technology, medical care and PA [personal attendant] services that they receive. . . . [Persons with disabilities] often have high, ongoing demand for health services. . . .
>
> On average, persons with disabilities spend more than four times as much on medical care, services and equipment as their non-disabled counterparts. While persons with disabilities make up between ten and 20% of the non-institutionalized population, they account for 47% of medical expenditures. These individuals see a physician an average of 14 times per year. Persons with disabilities who lack health insurance coverage utilize health care services much less frequently than those who do have insurance . . . .
>
> Another cause of disability is increased frailty brought on by aging. Bones can break more easily and chronic diseases can limit mobility, sight, hearing or clarity of thought. The population of elderly is growing in Louisiana. . . . *Nearly one in five elderly people in Louisiana live[s] in poverty* . . . . The population of elderly is predicted to nearly double by the year 2020 . . . .

> In 1995, over one-third of the elderly reported they were limited by chronic conditions. . . . Disabilities are much more common in the elderly.
>
> Poverty can be especially hard on the elderly. *Over the period of 1994-96 almost 18% of the elderly in Louisiana were living in poverty*. . . . For women, minorities and those living alone, this rate is even higher . . . . Poverty impacts health and well-being and is related to increased disability. Seventy-one percent of low-income elderly experience a disability [as opposed to] forty-eight percent of the overall elderly population . . . . It is estimated that the number of elderly with disabilities in the U.S. will grow to around 10 million by the year 2020 . . . .[78]

HCFA has acknowledged that "the average expenditure by a functionally disabled beneficiary was nearly three times higher than that of other Medicare beneficiaries living in communities in 1995 . . . [and that disabled persons] are much more likely than other [Medicare] beneficiaries to have problems obtaining [medical] care."[79]

In 1998, 14.1% of all Medicare beneficiaries in the United States were under 65-years-old and disabled. In Louisiana, however, the percentage of Medicare beneficiaries under 65-years-old who were mentally or physically disabled was 18.5% — an increase of *31% above the national average*.[80]

Disability, minorities and poverty are companions. Because Louisiana and New Orleans sit within the Southern Disability Belt, our state and our city have increased numbers of *non-elderly* dually eligible Medicare beneficiaries who are mentally or physically disabled, in addition to large numbers of *elderly* disabled dually eligible people. I am not asking for any special benefits for Louisiana's disabled dually eligible population. On the contrary, all that I am asking is that Louisiana DHH restore the crossover benefits and provide a benefit *equal* to that of non-dually eligible Medicare beneficiaries. Louisiana DHH is a governmental agency charged with protecting the health and well-being of all our citizens, the disabled as well as the robust. If Louisiana citizens carry an extra burden of disability, then at least provide adequate medical access for these citizens, and allow the physicians of Louisiana a chance to care for them.

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[78] Louisiana. Dept. of Health and Hospitals. Office of Public Health. Parish Health Profile 1999: Orleans Parish.

[79] United States. Dept. of Health and Human Services.HCFA. Health and Health Care of the Medicare Population.

[80] Green, Lisa H., Don F. Cox and Kathryn M. Langwell. Medicare State Profiles: State and Regional Data on Medicare and the Population It Serves. Barents Group. Washington: Kaiser Family Foundation, Sept. 1999. 5 May 2002 <http://www.kff.org/content/1999/1474/StateFacts.pdf>.

DID LOUISIANA ANALYZE THE EFFECTS OF THIS BUDGET CUT?

Did Louisiana DHH undertake a thorough analysis of the impact of this budget cut on elderly and disabled dually eligible citizens prior to eliminating Medicare-Medicaid crossover payments? According to HCFA, dually eligible people already had significant medical access problems prior to this latest budget cut:

> [The dually eligible population] was less likely to maintain a usual relationship with a doctor. Dual eligibles are less likely to have a regular source of health care, and they are four times more likely to meet their health care needs by seeking temporary help at places such as emergency departments, hospitals, or outpatient departments. . . . They were twice as likely to report difficulties in obtaining health care, and much more likely to delay health care due to cost. . . .
>
> [They] exhibited patterns of care related to inadequate disease management, such as higher rates of emergency department visits within a year for the same health problem, more frequent hospital admissions, and significantly higher rates of institutional care. The practice of substituting emergency medical services for regular health care is indicative of serious access problems. It raises issues about the lack of complete and quality disease management, because emergency room patients are often treated to [only] stabilize their conditions [and f]urther medical measures to manage their health care problems are not provided . . . ."[81]

Louisiana citizens already visit our state's emergency rooms 36% more than the national average, and are admitted to our state's hospitals 29% more than the national average.[82] As access to physicians' services decreases, emergency room visits, hospitalizations and nursing home placements will further increase as a result of the elimination of crossover payments. The 95-year-old, bed-bound, dually eligible patient with Alzheimer's disease whom I could not accept as a home patient in January 2001 is only one of several homebound patients that I have had to turn away. These unfortunate people will eventually have little choice but to wind up in New Orleans' emergency rooms, hospitals, and nursing homes for late-stage care that is far more expensive than regular, early-stage care by a physician. (See Attachment 2: Inability to make house call letter.)

Unfortunately, this issue was apparently not analyzed in detail before the budget cut was implemented. Officials at the Louisiana DHH as well as the Bureau of Health Services Financing have indicated that Louisiana was essentially in an emergency situation and had to take quick action to shore up its budgetary shortfall. Eliminating

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[81] United States. Dept. of Health and Human Services.HCFA. Health and Health Care of the Medicare Population.

[82] Kaiser Family Foundation. State Health Facts Online: Louisiana: Providers & Service Use, 2000. 5 May 2002 <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Louisiana&welcome=1&category=Providers+%26+Service+Use>.

these crossover payments was an obvious choice and a choice that other states had already taken.

What did Louisiana do with these emergency budgetary savings? Four months after the State of Louisiana eliminated the $23.5 million crossover payments for our elderly and disabled dually eligible population, Louisiana DHH "allocated an additional $20 million to increase reimbursement rates" for Medicaid beneficiaries,[83] most of whom are younger, "less expensive", non-dually eligible patients. Louisiana cut the physician payments for the oldest, poorest, and sickest patients in our state, and used 85% of this "savings" to pay for younger Medicaid patients. As a result, Louisiana DHH only realized a 15% budgetary savings — a total of $3.5 million, only 30% of which actually comes out of the Louisiana treasury — by eliminating crossover payments for our most frail citizens.

According to the Louisiana Register, "as a result of the . . . [crossover payment] reduction, some providers may find it necessary to reduce staff or staff hours of work."[84] Obviously the State of Louisiana knew that the reduction in payments would have some effect on physicians' behavior. But rather than "reduce [my office] staff" whom I depend upon daily, I have been forced to decrease access for the frail, vulnerable people who are affected by this budget cut. Instead of working so intensely with poor, dually eligible patients, I have increased medical access for patients with better medical reimbursement.

The State of Louisiana did not eliminate crossover payments for all physicians. The Louisiana Register states, "Medicare . . . claims for . . . hemodialysis and transplant services are excluded from this limitation of [crossover payments]." Hemodialysis and transplant services are specialized, visible and centralized services performed by only a limited number of physicians. According to the Louisiana Bureau of Health Services Financing, "Hemodialysis and transplant services were excluded from the . . . [Medicaid crossover elimination] because the Bureau felt that *it was inappropriate to limit access* to these services [emphasis added]."[85] Rather than risk a public outcry when medical access to these services became more limited, Louisiana wisely chose to continue paying for these services' crossover payments.

[83] Hood, David. Letter to the author.
[84] Louisiana. Office of the State Register.
[85] Victor, Sandra. Letter to the author. 5 Nov. 2001.

DUAL ELIGIBILITY AND LOUISIANA POVERTY

The key variable that will increase the number of dually eligible persons is poverty of which Louisiana has no scarcity. According to The Times-Picayune, the 2000 Census showed that from years 1998 to 2000 Louisiana's median household income actually declined by 5%.[86] In his July 2001 testimony before the U.S. Senate Special Committee on Aging, David Hood, Secretary of Louisiana DHH, described the poverty and medical burdens of our state's elderly citizens:

> By almost all measures, Louisiana's elderly are among the poorest and the most vulnerable in the country. According to federal statistics, the percentage of older people with incomes below the poverty level is second highest in the nation.
>
> The difference between Louisiana and the national average for poverty rates for seniors is almost double — 24.1% in Louisiana versus 12.8% nationally (Census 1990). And, we do not expect this statistic to get better. In fact, it is just the opposite — as our population ages, the number of those people living in poverty is expected to increase. This is also true for elderly people with disabilities . . . .
>
> Louisiana is third in the number of elderly citizens receiving Medicaid (17.3% in Louisiana versus 11.1% nationally.) We have a high proportion of elderly citizens who live alone. We have the second highest potential demand for publicly funded long-term care.
>
> Research suggests that the two most important resources for baby boomers to take into their later years are income and education. But in Louisiana, these are scarce resources. Compared to baby boomers nationwide, that same group in Louisiana has lower household incomes and lower educational levels.
>
> When these facts are combined with the outward migration of an able-bodied, well-educated workforce, the increased life expectancy, high poverty rates, expenses associated with aging, increased healthcare costs and other factors, Louisiana is facing a critical future when it comes to caring for older citizens.
>
> Compared to the rest of the nation, Louisiana continues to rank near the bottom . . . . Adjusted for age, we rank first in the death rates for diabetes and cancer, and we rank in the top 10 for other chronic diseases such as heart and cerebrovascular diseases. . . .
>
> There are a number of factors that contribute to our poor health status. Of course, our high poverty rate is the key factor. Other factors

[86] "State poverty rate steady, data show." The Times-Picayune [New Orleans] 26 Sept. 2001: A2.

> include: A continued lack of access to primary care . . . [T]he fourth highest rate of people who rely on public insurance (Medicare and Medicaid). [We have] very poor lifestyle factors: [such as] high rates of smoking and obesity, poor diets, [and] poor rates of exercise. . . .
>
> Louisiana ranks 49th of the 50 states in using home and community-based care services. . . . Because of this over-reliance on nursing home care, there is an oversupply of nursing home beds while there are people who must wait years for community-based services. . . . For many elderly citizens, nursing homes have been the only option in Louisiana." [87]

According to The Times-Picayune, Louisiana leads the United States in poverty, just as New Orleans leads Louisiana in poverty. The Census Bureau estimates that 20.3% of people in Louisiana live below the poverty line, compared with 12.5% of Americans nationally who live in poverty, "meaning Louisiana's poverty rate is more than a third higher than the nation's average. . . . [The state demographer] said the majority of the state's poor are concentrated in New Orleans and in the rural parishes of northeast Louisiana."[88]

Another recent article in The Times-Picayune announced "[New] Orleans' health is worst in [the] region," and described our city's poor health climate and its relationship to poverty. A health department spokesman said "we have to find a way to . . . provide people the health care they need before their illness becomes so great that they need hospitalization . . . Higher rates of certain illnesses in areas such as New Orleans . . . are attributable to larger numbers of poor residents in those areas . . . ."[89]

In a 1999 national report, Louisiana ranked 50th, at the bottom of the list of healthiest states, partly because of its lack of access to medical care:

> A major explanation for Louisiana's poor health status is the lack of access to routine and preventive health care. . . . Accessibility and availability of primary care practitioners . . . also pose a significant problem in the delivery of health care in the state. . . . In lieu of a primary care physician, many people seek care at hospital emergency rooms.[90]

In this study 23% of Louisiana citizens lacked access to a primary care physician. Louisiana ranked second only to Mississippi in having the poorest access to primary care physicians. The problems of dually eligible people have deep roots in Louisiana's poverty. Decreasing medical reimbursement for our elderly and disabled poor by eliminating crossover payments will worsen Louisiana's medical access problems.

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[87] Hood, David. Caring for Our Aging Citizens: The Louisiana Perspective. US Cong. Senate. Special Committee on Aging. July 18, 2001.
[88] Russell, Gordon. "Louisiana is setting a poor example." The Times-Picayune [New Orleans] 8 Aug. 2001: A1+.
[89] Ritea, Steve. "Orleans' health is worst in region." The Times-Picayune [New Orleans] 6 Apr. 2001: A1+.
[90] Louisiana. Dept. of Health and Hospitals. Office of Public Health. Division of Health Information. State Center for Health Statistics. 2001 Louisiana Health Report Card: Louisiana State Health Care System. Baton Rouge: Feb. 19, 2001. 173-95. <http:www.dhh.state.la.us/oph/statctr/default.htm>.

DISPROPORTIONATE SHARE PAYMENTS — IN REVERSE

Congress recognized that low-income persons have higher medical costs but lower insurance reimbursement, and created "Disproportionate Share Hospital" (DSH) payments. This program was designed to compensate hospitals that treat a greater proportion of low-income patients for the greater costs they incur. According to the AARP the DSH payments, which are paid to facilities through Medicare Part A, are "viewed as serving the broader purpose of ensuring continued access to hospital care for Medicare beneficiaries and low-income populations."[91]

Congress also "required states to make additional Medicaid payments to hospitals that provide treatment for a 'disproportionate share' (DSH) of low-income patients." In Fiscal Year 1998/1999 Louisiana's Disproportionate Share Hospital payments totaled $784 million, which represented 24% of the total $3.28 billion Medicaid budget.[92]

The federal government gives extra money to Louisiana to compensate for the extra medical costs of its poor citizens. Louisiana, however, is keeping this extra federal money and not using it to compensate medical providers who actually treat these costly, low-income persons, many of whom are dually eligible. On the contrary, by eliminating crossover payments for dually eligible patients, the State of Louisiana and DHH are imposing a geriatric penalty and *subtracting* a "disproportionate [dually eligible] share" from providers who care for these poor persons. This action perverts the stated purpose of disproportionate share payments and injures Louisiana's dually eligible citizens.

[91] Caplan, Craig. FYI: Medicare's Disproportionate Share Hospital Payments. AARP Public Policy Institute. Washington: Aug. 1998.
[92] Boyd.

"MEDICAL REDLINING" ELSEWHERE

Population demographics similar to New Orleans exist elsewhere in Louisiana and across the United States. Louisiana has the third largest African-American population in the nation.[93] All three of Louisiana's largest cities, New Orleans, Baton Rouge, and Shreveport have African-American majority populations.[94] Other states may have a majority of White persons similar to Louisiana, and still have cities where "minority groups" form the majority population. For example, the wealthy State of New Jersey has a population consisting of 73% White, 14% African American and 13% Hispanic people. But in the poor, inner city of Newark, the White population is only 27%, the African-American population is 54% and the Hispanic population is 30%. Similarly, although the wealthy State of Connecticut has an 82% White majority, the poor, inner city of Hartford is only 28% White and 72% African American, Hispanic and other minorities.[95]

A city or rural area containing large numbers of poor minority citizens may also contain disproportionate numbers of old, poor, African American and/or Hispanic, female and disabled citizens. The New York Times, in discussing this issue states that "poverty remains concentrated in the states' biggest cities . . . . There is . . . a component of racial segregation that goes hand in hand with economic segregation . . . ."[96] There is also a component of "medical segregation" because these areas may experience discrimination and medical redlining of their minority dually eligible citizens, similar to the New Orleans experience.

In 1999, Connecticut eliminated crossover payments for its dually eligible Medicare-Medicaid citizens, just as Louisiana did in 2000. Because of the demographics of Hartford, many of that city's dually eligible people affected by Connecticut's crossover cuts were probably minorities, females or disabled persons, all protected groups under the Civil Rights Act and the ADA.

