Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

April 20, 2010

The Honorable Joel T. Chaisson, II, President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear President Chaisson:

In response to House Resolution No. 91 (HR 91) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that DHH study the effect of decreasing Medicare-Medicaid crossover payments on dually eligible people with Medicare and Medicaid in Louisiana and report its findings to the legislature.

DHH is available to discuss the enclosed report and recommendations with you at your convenience. Please contact Ms. Ruth Kennedy, deputy director of the bureau of health services financing (Medicaid), at (225) 342-3891 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

April 20, 2010

The Honorable Jim Tucker, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

Dear Speaker Tucker:

In response to House Resolution No. 91 (HR 91) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that DHH study the effect of decreasing Medicare-Medicaid crossover payments on dually eligible people with Medicare and Medicaid in Louisiana and report its findings to the legislature.

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State of Louisiana

Department of Health and Hospitals

Office of the Secretary

April 20, 2010

The Honorable Kay Katz, Chairwoman
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

Dear Chairwoman Katz:

In response to House Resolution No. 91 (HR 91) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that DHH study the effect of decreasing Medicare-Medicaid crossover payments on dually eligible people with Medicare and Medicaid in Louisiana and report its findings to the legislature.

DHH is available to discuss the enclosed report and recommendations with you and the members of the House Health and Welfare committee. Please contact Ms. Ruth Kennedy, deputy director of the bureau of health services financing (Medicaid), at (225) 342-3891 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

DEPARTMENT OF HEALTH AND HOSPITALS

STUDY OF IMPACT OF MEDICAID REIMBURSEMENT METHODOLOGY ON ACCESS TO CARE FOR MEDICARE/MEDICAID DUALS

REPORT PREPARED IN RESPONSE TO HR 91
OF THE 2009 REGULAR SESSION

APRIL 2010

Contact:
Louisiana Department of Health and Hospitals
Ruth Kennedy, Deputy Director
Bureau of Health Services Financing
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225-342-3891
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EXECUTIVE SUMMARY

In response to concern that access to care for dually eligible Medicare and Medicaid eligibles had been impacted by a Medicaid reimbursement policy change in 2000, the Legislature, through House Resolution 91 of the 2009 Regular Session, asked the Department to study the effect of the policy change, incorporate public comment, and prepare a report for the Legislature.

"Duals" are individuals with Medicare coverage who are also eligible, based on income, for Medicaid benefits. While Medicare covers the majority of acute care costs for duals, Medicaid is the funding source for long term care and other service coverage and may pay the deductibles and co-insurance for many Medicare Part A and B services. In response to a budget shortfall in 2000 and as allowed by a recent change in federal regulations, the Department changed the methodology for reimbursing most claims crossed over to Medicaid from Medicare for payment of the deductible and co-insurance on behalf of dual eligibles.

Henceforth, the Department's rules indicated that a claim would be considered adjudicated with a zero payment if the Medicare payment equaled or exceeded the amount that the Medicaid Program allowed for that service. If the Medicaid allowable exceeded the Medicare rate for the service, Medicaid would pay the lesser of the co-insurance or deductible or up to the amount of the Medicaid allowable. Further the rule noted that the Medicare and Medicaid payment (including zero payments) were considered payment in full and that the recipient had no legal liability for the claim. This methodology meant that the provider of services received what would have been paid if the recipient had only Medicaid coverage.

The Department received input from the public, including both providers and patients. Both requested that the 2000 methodology be reconsidered, noting from their perspective, that the policy impacted access to medical and mental health care, and reduced the number of physicians available in communities. Several respondents indicated concerns that the policy discriminated against poor people, minorities in particular, and caused utilization of more expensive care.

The Department undertook a literature review and a study of Medicaid data. Research by the Commonwealth Fund found that few (3 percent) Medicare/Medicaid duals report not having a regular physician or a source for regular care. However, most reference sources note that duals are a vulnerable population and several studies note the need for restructuring of federal and state policy and funding to maximize health outcomes and efficiency in funding mechanisms.

The Department data review looked at three levels of indicators for access issues following the 2000 rule change. The review examined the patients per provider, visits per provider and visits per patients; no pattern of change in utilization or services was noted. A review of hospital crossover claims for "preventable hospitalizations" conditions indicated an increase in those services for years 2005 and 2006.

