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A Federal Crossover Program for Primary Care Services for Dually Eligible People With Medicare and Medicaid

A proposal to save Medicaid money and improve access for Dually eligible people with Medicare and Medicaid, Which costs *less than 2%* of the National Governors Association plan.

Sheldon Hersh, MD
New Orleans, Louisiana
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The Governors Open the Debate

The National Governors Association (NGA) recently announced the formation of a Medicaid Reform Task Force and thrust the issue of dually eligible people and their financing onto the national stage. Recognizing the enormous Medicaid costs for the states to care for dually eligible people with Medicare and Medicaid, the NGA stated,

> The governors have made Medicaid reform their highest priority for good reason. The program is crushing our budgets and we believe that restructuring it to meet the demands of the 21st century is one of the most effective actions we can take to bring state budgets under control. . . .

During the NGA's February 2003 Winter Meeting the governors adopted new NGA policies, including the following request.

> The federal government should assume *full responsibility* for the acute, primary, long-term, and pharmaceutical care of the dual eligibles, individuals who are enrolled in the Medicare program, but because of their low-income, are also eligible for the Medicaid program [emphasis added].

Is This Proposal Desirable?

Should the federal government assume "full responsibility" for the total cost of care for dual eligibles? Is this plan financially and politically possible? Would this proposal improve access and health care for vulnerable dually eligible people? Would this program save healthcare dollars for our nation, and not just for the states?

Although superficially this proposal appears to make sense, I do not believe the federal government should shoulder the entire cost of care for these people. Such a program will not save money for our nation. Nor would this proposal result in the best and most efficient care for our frail, elderly and disabled population.

Dually Eligible People

Dually eligible people are the oldest, poorest, sickest, and most disabled people in the country. As described by Senator John Breaux, dually eligible people are "the elderly and disabled poor." They are disproportionately elderly, women, minorities, and mentally or physically disabled people — all of whom are poor. There were six million dually eligible people in the U.S. in 1995. This number will double by 2030.

These people require medical care that is *twice* as expensive as that of non-dually eligible people. They comprise only 17% of the Medicare and Medicaid populations, yet they use almost 35% of *all* Medicare and Medicaid money. (See Figure 1.) Dually eligible people are the fastest-growing and the most expensive Medicare population. In

1995 the cost of caring for these people totaled $106 billion. By 1997 the cost of caring for these people had jumped to $120 billion — a $14 billion increase in just two years. In order to reform Medicare or Medicaid we must confront the issue of dually eligible people.

Dually eligible people live in the intersection where Medicare's elderly and disabled world overlaps with Medicaid's world of poverty. 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. Dually eligible people are the group of old, poor, frail or disabled persons who are at greatest risk of becoming ill and requiring long-term nursing home care. One quarter of the dually eligible population resides in expensive nursing homes, and approximately 70% of all nursing home residents are dually eligible people. Dually eligible people are *twelve* times more likely to live in a nursing home than non-dually eligible people. (See Figure 2.)

It Would be Financially, Socially, and Politically Unwise for the Federal Government to Pay All Medicaid Expenses for Dually Eligible People.

The political problem

States are broke. It is therefore understandable that the NGA would ask the federal government to pay for the Medicaid expenses of dually eligible people, their single most expensive population. However, in this time of fiscal belt-tightening, it would be difficult for the federal government to pay an additional *one-third* of all national Medicaid costs, amounting to *tens of billions of dollars* each year.

The financial problem

According to Senator John Breaux, dually eligible people consume 35% of the national Medicaid budget. According to HCFA, *85% of all national Medicaid money* spent on dually eligible people is spent on their *nursing home care*. (See Figure 3.) Multiplying the 85% by the 35% shows that 30% of our nation's entire Medicaid budget goes to house dually eligible people in nursing homes. (See Figure 4.) Their national Medicaid nursing home bill is approximately $34 billion.

Therefore, when the governors ask the federal government to pay all the Medicaid expenses of dually eligible people they are primarily asking the federal government to pay for the costs of their states' *nursing home payments* for dually eligible people.