According to geriatrician Dr. Eric Einstein of the Connecticut State Medical Society, the elimination of crossover payments led to decreased geriatric and medical access and difficulty obtaining appropriate care for frail nursing home patients:

> [M]any physicians have cut back on accepting nursing home patients and many nursing home[s] . . . are finding it increasingly difficult to find qualified primary care and specialist providers to come to the [nursing] homes. I personally have cut back from visiting three nursing homes to visiting just one. The consequence has been that patients entering nursing homes are losing their community based physicians, and medical directors

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[93] United States. Dept. of Health and Human Services. Substance Abuse and Mental Health Services Administration. State Profiles, 1999, on Public Sector Managed Behavioral Health Care. Washington: May 2000.
[94] United States. Census Bureau. Louisiana.
[95] United States. Census Bureau. Quick Tables.
[96] Herszenhorn, David. "Rich States, Poor Cities, And Power to the Suburbs." The New York Times 19 Aug. 2001: 53.

> are finding it increasingly necessary to rely on more expensive venues, such as emergency rooms and hospitals, for specialty care access. . . . The small short-term budget gains will result in a serious long-term impact on the quality of medical care available to our nursing home patients.[97]

The Fairfield County Medical Association in Connecticut conducted a survey of its members to determine the impact on patient access following Connecticut's withdrawal of crossover funding for dually eligible patients. The survey results highlighted the negative effects of this budget cut. Of the nearly 500 responses,

> 42% of physicians have limited, reduced, or stopped accepting any new dually eligible patients. In addition, 16% of the respondents indicated they have stopped seeing Medicaid patients in nursing homes and 14% stated they have disenrolled from the Medicaid program. . . .
>
> The reduction . . . is obviously having the unintended effect of significantly reducing access to medical care by those most in need . . . [The Association's Director said that] unless we are successful in Hartford, dually eligible patients, particularly those in nursing homes, are going to find it increasingly difficult to retain the services of their personal physician.[98]

Connecticut's elimination of crossover payments for dually eligible patients saved less than one-half of the money that it was predicted to save. Connecticut State Representative Christel Truglia, who sponsored legislation to reinstate Connecticut's crossover payments, summarized the problems caused by the crossover payment elimination, noting it "is not about physician reimbursement, [but rather] it is about an impending physician shortage and wellness of patients."[99] In response to this budget cut and its resultant decrease in medical access, Connecticut physicians mounted a campaign to reverse the budget cut. They formed a coalition of physicians, patients, legislators and the media, and recently succeeded in restoring crossover payments for dually eligible patients.

The problems of poor, minority, dually eligible people in our inner cities are spread across the nation. There will always be cries to save government money, but states that choose to eliminate crossover payments injure the very citizens they swore to protect.

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[97] Einstein, Eric. Statements of Eric Einstein, M.D. Geriatric Medicine.Connecticut State Medical Society. New Haven: 29 Mar. 2001.

[98] Fairfield County Medical Association.

[99] Connecticut State Medical Society. The Connecticut State Medical Society, legislators, physicians and patients urge the state to act responsibly and restore crucial funds. Press release. Mar. 29, 2001.

CROSSOVER PAYMENTS AND THE BALANCED BUDGET ACT OF 1997

Prior to the Balanced Budget Act of 1997 (BBA), arguments between the medical community and the states' Medicaid Departments — over who was responsible for dually eligible patients' crossover payments — raged in federal court. The states believed federal policy allowed them to eliminate crossover payments, but the medical community believed congress had originally intended for the states' to pay their citizens' crossover claims.

Beginning in 1992, four federal appellate court rulings agreed with the medical community and affirmed the states' responsibility to pay crossover claims for dually eligible persons. According to the American Medical News,[100] in the 1992 landmark federal case the court stated that if medical providers in New York were not reimbursed properly, "providers will . . . refrain from treating the most vulnerable of the elderly and disabled, those who are also poor [i.e., the dually eligible population]." Further, the court stated, "Such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act."

The medical community's support grew, and in 1997, prior to the passage of the BBA, the American Medical News stated, "the AMA [American Medical Association] and a coalition of 42 state medical societies want the Health Care Financing Administration [HCFA] to force every state to cover . . . [crossovers] for low-income Medicare beneficiaries." These medical groups were "pushing 18 states and the federal government to resolve a billing quagmire that has cost doctors several hundred million dollars — and blocked access to care for the poorest of the poor." The AMA's view was that "every beneficiary ought to be entitled to a first-class program. The fact that they're poor shouldn't mean they have a different status."

In response to these court challenges, state governments complained to congress that being forced to pay crossovers would cost them too much money. Congress supported the states' position and enacted legislation in the Balanced Budget Act of 1997, which formally gave the states permission to withhold these contested crossover payments.* Once congress passed this enabling legislation, all pending court cases became moot, and the issue was essentially dropped from organized medicine's agenda.

One month after this legislation was signed, a report by Andy Schneider at the Center on Budget and Policy Priorities noted that the BBA had a "provision allowing states to shift the cost of Medicare deductibles and coinsurance requirements for low-income Medicare beneficiaries [away] from their Medicaid programs [and on]to physicians and other providers." As a result of this provision, federal and state governments were predicted to save large amounts of money over several years. "[Congressional Budget Office] estimates that as a result of this provision, a substantial

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[100] Johnsson, Julie. "Medicine tells states: time to pay fair share of Medicare co-pays." American Medical News 3 Mar. 1997. 27 Dec. 2001 <http://www.ama-assn.org/sci-pubs/amnews/pick_97/pick0303.htm>.

* See the technical note regarding the elimination of Medicare-Medicaid crossover payments in the chapter titled, "Complaint 1: The Civil Rights Act Complaint."

number of states will no longer pay deductibles and coinsurance [crossovers] on behalf of poor Medicare beneficiaries, yielding . . . billion[s] . . . in . . . savings . . . ."

With great prescience Schneider warned of future medical access problems and accurately predicted that physicians would avoid treating poor, sick, and disabled dually eligible people because the BBA eliminated crossover payments and shifted billions of dollars away from providers and into government coffers. This author concluded that without crossover payments, medical providers, hospitals and nursing homes would shun low-income Medicare beneficiaries. This decreased medical access would primarily affect "those poor Medicare beneficiaries who are the sickest or most disabled and have a corresponding need for extensive medical care [i.e., dually eligible patients]. From a provider standpoint, these beneficiaries would carry the largest risk of causing significant amounts of deductibles and coinsurance to go unpaid."[101]

According to a study prepared for the Kaiser Family Foundation, prior to the passage of the Balanced Budget Act of 1997, 31 states reported paying crossover payments at the full Medicare rate. However, in the first two years following passage of the Balanced Budget Act, 15 states stopped paying crossover payments for dually eligible people with Medicare and Medicaid. By 1999, only 16 states continued to pay crossover payments — two-thirds of the states did *not* pay crossovers.

This report stated "payment at the lower rate can restrict access to providers." Without crossover payments providers dropped out of the program or limited the number of dually eligible people they would serve. The report concluded that without crossover payments, "states limit access for [dually eligible people] to only those providers willing to accept that [lower] rate, putting [dually eligible people] at a disadvantage compared to more affluent Medicare beneficiaries [i.e. a two-tiered benefit system]."[102]

The elimination of crossover payments in these 15 states following passage of the Balanced Budget Act of 1997 affected *almost two million dually eligible people* — approximately one-third of the entire dually eligible population in the United States.[103]

Louisiana has now arrived at the situation predicted in 1997. By allowing Louisiana and other states to eliminate crossover payments the Balanced Budget Act of 1997 placed a geriatric penalty on our oldest, poorest and sickest patients, and has decreased medical access for this vulnerable group of people.

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[101] Schneider, Andy. Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33. Center on Budget and Policy Priorities. Revised Sept. 8, 1997. 14 Nov. 2001 <http://www.cbpp.org/908mcaid.htm>.

[102] Nemore, Patricia B. State Medicaid Buy-In Programs: Variations in Policy and Practice. Washington: Kaiser Family Foundation, Dec. 1999. 26 Apr. 2002 <http://www.kff.org/content/2000/1566>.

[103] Kaiser Family Foundation. State Health Facts Online: 50 State Comparisons: Total Dual Eligibles, 2000. 5 May 2002 <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Dual+Eligibles&topic=Total+Dual+Eligibles>.

MEDICAL DISCRIMINATION RESULTS IN UNSATISFACTORY MEDICAL OUTCOMES

Several years ago the State of Wisconsin sued HCFA, alleging it was being harmed by disparities in HMO payment rates for different geographical areas of the state. In a legal brief, Wisconsin affirmed that Medicare must provide equal benefits for all beneficiaries and that *separate but unequal* benefit programs are illegal:

> Medicare was intended, in part, to redress inequities in health care access between different groups of seniors based on income, race, rural residence and age. . . . [T]wo-tier benefit programs [were] previously held unconstitutional. . . .
>
> Judicial deference to . . . an allegedly discriminatory classification . . . decreases as the degree and the duration of the discrimination increase. . . . If the inequalities at issue are great enough and long-lasting enough, they violate equal protection even if the underlying legislative approach is constitutionally valid in theory . . . .[104]

The inequalities caused by eliminating crossover payments for dually eligible patients are "great enough and long-lasting enough." This medical discrimination has been present for decades and has harmed many people. Dually eligible people in 1978 had a 50% higher death rate than non-dually eligible Medicare beneficiaries and were already known to be mostly old, poor, and female, with minority populations significantly over-represented.[105]

Twenty-five years have passed and the same situation exists today. As a result of medical discrimination, people who are old, poor, female, African American, or disabled — code words for dually eligible people — may still receive unequal medical care and experience unsatisfactory medical outcomes. This is in contradistinction to HCFA's Civil Rights Compliance Policy, wherein HCFA pledged to "ensure equal access; prevent discrimination; and assist in the remedy of past acts [of medical discrimination] adversely affecting persons on the basis of race, color, national origin, age, sex, or disability."[106]

Medicare beneficiaries who are racial minorities have more difficulty than White patients do in obtaining medical care. According to HCFA, twice as many African Americans reported having difficulty accessing medical care than White beneficiaries. African American and Hispanic Medicare beneficiaries are also more likely to delay seeking care because of cost, and are also less likely to consult a physician about a medical problem.[107]

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[104] Wisconsin v. DeParle. Plaintiffs Memorandum in Opposition to Motion to Dismiss. Case No. 00-C-0380. US Dist. Ct. East. Dist. WI. Madison: WI Dept. of Justice, n.d.
[105] McMillan.
[106] DeParle.
[107] United States. Dept. of Health and Human Services.HCFA. Health and Health Care of the Medicare Population.

In 1986, the national rate of coronary artery bypass grafting for African-American Medicare beneficiaries was *only 28%* of the rate of White Medicare beneficiaries, and "racial differences were greater in the Southeast . . . ."[108] Similarly, another study of cardiovascular procedures found that "the use of . . . procedures decreased with age and was less common among women and Blacks . . . ."[109]

One study found "Black patients with congestive heart failure or pneumonia received lower quality of care overall than other patients . . . ."[110] And, "African-American patients were significantly more likely than White patients to undergo above-knee, below-knee, and toe and/or foot amputation and significantly less likely to undergo lower-extremity arterial revascularization and . . . angioplasty."[111] Preventative medical services are also underutilized by minority groups. Mammography use was less for women who were older, poor and African American,[112] and "influenza vaccination rates are 21.6% lower among Black [Medicare] beneficiaries compared with White ones."[113]

In addition, use of rehabilitation services was "significantly less frequent among racial minorities, less well educated groups, and the oldest age group. . . . [This] suggests . . . sociodemographic inequalities in the use of rehabilitation services . . . in certain subgroups."[114] And, another study showed that "socioeconomic differences are responsible for the racial differences noted in prostate cancer . . . [and] may result from the many African Americans disproportionately uninsured throughout their lives . . . and thus using services at later stages of disease."[115]

The Health Care Financing Review summed up this issue stating, "Race and ethnicity in the United States are associated with health status. Every major health measure (mortality, morbidity, and disability) indicates that Black persons have poorer health than White persons."[116] In addition to causing needless suffering for African American and other racial minorities, medical discrimination and poor medical access results in increased costs to our nation. According to HCFA,

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[108] Goldberg, KC, et al. "Racial and community factors influencing coronary artery bypass graft surgery rates for all 1986 Medicare patients." JAMA 267 (1992): 1473-77. Abstract. PubMed PMID 1538537.

[109] Udvarhelyi, IS, et al. "Acute myocardial infarction in the Medicare population. Process of care and clinical outcomes." JAMA 268 (1992): 2530-36. Abstract. PubMed PMID 1404820.

[110] Ayanian, JZ, et al. "Quality of care by race and gender for congestive heart failure and pneumonia." Med Care 37 (1999): 1260-69. Abstract. PubMed PMID 10599607.

[111] Guadagnoli, E., et al. "The influence of race on the use of surgical procedures for treatment of peripheral vascular disease of the lower extremities." Arch Surg 130 (1995): 381-86. Abstract. PubMed PMID 7710336.

[112] Burns, RB, et al. "Variability in mammography use among older women." J Am Geriatr Soc 44 (1996): 922-26. Abstract. PubMed PMID 8708301.

[113] Aston, Geri. "Making Medicare color-blind." American Medical News. 3 Dec. 2001: 5-6.

[114] Mayer-Oakes, SA, et al. "Patient-related predictors of rehabilitation use for community-dwelling older Americans." J Am Geriatr Soc 40 (1992): 336-42. Abstract. PubMed 1556360.

[115] Vijayakumar, S., et al. "Prostate-Specific Antigen Levels in African Americans Correlate with Insurance Status as an Indicator of Socioeconomic Status." Cancer J Sci Am 2 (1996): 225. Abstract. PubMed 9166537.

[116] Gornick, Marian. "Disparities in Medicare Services: Potential Causes, Plausible Explanations, and Recommendations." Health Care Financing Review 21 (2000): 23-43.

> African-American beneficiaries had the highest Medicare expenditures compared to other racial or ethnic groups. Medicare expenditures for African-American beneficiaries were at least 40% higher per capita than for any other racial or ethnic group.
>
> Medicare expenditures for African-American beneficiaries in [nursing home] facility care were nearly double that of any other racial or ethnic group in any other living arrangement.[117]

In addition to minority patients having difficulty obtaining access to medical care, the American Medical News recently stated that even "minority doctors struggle to get care for their patients." In response to this problem, the American Medical News notes, "The federal government is undertaking an initiative to wipe out racial and ethnic disparities in health care by 2010."[118]

Eliminating racial and ethnic disparities in health care for dually eligible persons may be difficult, because in addition to the *medical* problems of the elderly and the disabled, dual eligibility inevitably includes the *social* problems of poverty and discrimination. Seventy-two percent of all physicians believe "the healthcare system treats people unfairly . . . based on health insurance status." Also, 77% of African-American physicians believe "race and ethnicity impact how people are treated."[119] As long as medical discrimination of dually eligible patients continues, the medical outcomes for these vulnerable people will be unsatisfactory.

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[117] United States. Dept. of Health and Human Services. HCFA. Characteristics and Perceptions of the Medicare Population.

[118] Adams, Damon. "Minority physicians struggle to get care for their patients." American Medical News. 3 Sept. 2001: 1+.

[119] Kaiser Family Foundation. National Survey of Physicians. Part 1: Doctors on Disparities in Medical Care. Mar. 2002. 25 Apr. 2002 <http://www.kff.org/content/2002/20020321a/Physician_SurveyPartI_disparities.pdf>.

THE MEDICARE-MEDICAID PAYMENT SEESAW AND OUR NURSING HOME BUDGET

The Civil Rights Act complaint requires a demonstration that a less discriminatory alternative exists for the State of Louisiana, and the Americans with Disabilities Act complaint requires Medicaid to make "reasonable modifications" to public programs in order to avoid discrimination. This "less discriminatory alternative" and this "reasonable modification" can both be realized by decreasing Louisiana's nursing home budget.