Although the indicators measured did not reflect a change in access pattern, the Department recognizes that the number of duals will be increasing as the population ages and that, combined with rising health care costs, will have an impact on the state Medicaid budget. The Department also understands that the programmatic funding, eligibility, cost sharing and service coordination between these two complex programs are areas that could be revisited—perhaps to the benefit of both Medicare and Medicaid operations, beneficiaries and tax payers, and will continue to work with Congress and state and local leaders to support changes.

REPORT TO THE LEGISLATURE

INTRODUCTION

This report is being written in response to House Resolution 91, which asked the Department of Health and Hospitals to examine whether a policy change implemented in 2000 by the Medicaid Program impacted access to health care for residents who receive both Medicare and Medicaid benefits, commonly known as dual eligibles. The resolution asked the Department to seek public input regarding the resolution and to include the input in the report to the Legislature.

BACKGROUND

As noted in the *Kaiser Commission on Medicaid and the Uninsured-Dual Eligibles Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005*, dual eligibles are individuals entitled to Medicare and are also eligible for some level of assistance from the state Medicaid Program. As the Kaiser report notes, the assistance may range from paying Medicare premiums and co-insurance to benefits not covered under Medicare such as vision, dental and long term care. [1] Title XVIII of the Social Security Act sets forth the authority for the Medicare Program, which is administered by the federal government. Medicaid (Title XIX of the Social Security Act) is a means tested program that is funded by both the state and federal government and is managed by the state.

As part of the Balanced Budget Act of 1997, Section 4714, federal law said that states were not required to provide any payment for any expenses related to deductibles, coinsurance or co-payments for Medicare cost-sharing to the extent that the payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the State Plan under this title for such services if provided to an eligible recipient other than a Medicare beneficiary. [2]

Therefore beginning in 2000, in response to a budget shortfall, the Louisiana Medicaid Program changed the method for calculating the payment on deductibles and co-insurance on many of the Medicare services that crossover to Medicaid on behalf of dually eligible recipients. Specifically for professional services, the new reimbursement methodology resulted in Medicaid comparing the rate of the Medicare procedure code payment to the Medicaid payment rate on file; if the Medicare rate equaled or exceeded the Medicaid rate, the claim was adjudicated as a zero paid claim. If the Medicaid rate exceeded the Medicare payment, the claim was reimbursed at the lesser of the co-insurance and deductible amount or up to the amount of the Medicaid maximum payment. The rule stated that the Medicare payment and the Medicaid payment, if any, were to be considered payment in full with no legal liability being incurred by the recipient. Exception to the reductions were made for the professional component of hemodialysis and transplant services.[3]

The change in the reimbursement methodology did not have an impact on the recipient, but if the Medicaid allowable was equal to the amount of the co-insurance or deductible on a claim, the service provider did not receive any additional payment; the provider received the amount that would have been paid had the recipient only had Medicaid coverage.

PROBLEM STATEMENT

As stated in the legislation, the concern is that the policy change in reimbursement methodology has resulted in reduced access to health care for Medicare/Medicaid dual eligibles and that the reduced access has resulted in more costly treatment, such as emergency room care and increased institutional care.

RESEARCH METHOD

(1) Online research of policy foundations, federal and state Web sites; (2) Review of Medicaid payment data; (3) Solicitation and review of public comments.

LITERATURE REVIEW

Kaiser Commission on the Medicaid and the Uninsured; Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries. This 2009 report notes that compared to other Medicare beneficiaries, duals are sicker and poorer—the most vulnerable of the aged and non-elderly with disabilities. Since Medicaid is a means tested program, all individuals qualifying for Medicaid coverage are low income and many have numerous health care needs. Funding care for duals is a costly proposition for both state and federal budgets. Kaiser indicates that on a national basis Medicaid covers nearly 60 percent of the total Medicaid and Medicare spending for duals. "Medicare pays for the majority of acute care services (62 percent versus 38 percent) while Medicaid while pays the vast majority of long-term care services (86 percent versus 14 percent.)" [4]

A research study published in 2005 funded by The Commonwealth Fund (*In the Literature*-**Unmet Long Term Care Needs: An analysis of Medicare-Medicaid Dual Eligibles)** reports the following: "Very few community-based dual eligibles have problems obtaining medical care. Only 3 percent report not having a regular physician or other regular sources of care." The study further observed that while duals report financial constraints, only four (4) percent said that they delayed medical care or went without medications because of financial problems. The research reported that access to long term cares services, especially assistance with daily living, is limited and noted that coordination on uniformity of services across states and increased funding at the federal policy level is needed to address this issue. [5]

