

CASE STUDIES OF MANAGED CARE ARRANGEMENTS FOR DUALY ELIGIBLE BENEFICIARIES

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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	X	X
		(only in a <i>related</i> plan)		
Los Angeles County	-	-	-	-
Miami	-	X	-	-
		(only in an <i>unrelated</i> plan)		
Philadelphia	X	X	X	-
		(in either <i>related</i> or <i>unrelated</i> plans)		

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.

SECTION 1 INTRODUCTION

Managed care is an important vehicle for improving health care delivery and controlling expenditures; however, 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 beneficiaries—who are covered by both Medicare and Medicaid.

In response to concerns about these challenges, the Centers for Medicare & Medicaid Services (CMS) contracted with RTI International to conduct a study of administrative and beneficiary perspectives on the delivery of medical services under Medicare+Choice (M+C) and/or Medicaid managed care organizations (MCOs) for dually eligible beneficiaries. The focus of this report is on managed care arrangements under existing authority, and opportunities for improvement to these arrangements through administrative action, changes in regulation or statutory change, not on managed care demonstrations that specifically target dually eligible beneficiaries.

The primary goals of this study were to

- describe the variation in Medicare and Medicaid managed care combinations under existing authority in which dually eligible beneficiaries are enrolled;
- identify problems that MCOs, beneficiaries, and providers encounter when dually eligible beneficiaries are enrolled in MCOs; and
- discuss the implications of these findings.

Traditional fee-for-service (FFS) reimbursement contributes to fragmented, inefficient, and sometimes duplicative medical care, as discussed extensively throughout the health policy literature. Overlaid with the separate development and administration of Medicare and Medicaid, this fragmentation can result in dually eligible beneficiaries' receiving two uncoordinated benefit packages and providers' being paid through two separate funding streams. Coordination is further complicated by the split between acute and long-term care (LTC) funding and delivery systems within the Medicaid program and, in some cases, by beneficiary participation in other services systems such as mental health and vocational rehabilitation. With no one responsible for the full range of services and costs for dually eligible beneficiaries, no one has a clear role or incentive to coordinate and efficiently deliver medical care that will lead to better clinical outcomes or overall savings for the two programs. Thus, federal and state policymakers look to managed care to address these issues by creating financial incentives and administrative structures that can support coordinated and efficient care.

This report provides background information on Medicare/Medicaid dual eligibility and managed care options available for these beneficiaries (the remainder of this section) and describes the data collection methods used to gather information (Section 2). Section 3 describes the variation in managed care combinations across market areas. In Section 4 we evaluate the information available to dually eligible beneficiaries to help them understand their coverage.

Section 5 details issues related to Medicare copayments, deductibles, and M+C premiums as described by M+C plans, Medicaid MCOs, and focus group participants. In Section 6, we describe issues related to Medicare and Medicaid enrollment and eligibility data problems. Section 7 describes case management and care coordination activities in managed care plans serving dually eligible beneficiaries, and specific challenges to coordinating benefits and care. Finally, Section 8 summarizes our findings and presents recommendations.

1.1 Background

1.1.1 Characteristics of the Dually Eligible Population

About 17 percent of Medicare beneficiaries in 1999 were also enrolled in Medicaid, representing about 6.2 million dually eligible beneficiaries (CMS analysis of Medicare Current Beneficiary Survey data). These dually eligible beneficiaries accounted for about \$50 billion in Medicare expenditures (24 percent of the total for all Medicare beneficiaries) and \$63 billion in Medicaid expenditures (35 percent of the Medicaid total). These beneficiaries receive assistance from their State Medicaid Programs with Medicare premium payments and their Medicare copays and deductibles. If their income and assets are low enough, dually eligible beneficiaries may also receive Medicaid benefits from their states, such as community and facility LTC, acute care, behavioral health, pharmacy benefits, and medical transportation. This group is sometimes referred to as “full-benefit” dually eligible beneficiaries. The categories of dual eligibility and their respective benefits are shown in Table 1 (see also www.hcfa.gov/medicaid/dualelig/).

Despite the additional resources available to dually eligible beneficiaries, serving these beneficiaries can be particularly challenging for medical care providers and for health plans in which they enroll. Compared to other Medicare beneficiaries, dually eligible beneficiaries are known to have poorer health status, higher health care costs, less education, be more culturally diverse, and have an increased likelihood of using LTC (e.g., Walsh, French and Bentley, 1996; HCFA, 1997; Pope, Adamache, Walsh, and Khandker, 1998; Liu, Long, and Aragon, 1998). Recent analyses of the 2000 Medicare Current Beneficiary Survey show 55 percent of dually eligible beneficiaries reported fair or poor health status compared with 26 percent among the non-dually eligible Medicare population. Sixty-three percent of dually eligible beneficiaries had less than a high school education in comparison to 29 percent of non-dually eligible beneficiaries. Twenty-two percent of dually eligible beneficiaries lived in LTC facilities compared with only 3 percent of non-dually eligible beneficiaries. Higher percentages of dually eligible beneficiaries have diabetes, pulmonary disease, stroke, and Alzheimer’s disease than non-dually eligible Medicare beneficiaries. Dually eligible beneficiaries also are disproportionately older, female, and from minority populations (Shatto, 2002).

Indeed, because Medicaid status (also known as welfare status) serves as a proxy for poor health in the demographic risk-adjustment models that are the basis of M+C capitation payments, M+C organizations receive substantially higher capitation payments for each dually eligible enrollee. As a result of their poor health status and increased likelihood of using a range of services, dually eligible beneficiaries are a group for which care and benefit coordination are simultaneously important and complex.

