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DISABLED DUAL-ELIGIBLE BENEFICIARIES

Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings

GAO Highlights

Highlights of GAO-14-523, a report to congressional requesters

Why GAO Did This Study

In 2009, the Medicare and Medicaid programs spent an estimated $103 billion on disabled dual-eligible beneficiaries—those individuals who are disabled, under age 65, and qualify for both Medicare and Medicaid benefits. Recently, Congress and CMS have emphasized benefit integration for all dual-eligible beneficiaries—both disabled and aged—including beginning a financial alignment demonstration, which CMS expects will improve care and reduce program spending.

GAO was asked to provide insights for potentially improving the care provided to disabled dual-eligible beneficiaries while reducing spending. GAO examined (1) spending, utilization, and health status patterns for the portion of this population with the highest spending, (2) the extent to which integrated D-SNPs provided high quality of care for this population while controlling Medicare spending, and (3) D-SNPs' and traditional MA plans' performance in serving this population based on quality and resource use measures.

To do this work, GAO analyzed Medicare and Medicaid 2009 claims and summary data—the most recent data available. GAO identified D-SNPs that met standards of quality and integration and compared their 2013 costs to expected Medicare FFS spending. GAO used 2011 data—the most recent data available when GAO began its analysis—from the Health Care Effectiveness Data and Information Set to evaluate D-SNPs' and traditional MA plans' performance.

View GAO-14-523. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Overall spending for high-expenditure disabled dual-eligible beneficiaries—those in the top 20 percent of spending in their respective states—was driven largely by Medicaid spending, and the service use and health status often differed widely between those with high Medicare expenditures and high Medicaid expenditures. For these beneficiaries, Medicaid expenditures accounted for nearly two-thirds of overall spending. Also, states with high Medicaid spending often had lower Medicare spending but nearly always had greater overall spending for these beneficiaries. Furthermore, service use and health status often differed widely between high-Medicare-expenditure and high-Medicaid-expenditure disabled dual-eligible beneficiaries. Those with high Medicare expenditures were considerably more likely than those with high Medicaid expenditures to have multiple health conditions and use inpatient services but far less likely to use long-term services and supports.

Dual-eligible special needs plans (D-SNP)—Medicare Advantage (MA) private plans designed to target the needs of dual-eligible beneficiaries—that fully integrated Medicare and Medicaid benefits often met criteria for high quality but had limited experience serving disabled dual-eligible beneficiaries or demonstrating Medicare savings. D-SNPs that the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare and oversees Medicaid—designated as Fully Integrated Dual-Eligible (FIDE) SNPs were far more likely to meet high quality criteria compared with other D-SNPs. However, relatively few FIDE-SNPs with high quality served disabled dual-eligible beneficiaries or reported lower costs for Medicare services than expected Medicare fee-for-service (FFS) spending in the same areas. Additionally, FIDE-SNPs that demonstrated the potential for Medicare savings often operated in service areas where D-SNPs with less integration of Medicaid benefits demonstrated more potential for Medicare savings (i.e., lower relative costs for Medicare services).

Moderately better health outcomes for disabled dual-eligible beneficiaries in D-SNPs relative to those in traditional MA plans did not translate into lower levels of costly Medicare services (that is, inpatient stays, readmissions, and emergency room visits). These results were also similar whether dual-eligible beneficiaries were at risk for high Medicare spending (those with six or more chronic health conditions), aged (those age 65 and over), or aged and enrolled in FIDE-SNPs.

These results suggest that CMS's expectations regarding the extent to which integration of benefits will produce savings through lower use of costly Medicare services may be optimistic. While operating specialized plans and integrating benefits could lead to improved care, GAO's results suggest that these conditions may not reduce dual-eligible beneficiaries' Medicare spending compared with Medicare spending in settings without integrated benefits.

CMS reviewed a draft of the report and provided technical comments, which GAO incorporated as appropriate.