In order to understand the problems of dually eligible people we must first recognize that dual eligibility is a social as well as a medical problem. In order to age successfully, people need three things: health, wealth, and education. Many of the factors which influence these items are under the control of the individual states, and not under the direction of the federal government. Poor states such as Louisiana may have a

scarcity of these items, whereas other states may have a healthier, more educated, more affluent citizenry.

Similarly, many of the issues affecting dually eligible people are under the control of state and local communities and cannot be controlled by the federal government. These include the supply and access to primary care physicians in the community who serve this population, the availability of local transportation services and personal care attendants, the availability of adult daycare centers and assisted living facilities, and state-approved home and community-based long-term care.

Also, dually eligible people may have complicated family, housing, and legal issues which are controlled by the states, and which affect their ability to stay in their own communities. The availability of social workers and social services such as food stamps, meals-on-wheels, Legal Aid, etc., may also impact the ability of dually eligible people to live in their own inexpensive homes, as opposed to expensive Medicaid-sponsored nursing homes. Finally, dually eligible people may be adversely affected by discrimination or violence in their communities, or positively affected by local religious and community organizations.

Many of the variables that determine the number of people who enter a nursing home and how large a state's nursing home bill will be can only be controlled by the states, and not the federal government. Asking the federal government to pay for all nursing home services, when it has so little say about how dually eligible people are treated by the states, is a prescription for fiscal irresponsibility.

At the present time each state is highly motivated to decrease its own nursing home bill by decreasing the number of nursing home residents and increasing the use of less expensive alternatives to nursing home care, such as home and community-based long-term care. The smaller the number of nursing home residents, the more money a state will save. Each state is essentially a financial and social laboratory, trying to figure out the best and least expensive method to care for its frail citizens. As long as the states have a financial stake in decreasing its nursing home industry, states will try to be as efficient as possible with their own money.

If the federal government begins paying all medical expenses for dually eligible people (85% of which are for nursing home payments), how can we expect the states to react? If the federal government takes away the states' financial incentive to decrease its nursing home budget, and instead substitutes an *open-ended nursing home entitlement*, then the states will have a perverse incentive to *increase* their nursing home usage. If the federal government pays for all nursing home costs, then encouraging nursing home placement will bring additional "free" federal dollars into the state. Any state that improves access to community services for dually eligible people would lose the federal money that would have entered the state if the patient had entered a nursing home. What incentive would the state have to encourage the use of outpatient physician services, improve transportation, improve social services, encourage better health habits and

educational achievement, improve its housing base, etc.? Such an open-ended program would certainly benefit the states' finances, but could impoverish the federal government.

We cannot expect states to spend someone else's money and get strict financial accountability. Such a program would eventually provoke a backlash leading to cutbacks in federal funding. The cycle would then start over, and we would again have to decide what to do about dually eligible people. Medicaid is a federal-state partnership. Asking the federal government to pay for the states' societal problems as they relate to dually eligible people will not work.

The social problem

The states and the federal government should work together to allow its dually eligible citizens to live in the community. Encouraging nursing home care at the expense of community care causes social upheaval for the elderly and disabled and their families. We are now in the midst of a revolution in the long-term care industry. For years the nursing home budget for dually eligible people was the largest single state Medicaid expense in Louisiana. We are now witnessing the growth of alternatives to nursing home care such as home and community-based services. In addition to costing less than nursing home care, these alternative services allow people to live out their final years in the dignity of their own homes alongside their own families.

In 1995 according to HCFA, 78% of the money spent on nursing home care went to pay for *custodial services* such as room and board and other non-medical services. Therefore, at least $27 billion of national Medicaid money was spent solely on room and board and other custodial services for dually eligible people in nursing homes. Increasing the use of alternative long-term care services will decrease nursing home occupancy and allow for more efficient use of this enormous nursing home bill. For example, in Louisiana, despite the increasing number of elderly people our nursing home industry already has 6,000 *empty* nursing home beds — resulting in a significant savings for Louisiana Medicaid. If, however, the federal government began to pay all nursing home costs for dually eligible people, the number of people admitted to our nursing homes would increase, and the number of empty nursing home beds would decrease. This regression would worsen the family dislocation and social isolation that frequently accompanies nursing home placement.

