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Dually Eligible People with Medicare and Medicaid

"The Elderly and Disabled Poor"

Notes for the Slide Presentation

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Slide No. 1. Dually Eligible People with Medicare and Medicaid — "The Elderly and Disabled Poor"

Welcome to New Orleans.

My name is Dr. Sheldon Hersh. I have been practicing internal medicine and geriatrics in the Mid-City area of New Orleans for 26 years.

I have a large number of elderly and disabled people who depend on me for their care.

Almost three-quarters of my Medicare practice is dually eligible and have both Medicare and Medicaid — a far cry from the 16% of the national Medicare population who are dually eligible, according to Senator John Breaux.

I began researching this issue in 2000 when the State of Louisiana eliminated Medicare-Medicaid *crossover payments* for dually eligible people. This decreased their insurance reimbursement from 20% to 80% and decreased healthcare access for these frail people.

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Slide No. 3. Section 1. Dually Eligible People

Slide No. 4. Dually Eligible People Have Both *Medicare* and *Medicaid*

Medicare is the promise of a single nationwide system of health care, with one set of equal benefits for everyone, regardless of race, sex, or income.

Medicaid, on the other hand, is more than 50 separate state programs, each with its own set of rules, personnel and computer systems.

These programs have different funding mechanisms and different healthcare missions. There is tension and competition between these programs, just as you would expect with one husband who is married to over 50 wives.

Medicare is an earned benefit. Medicaid is an entitlement.

Slide No. 5. Dually Eligible People with Medicare and Medicaid Are:

Senator John Breaux used the term "elderly and disabled poor" to describe dually eligible people in his opening statement before the Senate Special Committee on Aging in 1997.

Who are these people, what are their social and health characteristics, and how do they fit into our nation's healthcare system? My task is to put a name and a face on dually eligible people — "the elderly and disabled poor."

There were six million dually eligible people in 1995. Their number is expected to double by 2030.

There are many people who are old, or poor, or sick or disabled who are not dually eligible. But if we are discussing the largest group of people in the country who are the oldest, *and* the poorest, *and* the sickest, *and* the most disabled, then we must talk about dually eligible people.

Besides being elderly or disabled, dually eligible people are also defined by poverty. In general, a group's health problems increase as the group's income decreases. These four groups — the elderly, women, minorities and the disabled — have lower incomes than other populations in the United States.

1. The elderly. As people grow older on a fixed income and have more medical expenses, they become increasingly poor.

2. Women. Women spend less time in the labor force, work for smaller wages, and have less pensions and savings. Women have more chronic illness and disability, live longer than their spouses, and become poorer as they age.

3. Minorities. Minorities have less education, work for less money, leave the workforce earlier, have less pensions, more chronic illness and disability, and become poorer as they age.

4. The disabled. As for mentally or physically disabled people, if such a person cannot work, that person cannot earn any money.

If dually eligible people had only the first three characteristics listed on this slide they might continue to be only a low priority moral and social dilemma for our country, something to be dealt with in the distant future. But because they are both the fastest-growing *and* the most expensive Medicare population, our nation must deal with this problem now.

Slide No. 6. Dually Eligible People Are Vulnerable and Poor

Approximately three-quarters of dually eligible people are women — this is surely a women's issue.

The percentage of dually eligible Medicare beneficiaries who are minorities is three to four times as great as the percentage of minorities in the non-dually eligible Medicare population.

Most dually eligible people have a very low income.

Medicare has two dually eligible populations — the elderly, who are the majority of dually eligible people, and the "non-elderly disabled" who are under 65-years-old. According to the Health Care Financing Administration (HCFA) in 1997, the non-elderly disabled group (which includes people with end-stage renal disease) was 28% of the dually eligible population.

The "old-old" geriatric population who are over 85-years-old and the non-elderly disabled are the fastest growing Medicare and dually eligible populations.

Activities of Daily Living (ADLs) are activities related to personal care, including eating, bathing, dressing, using the toilet, transferring in and out of a bed or a chair, etc.

Dually eligible people are frail and vulnerable. They are the people at greatest risk of becoming ill and requiring expensive long-term nursing home care. This creates a significant financial problem because one-quarter of all dually eligible people live in nursing homes across the country.

Slide No. 7. Dually Eligible People Have More Chronic Illness

This list is a virtual "who's who" of internal medicine, geriatrics, and psychiatry.

Dually eligible people have many chronic illnesses, which increase their medical costs.