According to the Louisiana Register, eliminating crossover payments for dually eligible persons was estimated to save $23.5 million in its first year. Because the federal government contributes 70% of Louisiana Medicaid funds, the Louisiana treasury was estimated to save almost $7 million of this $23.5 million, and the federal government would save the remaining $16.5 million.[120]

Although $23.5 million is a significant number, it is small when compared to our total Medicaid budget. In fiscal year 1998/1999, Louisiana's Medicaid budget was $3.384 billion (of which the federal government paid 70%). The budget amount saved by the elimination of crossover payments amounts to seven tenths of one percent (0.7%) of the entire state Medicaid budget. This amount pales when compared to the $504 million, or 15% of the total Louisiana Medicaid budget, spent on long-term care expenditures for nursing homes. It also pales when compared to the $245 million, or 7% of the total Medicaid budget spent on physicians' services.[121]

The Louisiana nursing home budget is both over-budgeted and poorly utilized. According to David Hood, Secretary of Louisiana DHH,

> The current state of long-term care in Louisiana revolves around nursing homes. . . . to almost the near exclusion of other options. . . . '*Louisiana has a very high public demand on long-term care services. The state has the second highest number of nursing home beds per 1000 age 85+ in the nation; however, nursing home occupancy levels and resident acuity levels* [the amount of medical care they require] *are both very low*.' . . . In Louisiana, older residents who might only need intermediate care have few options other than admission to a nursing home.

This huge nursing home budget is particularly onerous for a poor state like Louisiana. Mr. Hood continued:

> In the Medicaid program, nursing home expenditures account for nearly $500 million yearly. . . . [F]or years this consumed the greatest portion of all Medicaid spending in Louisiana. . . .

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[120] Louisiana. Office of the State Register.
[121] Boyd.

> Louisiana spent $109 per capita on nursing home expenditures versus only $1.33 per capita on community-based services. . . . Because of this over-reliance on nursing home care, there is an oversupply of nursing home beds while there are people who must wait years for community-based services.
>
> The challenge for Louisiana . . . is to . . . get ready quick, in order to meet the needs of our aging citizens. . . . The Supreme Court's *Olmstead* decision has motivated states to make community-based services not only a choice, but a reality."[122]

Because nursing homes are very expensive, underutilized, and consume such a large portion of Louisiana's Medicaid budget, this nursing home budget is where most Medicaid savings can be realized. Cutting down this enormous half a billion dollar expense by *only 5%* would more than pay for the complete restoration of crossover payments for Louisiana's dually eligible population.

Medicare and Medicaid pay for most of the healthcare expenses for elderly and disabled dually eligible citizens. In addition to paying all of the costs of Medicare, the federal government also pays more than one-half of all national Medicaid expenses. The federal government, therefore, pays about three-quarters of all Medicare and Medicaid expenses combined. It is the remaining one-quarter of healthcare expenses that each state and its Medicaid department struggle to protect.

In general, Medicare provides coverage for *acute medical care* in the community — in the physician's office, in the hospital, and through home health. Only a small percentage of Medicare dollars is spent for long-term or nursing home care. Medicaid, on the other hand, pays a smaller amount for acute medical care, but pays the bulk of *chronic long-term care* nursing home expenses. Medicaid spends approximately one-third of its entire national budget on the relatively small dually eligible population. And in 1995, 85% of all money spent by Medicaid on dually eligible persons went to pay for their nursing home care, which included non-medical custodial services, such as room and board expenses, and assistance in their activities of daily living. Six percent of Medicaid's dually eligible payments went to pay for prescription medicines. Only 4% of these payments went to medical providers, and 3% went to inpatient hospital services.[123]

Because the Medicare and Medicaid programs have different missions and different funding mechanisms, the most important thing Louisiana can do to decrease the amount of money leaving its treasury is to *maximize* the amount of money spent by Medicare in the physician's office, hospital and through home health, while at the same time *minimizing* the amount of money spent by Medicaid in the long-term nursing care facility. In other words, keep people in the *Medicare-sponsored* community and out of *Medicaid-sponsored* nursing homes.

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[122] Hood, David. Caring for Our Aging Citizens: The Louisiana Perspective.
[123] United States. Dept. of Health and Human Services.HCFA. Health and Health Care of the Medicare Population.

Why is this so, and how can we accomplish this? Figure 6 demonstrates that the Medicare and Medicaid programs sit on a seesaw. On the left-hand side of the seesaw is the Medicare program with the three main services that it pays for: physician office services, hospital services, and home health services. On the right-hand side of the seesaw is the Medicaid program with its main service of nursing home payments. According to HCFA's Health and Health Care of the Medicare Population, for dually eligible people Medicare pays approximately 80% of all government-funded medical services on the left-hand or *community care* side of the seesaw, and Medicaid pays approximately 80% of all medical services on the right-hand or *nursing home* side of the seesaw.[124]

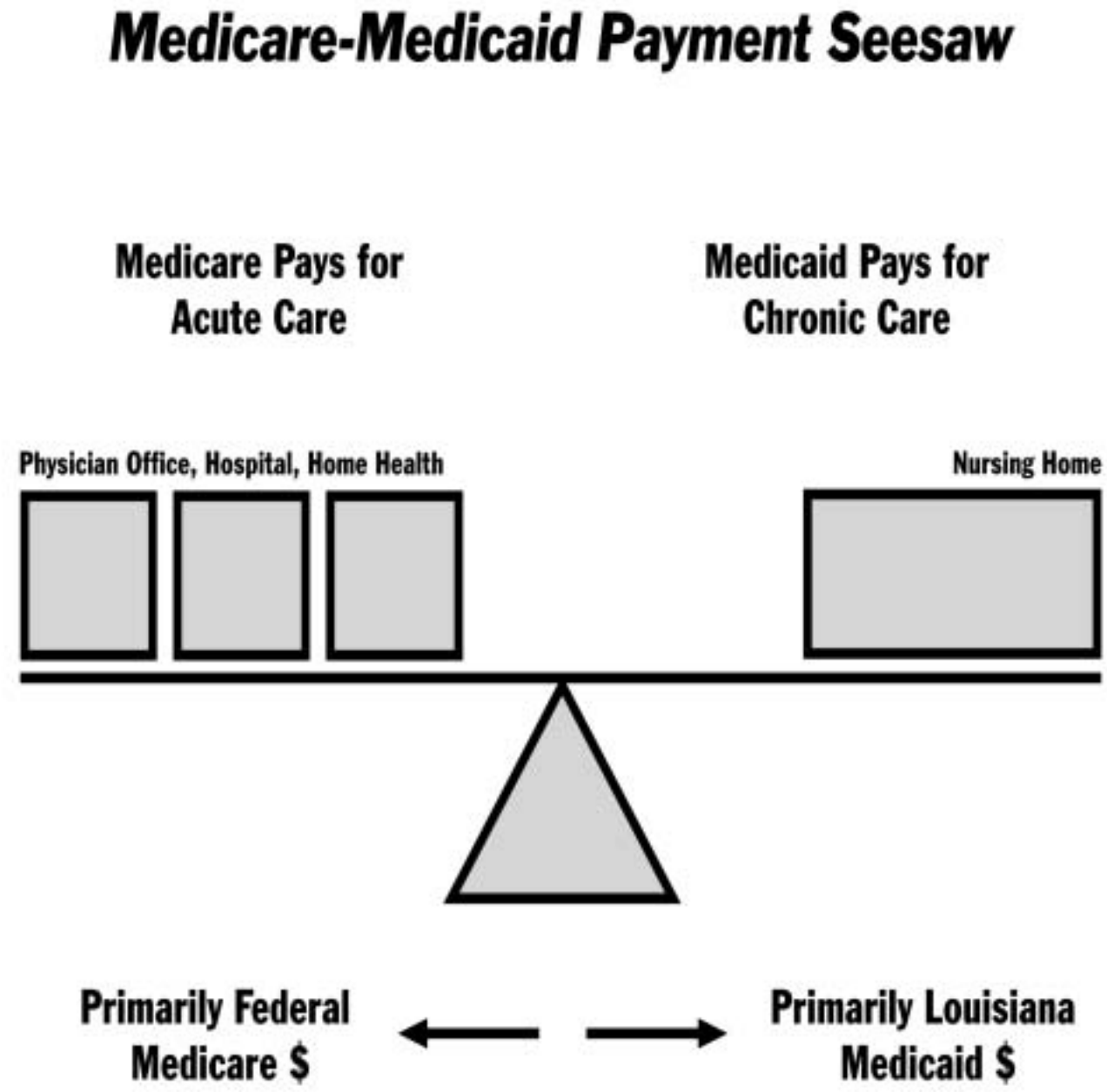
For every $100 of Medicare and Medicaid money spent on dually eligible people in the physician's office, hospital and through home health, approximately $80 is paid by Medicare, and the remaining $20 is paid by Medicaid. Because Medicaid is a joint federal-state program, Louisiana pays only 30% of its own Medicaid healthcare bills. Therefore, of this remaining $20 Medicaid office/hospital/home health expense, Louisiana only has to spend 30% of $20, or $6 of its own money to pay for its share of these expenses. This $6 Louisiana treasury share pays for all Medicare and Medicaid services for dually eligible people in Louisiana performed in the office/hospital/home health venues, which appear on the left-hand side of the seesaw.

Contrast this with $100 spent on nursing home services, which appear on the right-hand side of the seesaw. Here Medicare pays only 20%, leaving Medicaid to pay 80%, which is the bulk of the cost. Even with the 70/30 federal-state match, Louisiana still has to pay 30% of the entire expense. The result is that 30% of $80 equals $24. Here we see the negative effect nursing homes have on our Medicaid budget. For every $100 of healthcare bills spent on its citizens in the office/hospital/home health arena, the Louisiana treasury only has to pay $6 of its own money. But for every $100 of healthcare expenses spent on its citizens in the nursing home arena, the Louisiana treasury has to pay $24 of its own money, or *four times* the amount.

The reason nursing home payments are harmful to our state budget (in addition to there being so many nursing home residents) is that a significant portion of each dollar spent in the nursing home is *local Louisiana money*, as opposed to the money spent in the office/hospital/home health arena where the majority of the money is *someone else's money* (i.e., the federal government's money). Therefore, the key for Louisiana is to keep as many people as possible on the office/hospital/home health side of the seesaw to maximize Medicare's federal payment dollars, and as few people as possible on the nursing home side of the seesaw to minimize Medicaid's state payment dollars. Louisiana can do this, but in order to be successful, Louisiana must enlist the aid of its physician base.

[124] United States. Dept. of Health and Human Services.HCFA. Health and Health Care of the Medicare Population.

Figure 6.


Medicare-Medicaid Payment Seesaw
Medicare Pays for Acute Care
Medicaid Pays for Chronic Care
Physician Office, Hospital, Home Health
Nursing Home
Primarily Federal Medicare $
Primarily Louisiana Medicaid $

The physician is the medical service "gatekeeper" and patient advocate *par excellence.* Figure 7 shows the effect of physician services on the Medicare-Medicaid Payment Seesaw. The single purpose of the physician has always been to help keep patients as functional as possible, living in the community, and out of nursing homes. Therefore, physicians will always strive to push the seesaw down to the left. This helps keep patients on the office/hospital/home health-Medicare side on the left, and away from the nursing home-Medicaid side of the seesaw on the right. In addition to being medically and ethically correct, using the physician as gatekeeper to keep people in the community on the Medicare-payment side of the seesaw has the added bonus of keeping people out of the nursing home, thereby lowering the Medicaid bill for Louisiana.

Figure 7 shows that by allowing physicians to keep people in the community the seesaw is weighted down on the Medicare-payment side, resulting in a net saving for the Louisiana Medicaid program. At the bottom of this Figure is the "Louisiana Scorecard." By enlisting physicians to keep people out of nursing homes, the patients and their families are pleased, the physicians are pleased, and the Louisiana treasury is pleased. In order to obtain this result, however, Louisiana must be certain that physicians are adequately reimbursed to fulfill their patient advocate-gatekeeper role.

This situation is in contrast to the situation in Figure 8. This graphic represents the current state of affairs after Louisiana imposed its geriatric penalty on the very same group of physicians it needs to make this money-saving model work. In Figure 8, there is no physician counterweight on the left-hand Medicare side of the seesaw. Without the physicians' care and attention, the frail, vulnerable, dually eligible patients are left without their best patient advocate.

Since I (or any other physician) have decreased my geriatric (i.e., dually eligible) office practice by 10% and stopped making home visits to these frail patients, dually eligible patients have less access to timely medical care. I have, in effect, stepped off the office/hospital/home health side of the seesaw. The result is that dually eligible patients, whom I would have previously been happy to accept into my practice in year 1999 in Figure 7, have now shifted, in year 2001, to Figure 8. Because they have less medical access, these patients now have to wait for medical care until they become sicker and more vulnerable to nursing home placement. In this instance the seesaw has tilted to the right-hand, Medicaid-nursing home side, causing added expense to Louisiana and extra suffering for its dually eligible citizens.

This is exactly what was predicted in 1997 after the Balanced Budget Act was enacted into law. Louisiana's geriatric penalty on the oldest, poorest and sickest patients in our state has pushed me off the office/hospital/home health side of the seesaw, thereby allowing the scale to tip over to the nursing home side. The bottom of Figure 8 shows the revised Louisiana Scorecard. By imposing this geriatric penalty on dually eligible patients and their physicians, Louisiana has decreased medical access for our most vulnerable, dually eligible citizens. Now, the patients and their families are displeased, the physicians are displeased, and the Louisiana treasury is displeased.

Figure 7.