A recently issued (August 2009) brief by Kaiser Foundation- *Focus on Health Reform-Health Care Reform Opportunities: Improving Policy for Dual Eligibles,* also highlights the federal and state roles for duals and suggests some policy options that could improve the coverage, delivery, payment and financing for dual populations. Kaiser noted the need for better service delivery and coordination as well as the need for improvement around the eligibility process for additional assistance and premium/cost sharing financing. The article indicates that duals could benefit from integrated delivery systems of care, in limited existence throughout the United States, in terms of reduced hospitalization and long term costs but notes that the financial incentives between the two programs--Medicare and Medicaid--are not aligned to promote these outcomes. In summary, Kaiser identifies the current national reform efforts as the time to recognize the need for changes in the financing and delivery of services for duals and suggests that structural and policy changes could "...lead to enhanced quality of care received by dual eligibles and translate to more efficient spending on a high cost population." [6]

SCOPE OF DATA STUDY AND LIMITATIONS

To clarify, this study focuses on whether the available historical data indicates that access may have been impacted by the policy change related to crossover claims. Medicaid does not have access to Medicare payment data so this analysis does not attempt to determine, as asserted in the legislation, that duals receive only partial Medicare benefits while wealthy Medicare beneficiaries receive full Medicare benefits.

The data source is the Medicaid data warehouse, which is maintained by the Medicaid Program fiscal intermediary and has claims history beginning in 1995. The source for Medicaid eligibility data collection and maintenance changed in 2000; identification of Medicare/Medicaid dual eligibles cannot be assured prior to that timeframe. In fact, it is possible that the number of dual recipients reflected in the data may be overstated as a result.

REGULATORY AUTHORITY

(1) Balanced Budget Act of 1997 Section 4714; (2) 1999-2000 General Appropriation Act of the 1999-2000 Regular Session of the Louisiana Legislature.

RESEARCH QUESTION #1

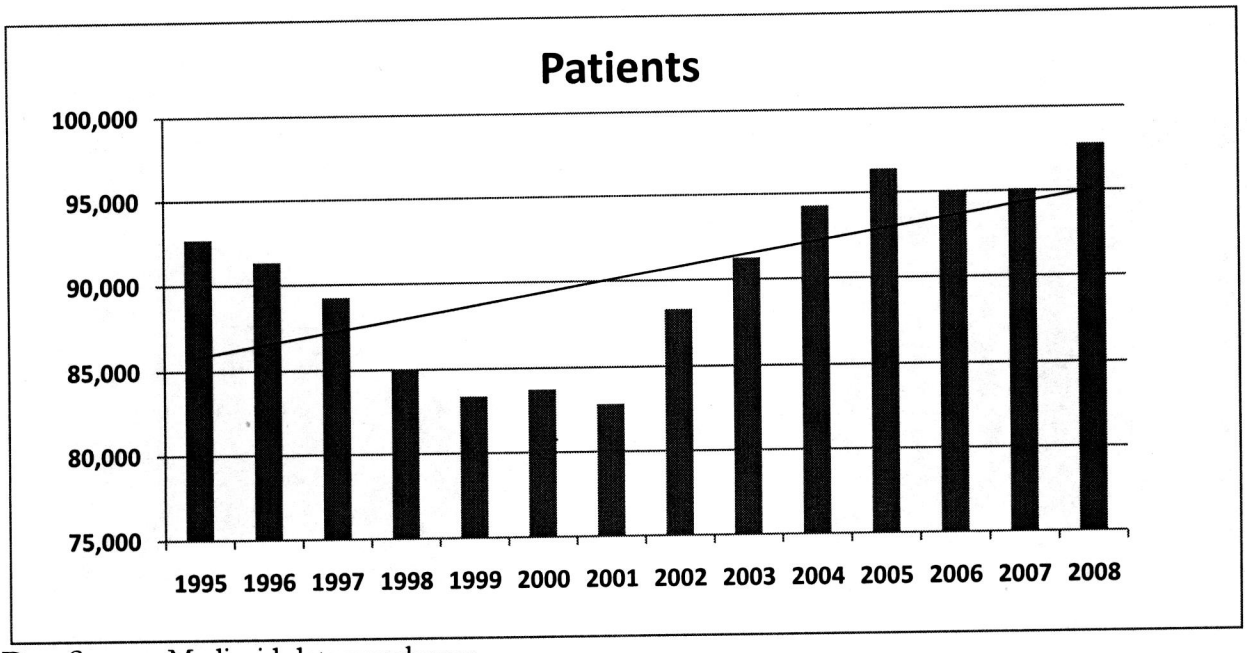
Does the data indicate a change in access to care subsequent to the policy change in 2000? This study will examine the three following indicators of access: (1) patients per provider; (2) visits per provider and (3) visits per patients.