Table 1-1
Summary of benefits for dually eligible beneficiaries

	Benefits	Income eligibility (per 1- or 2-person family, year 2000)	Asset eligibility (per 1- or 2- person family, year 2000)	Notes
SSI	Full Medicaid benefits (benefit package details vary by state plan) and SSI Medicare Part B premium payment, Medicare copays and deductibles	\$0–\$500 (1) \$0–\$751 (2)	\$0–\$2,000 (1) \$0–\$3,000 (2)	
Medically needy	Full Medicaid benefits (varies by state plan)	Set by state and requires out of pocket medical costs	\$0–\$2,000 (1) \$0–\$3,000 (2)	
Full Medicaid benefits without SSI	Full Medicaid benefits (varies by state plan) Medicare Part B premium payment, Medicare copays and deductibles	0-73 FPL (SSI income limit) \$0–\$500 (1) \$0–\$751 (2)	\$0–\$2,000 (1) \$0–\$3,000 (2)	Must have income under \$500 <u>and</u> assets under \$2,000 (1); otherwise QMB-Plus or QMB-only, depending on resources and state.
QMB-plus	Full Medicaid Benefits (varies by state plan) Medicare Part B premium payment, Medicare copays and deductibles	74-100 FPL \$501–\$716 (1) \$752–\$958 (2)	\$0–\$2,000 (1) \$0–\$3,000 (2)	Only some states exercise this option (CA, FL, HI, ME, MA, MI, MS, NC, NE, NJ, PA, RI, SC, UT and DC exercised this option)

(continued)

**Table 1-1
Summary of benefits for dually eligible beneficiaries (continued)**

	Benefits	Income eligibility (per 1- or 2-person family, year 2000)	Asset eligibility (per 1- or 2- person family, year 2000)	Notes
QMB-only	Medicare Part B premium payments, and Medicare copays and deductibles	< = 100 FPL \$0-\$716 (1) \$0-\$958 (2)	\$0-\$4,000 (1) \$0-\$6,000 (2)	
SLMB-plus	Full Medicaid benefits Medicare Part B premium payments	101-120 FPL \$717-\$855 (1) \$958-\$1,145 (2)	\$0-\$2,000 (1) \$0-\$3,000 (2)	
SLMB-only	Medicare Part B premium payment	101-120 FPL \$717-\$855 (1) \$958-\$1,145 (2)	\$0-\$4,000 (1) \$0-\$6,000 (2)	
QI-1	Medicare Part B premium payment	121-135 FPL \$845-\$947 (1) \$1,127-\$1,265 (2)	\$0-\$4,000 (1) \$0-\$6,000 (2)	Block grants first come first served Expires 12/31/02
QI-2	A small part of the Medicare Part B premium (~\$2.23)	136-175 FPL \$948-\$1,222 (1) \$1,266-\$1,633 (2)	\$0-\$4,000 (1) \$0-\$6,000 (2)	Block grants first come first served Expires 12/31/02
QDWI	Payment of Medicare Part A premium if employed	0-200 FPL \$0-\$1,452 (1) \$0-\$1,955 (2)	\$0-\$4,000 (1) \$0-\$6,000 (2)	

1.1.2 Characteristics of Coverage Received by Dual Eligibles

Full-benefit dual eligibles, those with both Medicare and full Medicaid benefits, have the richest set of health benefits available from public payers. Medicaid serves as both a medigap policy, paying Medicare copayments and deductibles, and as a wrap-around policy providing LTC benefits such as home and community-based services and nursing facility care, and extended benefits beyond the coverage provided by Medicare (e.g., additional hospital days and additional post-acute care services). Yet even full-benefit dual eligibles face problems accessing the care they are entitled to and receiving quality care or coordinated care. As discussed

extensively throughout the health policy literature, traditional FFS reimbursement contributes to fragmented, inefficient, and sometimes duplicative medical care.

The separate development and administration of Medicare and Medicaid, even when delivered through managed care arrangements, results in dually eligible beneficiaries' receiving two uncoordinated benefit packages and providers' being paid through two unintegrated funding streams. Coordination is further complicated by the split between acute and long-term care funding and delivery systems within the Medicaid program and by beneficiary participation in other services systems such as mental health and vocational rehabilitation. With no one responsible for the full range of services and costs for dually eligible beneficiaries (except in demonstrations like the Program of All-Inclusive Care for the Elderly—PACE; no one has a clear role or incentive to coordinate and efficiently deliver medical care that will lead to overall savings for the two programs. These conditions led CMS to investigate ways to control growth in these expenditures while maintaining its commitment to beneficiaries' well-being. Use of managed care is one such strategy.

1.2 Managed Care: History and Objectives

Policymakers have long promoted managed care as holding promise for care delivery through a model that could offer a high degree of coordination and integration across the spectrum of covered acute, chronic, and LTC services. The combination of risk-based capitation, comprehensive benefit packages, and broad flexibility in the allocation of services offered by health plans has been considered an arrangement that could lead to the efficient and cost-effective provision of high-quality services and care (Schlesinger and Mechanic, 1993; Walsh, French, and Bentley, 2000).

Neither Medicare nor Medicaid was designed to enable managed care options. However, both programs have been amended since their enactment in 1965 to develop managed care options. Title XVIII has been amended several times to enable risk-based financing for Medicare, with the M+C Program per the Balanced Budget Act of 1977 the current foundation for Medicare managed care. Medicaid programs have enabled managed care through voluntary health plans per the provisions of Title XIX Section 1915(a), and through Section 1115 waivers. Amendments to Medicaid in the early 1980s enabled states to develop primary care case management and MCOs that are capitated and may include mandatory enrollment options (Section 1915(b)). For many Americans dually eligible for both Medicare and Medicaid, all these provisions guide the delivery and payment for the health care benefits available to them under the Social Security Act, and interface with other entitlements such as Social Security itself and benefits from the Department of Veterans Affairs. Their totality represents an enormous and complex set of rules and regulations under which consumers, caregivers, providers, and government labor.

