CASE STUDIES OF MANAGED CARE ARRANGEMENTS FOR DUALLY ELIGIBLE BENEFICIARIES

by Edith G. Walsh, Project Director,
Angela M. Greene, Sonja Hoover, Galina Khatutsky
Christine Layton, Erin Richter

Federal Project Officer: William D. Clark, M.S.

RTI International*

CMS Contract No. CMS-500-95-0048

September 26, 2003

Edith G. Walsh, Ph.D.
Project Director

Janet B. Mitchell, Ph.D.
Scientific Reviewer

This project was funded by the Centers for Medicare & Medicaid Services under contract no. 500-95-0048. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. RTI assumes responsibility for the accuracy and completeness of the information contained in this report.

*RTI International is a trade name of Research Triangle Institute.

EXECUTIVE SUMMARY

While The Centers for Medicare and Medicaid Services (CMS) and individual States consider managed care an important vehicle for improving health care delivery and controlling expenditures, health plans contracting with Medicare or with individual State Medicaid Programs face many challenges. These challenges are particularly complex when health plans enroll beneficiaries—known as dually eligible—who are covered by both Medicare and Medicaid. In order to examine managed care arrangements for dual eligible beneficiaries, CMS contracted with RTI, Inc. (500-95-0048) to conduct case studies with 11 M+C Organizations and Medicaid managed care organizations, and four focus groups of plan enrollees were held to obtain beneficiary information and experiences. The market areas studied in 2000 were Los Angeles, Portland ME, Philadelphia and Miami.

The central goals of this report are to: (1) describe the existing variation in Medicare and Medicaid managed care combinations in which dually eligible beneficiaries are enrolled; (2) identify problems that managed care organizations (MCOs), beneficiaries, and providers encounter when dually eligible beneficiaries are enrolled in MCOs; and (3) discuss the implications of these findings. The focus of this report is on managed care arrangements under existing authority, not special managed care demonstrations or programs that specifically target dually eligible beneficiaries.

Before addressing these goals, we provide background information on Medicare/Medicaid dual eligibility and managed care enrollment available for these beneficiaries.

E.1 Managed Care Arrangements Vary across Market Areas

Dually eligible beneficiaries can be found enrolled in Medicare + Choice (M+C) plans, Medicaid plans, or both based on a combination of market factors and state regulations. In market areas with M+C organizations, M+C enrollment is open on a voluntary basis to all categories of dually eligible beneficiaries. However, enrollment in Medicaid MCOs is limited to full-benefit dually eligible beneficiaries and depends on individual state regulations as well as managed care markets.

States that allow or mandate any Medicaid MCO enrollment for dually eligible beneficiaries set enrollment policies for various subgroups. These policies include whether M+C enrollees are allowed, mandated, or forbidden to enroll in Medicaid MCOs. In states allowing simultaneous enrollment in M+C and Medicaid MCOs, policies further dictate whether simultaneous enrollment is permitted within the same health plan as the M+C plan. In addition, states set policies regarding Medicaid MCO inclusion or exclusion of home and community-based care recipients and nursing facility residents. The Medicaid enrollment policies in the four market areas we studied (Los Angeles County, California; Portland, Oregon; Miami, Florida; and Philadelphia, Pennsylvania) are shown in Table ES-1.

Table ES-1
Medicaid managed care enrollment policies for dually eligible beneficiaries in four market areas

	Mandatory MCO enrollment for duals in Medicare FFS	Medicare M+C enrollees	Home and community-based waiver clients	Nursing facility residents
Portland,	X	X (only in a *related* plan)	X	X
Los Angeles County	-	-	-	-
Miami	-	X (only in an *unrelated* plan)	-	-
Philadelphia	X	X (in either *related* or *unrelated* plans)	X	-

E.2 Beneficiaries Lack Important Knowledge about Their Coverage

Dually eligible beneficiaries enrolled in managed care for Medicare, Medicaid, or both need information about their coverage and about how Medicare and Medicaid interact. However, basic information is not readily available and beneficiaries have limited understanding of their coverage. Most sources of information about Medicare coverage do not address dual eligibility except to point out that low income beneficiaries may be eligible for Medicaid or for one of the Medicare Savings Programs. In addition, M+C marketing regulations meant to ensure nondiscrimination against classes of Medicare beneficiaries have been interpreted to forbid M+C plans from providing information specific to dually eligible beneficiaries. As a result, beneficiaries pay copayments for which they are not liable and some go without needed care due to the expense. In addition, beneficiaries may use providers that are not "in network" for all of their coverage, leading to discontinuities of care.