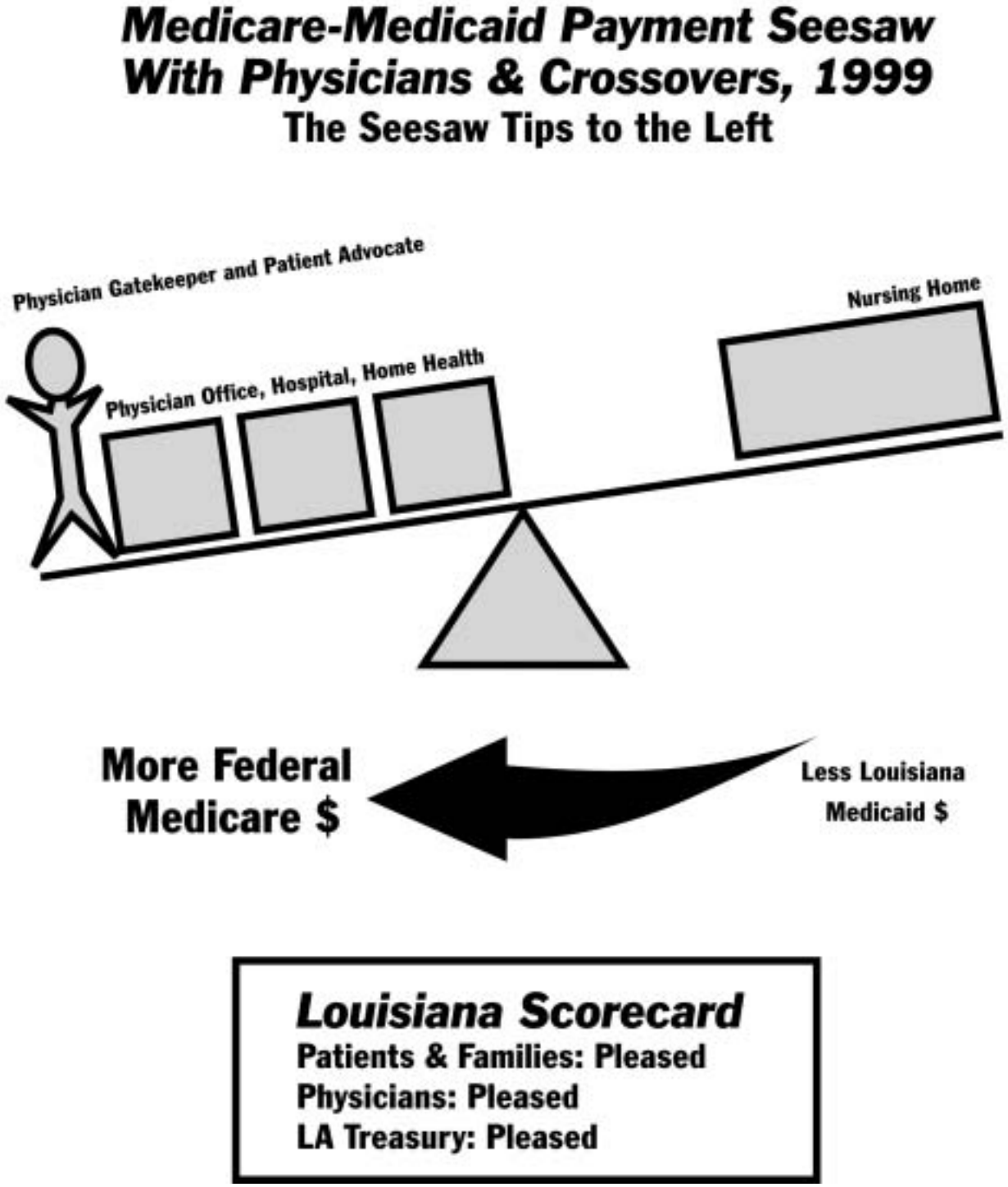
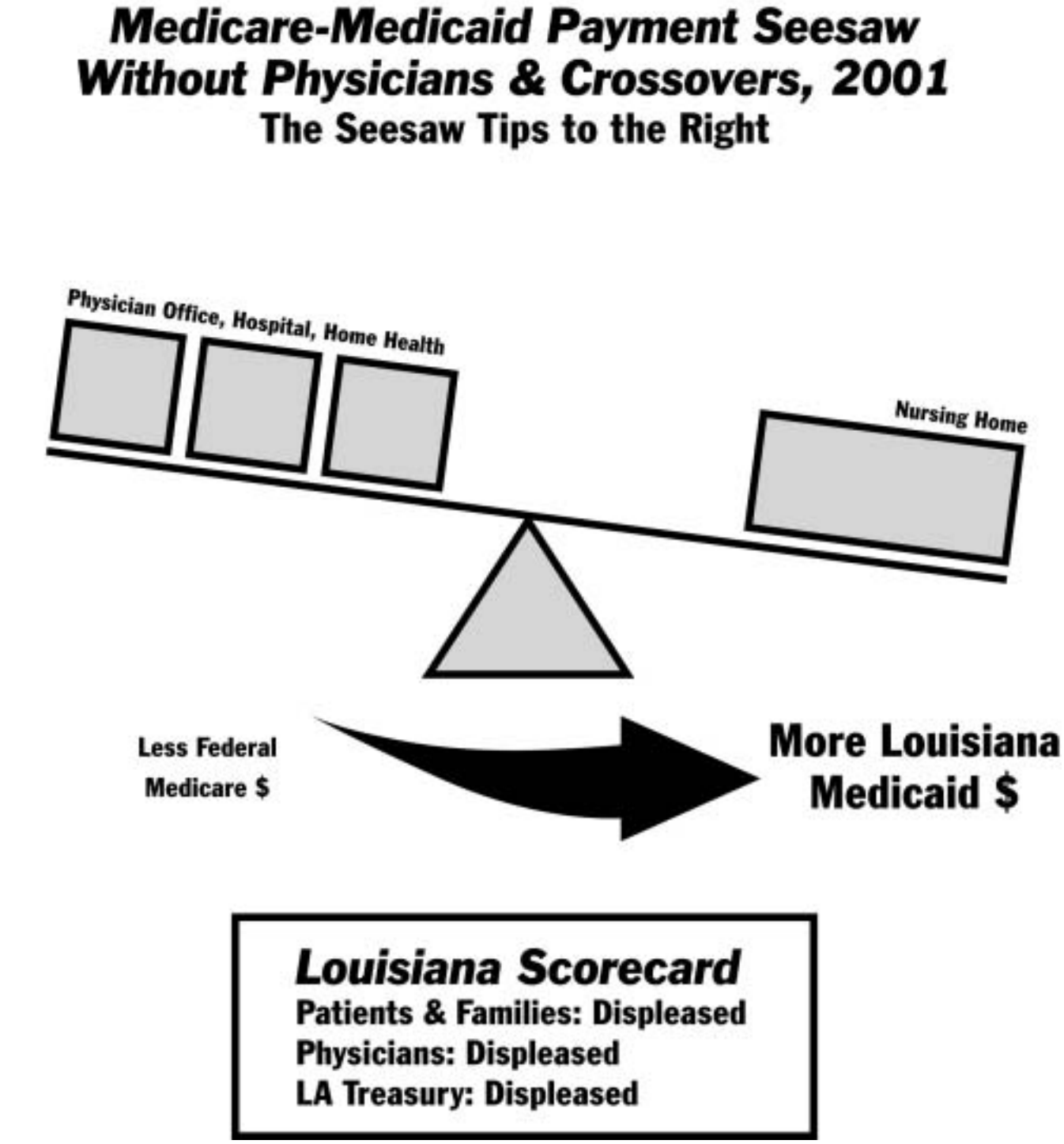

Medicare-Medicaid Payment Seesaw
With Physicians & Crossovers, 1999
The Seesaw Tips to the Left
Physician Gatekeeper and Patient Advocate
Physician Office, Hospital, Home Health
Nursing Home
More Federal
Medicare $
Less Louisiana
Medicaid $
Louisiana Scorecard
Patients & Families: Pleased
Physicians: Pleased
LA Treasury: Pleased

Figure 8.


Medicare-Medicaid Payment Seesaw
Without Physicians & Crossovers, 2001
The Seesaw Tips to the Right
Physician Office, Hospital, Home Health
Nursing Home
Less Federal
Medicare $
More Louisiana
Medicaid $
Louisiana Scorecard
Patients & Families: Displeased
Physicians: Displeased
LA Treasury: Displeased

The dually eligible population is the most likely group to be admitted to a nursing home. If only 5% of Louisiana's nursing home budget can be trimmed by providing timely medical care to this population, the entire crossover budget could be fully restored. If each physician in Louisiana was allowed to do his or her work unfettered by this discriminatory geriatric penalty on dually eligible patients, this amount of savings from the half a billion dollar nursing home budget could be realized.

DUALLY ELIGIBLE PEOPLE AND MEDICARE-HMOS — A POOR FIT

Frail, bedridden patients with costly illnesses are not sought after by the HMO industry. The U.S. General Accounting Office found that patients enrolled in Medicare-HMOs are "younger, healthier, [and have] lower cost."[125] Patients enrolled in a Medicare-HMO also have higher functional status and almost 50% fewer difficulties with their activities of daily living than traditional Medicare beneficiaries.[126] These reports are describing "younger [and] healthier" people and not dually eligible people.

Seniors join a Medicare-HMO because it is less expensive than traditional, fee-for-service Medicare. People in New Orleans with both Medicare and Medicaid benefits frequently join an HMO *by mistake*. Why else would a patient with Medicare and full Medicaid insurance coverage, who has the ability to see almost any physician, visit any hospital and obtain almost any brand-name medication, knowingly trade that privilege away to join an HMO where his or her choice of physician, hospital and medication formulary can be significantly limited? Dually eligible patients do not have the same financial incentives as non-dually eligible Medicare patients because Medicaid pays the rest of their medical bills. In his Senate testimony, Massachusetts Governor Cellucci described dually eligible patients' reluctance to join Medicare-HMOs:

> Dually eligible beneficiaries are also different from other Medicare beneficiaries in another, very important way: they do not have the same financial incentive to choose among fee-for-service and managed care options based on differences in price and benefits, because Medicaid programs cover their out-of-pocket cost and provide comprehensive coverage. In fact, national data show that dual eligibles are 75% less likely to enroll in a managed care plan than other Medicare beneficiaries.[127]

Pamela Parker, Director of Minnesota Senior Health Options testified before the Senate in 1997 that Medicare-HMOs may cause increased cost-shifting to Medicaid, and increased nursing home usage:

> Medicare managed care payment policies may encourage cost shifting to Medicaid nursing home care for dual eligibles. Medicare payments [to HMOs] are highest for persons in nursing homes. Since the Medicare risk plans [the HMOs,] are not liable for Medicaid long term care costs they have little incentive to avoid nursing home placements. . . . This . . . work[s] directly against Medicaid's desire to avoid premature institutional placement.

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[125] "Report finds Medicare HMO members are younger, healthier and lower cost than FFS [Fee-For-Service] seniors." Public Sect Contract Rep 3 (1997):174-75. Abstract. PubMed PMID 10175566.

[126] Bernick, J. J., and A. M. Mitchell. Are They Healthier? A Comparison of Senior HMO and Traditional Medicare Patients. American Geriatrics Society. 2001 Annual Meeting. Washington: 2001. Poster board P71. J Amer Geriatr Soc. 2001. S37.

[127] Celluci.

> Some innovative Medicare managed care plans are interested [in] enrolling stable chronically ill nursing home residents many of whom are dually eligible, because Medicare payments for them are high and they feel they can manage their acute care costs and avoid hospital stays more easily because they reside in a setting with 24 hour nursing coverage. Despite their many benefits, these plans also have the potential to shift cost to Medicaid in the form of higher nursing home per diems and higher nursing home utilization. This arrangement falls short . . . because [Medicare-HMO] plans are not liable for long term care costs.[128]

By encouraging dually eligible patients to enter a nursing home, Medicare-HMOs can tilt the Medicare-Medicaid seesaw in Figure 6 to the right-hand side and cost-shift the financial burden to Medicaid. The HMO still receives their capitated payments from Medicare while the patient is in the nursing home, but now Medicaid has to pay most of the bills for the patient's nursing home care.

In addition to the negative financial impact Medicare-HMOs may have on the Louisiana Medicaid budget, they also have a negative medical impact on dually eligible patients. A 1996 study in the Journal of the American Medical Association (JAMA) concluded, "Elderly and poor chronically ill patients had worse physical health outcomes in HMOs than in FFS [Fee-For-Service Medicare] systems." A patient's poverty status influenced the health outcomes in this study: "Outcomes favored FFS over HMOs for the poverty group, and favored HMOs over FFS for the nonpoverty group."[129] Since poverty in the geriatric population is a marker for dual eligibility, this study demonstrated that dually eligible patients did worse in the HMO.

Similarly, a 1997 JAMA article showed: "Patients in Medicare HMOs who experience strokes are more likely to be discharged to nursing homes and less likely to go to rehabilitation facilities following the acute event." In this study, 42% of HMO patients were discharged to nursing homes as opposed to 28% in traditional fee-for-service Medicare patients. This *50% increase in nursing home admissions* for Medicare-HMO patients would weigh heavily on Louisiana's Medicaid nursing home budget. Also, only 16% of the HMO patients were discharged to rehabilitation facilities versus 23% in traditional fee-for-service Medicare.[130] This 30% decrease in rehabilitation utilization (a Medicare-reimbursed service) is consistent with HMOs' desire to decrease Medicare-reimbursed services (rehabilitation care), at the expense of Medicaid-reimbursed services (nursing home care).

Although dually eligible patients are almost twice as likely to use home health services as are Medicare-only patients, home health usage (another Medicare-reimbursed service) is decreased in an HMO setting. Despite the fact that in 1997, "12% of all

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[128] Parker.

[129] Ware Jr., JE, et al. "Differences in 4-year health outcomes for elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. Results from the Medical Outcomes Study." JAMA 276 (1996): 1039-47. Abstract. PubMed PMID 8847764.

[130] Retchin, SM, et al. "Outcomes of stroke patients in Medicare fee for service and managed care." JAMA 278 (1997): 119-24. Abstract. PubMed PMID 9214526.

beneficiaries are enrolled in Medicare HMOs, the number of home health users in HMOs is very small."[131] In addition, older patients in an HMO who had a stroke had less access to neurology care and had a greater chance of dying than patients who were in traditional Medicare.[132]

In a study titled, "Medicare HMOs: who joins and who leaves?" Virnig et al. found: "At six months, higher percentages of Blacks, older beneficiaries (older then 85), and individuals from the lowest income area (less than $15,000 per year) had disenrolled" from the Medicare-HMO than other population groups.[133] The three cited beneficiary categories of minorities, the "old-old," and the poor, all point to the dually eligible population. Dually eligible patients disenroll from Medicare-HMOs more often than traditional Medicare beneficiaries do. They may be pulled out of the HMO because they do not get the care they need, or they may be pushed out by the HMO because of financial reasons, or they may have a combination of both problems.

Dually eligible Medicare beneficiaries fare better in traditional fee-for-service Medicare. In a 1998 meeting on managed care, Allan Bergman, director of State-Federal Relations for United Cerebral Palsy Associations, stated: "Managed care is, first and foremost, about costs. . . . It began in the private sector as a way of handling 11-12% healthcare inflation. Managed care equals cost containment. And cost containment has become a euphemism for rationing."[134] Enrollment in a Medicare-HMO system that is driven primarily by cost containment may be counterproductive for the dually eligible patient.

A recent study in the American Journal of Preventive Medicine confirmed that the "frail elderly" — code words for dually eligible people — do not do well in an arena with "stringent approaches to utilization control." The study found that frail, elderly Medicare beneficiaries who were enrolled in a Medicare-HMO were more likely to have a "preventable hospital readmission" compared to beneficiaries who were enrolled in standard fee-for-service Medicare. The study revealed that "policies promoting . . . early hospital discharge, reduced levels of post-acute care, and restricted use of home health services . . . may be problematic for the frail elderly."[135]

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[131] Foley, Lisa A., Normandy Brangan and Alison Jaffe-Doty. FYI: Who Uses Medicare's Home Health Benefit? AARP Public Policy Institute. Washington: Sept. 1998. 18 Feb. 2001 <http://research.aarp.org/health/fyi_hhealth.html>.

[132] Smith, MA, et al. "HMO membership and patient age and the use of specialty care for hospitalized patients with acute stroke: The Minnesota Stroke Survey." Med Care 37 (1999): 1186-98. Abstract. PubMed PMID 10599600.

[133] Virnig, BA, et al. "Medicare HMOs: who joins and who leaves?" Am J Manag Care 4 (1998): 511-18. Abstract. PubMed PMID 10179910.

[134] Center on Emergent Disability. University of Illinois at Chicago. Experts Meeting on Managed Care: How people with disabilities are affected by Medicaid managed healthcare programs. Issues in Independent Living. Chicago: 28 Aug. 1998.
28 Aug. 2001 <http://www.uic.edu/depts/idhd/ced/text/managedcaretxt.htm>.

[135] Experton, B., et al. "How does managed care manage the frail elderly? The case of hospital readmissions in fee-for-service versus HMO systems." Am J Prev Med 16 (1999): 163-72. Abstract. PubMed PMID 10198653.

Patients who are elderly, African American, in poor health, or required assistance with several ADLs — characteristics of dually eligible persons — are more likely to have a preventable hospitalization than other seniors.[136] Any attempt to hastily cut corners with expenses for these patients will only decrease medical access for this already expensive group. Dually eligible patients should remain in traditional fee-for-service Medicare.

