Managing Depressed Patients With Comorbidities and Dual-Eligibility Benefit Status

MICHAEL ARIZPE, RPh

ABSTRACT

OBJECTIVE: To discuss the challenges and requirements in developing and implementing strategies for the appropriate management of depression in a subpopulation of dual-eligible patients with comorbidities.

SUMMARY: Treating patients with comorbidities who are dually eligible for Medicare and Medicaid services is challenging. In this vulnerable population, condition management strategies should address new patient cost-sharing responsibilities, improve or minimize the disruptions in access to medications, monitor for potential adherence issues, and, most importantly, strive to maintain, if not improve, overall health outcomes. Complicating these essential strategies are concerns about defining who is responsible for providing treatment to dual-eligible patients and the potential loss of vital services at various levels, including transition of care or the possible disconnection of or severe limitations on reimbursement for key services.

CONCLUSION: Condition management strategies should be developed to deal with the unique needs of the dual-eligible population to ensure continuity of care. Additionally, an organizational infrastructure is necessary to give providers useful tools to help them deliver better-coordinated care to the dual-eligible population that struggles with depression.

KEYWORDS: Managed care, Mental illness, Dual eligible

Mental illness is a very real concern in the Medicare population. Approximately 2.5 million people (38%) of patients dually eligible for Medicare and Medicaid benefits have mental or cognitive impairment. In this population, with its older age, prevalence of disabilities, and other demographics, mental illness is often comorbid with one or more chronic illnesses.

Patients with comorbidities who are dually eligible for Medicaid and Medicare services are among the most vulnerable segments of our health care population. Adequate care of these patients involves coordinating multiple subspecialists, numerous medications, several services, and, consequently, very complex Medicare and Medicaid claims. True condition management strategies to improve overall health outcomes in these patients are concerned with addressing patient cost-sharing obligations if present, minimizing the disruptions in access to medications, and monitoring for potential adherence issues. However, providing adequate continuity of care in this clinically complex population is laden with overwhelming obstacles and requires a more tailored approach to management and implementation strategies.

Figure 1: Demographic Assessment—Who Is the Dual-Eligible?

- 64% >65 Years, While 36% Were Nonelderly (<65 Years) With Disabilities
- 23% in an Institution vs. 3% of Nonduals
- 3X More Likely to Be African American or 2X More Likely to Be Hispanic vs. Nonduals

Dual-Eligible Beneficiaries

By definition, a dual-eligible beneficiary is someone who is eligible for both Medicare and Medicaid benefits. Most of these patients are older than 65 years (64%), female (62%), of low socio-economic status, and 3 times more likely to be African American and 2 times more likely to be Hispanic (Figure 1). The dual-eligible beneficiaries who are not elderly have disabilities (36%). More than 60% of dual-eligible individuals live below the poverty level, with 94% of this subgroup living below 200% of the poverty level. Most dual-eligible patients live with a family member, 16% with a spouse and 31% with their children. However, 31% of dual-eligible parents live alone and another 23% reside in an institution.6

Relative to non-dual-eligible individuals, dual-eligible beneficiaries have more health issues. Slightly more than 20% of the dual-eligible population reports being in poor health as compared with less than 10% of the non-dual-eligible population.6 Dual eligibles are also more likely to have greater limitations in activities of daily living (ADLs)—e.g., bathing and dressing—than non-dual eligibles. One third of dual eligibles have impairments in 3 to 6 ADLs.6 Dual-eligible beneficiaries are also often burdened with one or more chronic illnesses such as hypertension, heart disease, stroke, diabetes, arthritis, and pulmonary conditions as well as behavioral health conditions (Table 1).5 In the year 2000, 45% of the dual-eligible patients younger than 65 years had hypertension. Of those older than 65 years, 63% had hypertension. On the other hand, 59% of the patients younger than 65 years had mental disorders, whereas 12% of people older than 65 years had a diagnosis of mental illness. It should be noted that while 12% may seem like an insignificant rate for the elderly, it is still twice the rate of mental illness in the same-age non–dual-eligible population.5