E.3 Medicare Cost-Sharing for Dually Eligible Beneficiaries in Managed Care is Inconsistent

Medicaid coverage is intended to help low-income Medicare beneficiaries with the Medicare cost sharing requirements. Medicaid pays the Part B premiums for full-benefit Medicaid beneficiaries, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs), regardless of managed care enrollment. However, full-benefit dual eligibles and QMBs are also entitled to assistance with Medicare copays and deductibles, and at the discretion of the state, for M+C premium payments. According to plans and

beneficiaries, implementation and common practices do not help these beneficiaries with Medicare cost sharing as consistently as intended. The result can be inappropriate charges made to beneficiaries, underpayments to providers, or additional payments made by plans for which they are not reimbursed.

The loss of "zero premium" plans in many market areas has caused new problems for dually eligible beneficiaries and the M+C plans enrolling them, as well as new challenges for states. States benefit from enrollment of their dually eligible beneficiaries in M+C plans to the extent the plan effectively manages care and provides benefits that would otherwise be covered by Medicaid (e.g., prescription drugs). Unless states assist dually eligible beneficiaries with these premiums, those enrolled may drop out and others may be discouraged from enrolling. To address this issue, California now pays M+C premiums to some plans on behalf of dually eligible beneficiaries. Such arrangements are authorized in M+C regulations (42 CFR 422.106). CMS has also determined that M+C plans are not required to disenroll dually eligible beneficiaries due to nonpayment of these premiums, however, plans are prohibited from including this information in any marketing materials

E.4 Plans Lack Necessary Information about the Status of Their Enrollees

Providing the appropriate benefits and coordinating care appropriately for dually eligible beneficiaries requires accurate information about dual status and about any concurrent enrollments in other plans. While conducting our site visits, it became evident that neither M+C plans nor Medicaid MCOs have access to this basic and essential information. Because the two programs are administered separately, Medicare and Medicaid MCOs access separate sources of eligibility data, each of which may be incomplete or not up to date. The lack of coordination of eligibility and enrollment information, combined with time lags that occur within each data system, are problematic for plans, providers, and beneficiaries. Without this information, plans do not receive the appropriate capitation, are hampered in their ability to coordinate benefits and care for their members, and have to correct payments already made to providers. Providers may receive inappropriate payments and face burdensome retroactive reconciliation processes. Beneficiaries do not receive all the care they are entitled to, and are inappropriately charged copayments and deductibles. In addition, Medicaid MCOs sometimes have to disenroll dually eligible beneficiaries who have also enrolled in an M+C plan, if the specific combination is not permitted in that market area.

E.5 Care Coordination and Case Management Activities Are Dispersed in Managed Care Plans

Both M+C plans and Medicaid MCOs engage in a wide range of case management and care coordination activities that generally do not focus on dually eligible beneficiaries directly. The various managed care combinations and the information gaps related to dual eligibility create case management challenges to plans serving dually eligible beneficiaries. The major care coordination activities are benefit coordination, utilization review and associated hospital discharge planning, and disease management programs. These activities are spread across various departments, including member services, utilization review, quality improvement, and special case management. Member service departments and health risk assessments are two common entry points to care coordination and disease management. Due to their health status,

dually eligible beneficiaries are likely participants in disease management programs or case management programs that address issues related to prescription drug, DME, home health and long-term care utilization.

Care coordination/case management is an area where the lack of up-to-date eligibility information limits the effectiveness of M+C plans. As the primary payer for dually eligible beneficiaries, M+C plans need information about additional coverages to maximize the resources available to their members. For example, dually eligible beneficiaries in M+C plans are able to access additional durable medical equipment, home health, pharmacy, and long-term care (LTC) benefits, but only if plan staff, providers, or the beneficiaries are aware of the additional coverage. To the extent there are time lags between a beneficiary's being approved for Medicaid and that information appearing in the CMS data, plans may not know of a beneficiary's dual status for several months. While retroactive reconciliations address the underpayment received by the plans during this period, real-time information is needed to appropriately coordinate care and benefits. In addition, the plans need to know whether a beneficiary is a "full-benefit" dually eligible beneficiary, a QMB-only, or a SLMB-only. The CMS data do not provide this detail.