One instance of a Medicare-HMO supposedly wanting more dually eligible patients was described in a recent lawsuit settled by the U.S. Department of Justice. This was a case alleging an HMO had provided inaccurate payment information to Medicare. By claiming they had more dually eligible patients than they actually had the HMO received more money because "Medicare pays a higher monthly payment to health plans to provide care for dually eligible beneficiaries."[137]

[136] Culler, SD, ML Parchman and M. Przybylski. "Factors related to potentially preventable hospitalizations among the elderly." Med Care 36 (1998): 804-17. Abstract. PubMed PMID 9630122.

[137] Humana Inc. U.S. Dept. of Justice Settlement Agreement. U.S. Dept. of Health and Human Services Corporate Integrity Agreement (6/6/00). HMO Lawsuit Watch. Mar. 2001. Crowell & Moring Website. 3 Nov. 2001 <www.crowell.com/content/resources/publications/browsebyPracticeGroup/HealthCare/hmo_watch.htm#23>.

DUALLY ELIGIBLE QMBS AND SLMBS

Many dually eligible people are categorically eligible to receive full Medicaid benefits because their assets are limited and their income is not greater than 73% of the Federal Poverty Level.[138] However, many elderly or disabled people are poor but do not meet all of the requirements to receive full Medicare and Medicaid benefits. In 1988, Congress recognized this problem and created the Qualified Medicare Beneficiary (QMB) program and Specified Low-Income Beneficiary (SLMB) program to help these "low-income Medicare beneficiaries" obtain partial Medicaid coverage and improved access to medical care.

According to an AARP report, many eligible people do not know this "secret benefit" exists. These programs help low-income Medicare beneficiaries by paying Medicare's premiums, deductibles and coinsurance. The QMB program helps people with incomes at or below 100% of the Federal Poverty Level by allowing Medicaid to "buy-in" and pay their Medicare Part A and Part B premiums along with their Medicare deductibles and coinsurance. Some states may also provide QMBs with other Medicaid benefits such as prescription coverage. The SLMB program helps people with incomes between 100 and 120% of the poverty level by allowing Medicaid to pay their Medicare Part B premium. Beneficiaries who receive QMB or SLMB benefits are considered *a subset of the dually eligible population.*

In 1997, Congress created two additional groups of "Qualifying Individuals," known as QI-1s and QI-2s. These Qualified Individuals may receive Medicaid help with Medicare Part B premiums if their income is up to 175% of the Federal Poverty Level.

Although these programs provide financial support for low-income Medicare beneficiaries and improve medical access, many eligible people are not aware of these programs and are not enrolled in these programs. In 1998, only 78% of eligible low-income Medicare beneficiaries participated in the QMB program nationally, and only 16% of eligible beneficiaries participated in the SLMB program

Some state officials believe these programs may decrease future Medicare and Medicaid expenses. By "remov[ing] financial barriers to care, Medicare beneficiaries' access to timely primary and preventive care is improved." This may result in a lower demand for expensive emergency room, hospital and nursing home services. Additionally, "By 'buying in' to Medicare Parts A and B coverage for low income elderly and disabled beneficiaries, the state Medicaid program is no longer the payer of first resort for providers."[139]

These are complicated programs, and social service workers, as well as needy patients are often unaware of these programs. A 1999 report prepared for HCFA showed:

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[138] Kaiser Family Foundation. Medicaid's Role for Low-Income Medicare Beneficiaries.

[139] Rosenbach, Margo L. and JoAnn Lamphere. Bridging the Gaps Between Medicare and Medicaid: The Case of QMBs and SLMBs. AARP Public Policy Institute. Washington: Jan. 1999.

> [M]any beneficiaries had never heard of the QMB, SLMB, or QI programs, and . . . some social service workers who provide services to the elderly are also not aware of these programs. . . . Lack of coordination between the Medicare and Medicaid systems forces beneficiaries to contact two separate offices to apply for benefits: the local Social Security office for Medicare benefits, and the local Medicaid office . . . for QMB/SLMB/QI benefits.[140]

In 1997, Louisiana had 560,807 Medicare Part B Beneficiaries. There were 94,611 low-income Medicare beneficiaries age 65 and over who qualified for QMB or SLMB protection. Of these 94,611 Louisiana citizens only 29,855 or 32% of eligible persons had QMB or SLMB protection for their medical bills. An additional 64,756 poor persons in Louisiana, or 68% of all eligible persons were not participating in these programs.[141]

According to David Hood, Secretary of Louisiana DHH, there were 104,110 dually eligible persons in Louisiana in fiscal year 2000. This number represents 14.3% of all Medicaid recipients in Louisiana,[142] and is *lower* than the national rate of 17% of the Medicaid population (which Senator Breaux said was dually eligible) because Louisiana has a high rate of poverty in our younger, Medicaid-only population. Using the 560,807 Louisiana Medicare beneficiaries in 1997 as a current approximation, 18.6% of our state's Medicare recipients were dually eligible. This rate is *higher* than the national rate of 16% of the Medicare population (which Senator Breaux said was dually eligible) because Louisiana has a high rate of poverty in our elderly and disabled populations.

As with other dually eligible populations, low-income Medicare beneficiaries who are most likely to be eligible for QMB and SLMB programs are "female, disabled, low educated, part of a non-White racial or ethnic group, single . . . . [and Medicare] beneficiaries with lower health status and lower measures of access to care . . . ."[143] If Louisiana enrolled only *one-half* of the 64,756 eligible, non-participating Medicare beneficiaries into the QMB/SLMB programs, the addition of these 32,378 low-income Medicare beneficiaries to the 104,110 current dually eligible persons would increase Louisiana's dually eligible population to 24% of our Medicare population, a number *50% higher* than the national rate.

Low-income Medicare beneficiaries are precariously balanced in the healthcare world. Although living in poverty, they may not meet the requirements for full Medicaid coverage, or for coverage of their prescription drug needs. Any new illness can place these patients at risk for catastrophic medical bills and nursing home placement. Once in a nursing home they quickly "spend-down" their assets, become Medicaid-eligible, and Louisiana becomes responsible for most of their nursing home bills. Louisiana should

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[140] Edder.
[141] Rosenbach, Margo L. and JoAnn Lamphere.
[142] Hood, David. Letter to the author.
[143] Laschober, Mary A., and Christopher Topoleski. A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries. Barents Group. Maryland: HCFA, April 7, 1999. <http://www.resdac.umn.edu/doc2go/dualelig.pdf>.

enroll as many of these persons as possible into these programs, and should begin an educational program so that patients, medical providers, and social service workers understand these complicated and underutilized programs.

DUALLY ELIGIBLE NURSING HOME PATIENTS

Nursing home residents are overwhelming dually eligible, and "nearly one-third of the dual eligibles spent part or all of the year in a long-term care facility:"

> In 1995, approximately 75% of NH [nursing home] residents were covered by Medicaid, compared with 17% of community residents. . . . [Because] first, Medicaid eligibility is often indicative of poor health, and chronic conditions or functional limitations. Second, Medicaid eligibility increases NH demand because dual eligibles are insulated from the full cost of NH services. [And] third, NH residents are more likely than their community counterparts to become eligible for Medicaid because NH expenses quickly deplete their assets.

Nationally, "a typical NH [nursing home] resident is an elderly white female with severe functional disability. . . . [and] limited income and low educational attainment, two characteristics often associated with poor health."[144] Forty-five percent of long-term care residents are over 84 years old as opposed to only 11% of the entire Medicare population, which is over 84 years old.[145] Approximately two-thirds of dually eligible beneficiaries are already on Medicaid when they enter a nursing home. The remaining one-third become dually eligible by spending down their assets and becoming Medicaid-eligible while residing in the nursing facility.

Dually eligible people usually enter a nursing facility because of functional limitations, which worsen as they get older:

> [M]ore than 90% of NH [nursing home] residents had moderate to severe functional disability, compared with 21% among community residents. . . . One-third of NH residents were diagnosed as having a mental disorder, compared with 7% among community residents. These beneficiaries have difficulty performing basic activities of living, such as eating, dressing, or bathing. . . .

It costs almost 50% more money to care for a disabled nursing home resident than for an aged nursing home resident. Nursing home patients have multiple medical problems and have "mortality rates [that] are much higher than those of Medicare beneficiaries living in communities. In 1995, more than 21.2% of NH residents died, compared with 3.4% of community-only Medicare beneficiaries." Once admitted to a nursing facility, "most beneficiaries stay in a facility until the end of their lives."

A state's nursing home policy and Medicaid payment schedule have a large impact on its nursing home industry and its dually eligible population:

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[144] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

[145] United States. Dept. of Health and Human Services. HCFA. Characteristics and Perceptions of the Medicare Population.

> NHs [nursing homes] . . . attract large numbers of dual eligibles because Medicaid distorts the demand for and supply of NH beds. By subsidizing the cost of NH care, Medicaid creates a greater-than-optimal demand for NH care by Medicaid [dual] eligibles. At the same time, states often have monopoly power over the NH market because Medicaid plays a large role in supporting NHs. This enables individual states to set Medicaid reimbursement rates below market rates for private payers. . . . These combined factors cause excess demand for NH care by Medicaid [dual] eligibles . . . .
>
> Medicaid [dual] eligibility [also] tends to hinder admission to NHs . . . in areas where the markets are tight. State-enforced lower reimbursement rates for Medicaid clients give NHs an incentive to admit private patients who will pay full rates. Because of the distortion in prices, Medicaid beneficiaries have a higher probability of being on a waiting list [in tight markets] . . . .

Critics claim "if better primary care services could be provided to NH residents, it might help to reduce costly inappropriate hospital inpatient and ER use. . . ." [146] But, after Connecticut eliminated crossover payments in 1999, nursing home patients were left with *decreased* access to geriatric and medical care.

[146] United States. Dept. of Health and Human Services. HCFA. Health and Health Care of the Medicare Population.

GERIATRICS: AN AILING SPECIALTY

The number of frail, elderly patients is increasing at almost three times the rate of our national population. According to the Census Bureau, while our nation's total population rose only 13% during the 1990s, the "number of Americans older than 85 surged 37%." According to demographers, "There were 4.2 million Americans above the age of 85 last year, a dramatic increase from the 3.1 million tallied in 1990." This group, the "old-old," increased from 1.2% of the population in 1990, to 1.5% of the population in 2000. Because of "investments in medical care and treatment" 400,000 fewer people needed care in a nursing home, which saved "$19 billion last year . . . at an average annual cost of $47,000" per nursing home resident.[147] These statistics demonstrate the benefit of providing appropriate medical access for our elderly and disabled citizens.

Just as it follows that the younger a child is, the more that child will benefit from a pediatricians' treatment, so too it is with geriatrics. The older a person is, the more that elderly person will benefit from a geriatrician's care. The elderly who are dually eligible are a perfect population group for the specialty of geriatrics to focus upon. These patients are elderly and frail, have many medical problems, multiple medications, and a host of social problems. If geriatrics can deliver a promise to our society that our nation's most vulnerable and expensive geriatric population would be cared for with compassion, and at an acceptable financial cost, then surely geriatricians would deserve the thanks and encouragement of our entire nation.

Just as homelessness and substance abuse, or a change in a patient's mental status, or being "found down" on the floor triggers a checklist of medical problems to screen for, dual eligibility should also be thought of as a marker or "risk factor" for other problems. But unlike most other medical markers dual eligibility problems often include social, financial, family, transportation, legal, and housing issues — issues that may prevent dually eligible people from realizing the full benefit of good medical care.

Dually eligible patients should receive a social service consultation, if not a complete geriatric assessment. This would allow identification of social problems that may interfere with the patient's medical care, and may prevent needless hospitalizations and nursing home admissions. What good is prescribing several medications for a dually eligible patient's hypertension, diabetes, arthritis and depression, if she cannot get to the pharmacy, cannot open up the prescription bottles, cannot remember how to take the medicines, and does not have transportation to return to the physician's office for follow-up? And, even if this dually eligible patient could get transportation, she may still have to wait for her grandson to get home from work to carry her down the five steps in front of her house.

Geriatrics, as it stands today, is an ailing specialty. Dr. John Burton, Professor and Chairman of the Department of Geriatrics at Johns Hopkins University School of Medicine, testified before the U.S. Senate:

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[147] Rosenblatt, Robert. "We're getting older . . . and better, too." The Times-Picayune [New Orleans] 15 May 2001: A5.

Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that helps patients maintain functional independence and improve their overall quality of life. . . . Geriatricians are primary-care-oriented practitioners who are initially trained in family practice, internal medicine, or psychiatry . . . .

Our country is aging rapidly. In 1900, there were 3.1 million Americans age 65 and older, and, today, there are roughly 39 million people. . . . By 2030, it is projected that one out of every five Americans will be over age 65. People age 85 and older are the fastest growing segment of the entire population, with expected growth from four million people today to 19 million by 2050. It is this group — the old, old — who are the heaviest consumers of health care. . . .

Americans are not dying typically from acute diseases as they did in previous generations. Now chronic diseases are the major cause of illness, disability, and death in this country accounting currently for 75% of all deaths and 80% of all health resource usage. People are now living longer with disabling chronic conditions. On average by age 75 older adults have between two to three chronic medical conditions and some have 10 or 12 conditions.

[O]lder persons in general have unique characteristics that differentiate them from younger populations. . . . [Physicians generally] have not been trained in geriatrics . . . because this training has until recently been a low priority for medical schools. . . . This situation potentially could translate into suffering by patients, concern from their caregivers and unnecessary cost to Medicare related to inappropriate hospitalizations, multiple visits to specialists who may be ordering conflicting regimens of treatment and needless nursing home admissions. . . .

Although nearly all practitioners will be called on to deliver care to the majority of the elderly, many experts agree that a sufficiently large core of geriatricians will be needed to provide care for the 15 to 20% of the elderly who are the oldest, most frail and most likely to have functional limitations [i.e., the dually eligible].

[There is a] shortage of geriatricians . . . . Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry. . . . **[The] major reason for [the] shortage of geriatricians [is] poor Medicare reimbursement**. A key reason for the lack of physician interest in geriatrics is financial.

Geriatricians are almost entirely dependent on Medicare revenues . . . . [B]ecause of the complexity of care needed and the time required to deliver

> quality care, Medicare currently provides a disincentive for physicians to care for Medicare beneficiaries who are frail and chronically ill.
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> [T]he physician payment system does not provide coverage for the cornerstone of geriatric care — assessments and the coordination and management of care . . . [The Medicare] system bases payment levels on the time and effort required to see an 'average' patient, and assumes that a physician's case load will average out with patients who require longer to be seen and patients who require shorter times to be seen over a given period. However the caseload of a geriatrician will not 'average' out. Geriatricians specialize in the care of the frail, chronically ill older patients; the average age of the patient case load is often over age 80.
>
> These patients not only have a greater number of chronic medical conditions than younger patients but also have impairments of hearing, vision, and function that increases both the time and effort required for their care. A 'typical' frail, elderly patient cannot fill out forms for the office staff, requires assistance to get to the exam room, needs help with disrobing, requires assistance to climb up on the exam table, cannot hear the physician ask questions, and sometimes cannot understand the physician's instructions. As a result, a geriatrician typically has fewer patients in his/her practice, provides fewer visits than other primary care physicians and has lower revenue. This is true not only for geriatricians, but for any primary care physicians who focus on caring for older Medicare beneficiaries.
>
> [Congress should] revise the current Medicare payment system to promote care management services for chronically ill beneficiaries . . . [and] to adequately compensate for high cost complex Medicare patients. The Medicare payment system should compensate providers who spend extra time with frail, older, functionally impaired patients whose care is often time consuming and complex. . . . Failure to act in this arena is likely to result in diminishing quality care for frail, older persons and, potentially, the decline of the geriatrics profession.[148]

In an American Geriatrics Society press release regarding his testimony, Dr. Burton sounded a further pessimistic tone:

> Currently there are fewer than 9,000 certified geriatricians, and this number is expected to decline dramatically in the next few years as practicing geriatricians retire at the same time the baby boom generation attains Medicare eligibility. . . . The Institute of Medicine and a recent MedPAC report identified low Medicare reimbursement as a major reason for

[148] Burton, John. Geriatrics: Meeting the Needs of Our Most Vulnerable Seniors in the 21st Century. US Cong. Senate. Committee on Health, Education, Labor & Pensions. June 19, 2001. 29 July 2001 <http://www.americangeriatrics.org/policy/burton.shtml>.

