High-Cost Beneficiaries: What Can States Do?:
A Skeptic’s Observations

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Some General Considerations

• The current discussions of dual eligibles and other high-cost Medicaid beneficiaries is the most exciting and substantive conversation about these people and services we’ve had in the last generation;

• *But*, diagnosis is not therapy: just because the status quo provides bad care at excessive expense, that doesn’t mean that anything would be better.

• There are serious questions of institutional capacity:
  – In state governments
  – In health plans
  – In the provider community

• The siren song of potential Medicare funds may cloud peoples’ judgment.
People

- Heterogeneity of duals/high-cost MA only
  - Many are just poor Medicare benes – and poverty is a major risk factor for high expense

- State track records re SPMI, DD, non-elderly disabled hardly basis for optimism
  - Medicaidization of failing state-run systems
  - Frequency of court orders
  - Financing reform has failed to reform delivery system

- Unprecedented challenge of growing population of frail elderly

- Are poor Medicare beneficiaries second-class citizens?
Programs

• Success stories few and far between
• Successes hard to scale
  – PACE
  – ICF/MR
• HCBS waivers have been on the books since 1983
  – Why are they all capped?
  – Why do we know so little about them?
Prospects

• In principle, we should have a once-in-a-generation opportunity for thoughtful, diverse experimentation with new service delivery and financing models.

• It’s not going to happen
  – States can’t wait
  – No one wants to pay for program monitoring, evaluation
  – Disenfranchisement of clients and their advocates

• In the absence of learning opportunities, the argument that it’s OK to put people at risk because the status quo is lousy has much less moral force.