Table 1

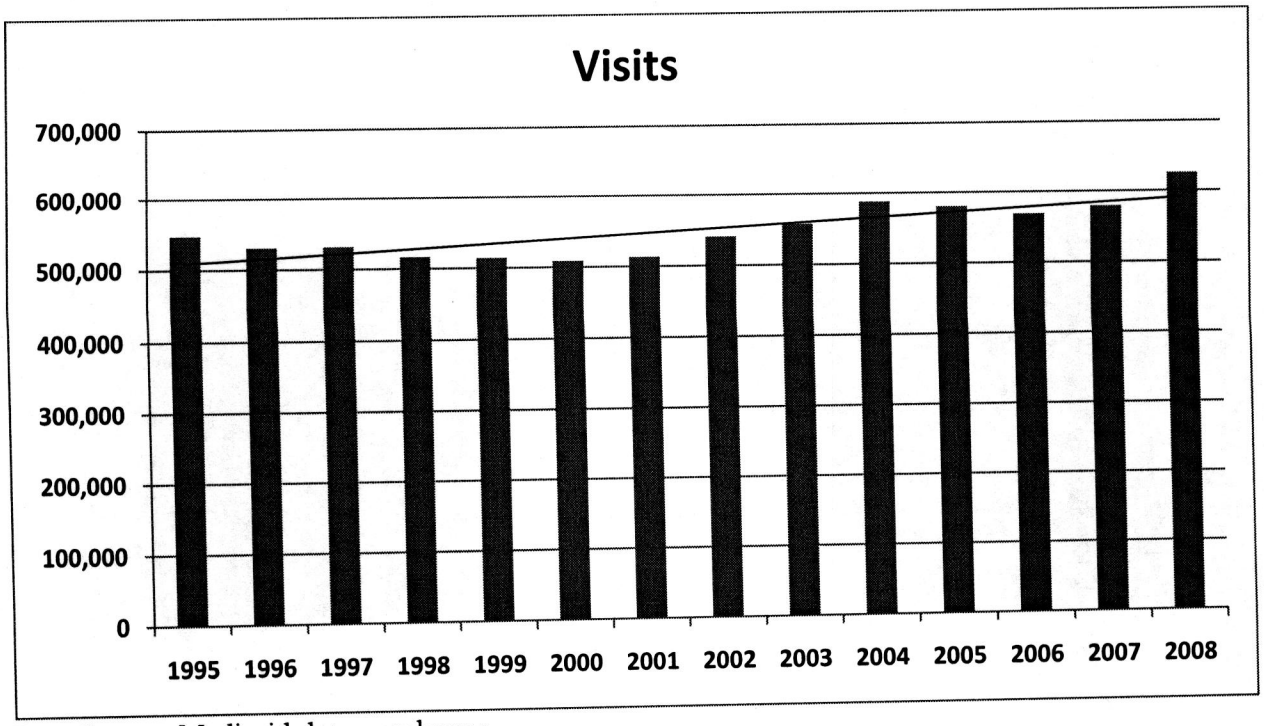
	Patients	Visits	Providers	Payments	Patients per Provider	Visits per Provider	Visits per Patient
1995	92,715	547,704	4,392	$ 3,683,981	21.1	124.7	5.9
1996	91,345	530,785	4,346	$ 3,015,278	21.0	122.1	5.8
1997	89,252	531,648	4,405	$ 4,562,971	20.3	120.7	6.0
1998	84,977	516,335	4,608	$ 7,001,916	18.4	112.1	6.1
1999	83,360	513,965	4,693	$ 7,285,001	17.8	109.5	6.2
2000	83,729	508,527	4,927	$ 3,187,120	17.0	103.2	6.1
2001	82,800	513,054	5,189	$ 2,904,737	16.0	98.9	6.2
2002	88,334	540,646	5,098	$ 2,960,157	17.3	106.1	6.1
2003	91,266	557,194	5,033	$ 2,864,396	18.1	110.7	6.1
2004	94,270	587,577	5,076	$ 2,856,621	18.6	115.8	6.2
2005	96,388	579,897	4,779	$ 2,983,887	20.2	121.3	6.0
2006	95,053	568,373	4,748	$ 3,053,042	20.0	119.7	6.0
2007	95,101	578,525	4,977	$ 4,291,391	19.1	116.2	6.1
2008	97,774	625,609	5,081	$ 8,581,175	19.2	123.1	6.4