"Second-Class Medicare" and Decreased Medical Access for Dually Eligible People: Lessons From My Geriatric Practice

In 1997, Congress tried to help states decrease their Medicaid expenses and passed the Balanced Budget Act. This Act allowed two-thirds of the states to essentially eliminate Medicare-Medicaid physician *crossover payments* (i.e., payment for the Medicare deductible and 20% coinsurance, which Medicaid used to pay) for dually eligible people. In so doing it decreased dually eligible people's access to primary

geriatric care in the community and has resulted in a *two-tiered,* discriminatory Medicare benefit system for four million dually eligible people — two-thirds of the six million dually eligible population — who now have what I refer to as "Second-Class Medicare." (See Figure 5.)

The elimination of crossover payments is a "geriatric penalty." As a result of the elimination of crossover payments, I have been forced to change two parts of my geriatric practice and have decreased medical access for these frail people. My first change was to stop making home visits to new dually eligible patients because, by eliminating payment for the Medicare deductible and coinsurance, Louisiana *cut the reimbursement for a home visit by 80%.*[1] I can no longer provide this service and stay in business. By cutting 80% of the reimbursement for a home visit Louisiana Medicaid has made it necessary for these patients to be seen in the emergency room, hospital, or nursing home 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 any geriatric (i.e., dually eligible) patients in my office. Instead, I do other medical work for which the financial reimbursement is better.

Medical segregation often coexists with economic and racial segregation. 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,

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[1] For a 45-minute Home Visit for a new patient, level 3, CPT code 99343, Medicare promised the patient and the physician an "allowable amount" of $133 for 2001. But with a dually eligible patient's deductible not being met in January at the start of the year, Medicare first subtracts the $100 yearly deductible from the $133 allowed amount, and then pays 80% of the remaining $33, for a payment to the physician of $26.40. The medical claim is then automatically "crossed over" and sent to Louisiana Medicaid to pay its portion of the remaining balance of $106.60.

Medicaid, however, says in essence, "I don't care if Medicare says this physician service should be paid $133. 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 Louisiana Medicaid payment for this service, including the money Medicare has already paid to you, the physician, would be $25.20. Since you already received more than this amount from Medicare, we are not going to pay you anything more."

In this instance, instead of the $133 the physician and the patient were promised by Medicare, the physician is receiving only $26.40 or 20% of what he or she had been promised. Because the State of Louisiana has stopped paying crossover payments and the physician is forbidden by law to bill the patient for this amount, this loss of $106.40 or 80% of the Medicare allowed charge can never be recovered. Dually eligible patients whose care is only reimbursed at 20% of the Medicare allowed charges cannot get equal access to medical care.

For a full discussion regarding crossover payments, see the chapter titled "Second-Class Medicare: How Do Medicare-Medicaid Crossovers Work?" in the monograph, *Dually Eligible People with Medicare and Medicaid*, on our web site, www.nacdep.org.

79% are female, and 34% are mentally or physically disabled — all groups which should be protected by our civil rights laws.

I stopped accepting new homebound dually eligible patients into my medical practice in 2001 because crossover payments for these patients were eliminated. For the two-year period from 1999 through 2000, *100% of my house calls* to dually eligible people were to the homes of disabled African-American patients who were all homebound and/or bed-bound due to severe medical problems. This is one part of my practice that I regret having to stop due to this geriatric penalty, but shifting the focus of my geriatric 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. Similarly in Connecticut in 1999, the elimination of that state's crossover payments led to decreased geriatric and medical access and difficulty obtaining appropriate care for frail, dually eligible nursing home patients.[2]

If *any* physician who treats dually eligible patients is forced to decrease access to geriatric patients in New Orleans — and many other poor urban and rural areas — the majority of the people whose access will be injured will be elderly, poor, minority 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. The road to decreasing disparities in health care runs straight through the issue of dually eligible people.

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[2] In 1999, Connecticut eliminated crossover payments for its dually eligible Medicare-Medicaid citizens, just as Louisiana did in 2000. Although Connecticut has an 82% White majority, Hartford is 72% African American, Hispanic and other minorities. Because of the demographics of Hartford, many of that city's dually eligible people affected by Connecticut's Medicaid crossover cuts were probably minorities, females or disabled persons.