1.3 Managed Care Initiatives

Managed care programs such as PACE and demonstrations such as the Social/Health Maintenance Organization (SHMO), the Minnesota Senior/Disability Health Options, and the Wisconsin Partnership Program have been designed and implemented with an orientation to enroll and serve dually eligible and frail or chronically ill populations. These programs have

been examined in some detail (e.g., Greenberg, Leutz, and Altman, 1989; Harrington and Newcomer, 1991; Branch, 1998; Kane et al., 2001). However, the vast majority of dually eligible Medicaid managed care enrollees nationwide (approximately 300,000) are in traditional M+C organizations. Very little is known about how these beneficiaries arrange to obtain for themselves the services to which they may be entitled under Medicaid, but for which their Medicare health plan has little or no obligation to provide assistance. Similarly, dually eligible Medicaid recipients also are enrolling voluntarily or are subject to mandatory Medicaid MCO enrollment in some States.

The following case study illustrates the problems that arise in the fragmented FFS system and touches on the variety of clinical and administrative issues that arise. These are the problems that policymakers have hoped managed care would address. Although an extreme case in terms of the number and types of medical conditions, Ms. C's case illustrates basic issues: the need for medical management, coordination of care, and coordination of benefits.

Case Study

Ms. C. has been struggling with her health and the health care system her whole life. Born with spina bifida with meningomyelocele, she has resulting paraplegia. She has both a colostomy and a urostomy (which she cares for herself) and she requires special nonlatex supplies because of a sensitivity to latex. In addition, Ms. C. has multiple comorbid conditions, including diabetes, hypertension, sleep apnea, and reflex sympathetic dystrophy in her arms. One of her legs has been amputated below the knee due to osteomyelitis; the other recently broke while she was attempting to transfer between her wheelchair and her bed. Ms. C's case provides an extreme example that highlights the challenges beneficiaries face struggling simultaneously with medical problems, medical coverage, and other social supports.

The health care system has been both generous and frustrating to Ms. C. She has Medicare and Medicaid coverage and is not enrolled in a managed care plan. Ms. C. sees seven specialists in addition to her primary care provider and receives treatment at a major medical center in a neighboring state. Medicare pays for her hospitalizations, physician visits, lab tests, wheelchair and hospital bed, home health services, and medical supplies. Medicaid covers her Medicare Part B premiums, Medicare copayments and deductibles (even for services provided out of state), medications, home and community-based waiver services, and hospital and post-acute care costs that exceed the Medicare benefit. The home and community-based waiver services are focused on keeping Ms. C out of a nursing home. These services include nurse case management of Medicaid services, daily homemaker services, limited home health services, and, when available, medical transportation. She has had 58 surgeries in her 45 years, and was hospitalized in the past year for cellulitis and sepsis (at a cost of \$51,000), conditions that are considered avoidable if adequate primary and ambulatory care are provided.

Ms. C has an extensive network of volunteer caregivers. Her minister and his wife spend about 10 hours a week helping Ms. C with errands and chores. They previously took her to medical appointments, but Ms. C's functional status has declined to the point that she is no longer able to transfer in and out of their vehicle, and they are not physically capable of lifting her. Another volunteer decodes her medical bills and advocates on her behalf with Medicare, Medicaid, and individual medical care providers regarding inappropriate bills and coverage denials.

Ms. C. lives in a ground floor apartment in a subsidized housing development. The apartment is considered accessible because she can wheel directly out the front door to the parking lot, to the walkway around the building, and to the sidewalk to town. With the assistance of a motorized wheelchair, she has done her own laundry in the apartment complex laundry room, motored to church a few blocks away in her wheelchair, and "gone for walks" in the neighborhood. However, none of her health care providers are within "walking" distance—getting to them requires coordinating transportation services difficult to access in her primarily rural county.

Despite her combined coverage and vocal advocates, Ms. C has unmet medical care and support service needs and faces ongoing challenges regarding coordination of care. In addition, no one is responsible for the overall medical effectiveness of her service plan, nor for thinking about how to deliver care to Ms. C in the most cost-effective manner. The challenges she faces fall into several categories: medical management, access to home health care, and benefit coordination.

Problems with Medical Management

Even though Ms. C has a primary care physician, the clinical aspects of her care are not coordinated and the various members of her clinical "team" do not communicate. Specialists do not routinely report back to her primary care physician, neither does the primary care physician consistently implement specialist recommendations when they are provided. This lack of communication resulted in a hospitalization for adverse effects of polypharmacy including severe kidney dysfunction. Lack of aggressive medical management may also have contributed to some of her other hospitalizations and her functional decline. In at least one recent instance, Ms. C did not contact her physician at the first signs of illness, due to her inability to recognize the seriousness of the symptoms and the difficulty she faces getting out to see the doctor. As a result, she became sick to the point of hospitalization.

Access to Home Health Care

Ms. C receives daily personal assistance services through the Medicaid program in her state; however, these services are scheduled with extended periods of time between visits, during which Ms. C may have no one to assist her with transfers in and out of bed. Although the personal assistance is supervised by a nurse case manager through quarterly in-home nursing assessments, it does not include care or monitoring of her frequent skin breaks and infections or monitoring of her health status. Ms. C's multiple medical conditions, her risk of skin breakdown

and infection due to immobility, her inability to treat skin breakdowns without assistance, and her limited ability to understand or accept the dietary requirements associated with diabetes make her a strong candidate for ongoing nursing monitoring. Regular in-home skilled nursing would provide this type of monitoring and treatment of active problems, as well as early detection of any complications or exacerbations of her underlying medical conditions.

