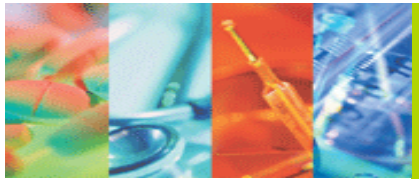

High-Cost Beneficiaries: What Can States Do?:
A Skeptic's Observations

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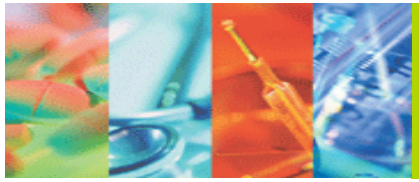
19th Princeton Conference
May 23, 2012

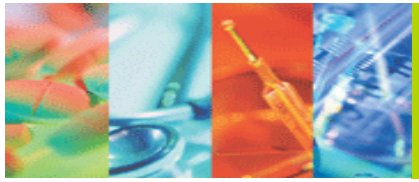


Some General Considerations

- 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.