> inadequate recruitment into geriatrics and, further, as a main reason that geriatricians struggle to keep their practices alive.[149]

In a recent study in the Journal of the American Geriatrics Society, first-year medical students learned early in their careers that "geriatrics is a low-status specialty." This low interest in geriatrics was related to "the nature of the work itself, the extra training required, and financial considerations." The authors stated, "Work with older people is, literally, more slowly paced. It is more likely to involve careful listening and monitoring over time than high-tech, 'sexy,' or dramatic interventions." The study's authors concluded, "Until financial considerations act to encourage doctors to choose geriatrics . . . young doctors will continue to make other choices."[150]

Geriatrics training in Louisiana is woefully lacking. According to the Louisiana Geriatrics Society, Louisiana has the lowest number of physicians with Certification in Geriatric Medicine, with only 45 out of the thousands of geriatricians certified nationally. In Louisiana there is only one medical school offering a total of four training positions in geriatrics. "Currently and in the past, physicians interested in a career in Geriatric Medicine leave the state to obtain fellowship training and in most cases, never return to Louisiana."[151]

In 1999, the National Health Policy Forum summarized the problems the frail geriatric population face, along with the problems of the physicians who treat them. According to the Forum, minority elderly have higher rates of disability and poverty, along with poor nutrition and education. The disabled elderly have a poorer quality of life, depend more on formal caretakers, and may have large medical and long-term care expenses.

Preventing or delaying disability can make a significant impact on the quality of life and medical expenses of the geriatric population — especially the frail elderly. Persons over 85 years of age have an annual health care bill that is almost six times greater than the bill for people 19- to 64-years-old. In addition to more hospital and medication usage, people over 65 years of age average nine physician visits a year, almost twice the general population's rate.

The Forum stressed that Medicare's procedurally-based payment schedule does not serve the medical needs of frail, elderly people, "the program does not reimburse for the extra time and resources it takes to evaluate and manage older patients — most of whom present with multiple problems — during an office visit. . . . To better manage frail, chronically ill patients, many recommend that Medicare be refined to recognize the social as well as medical components of elderly health care."[152]

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[149] American Geriatrics Society. American Geriatrics Society to Testify Before Senate Health, Education, Labor & Pensions Committee on Shortage of Geriatricians in U.S. Press release. June 19, 2001. 29 June 2001 <http://www.americangeriatrics.org/policy/testify.shtml>.

[150] Alford, Cynthia, et al. "An Introduction to Geriatrics for First-Year Medical Students." J Amer Geriatr Soc 49 (2001): 782-87.

[151] Louisiana Geriatrics Society. Newsletter. Vol. 3. New Orleans: June 2001.

[152] National Health Policy Forum. Filling the Geriatric Gap: Is the Health System Prepared for an Aging Population? Issue Brief No. 729. Washington: 25 Jan. 1999.

The American Geriatrics Society has advocated increasing opportunities for geriatric training and increasing payments for geriatric care. Unless this 20% to 80% geriatric penalty on the dually eligible is reversed, all efforts to increase geriatric payment and recognition will be wasted. There is no possible increase in the Medicare payment schedule that can undo the damage that the elimination of crossover payments is doing to dually eligible patients and to the practice of geriatrics. No matter how high the payment ceiling is raised, *geriatricians would always be losing a minimum of 20%* of the Medicare fee compared to physicians who do not treat these dually eligible patients.

Since the elimination of Medicare-Medicaid crossover payments is specifically targeted at our oldest, poorest, and sickest citizens, it is, by definition, also targeted at the physicians who are trained in geriatric medicine and who have devoted their professional careers to caring for this elderly, frail population. Medical students who leave medical school with the burden of student loans are less likely to choose a medical career where he or she is laboring under a minimum 20% penalty compared to all other specialties. As a result, fewer physicians will choose to treat elderly patients. Will geriatricians shun states such as Louisiana that have a geriatric penalty in favor of states that do not have a geriatric penalty? If this penalty is left to stand, geriatrics will forever be a "poor sister" to other medical specialties.

SUGGESTIONS TO IMPROVE MEDICAL ACCESS IN LOUISIANA

Improving access to health care for our elderly citizens will decrease the risk of nursing home placement and will save Louisiana money. Demonstrating that there are less discriminatory ways to deliver health care and still save Louisiana money is required by the civil rights complaints. The goal of patients, physicians, and our state government is the same: to allow our elderly to stay at home and age in place. What can Louisiana do to increase medical access for dually eligible and other vulnerable people?

Suggestion No. 1 - Restore the Medicare-Medicaid crossover payments for dually eligible patients

Suggestion No. 2 - Stop encouraging dually eligible patients to join Medicare-HMOs

Suggestion No. 3 – Increase the number of QMBs and SLMBs in Louisiana

Suggestion No. 4 – Provide better transportation for dually eligible patients

Transportation is a major obstacle for dually eligible people to obtain proper access to our healthcare system. As these people become older, more frail, and poorer, their ability to ambulate independently, and for long periods of time becomes more limited. Leaving these people to fend for themselves or to take public transportation is often intimidating for older people. The frail, elderly woman who needs a walker to go outside of her home, and who carries her purse on one arm and her bag of medicines on the other arm will have difficulty coming to the physician's office.

Although New Orleans does provide public transportation specifically for disabled people, having to make an appointment several days in advance can make it difficult for frail patients to see their doctor in a timely fashion. Even taking a taxi may prove daunting for dually eligible patients, because, as some patients report, sometimes the cab driver refuses to lift the patient's walker or wheelchair, claiming this would hurt his back. Providing better transportation for the frail elderly and dually eligible populations may decrease the severity of acute medical problems and the subsequent risk of hospitalization and nursing home placement.

Suggestion No. 5 – Provide more community care, home care, and assisted living

Long-term care "is generally defined as a broad range of personal, social, and medical services that assist people who have functional or cognitive limitations in their ability to perform self-care and other activities necessary to live independently."[153] Louisiana has historically preferred to place elderly and disabled persons in nursing homes rather than in community or home care situations. The U.S. Supreme Court's 1999 *Olmstead* ruling mandated that more community-based and home care services be made available for the elderly and the disabled. The Times-Picayune noted that while many states try to keep people in the community by investing in "at-home treatment and

[153] Pandya.

community services . . . Louisiana has continued to pour the bulk of its healthcare money into nursing homes and other facilities that segregate mentally and physically disabled people from the rest of society."[154]

According to The Times-Picayune, Senator John Breaux recently commented that Louisiana depends too heavily on nursing home care for its elderly citizens. Louisiana, he stated, ranks last in the nation in providing choices for the low-income elderly other than placing them in an institution when they become infirm and need help doing their day-to-day tasks.

At a Senate hearing, Vermont Governor Howard Dean testified that since Vermont decreased its reliance on nursing homes in 1996, the state's nursing home population decreased 18%. Vermont turned these savings into a "a menu of alternative-care options for elderly and disabled residents." For Vermont's "long-term patients" these options include "an average of 30 hours per week of services including therapy, housekeeping, bill-paying and shopping." Each nursing home resident costs Vermont $48,000 per year, whereas community-based care costs less than $20,000 per patient, per year. Governor Dean said, "we can take care of much sicker people in their homes and it's cheaper than it would be in a nursing home."

Last year Louisiana spent $491 million to care for more than 25,000 nursing home residents. But it only "spent $6.3 million last year on two programs offering 694 seniors health-related services such as daycare, a personal-care attendant and help around the house."[155] Louisiana, therefore, spent $19,640 to care for each of the 25,000 persons living in nursing homes. However, it cost only $9,078 to care for each of the 694 seniors living in less restrictive home-based settings, which resulted in a savings of over $10,500 for *each* of the home-based seniors.

According to the AARP, "The average annual cost of care in a nursing home in 1998 was about $56,000 or $153 [per patient,] per day. Total national expenditures for nursing home care in 1998 were $78.6 billion," of which Medicare paid 13% and Medicaid paid 40%. In 1997, 4.3% of the U.S. population age 65 and older resided in nursing homes. "About 70% of nursing home residents are supported . . . by Medicaid. Medicaid reimbursement systems for nursing homes vary considerably from state to state and averaged $95.72 [per patient,] per day [or $34,938 per patient, per year] in 1998."[156]

Louisiana's "nursing home owners . . . have been especially aggressive in lobbying for a share of the budget." According to the Louisiana Nursing Home Association, "At $71 per patient, per day, Louisiana nursing homes are among the lowest-paid in the nation."[157] Multiplying $71 per day, by 365 days, means that Louisiana is spending $25,915 per nursing home resident, per year. Whether the number

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[154] Walsh, Bill. "Ruling puts pressure on institutions." The Times-Picayune [New Orleans] 7 May 2001: A1+.
[155] Walsh, Bill. "More choices urged in care for seniors." The Times-Picayune [New Orleans] 19 July 2001: A1+.
[156] Pandya.
[157] Walsh, Bill. "Ruling puts pressure on institutions."

is $19,640 per year, or closer to $25,915 per year, nursing home care in Louisiana is very expensive, especially for Medicaid, which pays most of the bill.

In an article in The Times-Picayune, Senator Breaux suggested that Louisiana help pay the costs of assisted living services for low-income seniors who are "too frail to live by themselves but not sick enough to be confined in expensive nursing homes." Assisted living "provides seniors with basic services, such as cooking and bathing, while allowing them to live independently in private apartments." An assisted living advocate said, "about 30% of residents in nursing homes are able-bodied enough to be in assisted living, if it were available." Thirty-eight states have received a waiver from the federal government to use Medicaid finances to subsidize assisted living for poor people because they believe it will help people and will be less expensive than a nursing home. However, "Louisiana has never applied for a waiver."[158]

In a recent editorial, The Times-Picayune encouraged the use of "less restrictive forms of long-term care." Elderly Louisiana citizens who are ill and have difficulty doing their household chores "shouldn't have to choose between giving up their freedom [in a nursing home, or] being abandoned." According to this editorial, one-fifth of Louisiana nursing home beds are empty and providing more community-based alternatives could decrease the occupancy rate further. "Given the possibility of saving money while giving more seniors the chance to live happily and freely, there is no excuse for slow progress."[159]

The State of Vermont was able to save more than half of the nursing home costs by providing 30 hours a week of social services and medical care to the elderly enrolled in its community care program, and was able to decrease its nursing home population by 18%. Similarly, a study of three other states — Colorado, Oregon, and Washington — which have used community-based alternatives to nursing homes, showed these states had 18% to 39% fewer nursing home residents, and "saved between 9% to 23% of the amount they would have spent on long-term care."[160]

If Louisiana could save $10,500 a year for each person cared for in a community setting, home-based setting, or assisted-living facility, the amount of savings would easily restore crossover payments for the dually eligible population. If only 10% of our 25,000 nursing home population were able to live in the community, the entire $23.5 million needed to restore crossover payments would be realized. Moving people out of nursing homes and back into the community would also allow Louisiana to comply with the new realities of long-term care brought about by the Supreme Court's *Olmstead* ruling.

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[158] Walsh, Bill. "Breaux wants assisted living coverage." The Times-Picayune [New Orleans] 27 Apr. 2001: A5.

[159] "Options for older people." Editorial. The Times-Picayune [New Orleans] 22 July 2001: B6.

[160] Alecxih, Lisa Maria B., et al. Estimated cost savings from the use of home and community-based alternatives to nursing facility care in three states. AARP Public Policy Institute. Washington: Nov. 1996. Abstract. AARP AgeLine Database ID #9618 Dec. 1996. 9 Sept. 2001. <http://www.research.aarp.org/health/9618_savings.html>.

Suggestion No. 6 – Provide home health services to elderly and disabled homebound people who need "custodial care"

In order for a Medicare patient to have home health services, the patient must be homebound and need a "skilled nursing service," such as caring for a post-surgical wound or decubitus bedsore, or following a medically unstable patient. Many homebound or bed-bound Medicare-only people who are disabled by Alzheimer's disease, severe arthritis, lower extremity amputation, or other chronic conditions, do not need skilled nursing care. Although these elderly and disabled people are permanently homebound, they only need "custodial care." These people are not eligible to receive Medicare home health services because they only need help with their activities of daily living and do not need skilled nursing services. They are not eligible to receive Medicaid home health services either, because they do not have Medicaid benefits.

This lack of home nursing care for custodial patients greatly hampers my ability to properly care for these frail seniors at home. It is difficult to impossible for me to care for custodial patients at home who have hypertension, diabetes or other common geriatric problems, because these medical problems require medication that must be routinely followed with blood work, which is *not* a skilled nursing service. To treat patients blindly and hope the medication or the illness does not cause complications for the patient is dangerous to the patient and poses too great a malpractice risk for the physician.

I do not know of any local community organization, laboratory service or visiting nurse service that will consistently draw blood work on this type of homebound patient. No one will drive back and forth to a senior's home to draw blood work on these patients for the $3 that Medicare reimburses for this service. These patients are at risk of falling through the cracks, losing access to timely medical care, and ultimately entering a nursing home. Once admitted to a nursing home, these Medicare-only patients quickly spend-down their assets and become dually eligible Medicare-Medicaid patients, at great cost to the Louisiana Medicaid program. Providing basic home health services to these Medicare-only custodial care patients may allow them to live at home and avoid the dislocation and cost of nursing home placement.

SUGGESTIONS TO IMPROVE MEDICAL ACCESS FOR OUR NATION'S ELDERLY

Suggestion No. 1 - Fix the Balanced Budget Act of 1997 and restore Medicare-Medicaid crossovers payments for dually eligible persons

Suggestion No. 2 - Stop the Medicare "rule of 62s" for psychiatric care

This rule makes it more difficult for all Medicare beneficiaries to obtain psychiatric care at an affordable cost.

According to the American Medical News, the U.S. Senate recently approved a bipartisan "mental health parity amendment," which would "require health insurers to offer the same level of benefits for mental illness that they do for physical illness." Legislation sponsor Senator Paul Wellstone said, "For far too long, mental health consumers . . . have been discriminated against in the healthcare system — subjected to discriminatory cost-sharing, limited access to specialties and other barriers to needed services." The President of the American Psychiatric Association (APA) described the legislation as "a giant leap toward ensuring that the mental health needs of all Americans can no longer be ignored." The article continued: "The AMA, APA and more than 150 other medical, mental health, religious and community organizations have backed the measure . . . ."[161]

Unfortunately, according to Katie Tenoever of the AMA's Government Affairs Office, this "mental health parity amendment . . . does not apply to Medicare, and . . . does not affect the Medicare 'rule of 62[s].'"[162] Thus, a politically popular Congressional bill, supported by large numbers of medical, psychiatric and social organizations, continues to ignore the mental health needs of almost 40 million elderly or disabled Medicare beneficiaries.

Suggestion No. 3 - Ease restrictions on the release of Medicare eligibility information

In 2000 Louisiana physicians received an "Urgent Message from Louisiana Medicare Part B" stating that because of the 1974 Privacy Act, Medicare

> will no longer be able to provide Medicare eligibility information over the telephone to providers without proper authorizations from the Medicare beneficiary! . . . [HCFA has advised] all Medicare contractors that virtually any information regarding the Medicare beneficiary is classified as 'entitlement information,' and includes the following: Any Medicare eligible information. Any information regarding a patient's secondary and/or primary coverage status.