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. . . ."

For details see the monograph, *Dually Eligible People with Medicare and Medicaid,* on web site www.nacdep.org.

What We Can Do Now:

A Federal Crossover Program for Primary Care Services for Dually Eligible People with Medicare and Medicaid

Dually eligible people drive our nation's healthcare costs, and nursing home costs drive dually eligible people's Medicaid expenses. According to HCFA in 1995, only 4% of all Medicaid money spent by Medicaid on dually eligible people went to pay for physician crossover services. (See Figure 3.) It is, however, this small (4%) Medicaid physician crossover program which holds the key to the much larger (85%) Medicaid nursing home program.

Physicians will always be needed to help these frail, elderly and disabled citizens "age in place" in their own home, and not in an expensive Medicaid-sponsored nursing home. The most important thing we can do for dually eligible people is to improve their access to inexpensive, early-stage, primary care in the community. This will decrease their very expensive late-stage care in the nursing home and provide welcome relief for state Medicaid budgets. Because decreasing insurance reimbursement affects access to medical care, the elimination of the Medicare deductible and 20% coinsurance for dually eligible people — which Medicaid used to pay — decreases their access to primary medical care in the community. If dually eligible people cannot find access to a community physician's office because of lowered insurance reimbursement, they will be forced to find access to an expensive emergency room, hospital, or nursing home.

Eliminating Louisiana Medicaid's physician crossover program in 2000 saved Louisiana Medicaid $24 million. Dividing this $24 million crossover payment by the 104,000 dually eligible people who live in Louisiana shows the average dually eligible person's crossover payment in Louisiana would have been $230.77.[3] Multiplying this number by the six million dually eligible people in the United States shows the total national Medicaid physician crossover bill would be almost $1.5 billion. Dividing this estimated $1.5 billion national crossover bill by 50 states shows the average state's Medicaid crossover program costs approximately $30 million.

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[3] Average state crossover payments per person may vary because states have Medicaid payment rates, which are higher or lower than the Louisiana payment rate.

States with a relatively low Medicaid payment scale may have a larger crossover bill per person because the disparity between the Medicare schedule and the Medicaid schedule will be greater. Such a state will have to pay more money to cover the Medicare deductible and coinsurance.

Conversely, states with a relatively high Medicaid payment scale may have a smaller crossover bill per person because the disparity between the Medicare schedule and the Medicaid schedule will be smaller. Such a state will have to pay less money to cover the Medicare deductible and coinsurance.

The federal government already pays more than half of all Medicaid bills because Medicaid is a jointly funded federal-state program. Therefore, for each state's $30 million Medicaid crossover expense the federal government currently reimburses each state approximately one-half or $15 million of the state's crossover expenses. Only $15 million of each state's $30 million crossover expense is actually paid by state treasuries. Because of this federal-state partnership the states must pay only *one-half* of the estimated $1.5 billion national Medicaid crossover bill or $750 million in order to receive the promised $750 million federal matching share.

The federal government can improve dually eligible people's access to community health care and help decrease every state's Medicaid nursing home bill by *paying the states' share* of crossover payments for dually eligible people. Creating this "Federal Crossover Program for Primary Care Services for Dually Eligible People" will require the federal government to contribute an additional $750 million each year — averaging $15 million per state — to pay the states' share of crossover payments for dually eligible people. This $750 million is less than 2% of the National Governors Association's proposal, and is in addition to the already-promised federal matching rate of $750 million, which brings the total federal outlay to the estimated $1.5 billion.[4]

A Federal Crossover Program for Primary Care Services for Dually Eligible People would be a *social* success because it would help solve many of the demographic, racial, social, civil rights, and gender problems described on NACDEP's web site. A Federal Crossover Program would be a *financial* success because if the program saves only 2.2% of our national $34 billion Medicaid nursing home bill for dually eligible people — or $750 million — the program would pay for itself. A Federal Crossover Program would be a *political* success because the many varied dually eligible populations and their families, along with state officials, physicians, and other organizations dealing with "the elderly and disabled poor" would be pleased.