Slide No. 8. Dually Eligible People Are Frail and Require More Medical Services

People who are chronically ill use more medical services, which increase their medical costs.

Slide No. 9. Dually Eligible People Have More Difficulty Obtaining Medical Care

Despite their large number of medical illnesses and intensive use of medical services, dually eligible people may struggle for access to healthcare.

Louisiana ranks second only to Mississippi in having the poorest access to primary care. Over 20% of our state's population lack access to a primary care physician.

Substituting emergency room and hospital services for primary care physician services is a marker for inadequate disease management and inadequate patient follow-up.

Even the $3 per month prescription copayment for each of their eight to ten medications can be difficult, as may be the cost of taxi fare to the physician's office.

Approximately 10% of dually eligible people have no prescription medication benefits.

The problems of Louisiana's dually eligible population have deep roots in Louisiana's poverty.

Slide No. 10. Dually Eligible People Are Twice As Expensive As Non-Dually Eligible People

According to Senator John Breaux, the $106 billion spent on dually eligible people in 1995 was nine times more money than was spent nationally on medical research.

Dually eligible people live in the intersection where Medicare's elderly or disabled world meets Medicaid's world of poverty. Their costs are so high because the medical problems associated with being old or disabled are *multiplied* by the social problems of being poor.

The dually eligible population is the fastest-growing Medicare population. Their medical costs are *twice* as high as the medical costs of non-dually eligible people.

What will happen if they become 20% to 25% of the Medicare and Medicaid populations and consume 40% to 50% of Medicare and Medicaid resources?

Will the remaining 75% of Medicare and Medicaid beneficiaries struggle over the remaining 50% of the money? Clearly this situation is not sustainable.

Slide No. 11. Section 2. Second-Class Medicare

Slide No. 12. Insurance Reimbursement Affects Access to Health Care

In health care, as in the rest of our economy, "you get what you pay for." The higher your insurance reimbursement, the better your access to health care.

A patient who pays his or her "boutique physician" a $20,000 retainer gets excellent access to health care.

An uninsured person who pays his or her healthcare provider nothing will get poor access to health care.

Medicare payment rates are higher than Medicaid payment rates, so 99% of Louisiana physicians accept Medicare assignment, as opposed to less than 10% of Louisiana physicians who *actively participate* in the Medicaid program.

We are painfully aware of the 5.4% Medicare payment reduction in year 2002, and the proposed 4.4% payment reduction for 2003, along with the threats of decreased medical access these payment reductions will cause.

What would happen if we took the 17% of the oldest, poorest, sickest, and most disabled people in the nation — the dually eligible population — subtracted the 2002 5.4% Medicare reduction, and then dropped their total insurance reimbursement *another* 20% to 80%?

Any such drastic insurance reduction would surely reduce dually eligible people's access to health care.

This is what the State of Louisiana, along with *two-thirds of all states,* has done to dually eligible people's insurance reimbursement.

In February 2000, Louisiana eliminated Medicare-Medicaid crossover payments, which is payment for the yearly Medicare $100 deductible and the 20% Medicare coinsurance, which Medicaid used to pay.

In order to understand the consequences of this budgetary cut we must first examine how medical services for dually eligible people are financed.

Slide No. 13. How Crossovers Work: January 2000 — With Crossovers

For dually eligible people, Medicare is always the "first payer" and sets the payment rates. 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 or the patient's secondary insurance 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.

In this current example, a complicated geriatric dually eligible patient visits the doctor in January 2000, *before* crossover payments were eliminated.

Medicare says 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.

Slide No. 14. How Crossovers Work: February 2000 — Without Crossovers

This is an entirely different situation. Here it is one month later, in February 2000, *after* crossover payments have been eliminated.

Here is the same 45-minute new patient office visit. Medicare still "allows" $126 for this service. On the left of the slide, 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."

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 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.

Dually eligible patients whose care is only reimbursed at 27% of the Medicare allowed charges cannot get equal access to medical care.

On the right of the slide, with the "Medicare Deductible Met", Medicare pays 80% of the $126 "allowed," 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% for every dually eligible patient the physician sees for the remainder of the calendar year.

Recall that Medicare is the promise of a *single* nationwide system of health care, with one set of equal benefits for everyone, regardless of race, sex, or income. Without crossover payments we now have a *two-tiered* Medicare system, with dually eligible people who are disproportionately elderly, women, minorities and mentally or physically disabled

people getting a lower insurance reimbursement and, therefore, reduced access to health care.