Responsibilities of the Dual-Eligible Population

Dual-eligible patients have one of two types of eligibility—full eligibility and partial eligibility. The full dual-eligible patients have 100% coverage, with benefits including a waiver program, skilled nursing facilities, and other services. Full-dual-eligible patients are entitled to Medicaid benefits that Medicare does not cover, including Medicaid drug coverage. Partial-dual-eligible patients are only eligible for Medicaid payments that cover Medicare premiums, deductibles, and coinsurance for Medicare services. They are not entitled to Medicaid prescription drug coverage. Benefits for these partial-dual-eligible patients are stratified according to their needs and, hence, eligibility is limited in several categories of Medicaid coverage. Partial-dual-eligible patients maintain certain responsibilities, usually fiduciary responsibilities.3

The responsibilities of the dual eligible, particularly full-dual-eligible beneficiaries, changed considerably when their prescription drug benefits shifted from Medicaid to Medicare under the Medicare Modernization Act of 1993 (MMA) that went into effect January 1, 2006. The new legislation mandates that

Medicaid beneficiaries, including dual eligibles, receive their drug benefit through enrollment in a Medicare-subsidized private drug plan, the provision also known as Medicare Part D.7 The major difference is that full dual-eligible patients will now face a copayment; previously, they had no financial responsibility in most

### Table 1: Health Status Among Dual-Eligible Patients and Other Medicare Beneficiaries, by Age, 2000

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Dual Eligible (Years)</th>
<th>Other Medicare Beneficiaries (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;65</td>
<td>&gt;65</td>
<td>&lt;65</td>
</tr>
<tr>
<td>Fair/poor</td>
<td>63</td>
<td>40</td>
</tr>
<tr>
<td>Hypertension</td>
<td>65</td>
<td>63</td>
</tr>
<tr>
<td>Heart disease</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Stroke</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Diabetes</td>
<td>60</td>
<td>47</td>
</tr>
<tr>
<td>Asthma</td>
<td>64</td>
<td>60</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>59</td>
<td>12</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

From: Federal Medicare Prescription Drug Coverage: www.dshs.state.tx.us/council/agendas/050505/4.ppt, Texas Department of State Health Service.

### Table 2: Assessment—What Is the Dual-Eligible Responsible For

<table>
<thead>
<tr>
<th>Population</th>
<th>Premium and Deductible</th>
<th>Cost Sharing</th>
<th>Catastrophic Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full and non-full duals</td>
<td>No premium</td>
<td>No deductible</td>
<td>No cost sharing</td>
</tr>
<tr>
<td>All dual-eligible beneficiaries in institutions</td>
<td>No premiums</td>
<td>No deductible</td>
<td>No cost sharing</td>
</tr>
<tr>
<td>New low-income subsidy groups</td>
<td>No premium</td>
<td>No deductible</td>
<td>No cost sharing</td>
</tr>
<tr>
<td>• Up to 155% FPL</td>
<td>No premium</td>
<td>No deductible</td>
<td>No cost sharing</td>
</tr>
<tr>
<td>• 155% to 200% FPL</td>
<td>$2-$5 copay (generic/brand)</td>
<td>$150 of the cost of the covered drug</td>
<td>No copay after total drug expenses reach $5,100 in 2006</td>
</tr>
</tbody>
</table>

FPL = federal poverty level.
states. Dual-eligible patients in an institution have no cost sharing, no premium, and no deductible. There is a new low-income subsidy group in which members have incomes as low as 135% of the federal poverty level; patients in this group may or may not have a premium or deductible but do have some cost-sharing obligations. Data from the Texas Department of Health Services presented in Table 2 illustrate how the new legislation has changed the specific responsibilities of the full and partial dual-eligible population.6