Compared to tens of billions of dollars to pay for a financially unwise open-ended nursing home entitlement for the states, by spending $750 million the federal government can help all the states, all dually eligible people, and the physicians who serve them. Every state and local medical society, every state Medicaid department, and all state and federal officials should favor such a program. This will also allow states to continue to find innovative methods to further decrease their nursing home bills.

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[4] As seen in Figure 3, only 4% of all national Medicaid money spent on dually eligible people was spent on their physician services. Since the federal government pays more than one-half of all Medicaid bills, the federal government pays more than half of the physician crossover bill and the states pay less than half of the physician crossover bill.

The National Governors Association is asking the federal government to pay 100% of *all* national Medicaid expenses or tens of billions of dollars each year. NACDEP's plan calls for the federal government to pay less than half of *only* the physician crossover bills. Therefore, this plan would cost less than 2% of the National Governors Association's proposal.

Asking the federal government to pay for all expenses for dually eligible people is like asking for an enormous castle. Since this is not politically, socially or financially wise, then asking the federal government to pay crossover payments with 100% federal funds is the equivalent to asking for only the keys to the castle. Why request the entire castle when all we really need are the keys?

The stakes are high for dually eligible people and for our Medicaid and Medicare budgets. We cannot reform Medicare or Medicaid without dealing with the issue of dually eligible people. Increasing access to primary geriatric care in the community with a Federal Crossover Program for Primary Care Services for Dually Eligible People will help turn healthcare disparity into healthcare equality for these people.

NACDEP, the National Coalition for Dually Eligible People

As our society becomes more diverse our challenge in the 21st century will be to wipe out disparities in health care. The first step on this road must be to restore equal access to health care for our most vulnerable elderly and disabled citizens. What's good for dually eligible people is good for the nation.

NACDEP, the National Coalition for Dually Eligible People is a not-for-profit, educational organization. Our mission is to improve access and health care for dually eligible people. NACDEP's proposal for a Federal Crossover Program will improve access to community health care and decrease our nation's Medicaid nursing home bill for dually eligible people — while costing less than 2% of the National Governors Association proposal. The last slide on NACDEP's web-based slide presentation states:

Dually eligible people with Medicare and Medicaid —
At the center of the next debate

> Because of their frailty, their social and racial demographics, their great expense, and their expanding growth rate, dually eligible people — "the elderly and disabled poor" — will occupy a central position in the upcoming debates over national healthcare financing and disparities in health care in the 21st century.

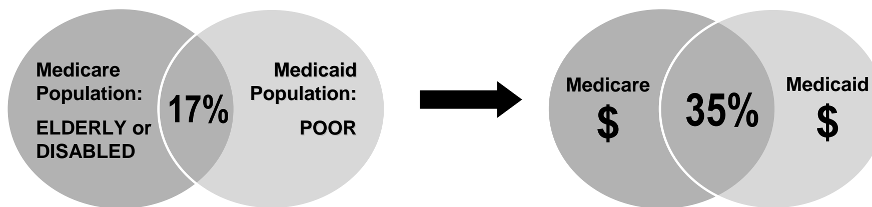
The debate has begun. Welcome to the debate. Please support this ethically, medically, socially, and financially correct plan to care for dually eligible people — our most vulnerable citizens.

Figure 1.

Dually Eligible People Are *Twice* as Expensive as Non-Dually Eligible People

Dually eligible people comprise Only 17% of the Medicare and Medicaid population.

Yet these same people use Almost 35% of of all Medicare and Medicaid money.