Given the challenges and expense associated with getting Ms. C to medical appointments, home health care would appear to be a key need. Yet, over the years, the local home health provider has cited Ms. C's ability to sit outside her apartment and use her motorized wheelchair to get around the neighborhood as evidence that she is not homebound, according to Medicare criteria for home health provision. This provision is intended to ensure that services are not provided in the home if the beneficiary is able to receive the same services on an outpatient basis, which is assumed to be less expensive.

In reality, getting Ms. C to a medical provider is a very expensive proposition, indeed, and one that cannot be accomplished frequently or on short notice. She requires help transferring from bed, dressing, and arranging for transportation, and assistance getting in and out of the van or other source of transportation and into the provider's office. Transportation arrangements often must be made days or weeks in advance. Thus, while it is feasible for Ms. C to see her physicians for scheduled outpatient visits, it is not feasible for her to see them on short notice or daily to treat problems such as skin breakdown. Contrary to the local home health agency's interpretation of Medicare regulations, the assistance Ms. C requires to get out of the home for medical care is consistent with home health eligibility criteria related to being "homebound."

Benefit Coordination

In addition to issues about Ms. C's clinical care and service plan, there are problems related to coordinating her Medicare and Medicaid benefits and ensuring that benefits are delivered appropriately. Ms. C lives in a state that covers all Medicare copayments and deductibles; however, each provider has to acquire a Medicaid provider number and submit a bill for these services. During a recent hospitalization, over 10 individual clinicians provided care to Ms. C, and many sent bills to her for the Medicare copayments. One of the volunteers assisting Ms. C spent many hours making phone calls and writing letters to educate each of these providers about Ms. C's dual eligibility and the Medicaid billing requirements in her state.

Ms. C has also had problems with durable medical equipment and medical supplies. The type of tape she needs for her ostomies is not covered by either her Medicare or Medicaid benefits. The cushions she sits on in her wheelchair to reduce the chances of developing decubitus ulcers wear out long before her insurance covers replacements. Medicare provides only one wheelchair, even though many people with disabilities need a motorized chair to get around independently and a collapsible, manually powered chair for travel by car.

How Would Managed Care Enrollment Help Ms. C?

Beneficiaries and advocates are often concerned with how managed care enrollment can limit access to needed care; indeed, this concern is valid at times in both Medicare and Medicaid managed care. However, if Ms. C were enrolled in the ideal managed care plan, one that is responsible for both her Medicare and Medicaid benefits, the following improvements could be seen over her current care:

- Identification as a target for case management or disease management programs through health risk assessment screening or utilization review.
- Case management that is focused on the best and most cost-effective approach to managing her overall condition and costs, without being constrained by the limits of the standard Medicare and Medicaid benefits (e.g., provision of the necessary tape for her ostomies and additional pads for her wheel chair, possibly help to maintain both a manual and motorized wheelchair). In addition, member services or case management staff could deal with ancillary providers (home health agencies, transportation providers, durable medical equipment suppliers, and medical supply vendors) who are not meeting the beneficiaries' needs, and by authorizing home health services could reassure the home health agency that services provided will be covered.
- Pharmacy benefits management that would identify and address potential polypharmacy issues.
- Referral requirements that would increase the likelihood of communication among the various physicians treating Ms. C.
- A degree of control over the quality of the treating physicians, based on the managed care organization's credentialing process and the presence of a medical director who could work with individual physicians to ensure compliance with clinical standards of care.

Implications of the Case Study for This Report

Managed care clearly has the potential to improve the appropriateness and quality of care received by dually eligible beneficiaries, and to assist them with coordinating their benefits. The rest of this report examines aspects of the regulatory environment in which managed care organizations work to deliver care to these beneficiaries, the structures and processes plans have in place to coordinate benefits and care to dually eligible beneficiaries, and the experience of dually eligible beneficiaries in various managed care arrangements.

SECTION 2 METHODS

To understand the types of managed care combinations available and the number of dually eligible beneficiaries participating in various arrangements, we reviewed CMS data (analysis of the 1998 Medicare Denominator File and the Enrollment Database; analysis of group health program data) and state data (Kaye et al., 1999); and enrollment and eligibility data from selected states' Web sites in 1999. We also used these data to select four market areas— Los Angeles County, California; Portland, Oregon; Miami, Florida; and Philadelphia, Pennsylvania—for site visits and extensive case studies, as we discuss in detail in Section 3. The market areas were selected because they each have a substantial M+C presence, enroll at least some of their dually eligible beneficiaries in Medicaid managed care, and reflect varied Medicaid managed care policies regarding enrolling dually eligible beneficiaries.¹ State administrators provided guidance in selecting plans, and entrée to Medicaid managed care plans in the target market areas. We approached M+C plans directly.

2.1 Plan Site Visits

In each market area, we met with administrators and staff of at least two MCOs. Across the four market areas, we met with M+C-only plans (two plans), Medicaid-only plans (two plans), and health plans offering both M+C and Medicaid (five plans), including a mixture of for-profit and not-for-profit organizations. We held a series of meetings at each plan, interviewing government relations administrators responsible for compliance with Federal and State regulations, enrollment, member services, provider relations (for issues affecting physicians and other providers), utilization review, case management and quality improvement staff (including the medical directors), and claims processing departments. The site visits occurred between October 2000 and April 2001. The interview protocols are attached as Appendix A.

We conducted site visits to managed care plans in Los Angeles County, California; Portland, Oregon; Miami, Florida; and Philadelphia, Pennsylvania. In Philadelphia and Los Angeles County, we also conducted beneficiary focus groups (11 groups in total). This effort was supported by assistance from the health plans. The focus group participants were all dually eligible beneficiaries (or their caregivers), age 65 or over, who had been enrolled in health plans for either their Medicare or Medicaid benefits, or for both for at least 6 months. The focus groups were held in June, July, and August 2001. (The focus group protocols can be found in Appendix B.) The focus groups included questions designed to assess beneficiary understanding of their coverage, sources of information used by beneficiaries to understand their joint coverage, and to learn about beneficiaries' experience receiving medical services and accessing payment for that care. We further supplemented our case study activities with numerous Web-based searches of CMS and state information for beneficiaries and with follow-up discussions with managed care administrators and state informants.