Slide No. 15. The Elimination of Crossover Payments for Dually Eligible People is a "Geriatric Penalty"

This "geriatric penalty" will have varying effects on physicians' practices. A pediatrician or obstetrician who treats few 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.

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 house calls to new dually eligible patients.

In January 2001 I was forced to send a letter to the daughter of a 95-year-old, bed-bound, dually eligible patient with Alzheimer's disease. This letter explained that I was no longer able to make a house call to see her mother because, by eliminating Medicare-Medicaid crossover payments, the State of Louisiana had cut the reimbursement for a physician house call service *by 81%*.

A house call is the archetypal geriatric service — usually focusing on the patient's function and comfort, and often ending with a family conference regarding case management of the patient. 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.

If I decrease my geriatric office hours by 10% and the physician across the hall does the same, then who is left to see these vulnerable people except the costly emergency rooms, hospitals and nursing homes?

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.

Slide No. 16. My New Orleans Dually Eligible Population, 2000

Who in New Orleans is affected by this geriatric penalty?

This is a snapshot of my New Orleans dually eligible population in 2000.

Of all dually eligible patients in my practice, 89% are African American.

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.

Seventy-nine percent of my dually eligible patients are women. This is consistent with other surveys, which showed that three-quarters of dually eligible people are women.

Thirty-four percent of my dually eligible patients are under the age of 65 and disabled — a higher number than the 28% of non-elderly disabled dually eligible patients nationally.

New Orleans has a higher percentage of disabled people than the rest of Louisiana, and Louisiana has a higher percentage of disabled people than the rest of the country.

Additionally, 100% of these people are also poor.

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 — 100% of whom were also "disabled," because they were all bed-bound and/or homebound due to severe medical problems.

The majority of my dually eligible practice focuses on treating elderly African-American grandmothers and great-grandmothers.

Slide No. 17. African-American Population and the "Southern Black Belt"

According to the 2000 U.S. Census, African Americans represent 12% of the total United States population. African Americans, however, are not evenly dispersed across the country. Over 50% of older African Americans are concentrated in the Southeastern United States, stretching across an 11-state area from Virginia to Texas, an area which 100 years ago Booker T. Washington called the "Southern Black Belt."

Also called the "Third World of the United States," this area has large African-American populations and high poverty rates, along with poor employment rates, poor healthcare access, poor housing, poor educational statistics, and high infant mortality rates

Within this Southern Black Belt sits Louisiana and New Orleans. Although the national percentage of African Americans is 12%, Louisiana has an African-American population of 33%, and New Orleans has an African-American population of 67%. One census tract in New Orleans' Lower Ninth Ward had 99.4% African Americans and 0.1% White persons.

My geriatric practice in Mid-City New Orleans draws patients from several predominantly African-American neighborhoods, and my dually eligible patients are overwhelmingly African American. This Lower Ninth Ward census tract is an area that feeds my practice and where I have made home visits to disabled, bed-bound, African-American patients.

Dual eligibility is a marker for poverty in our elderly and disabled population. Because New Orleans is a poor city with a large African-American population, and women outlive men, most of my dually eligible patients are elderly, African-American women.

Other states' racial compositions may also vary with geography. In Georgia, which forms part of the Southern Black Belt, 45% of dually eligible people are African American, compared with just 6% in Colorado, which lies outside the Southern Black Belt.

The pattern of well-demarcated areas of disadvantaged populations occurs in other cities and rural areas across the nation whose demographic map mirrors New Orleans. All three of Louisiana's largest cities, New Orleans, Baton Rouge, and Shreveport, have African-American majorities.

Although the wealthy State of Connecticut has a population that is 82% White, the poor city of Hartford is only 28% White, and 72% African American, Hispanic, and other minorities. When Connecticut eliminated Medicaid crossover payments in 1999, as Louisiana did in 2000, 42% of physicians decreased access for dually eligible people — who were mostly elderly, minority women — especially in nursing homes.

The elimination of Medicaid crossover payments for dually eligible people disproportionately affects the elderly, minorities, women, and mentally or physically disabled people. This affects four million of the six million dually eligible people in the United States, because two-thirds of the states have eliminated Medicare-Medicaid crossover payments.

This violates the "disparate discrimination" clause of the Civil Rights Act of 1964 because the elimination of crossover payments has a *disproportional* or "disparate impact" on several protected groups of people, including the elderly, minorities, women, and mentally or physically disabled persons.