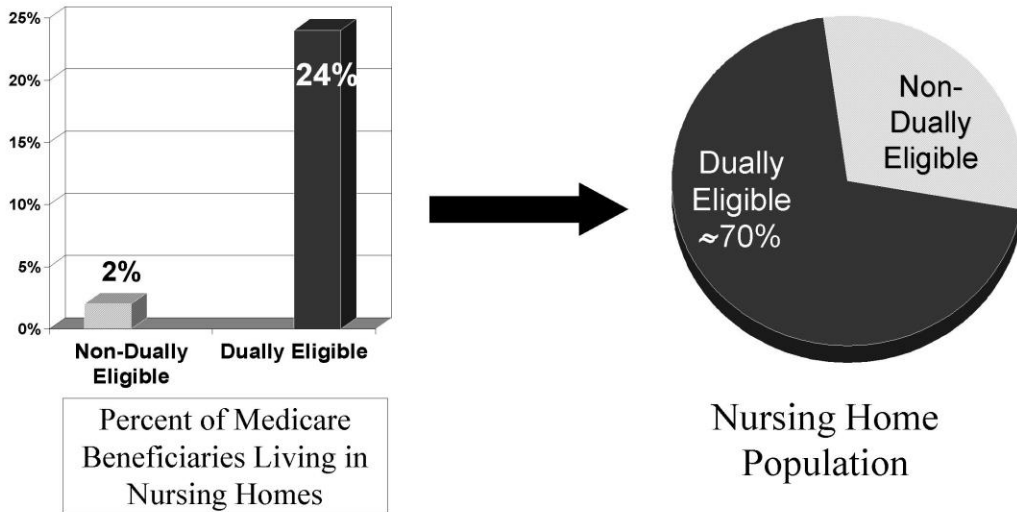
The cost of caring for these people Totaled *$106 Billion* in 1995.

Source: Breaux, John. Torn Between Two Systems.

Dually eligible people are the fastest-growing and most expensive Medicare population.

The road to reforming Medicare and Medicaid runs directly through the issue of dually eligible people.

Figure 2.



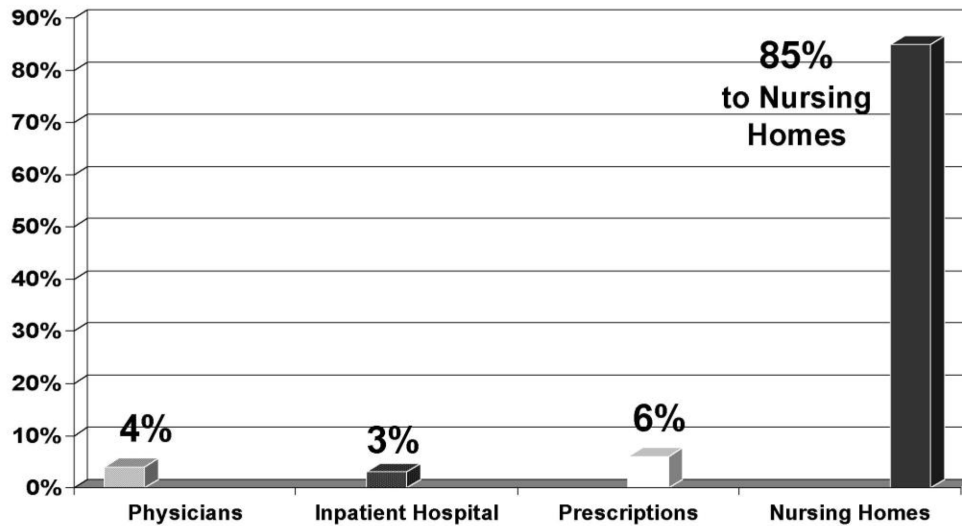
Source: HCFA

One-quarter of the dually eligible population lives in nursing homes.

Seventy percent of all nursing home residents are dually eligible people.

Dually eligible people are *twelve* times more likely to live in a nursing home than non-dually eligible people.

Figure 3.



Source: HCFA

In 1995, 85% of all money spent by Medicaid on dually eligible people went to pay for their nursing home care.

Only 4% of all Medicaid money spent on dually eligible people went to pay for their physician services.

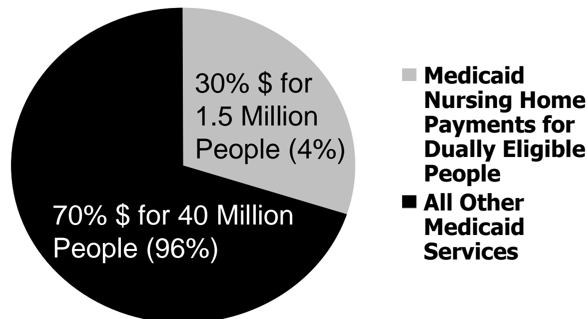
The National Governors Association proposal asks the federal government to pay 100% of *all* Medicaid expenses for dually eligible people.