Data Source: Medicaid data warehouse

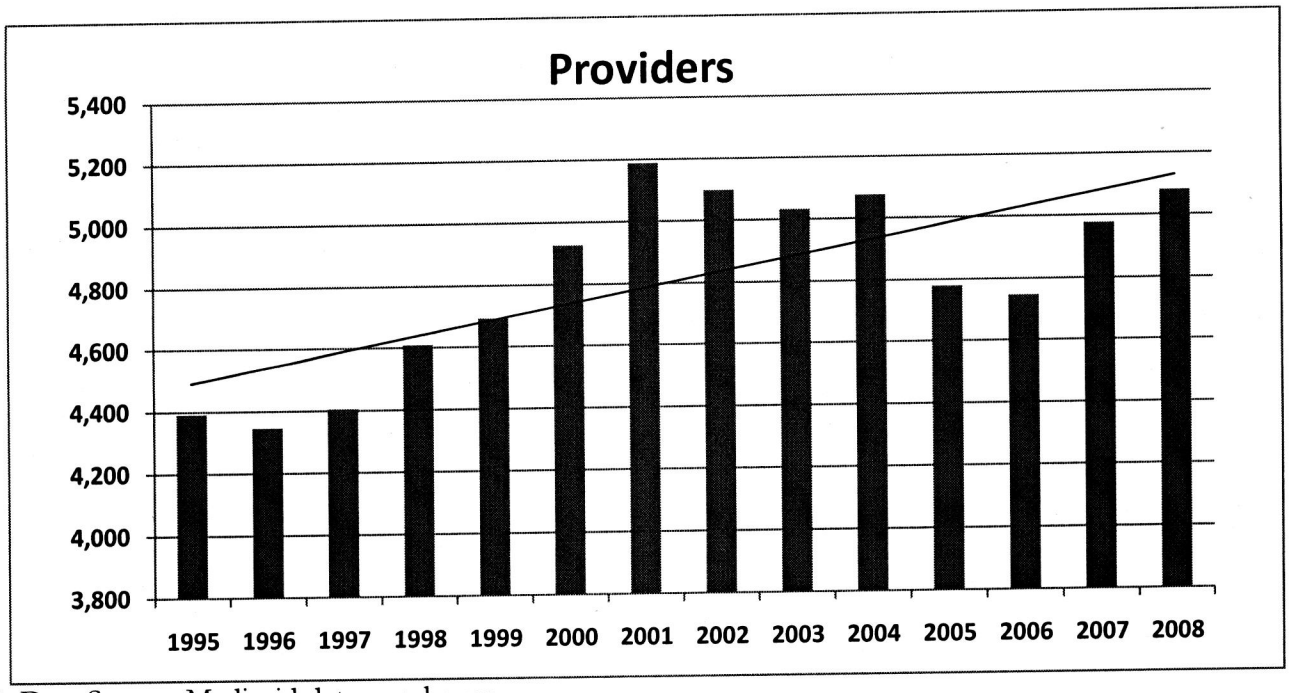
Data review: A claims history review for dually eligible Medicare/Medicaid recipients was conducted on crossover claims for the professional (physician) component. The information in Table 1 is based on in-state providers only. Data indicates an increase in both patients and providers and further demonstrates that provider participation has kept pace with the increase in patients. The patient per provider ratio shows this by remaining relatively steady in the last ten years. Indicators of utilization, visits per patients and visits per provider, have risen during the same time period.



Data Source: Medicaid data warehouse



Data Source: Medicaid data warehouse



Data Source: Medicaid data warehouse

RESEARCH QUESTION #2

Does data indicate a change in the level of hospitalizations with a "Preventable hospitalization" diagnosis?