Slide No. 18. The "Southern Disability Belt"

This situation also violates the Americans with Disabilities Act of 1990 (ADA).

One-quarter of the national dually eligible population has already been declared disabled by the Social Security Disability Program and is protected by the ADA.

The remaining three-quarters of the dually eligible population are frail, elderly people with multiple impairments, illnesses, and limited activities, and therefore also qualify for protection under the Americans with Disabilities Act.

Dually eligible people suffer discrimination and decreased healthcare access solely because they are disabled and poor.

According to the Census Bureau, there is also what I refer to as the "Southern Disability Belt." This Southern Disability Belt occupies much of the same area of the country as the Southern Black Belt.

New Orleans and Louisiana also live within the Southern Disability Belt. New Orleans and Louisiana have higher percentages of disabled persons than the rest of the United States.

Slide No. 19. Second-Class Medicare

On the left of the chart is "First-Class Medicare," where "healthy and wealthy seniors" who have paid 100% of their taxes can expect to receive 100% of their Medicare benefits.

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

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. Few psychiatrists can accept many mentally disabled dually eligible patients whose bills are only paid at 50% and still stay in business.

Medicare beneficiaries who are mentally disabled are younger, poorer, and more socially isolated than physically disabled beneficiaries are. They are also more likely to be minorities and dually eligible people.

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.

In addition to creating ethical and civil rights problems, Second-Class Medicare also decreases access to health care for dually eligible people.

Decreasing medical access for these elderly and disabled poor people results in higher Medicaid nursing home costs across the country.

Slide No. 20. Section 3. The Nursing Home Burden

Slide No. 21. Most Nursing Home Residents Are Dually Eligible People

Although dually eligible people are only 16 to 17% of the Medicare and Medicaid populations, approximately 70% of the nursing home population are dually eligible people.

Dually eligible people are vulnerable to nursing home placement because they are old, poor, and ill.

Dually eligible people are twelve times more likely to live in a nursing home than non-dually eligible people are. One-quarter of dually eligible people live in nursing facilities as opposed to only 2% of non-dually eligible persons.

Slide No. 22. Medicaid Payments for Dually Eligible People, 1995

This concept put the financing of dually eligible people's medical care into perspective and helped shape the focus of this project.

I was upset when Louisiana Medicaid eliminated $24 million from the physician crossover program in January 2001 and decreased access for dually eligible people in the community. Only later did I realize this represented *less than 4%* of all Medicaid money spent on dually eligible people.

According to HCFA (now renamed CMS, the Centers for Medicare & Medicaid Services), 85% of all Medicaid money spent to care for dually eligible people goes to house dually eligible people in expensive nursing homes.

Eliminating crossover payments for dually eligible people decreases their access to medical care in the community. If dually eligible people cannot find access to medical care in the community they will find it in the nursing home.

Slide No. 23. 30% of Medicaid Budgets Is Spent to House Dually Eligible People in Nursing Homes

The 4% of the Medicaid population who reside in nursing homes consume 30% of all Medicaid budgets.

Only 70% of Medicaid budgets is available to care for the remaining 96% of the Medicaid population.

The burden of financing nursing home care for dually eligible people contributes to Medicaid's financial problems.

Slide No. 24. Second-Class Medicare Leads to Decreased Medical Access & Increased Nursing Home Costs: The State View

Here is the 95-year-old, bed-bound woman with Alzheimer's disease to whom I could not make a house call in 2001 because, by eliminating crossover payments, Louisiana Medicaid had decreased the reimbursement for a house call by 81%

Louisiana is pleased because Louisiana Medicaid saved $108 by eliminating crossover payments for the house call I could no longer perform.

But, since I can no longer make a house call to see her, she must wait until she becomes sicker and more vulnerable, and then travel to the emergency room by ambulance. From there it is short journey into the hospital and then into a nursing home.

Although Louisiana Medicaid was pleased to save $108 on the house call, it now has to spend $26,000 every year to keep this woman in the nursing home.

The average national Medicaid nursing home payment rate is about $35,000, and the rate for non-Medicaid residents is over $50,000 per year.

One-quarter of Louisiana's 104,000 dually eligible people or approximately 26,000 dually eligible people live in nursing homes. This 95-year-old woman is but one piece of a large Medicaid nursing home pie chart.

The entire Louisiana State budget is $16 billion. Dividing the $500 million Louisiana nursing home bill for dually eligible people by the $16 billion state budget demonstrates that approximately 3% of *total* Louisiana expenditures goes to house people like this 95-year-old dually eligible woman in our state's nursing homes.