¹ Further information about site selection is available on request from the authors. Information about the plans, however, is not available as we guaranteed them anonymity.

2.2 Plan Confidentiality

Plan participation in this study was voluntary, as was assistance in recruiting focus group participants. Participation was time consuming, and in recognition of the burden placed on the plans, we were not aggressive about gathering follow-up information or plan documents. To encourage open discussion of issues experienced by the plans, including issues where plans were critical of CMS or state policies, or in which the plans believed themselves to be out of compliance with regulations, we agreed not to identify plans by name and did not tape record the interviews. The focus group protocols were approved by the RTI Institutional Review Board (IRB), and participants were assured of confidentiality as well.

SECTION 3

MANAGED CARE ARRANGEMENTS FOR DUALY ELIGIBLE BENEFICIARIES

In this section, we describe the various factors that determine whether dual eligibles are enrolled in M+C or Medicaid MCOs or both, provide information about M+C and Medicaid MCO enrollments by state, and describe in further detail the managed care arrangements in each of our four case study sites.

3.1 Factors Affecting Managed Care Enrollment for Dually Eligible Beneficiaries

Dually eligible beneficiaries can be found enrolled in 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. In contrast, enrollment in Medicaid MCOs is limited to full-benefit dually eligible beneficiaries, and depends on individual state regulations as well as managed care markets.

State policies dictate whether dually eligible beneficiaries have the option to enroll in Medicaid MCOs at all, and whether enrollment is voluntary or mandatory. States with Medicaid MCO enrollment for dually eligible beneficiaries establish policies on the combinations of Medicaid MCO and Medicare coverage permitted (i.e., whether those enrolled in M+C plans are encouraged, allowed, or forbidden to enroll in Medicaid managed care simultaneously). Where such simultaneous enrollment is permitted, states further determine whether beneficiaries may receive both benefits within the same MCO, or from two unrelated health plans. These varying combinations can differ not only from state to state, but within market areas of individual states, depending on managed care penetration or state regulations. Thus, dually eligible beneficiaries may be enrolled in varying combinations of managed care and FFS for each of these two benefits.

The number and percent of dually eligible beneficiaries who are enrolled in Medicaid managed care varies across states and across market areas within states due to a combination of factors. The presence of M+C is primarily determined by individual health plans in response to county-level payment rates leading to areas with sizable M+C penetration and others with no M+C presentation at all. The types of state regulations described above, as well as business decisions of individual health plans determine the presence of Medicaid managed care. For our case studies, we wished to identify states with a high M+C penetration rate, with a sizable enrollment of dual eligibles in Medicaid MCOs, and with varying state regulations regarding Medicaid MCO enrollment for dual eligibles.

3.2 Enrollment in M+C by State

To look at Medicare managed care enrollments on the state level, we analyzed the 1998 Enrollment Data Base (EDB). Table 3-1 displays by state the number of M+C beneficiaries, the total number of dual eligibles, and the number and percent of dual eligibles enrolled in M+C plans. Many states had relatively few dually eligible beneficiaries enrolled in Medicare HMOs, with less than 7 percent of all dually eligible beneficiaries enrolled in Medicare HMOs nationwide. Only 17 states had more than 5,000 dually eligible beneficiaries in Medicare managed care. From this table it is evident that Arizona and Oregon had the highest proportions

of dual eligibles enrolled in M+C plans (24 percent and 37 percent respectively), while California and Florida had the largest number of dual eligibles in M+C plans (105,275 and 64,519 respectively). In addition, Arizona, Illinois, New York, Ohio, Oregon, Pennsylvania, Texas, and Washington State each had at least 10,000 dual eligibles enrolled in M+C plans, while Colorado and Massachusetts had almost 10,000 each.

3.3 Enrollment in Medicaid Managed Care by State

While it is comparatively easy to use the EDB or denominator file to find out Medicare managed care enrollment of dual eligibles, as we did to generate Table 3-1, MSIS data is the logical source for a similar analysis of dual eligibles by state. However, there have been substantial delays in the availability of MSIS data nationally. Without the benefit of MSIS data for all the states, it is more challenging to learn which states enroll dual eligibles in Medicaid managed care and the nature of these Medicaid managed care programs. The National Academy for State Health Policy (NASHP) (Kaye et al., 1999) reported 21 states enrolling at least some dual eligibles in Medicaid managed care programs. Some of these programs are limited to selected counties within a state. We reviewed these data, in combination with the information about M+C enrollments, to categorize states on two dimensions: M+C penetration and enrollment of dual eligibles in Medicaid MCOs. Using this information, we determined that the following states enrolled at least some of their dually eligible beneficiaries in Medicaid MCOs, and had at least 10,000 or 10 percent of their dually eligible beneficiaries enrolled in M+C plans: Arizona, California, Colorado, Florida, Maryland, Nevada, Oregon, Pennsylvania, and Texas.

3.4 Case Study Sites

To explore issues of care and benefit coordination for dually eligible beneficiaries in various arrangements, we selected four market areas from states with substantial M+C penetration and enrollment of dual eligibles, and with at least some enrollment of dual eligibles in Medicaid MCOs. We further targeted market areas that met the following additional criteria: multiple M+C plans, multiple Medicaid MCOs, at least one plan that had both Medicare and Medicaid products, and that represented a variety of state policies regarding enrollment of dual eligibles in Medicaid MCOs.