[161] Landa, Amy Snow. "Senate backs expansion of mental health parity law." American Medical News. 19 Nov. 2001: 5+.
[162] Tenoever, Katie. "Mental Health Parity." E-mail to the author. 6 Dec. 2001.

> [Any] HMO involvement [and any] Medigap or complimentary crossover information.[163]

This vital information can now only be released to the Medicare patient, or his or her legal representative.

Louisiana has many elderly and disabled patients who have severe neurological, psychiatric and/or developmental problems. This new interpretation of a 26-year-old privacy law can be an insurmountable obstacle to their care.

Many elderly or disabled people have little formal education and are skeptical about signing legal documents. Many live outside of a family unit, and are cared for by friends, church members, or relatives other than their spouse or children. The informal caretaker cares for the elderly person in the caretaker's home, and the elderly person's Social Security check helps pay the caretaker's rent. Many elderly people are satisfied with this arrangement because they feel almost any family-style home situation is better than having to live in the institutional atmosphere of a nursing home. Some of these people have had strokes or have Alzheimer's disease, and are not competent to make legal decisions for themselves. Many do not have a formal authorized representative, which Medicare now requires before it will release information the physician needs to begin treating the patient.

Prior to this new Medicare Privacy Policy, it was easy to accept these patients into my geriatric practice. I used to call Medicare and confirm the patient's Medicare eligibility and HMO status. Now, however, each new Medicare patient must hold my office telephone to their ear, speak to the Medicare representative on the telephone, and answer questions about their social security number and date of birth. If a patient's Medicare eligibility cannot be verified because the patient is confused or unable to speak, and does not have an authorized representative, I may not be able to see that patient.

Several months ago I received a telephone call from the sister of a bed-bound patient with Alzheimer's disease who had been discharged from a local hospital with "tubes and pipes in her." The sister felt that her previous doctor had "sent her home to die," and asked me to come to their home to evaluate and care for the patient. Before this new Medicare Privacy Policy, I could easily agree to make a home visit to the patient. This time, however, I was stymied because I could not verify this needy patient's Medicare eligibility and HMO status. I cannot travel to a patient's home only to find out Medicare will not release the patient's eligibility and billing information to me. I must know this information before I leave my office. Unfortunately, in this case, Medicare would not release the information to me or to the caretaker-sister, despite several rounds of three-way telephone conversations. Because of this Medicare Privacy Policy I could not accept this patient into my practice and could not make a home visit to her.

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[163] United States. Dept. of Health and Human Resources. HCFA. Urgent Message from Louisiana Medicare Part B. Baton Rouge: 2000.

This new Privacy Policy costs a great deal of staff and telephone time, makes it difficult to deal with the "old-old", the disabled, and the dually eligible population, and decreases medical access for all Medicare beneficiaries.

Suggestion No. 4 - Increase the number of geriatricians and their reimbursement

The current Medicare reimbursement system makes it difficult for geriatrics to survive. A sign of the increasing frustration at the problems in the current payment system found voice in a recent American Geriatrics Society symposium titled: "Can You Afford to Care for the Complex Geriatric Patient?"[164] We will not have adequate numbers of geriatricians to care for this population unless we are willing to properly train them and properly pay them for their services. There are currently several bills in Congress calling for increased graduate medical education positions for geriatricians, and increased reimbursement for geriatric services and case management. This legislation should be passed.

Suggestion No. 5 - Increase QMB and SLMB awareness on a national level

The QMB, SLMB and QI programs are national programs. There are 20 million Medicare beneficiaries with an income less than 200% of the Federal Poverty Level. This number includes 45% of all Medicare beneficiaries, and 59% of all beneficiaries over 85 years old.[165] These people may be eligible for some type of assistance from these programs. According to congressional testimony, approximately 10% of dually eligible patients nationally are enrolled in the QMB and SLMB programs:

> The majority of the six million dual eligible beneficiaries, about 5.4 million, receive full Medicaid coverage. Medicaid provides coverage for their Medicare premium and cost-sharing expenses and for services not covered by Medicare, including long-term care and outpatient prescription drugs.
>
> The remaining 600,000 beneficiaries are not eligible for full Medicaid coverage but do receive Medicaid assistance for Medicare premiums and/or cost-sharing expenses [through the QMB, SLMB, and Qualified Individuals programs].[166]

The percentage of eligible low-income Medicare beneficiaries enrolled in these QMB/SLMB/QI programs varies widely from state to state. A national informational program is needed to educate medical providers, social service workers, and Medicare beneficiaries about these programs.

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[164] American Geriatrics Society. 2001 Annual Scientific Meeting Reporter. Can You Afford to Care for the Complex Geriatric Patient? Symposium. New York: May 2001.

[165] Rowland, Diane. The Challenge of Meeting the Diverse Needs of Medicare's Beneficiaries. US Cong. Senate. Committee on Finance. Hearing on Medicare Reform. Washington: Kaiser Family Foundation, May 5, 1999. 5 May 2002 <http://www.kff.org/content/archive/2140/challenge.pdf>.

[166] Scheppach, Ray. Changes to the Medicare system. US Cong. Senate. Finance Committee. May 27, 1999. 18 July 2001 <http://finance.senate.gov/5-27sche.htm>.

Suggestion No. 6 - Provide better prescription drug coverage for the elderly and disabled poor

Many dually eligible patients have full prescription drug coverage through their state Medicaid program, but many elderly or disabled people do not have this coverage, despite being poor and being in the QMB/SLMB/QI program. The difference between one patient who is eligible for drug coverage, and another patient who is not eligible for drug coverage may be only a few dollars a month in their Social Security check.

Occasionally in my practice, I see a disabled patient or an elderly female patient who is dually eligible and who gets a "raise in their Social Security check." This happens at times because the disabled patient's parent or the elderly woman's former husband died and the patient becomes eligible for increased Social Security benefits. This "raise," however, may cause their income to appear too high to continue their Medicaid (and their all-important drug coverage) benefits.

Few elderly patients in my practice can afford to purchase all of their medicines for all of their medical problems. Adding up the costs of a patient's two diabetes drugs, three hypertension drugs, three drugs for heart failure and arthritis, one drug for depression, one drug for heartburn, and the vitamins and calcium supplements they take for their bones, I get a dollar amount few elderly or disabled patients in Mid-City New Orleans can afford. These patients may actually be *worse off* with their Social Security raise. Prior to the raise, they were poor but could more or less afford all of their medicines and medical care with their added Medicaid coverage. After their so-called raise, they are poorer, because now they cannot afford their medical care or their prescription costs.

The same can be said of people who qualify for the QMB/SLMB/QI program. They may qualify for Medicaid payments for their Medicare deductible and coinsurance costs when they come to the office, but many do not have any drug coverage. These patients have the promise of good medical care but no money for the medicines. Without drug coverage, these patients are dependent upon whatever drug samples I happen to have in my drug cabinet that month. I cannot change the patient's drug regimen every month depending on the availability of my drug samples, and I will never be able to provide the amount and variety of medicines that these patients need. When these patients get ill, and their medicine bills climb, I must refer them to our local public hospital for their care.

We have already identified patients in the QMB/SLMB/QI program, as well as all low-income Medicare beneficiaries, as being poor and needing help with their medical bills. If there is to be a prescription drug benefit in Medicare, then it should begin with these people.

Suggestion No. 7 - Establish one federal agency to deal with dual eligibility issues

There is no primary governmental agency that has an acknowledged responsibility for the dually eligible population, even though the medical cost for treating dually

eligible people is over $100 billion annually. As a result there is no centralized database where information and research relating to the dually eligible population can be stored, analyzed, and easily retrieved.

Policymakers do not agree as to who should have primary responsibility for the dually eligible population. According to Thomas Hamilton, Director of the CMS Center for Medicaid and State Operations at the U.S. Department of Health and Human Services (see Attachment 3, Letters from Senator Breaux and Director Hamilton), this is a federal issue:

> The Balanced Budget Act (BBA) of 1997 allowed states the option to limit their Medicaid crossover payment . . . Accordingly, only federal legislation could correct this situation by . . . requiring states to pay Medicare cost-sharing at rates higher than those currently authorized by their Medicaid program.[167]

However, according to the American Geriatrics Society (AGS), this is really a "state's issue."

The problem is that they are both correct. Dually eligible people are enrolled in one federal Medicare program that is coupled with over 50 independent Medicaid agencies. There are large bodies of information on people who have Medicare *or* Medicaid, but relatively little information on people who have both Medicare *and* Medicaid. I have been unable to find any current federal government document listing which states pay their crossover payments, and which states do not. Nor have I located information about the impact that the elimination of crossover payments has had on each state and its citizens. These are basic informational questions for a $120 billion program. We need a federal-state partnership to build a new "Dually Eligible Agency."

Suggestion No. 8 - The frail elderly need a personal care attendant

The goal of geriatrics is for our elderly to remain as functional as possible, for as long as possible. For this to happen, many frail, elderly persons require personal care services, which are individualized, "hands-on" help with ADLs, including dressing, eating, using the toilet, bathing, and transferring in and out of a chair or bed. Some programs also allow assistance with "instrumental activities of daily living" (IADLs), which "include activities such as shopping, preparing food, managing money, using the telephone, and performing housework." Personal care does not include medical care.

Persons with cognitive impairment such as Alzheimer's disease may be physically able to perform their ADLs and IADLs but "need supervision and reminding to complete a task" because of their impairment. Therefore, states must use broad "functional eligibility requirements" and measure cognitive impairment in order to determine eligibility for personal care services.

[167] Breaux, John, and Thomas Hamilton. Letters to the author. 21 May 2001, 19 Apr. 2001.

Medicaid pays for personal care attendants through the use of home and community-based service "waivers," which allow states to provide these services to people who would otherwise be eligible for expensive nursing home placement. Medicaid may also incorporate a "Personal Care Option" into its state Medicaid plan. Although most long-term care is provided "informally by family members and friends," some states train and pay family members to provide services to beneficiaries. "In Washington, about 7,000 individuals have received training to provide care and about 50% of these providers are family members."[168]

In New Orleans, personal care attendants (PCAs) who bring patients to the physician's office are paid and supervised by local social service organizations, which are under contract with Medicaid. This Medicaid-based program keeps mentally or physically disabled people who need help with their IADLs from repeated admissions to hospitals, homeless shelters, or nursing homes because of difficulties they encounter with housing, cooking, safety, transportation, medication and financial problems.

There is no organization, however, that readily provides personal care services for the frail elderly. Community-dwelling elderly persons may find relatively simple tasks, such as shopping, cooking, cleaning, bathing, paying bills, or transportation to the doctor or pharmacy to be a significant problem. A daily or weekly visit from a PCA may be all that a frail, elderly person needs to comfortably stay at home. They should not have to enter an expensive nursing home because they need help with non-medical personal care needs.

Suggestion No. 9 - We cannot afford less home health care

Government expenditures for home health services have soared. Louisiana, in particular, has been criticized because in 1999 it had the highest number of Medicare home health visits per person served in the country.[169] Because of the explosive growth of this service, congress attempted to rein in the costs, along with the access to home health care. According to David Hood, Secretary of Louisiana DHH,

> Changes at the federal level resulting from the Balanced Budget Act have greatly reduced the number of home health agencies operating in Louisiana. Home health is a vital component of the continuum of care for elderly citizens who do not want to utilize a nursing home when they get older and need some assistance in daily living activities.[170]

The AARP states that 28% of the 10 million Medicare beneficiaries who are discharged annually from short-stay hospitals require care in a skilled nursing facility or at home with a home health agency. The Medicare home health population also includes

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[168] Mollica, Robert L. Personal Care Services: A Comparison of Four States – Executive Summary. AARP Public Policy Institute. Washington: Mar. 2001. 9 Sept. 2001 <http://www.research.aarp.org/health/2001_04_care_1.html>.

[169] Lamphere, JoAnn, et al. Reforming the Health Care System: State Profiles 1999 — Highlights. AARP Public Policy Institute. ID D17094. Washington: Dec. 1999. 18 Feb. 2001 <http://research.aarp.org/health/d17094_states99_1.html>.

[170] Hood, David. Caring for Our Aging Citizens: The Louisiana Perspective.

a second group, which "consists of beneficiaries living at home with disabilities, chronic conditions, or complex medical needs," and who have not been in the hospital for at least six months. This chronically ill homebound group accounted for 43% of all home health visits. "[T]hese beneficiaries use Medicare home health over a longer period, have higher numbers of visits, and utilize home health aide services at higher rates."[171]

Home health is frequently used as a home-based alternative to long-term nursing home placement. It is frequently used by dually eligible people because of their age, poverty, multiple medical problems, and inadequate family structure. Louisiana's high home health service usage is a marker for Louisiana's medical, social and economic woes. Eliminating further home health benefits will remove the home health component from the left-hand side of the Medicare-Medicaid Payment Seesaw in Figure 8 resulting in more nursing home admissions.

This theme is echoed in the 1999 congressional testimony of Christine Ferguson, the Director of the Rhode Island Department of Human Services, regarding the Balanced Budget Act's negative impact on the Medicare home health benefit in her state:

> Medicare beneficiaries are receiving fewer services and Medicaid is frequently picking up the slack. . . . [T]here has also been a widespread decrease in access to home care services for all Medicaid recipients and private pay patients due to limited capacity and forced closures of home health agencies. We believe, but can't yet prove, that the result has been an increase in the number of hospitalizations as well as an increasing number of individuals with disabilities and the elderly at risk of long-term institutionalization . . . .[172]

[171] Foley, Lisa A. Care Management: Policy Considerations for Original Medicare – Part One. AARP Public Policy Institute. ID IB38. Washington: June 1999. 9 Sept. 2001 <http://www.research.aarp.org/health/ib38_care_1.html>.

[172] Rhode Island Dept. of Human Services. Christine Ferguson to Testify Before US Senate Finance Committee Tomorrow Regarding Medicaid and Medicare. Press release. May 11, 1999. 23 July 2001 <http://www.dhs.state.ri.us/dhs/press/dirtest.htm>.

DUALLY ELIGIBLE PEOPLE NEED AN INTEGRATED DELIVERY SYSTEM

Medicare and Medicaid do not serve dually eligible persons and the frail elderly as well as they should:

> Because of a lack of coordination between federal and state programs and the resulting fragmentation of healthcare delivery, [dually eligible] recipients face overlapping health benefits, separate eligibility requirements, different billing procedures and a plethora of claim forms. This often causes confusion and frustration, and becomes a barrier to accessing health care.[173]

There is tension between the Medicare and Medicaid programs, and a desire to "cost-shift" resources from one program to another. Medicare pressures hospitals to discharge patients quickly, often to a nursing home where Medicaid will be responsible for the bills. On the other hand, a nursing home may be able to treat a patient's pneumonia, but rather than spend money on extra nursing care, the nursing home may send the patient to the hospital where Medicare will be responsible for the bills. Similarly, post-hospital nursing home care and home health care can be funded by Medicare if it is deemed to be "rehabilitative," or by Medicaid if it is deemed to be "chronic or custodial care."[174]

Instead of cooperating to help the patient, there is a financial incentive for each program to protect its own resources, and to push the other program to pay for needed services. Medicare wants to keep people out of the hospital, and Medicaid wants to keep people out of its nursing homes. "When each player considers only that player's interest, cost shifting is most likely and the consumer loses." In this time of fiscally-challenged government, "If states and the federal government independently 'ratchet down' their parts of the system, dually eligible persons will be subject to double jeopardy."[175] When state Medicaid departments cut the crossover program, patients with Medicare are the ones who suffer.