Slide No. 25. Second-Class Medicare Leads to Decreased Medical Access and Increased Nursing Home Costs: The National View

Each state contributes one slice to the national $34 billion Medicaid nursing home bill for dually eligible people.

Louisiana contributes its $500 million slice.

This $34 billion Medicaid nursing home bill for dually eligible people is approximately 1.8% of *total* federal expenditures.

Slide No. 26. The Medicare-Medicaid Payment Seesaw

In order to understand the significance of this $34 billion Medicaid nursing home bill we must first understand how medical and nursing home services for dually eligible people are financed.

The Medicare and Medicaid programs sit on a seesaw — the "Medicare-Medicaid Payment Seesaw."

On the left-hand side of the seesaw is the Medicare program with the three main *community* services 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.

Medicare pays approximately 80% of all 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.

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, Louisiana must keep people in the *Medicare-sponsored* community and out of *Medicaid-sponsored* nursing homes.

Slide No. 27. The Medicare-Medicaid Payment Seesaw — With Physicians and Crossovers, 1999.

The physician is the medical service "gatekeeper" and patient advocate. The single purpose of the physician is to help keep people functional, living in the community and not in a nursing home.

Physicians will 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, keeping people in the community on the Medicare-payment side of the seesaw has the added bonus of lowering Louisiana's Medicaid nursing home bill.

The "Louisiana Scorecard" shows that 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. This is a win-win-win situation.

Slide No. 28. The Medicare-Medicaid Payment Seesaw — Without Physicians and Crossovers, 2001.

This represents the current situation after Louisiana eliminated crossover payments and imposed its geriatric penalty.

Now there is no physician counterweight on the left-hand Medicare side of the seesaw. Without the physicians' care and attention, frail, dually eligible people are left without their best patient advocate.

The physician has, in effect, been pushed off the office/hospital/home health side of the seesaw. The result is that dually eligible patients have less medical access. They 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.

The Louisiana Scorecard shows that by imposing this geriatric penalty on dually eligible people, Louisiana has decreased medical access for our most vulnerable, dually eligible citizens and increased costs for the state nursing home budget. Now, the patients and their families are displeased, the physicians are displeased, and the Louisiana treasury is displeased. This is a lose-lose-lose situation.

Slide No. 29. For Louisiana and All State Treasuries: Community Care is a Bargain. Nursing Home Care is a Burden.

Medicare has recognized that much of the care in nursing homes is not medical care and refuses to pay for people with few medical problems to live in expensive nursing homes.

According to Medicare's philosophy each state has a responsibility to encourage its citizens to live in their own community. If a state cannot or will not adopt policies to encourage the use of community facilities — such as the physician's office, hospital, and home health — and instead substitutes the use of expensive nursing homes, then the state must pay for that choice by itself, using money that comes out of its own pocket.

For Louisiana Medicaid and for *all* state treasuries community care for dually eligible people is a bargain, while nursing home care for dually eligible people is a burden.

Medicare pays four times as much money for medical care in the community than Medicaid does. Therefore, in the community dually eligible people are *Medicare*-Medicaid with *Medicare paying 80%* of the bill with federal dollars.

Medicaid pays four times as much money for care in the nursing home than Medicare does. Therefore, in the nursing home dually eligible people are essentially *Medicaid*-Medicare with *Louisiana Medicaid paying 80%* of the bill using Louisiana treasury dollars.

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 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).

The financial key for Louisiana Medicaid is to keep as many dually eligible people as possible on the office/hospital/home health side of the Medicare-Medicaid Payment 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.

Slide No. 30. Effects of a $27 Million Louisiana Nursing Home Raise, 2002

In 2002 Louisiana Medicaid gave the nursing home industry a $27 million "cost-of living raise" — even though 20% of nursing home beds in Louisiana are empty.

This $27 million nursing home raise for the predominantly dually eligible population is essentially the same $24 million (plus an additional $3 million) that Louisiana Medicaid removed from the physicians' program in 2000 when it eliminated crossover payments for dually eligible people.

Medicare pays approximately four times as much money for medical care in the community than Medicaid does. Therefore, Louisiana Medicaid could have used the $27 million nursing home subsidy to better financial advantage if it spent the $27 million on *community* services, as opposed to nursing home services.