Table 3-2 presents information about dually eligible beneficiaries and managed care enrollment in the four states selected as case study sites. Of these states, California has the highest number of Medicare beneficiaries (4.1 million), almost 1 million of whom are dually eligible. About 11 percent of California's dually eligible beneficiaries were enrolled in an M+C plan in 2001. California's requirements regarding enrollment in Medicaid managed care for dually eligible beneficiaries vary by county of residence, with about 93,000 enrolled in Medicaid MCOs in February 2000. (We do not present the percent of dually eligible beneficiaries enrolled in Medicaid managed care by state because the appropriate denominator is not clear: state and Federal figures differ on the total of dually eligible beneficiaries in each state and are from different time periods. In addition to discrepant time periods, the differences may relate to which categories of dually eligible beneficiaries states and CMS track, or lags in state reporting of dually eligible beneficiaries enrolled or other factors.)

**Table 3-1
Medicare managed care penetration rate of duals, by state**

State	Number of Medicare beneficiaries ¹	Number of dual eligibles ²	Number of duals in Medicare managed care ²	Percentage of duals in Medicare managed care ²
Alabama	669,585	141,692	6,725	4.7
Alaska	38,226	8,553	61	0.7
Arizona	651,498	60,729	14,293	23.5
Arkansas	433,250	88,716	1,046	1.2
California	3,782,967	853,260	105,275	12.3
Colorado	451,056	60,399	9,962	16.5
Connecticut	509,969	59,340	2,202	3.7
Delaware	107,932	11,099	326	2.9
District of Columbia	75,672	15,169	895	5.9
Florida	2,760,956	361,612	64,519	17.8
Georgia	884,774	193,598	3,909	2.0
Hawaii	158,987	22,271	1,970	8.8
Idaho	159,194	17,876	399	2.2
Illinois	1,625,913	170,691	10,612	6.2
Indiana	841,097	98,526	1,899	1.9
Iowa	475,962	57,895	759	1.3
Kansas	388,743	45,314	910	2.0
Kentucky	609,632	121,545	1,504	1.2
Louisiana	595,588	127,487	8,593	6.7
Maine	210,621	37,224	65	0.2
Maryland	627,985	76,093	7,751	10.2
Massachusetts	950,902	153,804	9,407	6.1
Michigan	1,379,162	157,597	2,808	1.8
Minnesota	643,877	68,323	5,724	8.4
Mississippi	411,212	117,768	135	0.1
Missouri	850,544	95,229	2,924	3.1
Montana	134,216	13,904	121	0.9
Nebraska	251,715	21,785	404	1.9
Nevada	222,958	22,162	4,117	18.6

(continued)

Table 3-1
Medicare managed care penetration rate of duals, by state (continued)

State	Number of Medicare beneficiaries ¹	Number of dual eligibles ²	Number of duals in Medicare managed care ²	Percentage of duals in Medicare managed care ²
New Hampshire	164,621	8,528	314	3.7
New Jersey	1,188,597	158,755	7,806	4.9
New Mexico	225,242	38,862	2,225	5.7
New York	2,666,286	386,382	15,873	4.1
North Carolina	1,094,364	243,231	2,097	0.9
North Dakota	102,927	6,717	45	0.7
Ohio	1,688,794	207,674	16,448	7.9
Oklahoma	500,600	74,320	2,198	3.0
Oregon	481,306	62,287	22,715	36.5
Pennsylvania	2,089,235	212,204	16,229	7.6
Rhode Island	170,020	19,423	1,532	7.9
South Carolina	545,859	121,319	667	0.6
South Dakota	118,384	14,648	23	0.2
Tennessee	806,892	187,441	1,769	0.9
Texas	2,195,710	386,556	23,804	6.2
Utah	198,028	18,048	941	5.2
Vermont	86,588	14,786	52	0.4
Virginia	864,647	128,984	2,084	1.6
Washington	717,575	99,551	10,206	10.3
West Virginia	334,496	51,311	602	1.2
Wisconsin	774,798	84,176	1,400	1.7
Wyoming	63,504	7,036	55	0.8

NOTES: A number of these states have limited the enrollment of dually eligible beneficiaries to selected counties within the state.

¹HCFA 1999. "Medicare Beneficiaries Enrolled as of July 1 of Each Year, Years 95-98." <http://www.hcfa.gov/stats/histenr1.htm>; accessed 17 November 99.

²Medicare Denominator File 1998, NASHP 1998.

Table 3-2
Enrollment of dually eligible beneficiaries in M+C
and Medicaid managed care in four states

State	Total beneficiaries		Dually eligible beneficiaries		
	Medicare	Dually eligible	Medicare managed care	Percent in Medicare managed care	Medicaid managed care
California	4,139,502	856,974	89,694	10.5	93,000
Florida	2,994,687	367,546	51,946	14.1	18,267
Oregon	522,499	65,413	18,018	27.5	21,143
Pennsylvania	2,195,187	218,656	18,469	8.4	54,300

Within each state, there may be different Medicaid MCO policies by county, or different options available. For example, M+C plans are generally concentrated in metropolitan areas where the capitation payments from CMS are highest. Rural areas are also less likely to have Medicaid MCO penetration. Some states have also chosen to implement Medicaid managed care incrementally or to enroll dually eligible beneficiaries in Medicaid managed care incrementally. The following section provides information about the managed care environments in the four case study states at the time we were selecting market areas for this study.

3.4.1 Managed Care Environment in Case Study Sites

California—California has the largest number of dually eligible beneficiaries in the country, 853,000 in 1998 (RTI analysis of the EDB). Over 100,000 (about 11 percent) are enrolled in a Medicare managed care plan (GHP, 2/2000) and about 93,000 (about 11 percent) are enrolled in a Medicaid managed care plan (California enrollment data, 2/2000). The organization and features of Medicaid managed care varies by county. Seven counties have county-organized health systems in which dually eligible beneficiaries are required to enroll. In the Two-Plan Model and Geographic Managed Care counties, enrollment is voluntary for dually eligible beneficiaries. To learn about these programs and the size of the enrollments, we spoke with MediCal staff and received February 2000 enrollment reports. We also used data from a February 2000 GHP run to ascertain information about Medicare managed care enrollments by plan and by county.

Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, and Solano counties have county-organized health systems (COHS) with mandatory enrollment in managed care for dual eligibles.¹ CalOPTIMA in Orange County has the largest number of dually eligibles enrolled in their program in the state (39,026; California Enrollment Data 2/2000). Four of these COHS plans enroll nursing facility residents in managed care (CalOPTIMA, Partnership Health

¹ Although Monterey is classified as a COHS, only half of its dual eligibles are enrolled in Medicaid managed care while the other half are in FFS.

Plan, Santa Barbara Health Initiative, and Santa Cruz County Health Options) and one also includes LTC services (CalOPTIMA).

Residents in other counties may voluntarily enroll in a Medicaid managed care plan. There are a number of counties with what is called a Two-Plan Model: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. In actuality, more than two plans may be operating in these counties with one serving as an umbrella organization holding the contract with the state and subcontracting to other health plans. This arrangement was intended, at least in part, to reduce the number of contracts the state had to administer. While simplifying contracting for the state, some plans lost contracts, and others have had to develop multiple contracts covering each of several counties. The percentage of dual eligibles enrolled in Medicaid managed care ranges from 3 to 6 percent, while the actual number of enrollees ranges from 163 in Tulare to 6,260 in Los Angeles County (California Enrollment Data 2/2000). Residents in nursing facilities and clients of home and community-based waiver programs are excluded from enrollment.

California has geographic managed care programs in Sacramento and San Diego counties as well. Dual eligibles are spread across a number of plans in the counties. In Sacramento County, 2,731 dually eligible beneficiaries are enrolled in Medicaid managed care (12 percent of all dually eligible beneficiaries in that county), the majority of which belong to Kaiser and Blue Cross (California Enrollment Data 2/2000). In San Diego, a similar number of dual eligibles, 2,317, are enrolled in Medicaid managed care, although this number represents a much smaller percentage of potential enrollees (5 percent), over half of which are enrolled in San Diego Community Health Group (California Enrollment Data 2/2000). In Sacramento's model, neither nursing facility residents nor home and community-based users are enrolled in Medicaid managed care. Like the Two-Plan Models, residents in a nursing facility and clients of a home and community-based waiver program are excluded from enrollment in Medicaid managed care organizations.

In conjunction with CMS, we chose to include Los Angeles County, a Two-Plan Model county in the case studies. Los Angeles County has large numbers of dually eligible beneficiaries in managed care and many managed care organizations of varying types (Medicare-only, Medicaid-only, and plans with both).

Florida—Florida is second only to California in its total number of Medicare beneficiaries and the number of dually eligible beneficiaries who are enrolled in Medicare managed care. Of its 361,000 dually eligible beneficiaries, nearly 18 percent (64,519) are enrolled in Medicare managed care (RTI analysis of the EDB). Five percent (18,267) are enrolled voluntarily in Medicaid managed care (Florida enrollment reports, 2/2000). Neither nursing facility residents nor home and community-based users are enrolled in Medicaid managed care. To learn about Medicaid managed care for dually eligible beneficiaries, we spoke with Florida's Medicaid agency and retrieved enrollment information from the state's website. The greatest concentration of enrollments in both M+C and Medicaid MCOs is in south Florida, including Dade and Hillsborough counties. One plan enrollees almost 20,000 dual eligibles, while the second and third largest enrollments are substantially smaller at 5,342, and 3,762 respectively (GHP run, 2/2000). Medicaid MCO enrollment of dually eligible beneficiaries in these two counties is concentrated in three plans, only one a large M+C plans as well. Although

there are plans with both Medicare and Medicaid products, Florida does not permit enrollment in both simultaneously.

Oregon—As a less populous state, Oregon does not have a large total number of dually eligible beneficiaries, but the state has the greatest percentage of dually eligible beneficiaries enrolled in managed care arrangements. Plans in Oregon not only serve a higher proportion of dually eligible beneficiaries than in other states, but also have been serving this population for a longer period of time (Medicaid managed care went into effect for dually eligible beneficiaries in 1995). Thus, plans have more experience with the issues of benefit and care coordination for dually eligible beneficiaries. Programmatically, Oregon is also interesting because long-term care users (including both community- and facility-residing beneficiaries) are enrolled in Medicaid managed care, even though their LTC services remain carved out.

The distribution of Oregon’s dually eligible beneficiaries across managed care arrangements is displayed in Table 3-2. Within the Portland metropolitan area, at the time of this study, there were two or more plans in each of the possible categories: those that provide Medicare managed care only, Medicaid managed care only, and managed care organizations that provide both. Since the case studies were conducted, all but one plan have withdrawn from the Medicaid managed care market in Oregon.

Table 3-3
Distribution of dually eligible beneficiaries by type of managed care arrangement

Medicare	Medicaid	Percent
HMO	HMO	34.6
HMO	Fee-for-service	5.3
Fee-for-service	HMO	30.5
Fee-for-service	PCCM	8.1
Fee-for-service	Fee-for-service	21.6
All		100.0

SOURCE: Mitchell, J and Saucier P: *Enrolling Elderly and Disabled Beneficiaries in Medicaid Managed Care: Lessons from the OHP*. Waltham MA: Health Economics Research, Inc. HCFA Contract No. 500-94-0056, September 1998.