NACDEP's plan calls for the federal government to pay less than half of *only* the physician crossover expenses, which is less than 2% of total Medicaid expenses.

Figure 4.

30% of Medicaid Budgets Is Spent to House Dually Eligible People in Nursing Homes

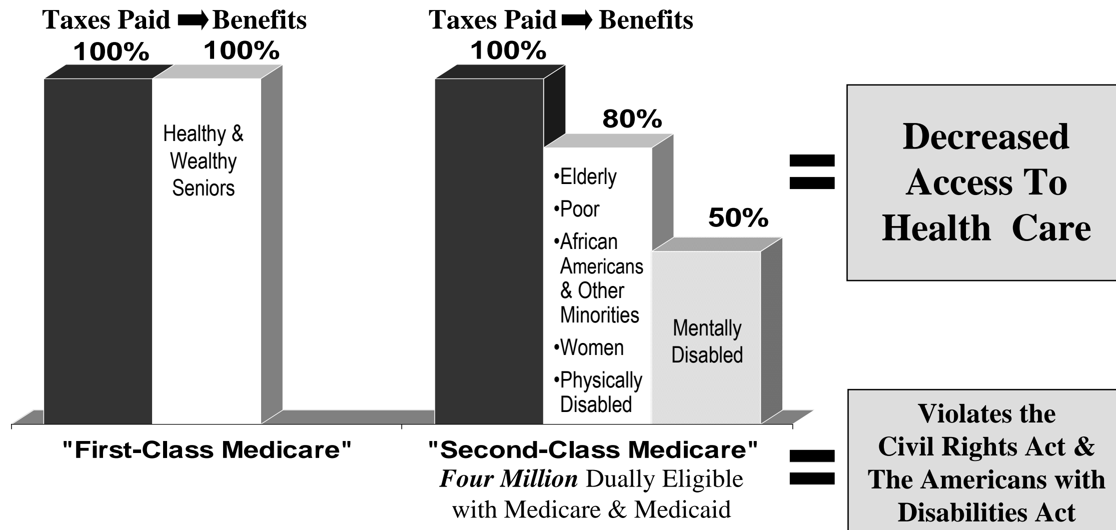
- Dually eligible people consume 35% of all Medicaid money — Senator John Breaux
- 85% of all money spent by Medicaid on dually eligible people is spent on their nursing home care — HCFA
- Therefore, 85% x 35% = 30% of state and federal Medicaid budgets is spent to house dually eligible people in nursing homes.
- Only 70% of Medicaid budgets is available to pay for *all* other services, patients, and healthcare providers.



Medicaid spends 30% of its national budget on only 4% of the Medicaid population, which resides in nursing homes.

This contributes to the perpetual crisis in Medicaid funding across the nation.

Figure 5.



Medicare in Louisiana and two-thirds of all states is a *two-tiered* discriminatory benefit system. Two-thirds of the more than six million dually eligible people in the United States or approximately four million dually eligible people have Second-Class Medicine.

On the left is "First-Class Medicare," where non-dually eligible beneficiaries who have paid 100% of their taxes can expect to receive 100% of their Medicare benefits.

On the right is "Second-Class Medicare," where dually eligible people have paid 100% of their taxes. Because of the elimination of Medicare-Medicaid crossover payments, however, the *most* Medicare benefits they can receive is 80%. These dually eligible people are disproportionately elderly, minorities, women, and physically disabled people — all of whom are poor.

Mentally disabled people fare worse, because Medicare pays only 50% of the medical bill for patients with psychiatric illness, as opposed to paying the customary 80% of the bill for patients with non-psychiatric illness.

In addition to creating ethical and civil rights problems, Second-Class Medicare decreases access to health care for dually eligible people. Decreasing medical access for elderly and disabled poor people results in higher Medicaid nursing home costs.

(See our web site, www.nacdep.org, for details.)