### Continuity of Health Care for the Dual-Eligible Population

In addition to barriers to care posed by the unique demographics of the dual-eligible populations, the impact of several recent and anticipated changes to the infrastructure supporting this group is also a primary concern. For patients with serious and/or multiple afflictions and limited fixed incomes, a notably significant subgroup of the dual-eligible population, even the most modest copayment responsibilities are beyond reach.7 Consider that it is the totality of the cost-sharing impact that can affect treatment.7

Other concerns for providing continuity of drug and health care delivery for the dual-eligible population involve identifying the providers who will be treating this population and, potentially, the services that these patients may lose at the state level. Additionally, constant attention is needed to address where the dual-eligible population comes from and goes to, both from benefit coverage and site-of-care standpoints. Differing formulary selections provided by 2 prescription drug benefits and moving from the home to a rehabilitation or skilled nursing facility are 2 such examples. Each change requires vigilance to assure continuity of care to maintain the patient’s current health status.

The relationships between a pharmacy benefits manager and various parties pertaining to a prescription benefit are shown in Figure 2.10 When caring for the dual eligible, the picture becomes more complex as we follow the trail of the prescription—trying to determine where the prescription is going, who is writing it, and who is rendering care.

As mentioned previously, 38% of dual-eligible individuals have a mental or cognitive impairment.4 According to the National Mental Health Organization, 37% of older adults show signs and symptoms of depression when they visit their primary care physician (PCP). In addition, older adults have the highest rate of suicide of any age group in the country. More than half of all Medicare recipients younger than 65 years who have disabilities also have problems with mental health functioning.4 Additionally, the demographic characteristics of the group indicate a health literacy deficit.8,9 Dual-eligible beneficiaries are more likely to be less educated, with only 28% having a high school diploma compared with 62% of the non-dual-eligible population. This is a significant concern when we consider how providers will educate and treat these patients.

The PCP is just one of the many individuals who may be responsible for the care of the dual-eligible population. There are many types of specialty providers who could potentially treat the comorbid conditions of the dual-eligible population. Unfortunately, this population is at risk of losing valuable services and benefits, a loss that could also make effective drug delivery difficult.8,9 The diagram in Figure 3 illustrates 3 levels of care—

The referral machine supporting primary care providers in the care of dual-eligible patients. Depending on comorbidities, health care professionals provide delivery/coordination of care such as home health, and finally, those who provide support care such as home health, and finally, those who provide...
such services as podiatric, vision, or dental care or social care management. Care given by this last group of providers is at risk because their funding could be eliminated at the state level. 16

Consider the clinical impact resulting from the lack of such ancillary services as podiatry or vision care. Imagine, for example, the problem of telephone outreach for hearing-impaired patients who do not have coverage for hearing aids or providing printed educational materials to low-vision patients who would have difficulty reading them without reading aids. Elimination of these services can become an impediment to the PCP who is trying to achieve optimal outcomes when treating dual-eligible diabetes patients. 17 The refinement and maintenance of such ancillary services infrastructure is vital for these interventions to be appropriate, timely, and effective. Fortunately, from a patient advocacy perspective, groups such as Families USA and the National Council for Community Behavioral Healthcare can provide a voice for health care consumers and support these services.

In addition, the dual-eligible population may come to and from multiple sites of care, including hospitals and skilled nursing facilities. Although the decision to transition patients may depend on the affordability of their care, this transition must be better coordinated. Patients who transition to a long-term health care facility from a hospital or to their homes need increased attention paid to maintaining their pharmaceutical care. This requires a coordination activity that primarily centers on maintaining, if not enhancing, the prescribed pharmacotherapy regimen to streamline treatment. For example, medications not only need to be delivered after a discharge from a hospital or home to the next facility that is delivering care—e.g., a rehabilitation unit—but they must also be assessed for the appropriateness of the medication use in the facility. This may include matching fixed strengths of 2 medications to a combination regimen or considering an extended-release formulation. Both of these examples can lead to more efficient care and reduce the cost impact for the patient or payer. If there is a disruption in the provision of medications, it is uncertain who is responsible for remaining these pharmacotherapies. Thus, while changing the level of service may lead to a more optimal site-of-care or cost savings, the delivery of pharmaceutical care may be disrupted and delayed.