Since *Medicaid only pays 20%* of a dually eligible person's community healthcare bill and Medicare pays 80%, multiplying the $27 million — the *Medicaid 20%* — by five, shows this $27 million nursing home raise could have helped purchase approximately $135 million of *Medicare-sponsored* healthcare services in the physician's office, in the hospital or through home health, using an additional *$108 million* of the federal government's money.

Conversely, since *Medicaid pays 80%* of a dually eligible person's nursing home bill and Medicare pays only 20%, dividing the $27 million Medicaid nursing home raise by 80% reveals this $27 million has only helped purchase a total of $34 million of nursing home

services in the *Medicaid-sponsored* nursing home, using an additional *$7 million* of the federal government's money.

Subtracting the actual $7 million Medicare *nursing home* investment Louisiana *will* receive from the $108 million Medicare *community* investment Louisiana *could have* received, shows that Louisiana Medicaid lost the chance to bring an *additional* $101 million of federal healthcare dollars into our state by encouraging dually eligible people to live in nursing homes instead of in their own communities.

Instead of the federal government paying for the majority of the larger $135 million Community Services pie on the left, most of the smaller $34 million Nursing Home pie on the left must now be paid with local Louisiana Medicaid money that comes directly out of the *Louisiana treasury*.

Slide No. 31. 78% of Nursing Home Costs Are for *Custodial Services* — Room and Board, Activities of Daily Living

There are two parts to nursing home care. The first is the nursing, or medical part, and the second is the home, or custodial part.

According to HCFA in 1995, 78% of money spent on nursing home care went to pay for *custodial services* such as room and board and non-medical services, such as assistance with activities of daily living that include eating, dressing, and bathing.

Only 22% of long-term care expenses were for *medical* services.

Multiplying Louisiana's nursing home bill and the nation's nursing home bill by 78% shows that $390 million of Louisiana Medicaid money and $27 billion of national Medicaid money was spent on room and board, and other custodial services for dually eligible people who live in nursing homes.

This represents 2.4% of all Louisiana State expenses and 1.4% of total federal expenditures.

Louisiana has historically preferred to place elderly and disabled persons in nursing homes, rather than in community or home care. But saving money by utilizing home and community-based long-term care should change this.

Vermont Governor Howard Dean testified at a Senate hearing that Vermont was able to save *more than half* of nursing home costs by providing 30 hours a week of social services and medical care to elderly and disabled residents enrolled in its community care program, and was able to decrease its nursing home population by 18%.

Similarly, Louisiana saved *over half* of the nursing home costs for 700 elderly people living in a less restrictive, home-based setting by providing community-based services.

Since most of the money spent on nursing home care is local Medicaid money, state treasuries will be major financial beneficiaries of home and community-based long-term care savings.

How many more childhood vaccinations, obstetrical services, and adult daycare services could Louisiana and our nation provide for all citizens if there were extra millions or billions of dollars available each year?

The main question is this: Do people needing long-term care live in their own inexpensive homes, or do they live in expensive, Medicaid-sponsored nursing homes?

Slide No. 32. Section 4. Possible Solutions

Slide No. 33. Escalating Costs for Dually Eligible People

Costs for dually eligible people continue to rise.

Senator John Breaux said it cost $106 billion to care for dually eligible people in 1995.

In his Senate testimony, Massachusetts Governor Celluci said that by 1997 these costs had risen to $120 billion, an increase of $7 billion per year.

Multiplying $7 billion per year by six years and adding that number to the $120 billion total in 1997 shows we should be at the $150 to 160 billion per year mark by 2003.

Again, this rate of growth is not sustainable.

Slide No. 34. NACDEP, the National Coalition for Dually Eligible People

There is a large amount of information about people who have either Medicare *or* Medicaid, but relatively little information about 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.

In response to the current situation, I have established NACDEP, the National Coalition for Dually Eligible People.

NACDEP, the National Coalition for Dually Eligible People, is a not-for-profit, Louisiana-based educational organization dedicated to improving access and health care for elderly and disabled dually eligible people with Medicare and Medicaid — "the elderly and disabled poor".

NACDEP serves as a national clearinghouse for information regarding dually eligible people and their impact on our nation's healthcare system.

Our nation's elderly and disabled poor citizens need your help and your support. Please join us at our web site: www.nacdep.org.

Slide No. 35. Healthcare Elephant

Many organizations have a mission statement.

This is NACDEP's mission graphic.

Public Awareness is standing in the Healthcare Financing House in 1997. He is unable to see there is an enormous financial problem living in the house with him.