Table 2

	Admissions	Patients	Providers	Payments	Patients per Hospital	Admits per Hospital	Admits per Patient
1995	694	665	118	$ 490,226	5.6	5.9	1.04
1996	689	667	115	$ 484,088	5.8	6.0	1.03
1997	725	698	112	$ 533,471	6.2	6.5	1.04
1998	702	681	107	$ 527,974	6.4	6.6	1.03
1999	730	704	115	$ 419,199	6.1	6.3	1.04
2000	742	717	105	$ 223,812	6.8	7.1	1.03
2001	690	690	109	$ 237,504	6.3	6.3	1.00
2002	694	669	110	$ 302,372	6.1	6.3	1.04
2003	659	639	104	$ 379,154	6.1	6.3	1.03
2004	776	751	115	$ 330,174	6.5	6.7	1.03
2005	890	853	117	$ 499,626	7.3	7.6	1.04
2006	1,192	1,156	110	$ 626,917	10.5	10.8	1.03
2007	1,051	1,012	113	$ 645,322	9.0	9.3	1.04

Data Source: Medicaid data warehouse

Data Review: Information in Table 2 is based on inpatient hospital crossover claims for the diagnosis codes listed below. Adult hospitalizations for these conditions are called "preventable hospitalizations" because if the person had access to and cooperated with outpatient health care, hospitalizations for the conditions could be potentially avoided. As Table 2 indicates, inpatient hospitalizations for "preventable hospitalizations" decreased after 2000 but jumped after 2005.

"Preventable Hospitalization" Codes:

Bacterial Pneumonia: 482.9	Dehydration: 276.51
Urinary tract infection: 599.0	Perforated appendix: 540.0
Angina (without procedure): 413.9	Congestive heart failure: 428.0
Hypertension: 401.0	Adult asthma: 493.0-493.2, 493.8, 493.9
Chronic Obstructive Pulmonary Disease: 496	Diabetes: 250.0-250.9
Lower extremity amputation (in diabetes) 897.0-897.7	

Public input: As required in the legislation, the Department asked for public input on HR 91. The Department received responses from five people; one response included a petition with forty names. Respondents indicated that Medicare/Medicaid duals are the oldest, sickest and most disabled people in the state. They noted, due to the poverty, duals suffer a disproportionate decrease in access to health care and that lack of access results in costly treatment such as hospitalizations and long term care services. Respondents noted that in addition to impacting access to preventive care, the change in methodology also greatly impacted mental health services for duals.

The petition was directed to the elected government officials in New Orleans and Washington D.C. and indicated that those signing had paid payroll taxes and were entitled to 100% of their Medicare benefits. The petitioners requested a change in the health care policy toward that end.

CONCLUSION

The analysis of Medicaid data does not reflect a pattern of change in access for duals—neither the number of physicians, physician panel size nor the visits per patient has changed significantly over the study period. However the Department does recognize that with continued growth in the aging population and increased costs in premiums and cost sharing, there is a need to work with federal leaders and policy makers as well as state and local leaders to address ways to improve care delivery/coordination and restructure funding streams.

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[2] Balanced Budget Act of 1997-Section 4714. The Library of Congress-THOMAS. http://thomas.loc.gov/cgi-bin/thomas.

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[5] Komisar, Harriet L. Felder, Judith. Kasper, Judith D. Unmet Long-Term Care Needs: An Analysis of Medicare–Medicaid Dual Eligibles." The Commonwealth Fund. Volume 14. October 13, 2005. http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2005/Oct/Unmet-Long-Term-Care-Needs---An-Analysis-of-Medicare-Medicaid-Dual-Eligibles.aspx

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ENROLLED

Regular Session, 2009

HOUSE RESOLUTION NO. 91

BY REPRESENTATIVE HINES

A RESOLUTION

To urge and request the Department of Health and Hospitals to study the effect of decreasing Medicare-Medicaid crossover payments on dually eligible people with Medicare and Medicaid in Louisiana and to report study findings and recommendations to the House of Representatives prior to the convening of the 2010 Regular Session of the Legislature.