Tailoring Condition Management Strategies for the Dual-Eligible Population

Tailoring the designs of the condition management strategy to the unique needs of the dual-eligible population is key. Implementing a “best-in-class” strategy in this population specifically requires considering shifts away from traditional cost control trends such as 3-tier plan design, PCP-centered provider unit cost profiling, counter-detailing, and preauthorization interventions (Figure 4). 18,19

Newer cost-containment approaches might include preferred drug-to-condition lists, rebate systems, health funds, and more practical systems to disseminate information to PCPs, including e-messaging from hand-held personal digital assistant devices.

With these shifts come questions about accountability. The traditional unit-cost mentality has taken a very incremental approach to the treatment of dual eligibles in which the prevailing philosophy of a return on investment is based on the best decision that applies specifically at that time to that patient. The newer unit cost of a condition for dual eligibles should integrate step therapy, formulary, and shift analysis with accountability based on the prevailing unit cost tied to metrics, it should be tied to at least 1 financial metric but, ideally, also to 2 quality metrics. The 2 quality metrics envisioned are a combination of the overlap of a nationally recognized but locally accepted medical-community guideline component and a patient-perceived benefit. These additional considerations may enhance the outcomes of the chronic care model.

Management strategies focused on addressing accountability must review the functionality of depression screening, member-specific adherence to medication, and utilization reports in this particular dual-eligible population. Such specific evaluations of patient adherence are necessary to optimize condition management and drug use. As one of the many individuals who may be responsible for the care of the dual-eligible population, the PCP needs to screen for depression just as for other chronic disease states. Since most screening for depression takes place within the primary care setting, 18,19 PCPs must receive adequate reimburse-
ment for accurate diagnosis and prompt follow-up, including drug management. Related issues impacting depression are guidelines for screening and the various treatment methods to be used. For example, it is important to determine just how referrals impact reimbursement in this population and make changes accordingly. Several medical organizations, including the American College of Physicians, have been involved in lobbying for and developing pay-per-performance standards for their constituents.2

The most responsive infrastructure must be able to support either a chronic care model for care delivery or resources for PCPs to help them tailor their services to the dual-eligible population. Organizational resources need to be dedicated to monitoring of patient adherence to medications, with clinicians receiving patient-specific utilization reports that detect medication omissions and discontinuation rates. Once developed and routinely used in clinical practice management, such tools will allow clinicians to deliver continuous, better informed, quality care to their dual-eligible patients.1

Conclusion

While dual-eligible patients comprise only 16% of all Medicaid patients, they consume 42% of all Medicaid expenditures.3 The dual-eligible population is a demographically unique population and notably distinct from the overall Medicare population (Figures 1 and 3).4 Although significant changes may not appear to be possible, we must still ensure that the infrastructure to support these individuals can overcome their barriers to care and be sustained.1 Cultural competencies must be in place to accommodate the economic, ethnic, and educational diversity of this population.

The more integral role of family in the care of this population necessitates a combined infrastructure of community outreach and health delivery system to support both the patient and the family member who often serves as an at-home caregiver. Furthermore, we must monitor the implementation of the recent MMA-mandated shift in drug benefit to ensure that adequate provisions are made for prominent subgroups of this population—such as those with disabilities, those older than 85 years, and those with exceedingly low incomes—for whom increased financial obligations might impede access to appropriate drug coverage. An organizational infrastructure that supports either a chronic care model for care delivery and provides resources for PCPs will deliver better-coordinated care to the dual-eligible population that struggles with depression.

DISCLOSURES

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REFERENCES