Managed care, as presently structured, does not work well for dually eligible persons, and many of these people do not understand how managed care works:

> The concept of managed care is especially confusing to dual eligibles, many of whom think there are now three programs (Medicare, Medicaid, and managed care). Many dually-eligible beneficiaries have little or no prior experience with managed care and need to be introduced to the concept of the 'gatekeeper' or case manager.[176]

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[173] Edder.
[174] Ripley, Jeanne. "Coordinating Care for the Dual-Eligible Population." Healthcare Financial Management 55 (2001): 39-43.
[175] Mitchell, Elizabeth. "Medicaid, Medicare, and Managed Care." Journal of Case Management 6 (1997): 8-12.
[176] Edder.

The American Medical News reported that the Centers for Medicare & Medicaid Services announced that in year 2002, "Medicare HMOs [will be] abandoning half a million seniors." According to the Medicare Rights Center, Medicare-HMOs are "unstable and . . . unreliable." They are "after all, private health plans, and they respond to the bottom line." Insuring old or sick people may not be good business for the insurance industry. "In the healthcare marketplace, [HMO] plans won't participate unless they can make a profit."[177]

In order to deal with the medical and social problems of the frail elderly, an *integrated healthcare system* is needed. This is a system that financially merges Medicare's acute care programs with Medicaid's long-term care programs, and incorporates the case management tools and coordination of services needed to effectively treat dually eligible and other frail elderly persons:

> [I]f a new state-federal partnership emerges, dually eligible persons could end up with better care at a lower cost. . . . Integrated systems should improve cost-effectiveness. Pooling of resources and financial liability through integration could provide incentives for both sides to work toward the obvious win/win solution: providing the least restrictive appropriate care for the best price.[178]

According to Eli Feldman of Metropolitan Jewish Health System and Elderplan in Brooklyn, New York, integrating acute and long-term care services

> represents a more effective strategy for reducing Medicare and Medicaid expenditures than simply reducing provider payments, since these programs restructure financing and delivery approaches, and align provider and payor incentives with respect to clinical and financial goals.[179]

One of the first attempts to develop a seamless acute and chronic care integrated delivery system for frail seniors is the Program of All-inclusive Care for the Elderly (PACE). Begun in 1990, this program features a team approach to medical care, and was designed to treat small numbers of patients in a centralized adult daycare center location. PACE serves an exclusively frail elderly population and is financed by both Medicare and Medicaid on a capitated basis.

The goal of the PACE program is to keep frail elderly people living in the community and out of expensive nursing homes. The PACE population is difficult to treat and participants must be eligible for nursing home care in order to stay in the program. "The average age of a PACE enrollee is about 80; they average five to six

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[177] Aston, Geri. "Medicare HMOs abandoning half a million senior citizens." American Medical News. 8 Oct. 2001. 1+.
[178] Mitchell.
[179] Feldman.

diagnoses and are usually on 10 to 12 medications. About 90% of PACE enrollees are dually eligible for Medicaid and Medicare."[180]

According to the Robert Wood Johnson 2000 Anthology, even though PACE participants are very frail, their hospital use rate "is lower than that of the Medicare 65-plus population, which includes healthy older persons." PACE participants "have shorter lengths of stay in the hospital . . . [and] had Medicare savings of 38% in the first six months after enrollment and 16% savings over the next six months." The PACE model "offers policy makers a less costly community-based alternative to constructing new nursing home beds."[181]

Other integrated delivery models, such as "Social HMOs," serve overwhelmingly Medicare-only beneficiaries and seek a cross-section of both the well and the frail elderly. The Social HMO benefit package includes case management, personal care assistance, homemaker services, respite care, transportation for medical visits, adult daycare, some nursing home care, and a personal emergency response system. Even though Social HMOs have been unable to fully integrate Medicaid benefits because of problems with plan administration and Medicaid financing issues, "social HMOs reduced Medicaid spending on nursing home care . . . [by] delaying or avoiding [nursing home placement] and Medicaid spend-down."[182]

There are at least eight examples of *state-run* Medicare and Medicaid integrated managed care pilot programs in the United States. The Minnesota Senior Health Options (MSHO) is one of the most innovative programs for dually eligible people. This is a large-scale project, which offers large geographic coverage, wide health plan and provider participation, and a broad range of covered services. The MSHO "combines the financing of Medicare, Medicaid, and home- and community-based elderly waivered services . . . into one capitated monthly payment." The program uses these pooled funds to "provide senior citizens with a complete network of care, including prescription drugs, preventive health services, and some nursing home care."[183] Pamela Parker, the Director of MSHO, stated in her congressional testimony, that "because the coverage they receive includes long-term care benefits, dual eligibles [in MSHO] have even more comprehensive coverage than most seniors who pay for private insurance coverage."[184]

A report in the Robert Wood Johnson 2000 Anthology describes the broad medical and social benefits, which MSHO offers the frail elderly. The MSHO offers all standard Medicare and Medicaid services, in addition to home and community-based services and up to 180 days of nursing home care. After the first 180 days, the nursing home is reimbursed on a fee-for-service basis. Nursing home care is an important option because 77% of MSHO participants reside in a nursing home. MSHO's home and community-based services "include case management, companion services, caregiver training, extended home health aide, extended personal care assistance, adult foster care,

[180] National Health Policy Forum.
[181] Alper.
[182] Feldman.
[183] Ripley.
[184] Parker.

adult daycare, assisted living, residential services, homemaker services, home delivered meals, respite care, home modification, and supplies and equipment. Each senior has a 'care coordinator' to assist with care planning and service access."[185]

Massachusetts has its own version of a comprehensive, integrated program for its dually eligible and frail elderly citizens called MassHealth Senior Care Options. In addition to acute and community-based long-term care services, Massachusetts also included mental health and substance abuse services in their benefit package.[186]

[185] Alper.

[186] Willrich, Kate, et al. Demographic Profile of Dually Eligible Seniors in Massachusetts 1997. The Massachusetts Division of Medical Assistance, et.al. Mar. 2000.

WE NEED HELP WITH THIS NATIONAL ISSUE

Improving healthcare delivery and medical access, as well as reforming Medicare and Medicaid are major concerns for our state and federal governments, for physicians, and for patients. The federal government should not allow Louisiana, or any other state, to provide a full "one-dollar healthcare ticket" for its wealthier Medicare beneficiaries, and only provide an "80-cent healthcare ticket" to its poorer Medicare beneficiaries. Surely congress never intended to make it *more* difficult for our nation's most aged and poorest people to access the cost-effective and efficient care they deserve.

The elimination of Medicare-Medicaid crossover payments for our elderly and disabled is a *national* issue. Our nation has previously recognized that certain populations are more vulnerable than other populations and has, for example, created special programs to help poor children and poor pregnant women. Our poor elderly and disabled are a special population that cries out for similar protection. To leave our oldest, poorest and sickest people at the mercy of financially challenged state governments, or to the vicissitudes of the marketplace is shortsighted, dangerous and unjust.

This group of frail, elderly and disabled persons makes up a significant and costly portion of our Medicare population. Any effort to increase medical access for this vulnerable group may be frustrated as long as each state has the option, as outlined in the Balanced Budget Act, of imposing a geriatric penalty of at least 20% on this population. The national solution for this problem is to void specific provisions of the Balanced Budget Act, and make Medicare-Medicaid crossover payments a fully funded federally mandated program. Only by removing this issue from the grasp of perpetually cash-starved state Medicaid departments — who may slowly but surely opt out of paying these "voluntary" crossover payments — will we be able to assure these people proper access to efficient, cost-effective medical care.

In 1965, the United States Congress made a pact with our nation's elderly and disabled citizens and established Medicare. By establishing fair Medicare payment rates, congress guaranteed our elderly and disabled citizens proper access to medical care. By eliminating Medicare-Medicaid crossover payments for its dually eligible population, Louisiana has broken this 37-year-old promise and has injured our elderly and disabled people and the physicians who serve them.

In November 2001, the Centers for Medicare & Medicaid Services announced that next year's Medicare fee schedule would be cut by 5.4%. This was made possible by a flaw in the formula used to update the yearly Medicare payment schedule. Immediately after that announcement medical organizations mobilized to stop this budget cut from harming Medicare beneficiaries and the physicians who treat them. One AMA fax stated,

> *Medicare Cuts Affect Patient Access.* Across-the-board cuts in Medicare physician payments will have immediate negative consequences for patient access to physician services. Already, surveys have shown that patients in some localities have trouble finding physicians who are

> willing to accept new Medicare patients. These problems will quickly worsen with an across-the-board reduction.[187]

The ACP-ASIM Observer, the national newspaper for internal medicine physicians, opined that internal medicine physicians care for more Medicare beneficiaries, and "internists will rightly respond with anger if Medicare fees are cut . . . . Medicare cannot claim to put the interests of patients first if it continues to devalue the important work of the doctors who actually care for those patients."[188]

If the threat of a 5.4% budget cut for all Medicare patients, which include many healthy and wealthy seniors throughout our country, draws such an impassioned response from organized medicine, then how is it possible that so few voices protest Louisiana's geriatric penalty that *at a minimum cuts an additional 20% of the Medicare payment* for our oldest, poorest, and sickest dually eligible patients? These patients have a right to expect the same outrage over this scandalous budget cut in crossover payments — a budget cut that may eliminate 70% to 80% of an elderly or disabled dually eligible Medicare patient's initial office visit or house call reimbursement.

It seems impossible that 104,110 dually eligible persons in Louisiana, as well the multitude of dually eligible persons nationwide, could be *so invisible* that so few caregivers, medical providers, and policymakers would object to our state's poorly reasoned attempt to save money by decreasing medical access for this neediest and most expensive population group. If a proposed budget cut of 5.4% looks bad because it "will have immediate negative consequences for patient access to physician services," then consider how dire the consequences will be of this additional 20% to 80% reduction in Medicare payments.

Congressman Pete Stark, cosponsor of the Chronic Illness Care Improvement Act of 2000, stated,

> [I]mproving health care for chronic illness . . . is the most effective way to prevent the disability and dependence that otherwise leads to institutionalized long-term care . . . [P]revention, coordination and integration of care for chronic illness would spend the healthcare dollar more wisely while greatly enhancing both the quality of care and the quality of life.[189]

Although this is true for all elderly and disabled persons, it is especially true for our dually eligible citizens. In discussing this group, Senator John Breaux has stated: "These are our most vulnerable citizens, and we owe them the best of our nation's health

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[187] Orleans Parish Medical Society. Important Facts Regarding the 2002 Medicare Physicians Payment Update (From the AMA). Fax to the author. 6 Dec. 2001.

[188] Doherty, Robert B., "News about Medicare: a good-news, bad-news scenario." ACP-ASIM Observer. Dec. 2001: 10.

[189] Stark, Pete. Congressman Pete Stark's Statement: The Chronic Illness Care Improvement Act of 2000 to Expand Preventative Services and Streamline, Coordinate, and Integrate Care Across All Health Care Settings. US Cong. House. Washington: July 11, 2000. 14 Aug. 2001 <http://www.house.gov/stark/documents/106th/hr4981dc.html>.

care."[190] Restoring crossover payments for dually eligible Medicare-Medicaid people in Louisiana must be the first step on the road to improving access to health care for all of our nation's frail and "vulnerable citizens."

In response to the imposition of Louisiana's geriatric penalty on dually eligible persons, all medical, political, social, religious and community groups who are interested in the health and well-being of people who are old, poor, female, African American or other minority, or mentally or physically disabled should join together in urging our state and federal officials to restore crossover payments for dually eligible citizens. Everyone should join forces behind this issue, because by working together *we can stop* Second-Class Medicare, and we can make a difference in the health care for our neediest citizens.

[190] Breaux, John. Torn Between Two Systems

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ATTACHMENTS

1: “Budget cuts hit doctors hard, putting poorest patients at risk.”

2: Inability to make house call letter

3: Letters from Senator Breaux and Director Hamilton

Attachment 1: "Budget cuts hit doctors hard, putting poorest patients at risk."

1. Go to Internet site: www.neworleanscitybusiness.com/archives/search_at.asp
2. Enter date: 01/08/2001
3. Enter article title: Budget cuts hit doctors hard, putting poorest patients at risk

(Letter sent on Hersh Medical Clinic stationery)

January 15, 2001

XXXXXXXXXXXX
XXXXXXXXXXXX
New Orleans, LA XXXXX

Re: Inability to make a house call
for XXXXXXXX

Dear Ms. XXXXXX:

As I told you on the telephone last week, I am sorry that I will not be able to make a house call to see your mother. I realize that your mother is 95 years old, has Alzheimer's disease and has had cancer. I realize that your mother is completely bed-bound and will need an ambulance to leave the house to go to see a doctor. I understand that this is a hardship for you and your mother. However, as I explained to you on the telephone, the Medicaid Department and the State of Louisiana have severely and unjustly cut the reimbursement for elderly patients such as your mother who have both Medicare and Medicaid insurance. Since last year, Louisiana Medicaid has cut the reimbursement for a house call to your mother by 81%. They have, therefore, made it more difficult for your mother to get efficient, cost-effective medical care.

I would be pleased to see your mother in my office in the near future, but I am not certain if Medicare or Medicaid would pay for an ambulance to bring her to my office. If necessary you may bring your mother to the hospital Emergency Room where the doctor-on-call will see your mother. I realize that this doctor may not be an internal medicine physician or a geriatrician who specializes in treating the elderly. I realize that this doctor will not know you or your mother and that you may never see this doctor again in the future.

The Medicaid Department and the State of Louisiana have made a serious mistake and are discriminating against the elderly. The cost of the ambulance service and the Emergency Room visit will far outweigh the money they think they are saving by abolishing the payments for dually eligible Medicare-Medicaid patients such as your mother. If you are as angry about these unjust cuts as I am, then I suggest you write a letter to the people on the enclosed list and urge them to reverse these severe and unjust budget cuts. You may also enclose a copy of this letter with your correspondence.

Sincerely yours,

Sheldon Hersh MD

Enclosures.

JOHN BREAUX
LOUISIANA

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COMMERCE, SCIENCE, AND TRANSPORTATION
FINANCE
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May 21, 2001

Dr. Sheldon Hersh
Hersh Medical Clinic, Inc.
3315 Tulane Avenue
New Orleans, Louisiana 70119

Dear Dr. Hersh:

In response to your letter regarding the abolition of Medicare-Medicaid crossover payments and its effect on the elderly in Louisiana, I contacted federal officials. Enclosed is the response provided to me from U. S. Department of Health and Human Services.

I hope this information is helpful. If I can assist you in any other way, please let me know.

With kind regards,

Sincerely,

John

JOHN BREAUX
United States Senator

JB/set/ejo
Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
7500 Security Boulevard
Baltimore, MD 21244-1850

APR 19 2001 01 APR 24 PM 2:12

The Honorable John Breaux
United States Senate
Washington, DC 20510-1803
ATTN: Sara Traigle

Dear Senator Breaux:

I am responding to your letter to Carleen Talley, Director of the Congressional Affairs Division in the Health Care Financing Administration, about a letter from your constituent, Dr. Sheldon Hersh. In his letters, Dr. Hersh is concerned that the State's reduction of Medicaid payments ("crossover payments") for Medicare/Medicaid dually eligible patients is unfair to doctors and will ultimately hurt the elderly and disabled patients in Louisiana and throughout the nation.

The Balanced Budget Act (BBA) of 1997 allowed States the option to limit their Medicaid crossover payment for services provided to Qualified Medicare Beneficiaries (QMBs) to an amount that, when combined with the payment the provider receives from Medicare, does not exceed the amount that the State's Medicaid program would have paid for that same service.

Louisiana has chosen this option under BBA. Accordingly, only Federal legislation could correct this situation by restricting this State flexibility and requiring States to pay Medicare cost-sharing at rates higher than those currently authorized by their Medicaid program.

I hope this explanation is helpful. If you have any questions or need further information, please contact Robert Nakielny at (410) 786-4466.

Sincerely,

Thomas E. Hamilton
Director