It is NACDEP's job to "turn on the light," so that Public Awareness can see the Healthcare Elephant, which is the "$120 Billion for Elderly and Disabled Dually Eligible People with Medicare and Medicaid."

Slide No. 36. Bottom Line for Louisiana and the Nation

What works for Louisiana and its dually eligible population also works for other states and for the country as a whole.

Decreasing Louisiana Medicaid's nursing home budget is the financial key. Louisiana must help keep dually eligible people in the community and out of expensive nursing homes.

A state cannot decrease community and physician access programs while increasing payments to nursing homes and expect dually eligible people to continue to stay in the community.

Transferring money out of the already small (4%) Medicaid physician program, and into the already large (85%) Medicaid nursing home program results in decreased access to primary care physicians, increased use of nursing homes, and costs the Louisiana treasury a great deal of money.

Dually eligible people need access to First-Class Medicare in the community.

Second-Class Medicare may save a small amount of money on the front-end of the system by decreasing access to community physicians' offices, but it will increase costs on the back-end of the system by inflating Medicaid nursing home costs.

Slide No. 37. Short-Term Solution

The situation could be fixed at the state level by having two-thirds of all the states decide individually to restore Medicare-Medicaid crossover payments.

This would be difficult because many states are already having financial difficulty. Also, launching a successful campaign in each state would be politically difficult.

At the federal level, congress could remedy this problem by changing part of the Balanced Budget Act of 1997 (BBA). Since the BBA allowed states to eliminate crossover payments, voiding the BBA would restore crossover payments.

But this would have a negative financial effect on the states because the states' Medicaid departments would be forced to spend more money again. This choice, too, is financially and politically unpalatable.

The best solution is to pay Medicare-Medicaid crossover payments with *100% federal* funds.

Having one federal solution is administratively, politically, and financially superior to having 50 different state solutions.

Slide No. 38. A "Federal Crossover Program"

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.

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.

Medicaid is a jointly funded federal-state program. The federal government already pays more than half of all Medicaid bills.

Therefore, states must pay only one-half or $750 million of the estimated $1.5 billion "Federal Crossover Program" to receive the promised $750 million federal matching share.

The federal government can improve dually eligible people's access to health care and help out every state by contributing an *additional* $750 million each year — averaging $15 million per state — to pay the *states'* share of crossover payments for dually eligible people.

A Federal Crossover Program would be a *social* success because of all the demographic, racial, social, civil rights, and gender problems I have described.

A Federal Crossover Program would be a *financial* success because if the program saves only 2.2% of our national Medicaid nursing home bill — 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.

Slide No. 39. Medicare Money Saved by Regulating Direct-to-Patient Advertising of "FREE" Geriatric Medical Equipment Could Help Fund a Federal Crossover Program

Out-of-state companies print newspaper ads, and beam radio and television ads to our state's elderly and disabled population creating a market for their expensive products.

Ads describing scooters and electric wheelchairs often use words like "FREE, . . . with proper insurance," or "Could cost you $0.00." These ads are attractive to people who have a Medicare Supplementary Insurance and to dually eligible people with Medicare and Medicaid.

After a patient answers the ad the physician receives a fax which states "your patient has requested" this piece of equipment. The form asks the physician to attest to the medical necessity of the ordered medical equipment under penalty of civil or criminal sanctions.

According to the forms I have received, the "Medicare Allowable" for a fully equipped electric wheelchair may total $7,744.00. This does not include after-the-sale expenses for new wheels, batteries, and general repairs.

Devices such as this are rarely indicated. Similarly, comfort knee supports, heating pads, and seat-lift chairs are all too attractive when the cost to the beneficiary is zero.

Medicare "allowed" $49.20 in 2002 for CPT Code 99213, a mid-level office visit for an established patient. The 20% Medicare coinsurance for this service is $9.84, which is part of the eliminated crossover payments. Dividing $9.84 into the $7,744 price for each unsolicited electric wheelchair shows that *each* electric wheelchair could have paid the

20% Medicare coinsurance and improved access for 787 dually eligible people in Louisiana in 2002.

Slide No. 40. Long-Term Solution

Medicare and Medicaid do not serve frail, dually eligible people as well as they should because of a lack of coordination and fragmentation of healthcare delivery 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.

When state Medicaid departments cut the crossover program, patients with Medicare are the ones who suffer.

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.

In order to successfully 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 and community care programs with Medicaid's long-term care programs and medication programs, and incorporates the case management tools and coordination of services needed to effectively treat dually eligible and other frail elderly persons.