WHEREAS, the Congressional Balanced Budget Act of 1997 made it essentially illegal for one hundred eight thousand poor Medicare beneficiaries in Louisiana and five million people across the nation to receive their full Medicare benefit; and

WHEREAS, all Medicare beneficiaries worked, paid payroll taxes, and earned the same Medicare benefits; but the Balanced Budget Act allowed Louisiana and two-thirds of all states to decrease their share of the Medicare payment for poor beneficiaries which "crossed over" to Medicaid; and

WHEREAS, this Act created a two-tiered, discriminatory Medicare system where wealthy beneficiaries receive full Medicare benefits while poor beneficiaries receive only partial Medicare benefits; and

WHEREAS, poor Medicare beneficiaries typically have both Medicare and Medicaid and are "dually eligible people"; and

WHEREAS, this segment of society are the oldest, poorest, sickest, and most disabled people in the nation; and

WHEREAS, they are one-quarter of all Medicare beneficiaries over eighty-five years old, they fill two-thirds of all nursing home beds, and they are one-quarter of all Medicare beneficiaries in Louisiana; and

WHEREAS, in 2003, Tommy Thompson, secretary of the United States Department of Health and Human Services, reported to congress that decreasing Medicare-Medicaid crossover payments for dually eligible people decreased their access to primary medical care by five percent and decreased their access to mental health services by twenty-one percent; and

WHEREAS, dually eligible people in Louisiana and nationwide are disproportionately elderly minorities and mentally and physically disabled people; and

WHEREAS, decreasing health care access for these vulnerable, protected groups violates the Civil Rights Act of 1964 and violates the Americans with Disabilities Act; and

WHEREAS, when access to primary care and mental health services decrease, expensive emergency room visits, hospitalizations, and nursing home admissions increase; and

WHEREAS, this practice increases health care costs for Louisiana and our nation; and

WHEREAS, dually eligible Medicare beneficiaries have a preventable hospitalization rate that is forty percent higher than beneficiaries who are not dually eligible; and

WHEREAS, dually eligible Medicare beneficiaries are the most expensive population served by publicly funded health care programs as their expense is more than four times the expense of Medicare beneficiaries who do not have Medicaid; and

WHEREAS, total government spending on seven million dually eligible people exceeds spending on all thirty million Medicare beneficiaries who do not have Medicaid; and

WHEREAS, sixty percent of spending on dually eligible people is financed by state Medicaid agencies; and

WHEREAS, in December 2008, the New Orleans City Council passed a resolution requesting Louisiana to restore Medicare-Medicaid crossover payments so all Medicare beneficiaries have equal access to their Medicare benefits; and

WHEREAS, the restoration of crossover payments is supported by the Louisiana State Medical Society, Louisiana Geriatrics Society, Louisiana American Medical Directors Association, American Geriatrics Society, New Orleans Medical Association, New Orleans

Council on Aging, the City of New Orleans Health Department, New Orleans NAACP, and others; and

WHEREAS, restoring Medicare-Medicaid crossover benefits will improve access for five million poor Medicare beneficiaries, stop civil rights violations, decrease health care disparities, decrease national health care costs, and increase the number of primary care physicians and mental health providers; and

WHEREAS, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, in its Civil Rights Compliance Policy Statement, pledged to abolish discrimination in all its programs; CMS pledged to "allocate financial resources to the extent feasible 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"; and

WHEREAS, this is a national problem, and Louisiana and other states have financial difficulty; and

WHEREAS, the United States Congress, which created the Balanced Budget Act, can help Louisiana and other states restore crossover payments by supplying federal funds without requiring state matching funds; and

WHEREAS, the Louisiana delegation in the United States Congress should seek to restore Medicare-Medicaid crossover payments nationally so all Medicare beneficiaries in Louisiana and nationwide have equal access to their Medicare benefits; and

WHEREAS, as the Department of Health and Hospitals conducts this study it should incorporate a public review of the effect that the reduction of Medicare-Medicaid crossover payments on dually eligible people has had on health care access for vulnerable populations and on the total Louisiana health care costs.

THEREFORE, BE IT RESOLVED that the House of Representatives of the Legislature of Louisiana does hereby urge and request the Department of Health and Hospitals to study the effect of decreasing Medicare-Medicaid crossover payments on dually eligible people with Medicare and Medicaid in Louisiana and report its findings to the House of Representatives prior to the convening of the 2010 Regular Session of the Legislature.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the secretary of the Department of Health and Hospitals.

SPEAKER OF THE HOUSE OF REPRESENTATIVES