As the secondary payer, Medicaid MCOs are responsible for Medicare covered services such as hospital stays, skilled nursing facility care, and home health care after the Medicare benefit is exhausted. However, Medicaid MCOs may not learn of these services before the beneficiary exhausts his/her Medicare benefits. As a result, the Medicaid MCO has no opportunity to manage such episodes or direct their members to in-network providers.

E.6 Transitions to Post-acute and Long-term Care Are Fraught with Challenges for Dually Eligible Beneficiaries in Managed Care and for the Plans and Providers Serving Them

The presence of managed care and its associated provider networks create particular problems in continuity of care as dually eligible beneficiaries make transitions from acute to post-acute care, to long-term care, or as they exhaust their Medicare benefits. M+C contracted providers may not accept Medicaid, and providers serving dually eligible beneficiaries under Medicare fee for service (FFS) may not participate in a Medicaid MCO's network. In addition, many standard managed care practices conflict with the reality of service delivery in a given type of facility. While an M+C enrollee in an acute care facility receives ancillary services (e.g., rehabilitation therapies, imaging services, and laboratory services) and pharmacy as arranged by the acute care facility, enrollees in nursing facilities are expected to use the vendors with whom the M+C plan contracts. This requirement results in a clash between facility operations and managed care practices, and the inability of facilities to exert any influence over these vendors.

State limitations on enrollment in Medicaid MCO by service-use category can create an additional problem for dually eligible beneficiaries who develop a need for home and community-based services or nursing facility care and for the plans that serve them. For example, Medicaid MCO enrollees in states that prohibit Medicaid MCO enrollment for LTC users must disenroll from their health plans once the nursing facility becomes their permanent home, or in some states, after a 30-day stay.

M+C plans have tried varying approaches to these issues, including encouraging their enrollees who transition to long-term care to use primary care doctors who specialize in caring for nursing facility residents, and providing lower caseloads for these doctors. In some cases, M+C plans authorize these physicians to use out of network ancillary providers.

E.7 Conclusions and Recommendations

While many dually eligible beneficiaries are getting their medical services under each of the existing managed care arrangements, and health plans are engaged in a variety of disease management and other case management activities, it is clear from this study that current systems do not facilitate coordination of Medicare and Medicaid benefits in managed care. Health plans seeking to address these issues often encounter bureaucratic barriers and beneficiaries do not have the information they need to access the full range of benefits to which they are entitled. To address these issues, we offer the following recommendations.

Increase information available to beneficiaries.

- Develop and disseminate dual-specific information about Medicare benefits. The information should include (1) what is covered by Medicare and Medicaid respectively; (2) that full-benefit dual eligibles and QMBs are not responsible for Medicare copayments and or deductibles; (3) what beneficiaries should do if they are charged for copayments or deductibles; and (4) what arrangements the beneficiary's state may have made for paying M+C premiums.

- Review the M+C marketing regulations and revise to enable M+C plans to correctly inform dually eligible beneficiaries about their reduced liability for copayments and deductibles.

- Allow and encourage plans to provide dual-specific information in member handbooks and on their membership cards.

- Coordinate the federal and state approval processes for marketing materials disseminated by health plans providing both M+C and Medicaid managed care.

- Encourage health plans to include information about dual status on all databases used by member services and case management staff.

Improve the accuracy and timeliness of information available to health plans.

- Review how information flows from states to CMS to M+C plans regarding dual eligibility and identify means to increase the timeliness and accuracy of this information.

- Develop an efficient mechanism for Medicaid MCOs to query CMS data about M+C enrollments.

Improve coordination of Medicare and Medicaid benefits for dually eligible beneficiaries in managed care.

- Encourage states to create a wrap-around Medicaid benefit packages for dually eligible beneficiaries in M+C, allowable under current regulation [CFR422.106].

- Reconsider the value of specific managed care combinations. It is not clear that Medicaid MCO enrollment is a workable arrangement for any dually eligible beneficiaries except those simultaneously enrolled in the M+C product within the same health plan or in plans designed specifically for dually eligible beneficiaries.

- Provide guidance to both M+C plans and Medicaid MCOs about optimal arrangements for dually eligible beneficiaries receiving long-term care services. Current managed care practices and state regulations create discontinuities of care and can interfere with efficient facility operations and the delivery of appropriate care for beneficiaries.