Pooling resources and avoiding service duplication would benefit state and federal governments as well as providing better service to vulnerable patients at a better price.

Slide No. 41. Section 5. Geriatrics — An Ailing Specialty

Slide No. 42. This "Geriatric Penalty" Erodes the Specialty of Geriatrics

Dr. John Burton is Professor and Chairman of the Department of Geriatrics at Johns Hopkins University School of Medicine. His sentiment is shared by many geriatric professionals.

Medicare alone cannot solve this problem. Even if Medicare raised its rates to $1,000 a visit physicians treating dually eligible people would still receive 20% less than physicians treating non-dually eligible people.

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.

Assume I was upset when Louisiana eliminated crossovers in 2000, so I packed up and moved to South Carolina. Then in 2001, South Carolina decided to eliminate crossover payments, so I packed up again and moved to Missouri. But guess what Missouri did in 2002? It, too, eliminated crossover payments for dually eligible people.

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.

Slide No. 43. Making Rounds with Two Louisiana Geriatricians, January 2002

This demonstrates the effect dually eligible people may have on geriatricians' practices.

Here are two well-trained geriatricians practicing in Louisiana. The first geriatrician opens his office in a wealthy suburban location and does not see any dually eligible people in his practice. Many of his patients are in relatively good health and take few medications. This geriatrician performs ten patient care services and receives $1,019 for his services, which is fair.

The second geriatrician opens his office in a poor, urban location and sees mostly dually eligible people. These people are often time-consuming, have multiple medical problems, and take many medications. This geriatrician performs the same ten patient care services and sends in the same bills.

However, since this is January and the patients' Medicare deductibles have not been met, Medicare will first subtract $100 from each service and pay 80% of the remaining allowed amount.

Because crossover payments — which is payment for the Medicare deductible and 20% coinsurance — have been eliminated, this second geriatrician will receive payment at essentially the *Medicaid* payment rate instead of the *Medicare* rate and will receive only $351 or 34% of what our first geriatrician received.

How long will the second geriatrician continue to treat dually eligible people? What would his advice be to medical students considering a career in geriatrics?

How then, do we as a society ensure our most frail and vulnerable citizens adequate access to health care when we discourage physicians from entering geriatrics and financially discourage physicians from welcoming dually eligible people into their medical practices?

Slide No. 44. Section 6. The Past, Present, and Future

Slide No. 45. The View From 1978 — Not Much Has Changed

Much of this information has been know for decades.

In 1978 dually eligible people were already recognized as being an elderly, female population with a large percentage of minorities and a large burden of illness.

Twenty-five years have gone by, but little has changed.

The social environment in which dually eligible people live influences their health and their healthcare needs.

Slide No. 46. What Causes Healthcare Costs to Increase?

Two generally accepted causes of increased healthcare costs are increased population growth and increased medical expenses.

There is a third cause of rising healthcare costs: dually eligible people — "the elderly and disabled poor."

Dually eligible people drive healthcare costs more than any other population group.

Dual eligibility is both a medical and a social problem.

Research is needed to better understand and manage our dually eligible population, particularly their use of the "final social safety-net," which is long-tem care.

The social safety-nets, which poor and disabled people use when they are young costs *millions* of dollars. But the final social safety-net, which elderly and disabled poor people use is the nursing home, which costs *billions* of dollars.

Slide No. 47. Cumulative Healthcare Expenditures at Age of Death

Healthcare expenditures increase as the population ages. But what is it that actually drives these expenditures?

All costs rise with age. But costs for prescription drugs and home health care at the bottom of the graph rise very little. Even Medicare costs rise until about 80-years-old, at which point the Medicare charges begin to level off.

The costs for nursing home care begin to ascend at about the 80-year-old mark and continue on a steep slope upwards. It is this increase in nursing home costs that drives healthcare expenses in our elderly population.

Slide No. 48. "Racial and ethnic minorities tend to receive a lower quality of healthcare. . . ."

This is the first sentence of the first paragraph of the Summary chapter of the Institute of Medicine's 2003 publication, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.*

In 2002, the American Medical Association also announced the creation of a program aimed at eliminating racial and ethnic disparities in health care.

Disparity in access to health care is a national problem.

Slide No. 49. Dually Eligible People — at the Center of the Next Debate

Whether we approach the problems of dually eligible people from a moral, ethical, social, racial, or financial point of view, this is a compelling issue which touches the core of our healthcare system and the soul of our society.