Pennsylvania—Like Florida, Pennsylvania has a very large Medicare population and a substantial number of dually eligible beneficiaries (212,204; RTI analysis of EDB). While only about 8 percent of the dually eligible beneficiaries are enrolled in Medicare managed care, this translates to over 16,000 beneficiaries (RTI analysis of EDB). In addition, Pennsylvania mandates managed care enrollment for some dually eligible beneficiaries for those who live in Philadelphia, Bucks, Chester, Delaware, and Montgomery counties. Pennsylvania includes services that are medically necessary for home and community-based clients in Medicaid managed care and excludes nursing facility residents. LTC services remain carved out of managed care (with the exception of three small demonstrations). At least two of Pennsylvania’s larger plans have both Medicare and Medicaid products. The number of dual eligibles found in Medicare managed care appears to be concentrated in Philadelphia County. Dually eligible

beneficiaries are permitted to enroll in both a Medicare and Medicaid managed care plan. Beneficiaries may choose to enroll in unrelated managed care entities or in the same plan for both products. If a Medicare managed care entity becomes Medicaid-eligible and fails to choose a Medicaid plan, the auto-assign algorithm would place the beneficiary in the companion plan if possible. The beneficiary retains the right to change Medicaid plans at any point, as Pennsylvania does not have a lock-in provision.

3.4.2 Medicaid Managed Care Enrollment Regulations by Market Area

In Table 3-4, we summarize Medicaid MCO enrollment policies for full-benefit dually eligible beneficiaries by each of the four market areas.¹ Each of these market areas is subject to a different set of state policies based on Medicare enrollment status (FFS or M+C). For example, although there are liberal exemptions on an individual basis and those with Medigap policies or other third-party resources are excluded from Medicaid MCO enrollment in Oregon, in general, dually eligible beneficiaries who receive their Medicare benefits on a FFS basis are required to enroll in a Medicaid MCO. Medicaid MCO enrollment for individuals choosing M+C plans in Portland, Oregon, is more complicated: dually eligible beneficiaries who are in M+C plans that have a companion Medicaid product are mandated to enroll in that companion product, while those in a M+C plan without a companion Medicaid product are prohibited from enrolling in another Medicaid MCO (Mitchell and Saucier, 2000). In contrast, in Los Angeles County, California, dually eligible beneficiaries may choose to enroll in either an M+C plan or a Medicaid MCO, but not both, regardless of whether or not companion plans exist—even if enrolling in a staff model health maintenance organization. In Miami, Florida, the state allows simultaneous enrollment in both M+C and a Medicaid MCO, but only in two unrelated plans, while in Philadelphia, Pennsylvania, dually eligible beneficiaries enrolled in an M+C plan may choose to remain in Medicaid FFS or enroll in a related or an unrelated Medicaid MCO.

States also categorize their Medicaid beneficiaries according to services they use, such as those who live in institutions (LTC, psychiatric facilities, or others), or whether they receive services through Section 1915(c) 2176 home and community-based services (HCBS) Waivers. Medicaid managed care enrollment may be required, optional, or unavailable for individuals in some or all of these categories. As seen in Table 3-5, only Oregon enrolls nursing facility residents in Medicaid MCOs, both Oregon and Philadelphia enroll HCBS waiver clients in Medicaid MCOs, while both categories of LTC users are excluded from Medicaid MCOs in Los Angeles and Miami. Even when LTC users are enrolled in Medicaid MCOs, their LTC services (both HCBS and facility-based care) are carved out and delivered on a FFS basis.

¹ Medically needy, qualified Medicare beneficiaries (QMB)-only and specified low-income Medicare beneficiaries (SLMB) are free to enroll in M+C plans, but are not enrolled in Medicaid MCOs.

**Table 3-4
State policies regarding combinations of Medicare and Medicaid managed care
for dually eligible beneficiaries**

	Medicare enrollment		
	Medicare FFS	Enrolled in M+C	
		Medicaid MCO in same organization	Medicaid MCO in a different organization
Portland, Oregon	Mandated enrollment in a Medicaid MCO	Mandated enrollment in companion Medicaid MCO	Enrollment prohibited in an unrelated Medicaid MCO
Los Angeles County	Mandatory	Prohibited	Prohibited
Miami	Voluntary	Prohibited	Voluntary
Philadelphia	Mandatory	Permitted	Permitted

**Table 3-5
State policies regarding Medicaid managed care enrollment
for LTC service users in four market areas**

	Home and community-based waiver clients	Nursing facility residents
	Portland	enrolled
Los Angeles	–	–
Miami	–	–
Philadelphia	enrolled	–

SECTION 4

HOW BENEFICIARIES LEARN ABOUT THEIR COVERAGE

4.1 Overview

In various sections of this report, we describe problems associated with beneficiaries' limited understanding of their dual coverage. In addition, since health plans lack even basic information about dual status (as described in Section 6) the burden is on beneficiaries to understand their coverage and advocate for appropriate coordination of benefits. In this section, we look explicitly at the sources of information available to dually eligible beneficiaries and how accessible these sources are to these low-income, often poorly educated Medicare beneficiaries. We discuss what dually eligible beneficiaries need to know and the potential efficacy of information sources. We focus on information materials produced by health plans and state and federal governments. Table 4.1 (at the end of Section 4) summarizes the materials we reviewed. This section also includes findings from our review of information, and from discussions with beneficiaries in focus groups and with health plan representatives.

4.2 Information Needs of Dually Eligible Beneficiaries

Fundamentally, dually eligible beneficiaries need information that explains their health care benefits, including:

- who pays for what;
- when to use Medicare versus Medicaid, and
- if they are liable for any out of pocket costs, including
 - what costs they are not liable for,
 - how getting care in one system affects access to care under other systems, and
 - where to go with questions.

Past work, like that by Harris-Kojetin, et al., (1999) shows that dually eligible beneficiaries want more information regarding how “the two public insurance programs coordinate services and coverage” (Harris-Kojetin, et al., 1999). When we looked at the information available to dually eligible beneficiaries in managed care for either their Medicare benefit, or Medicaid benefits, or for both, we found little help answering these questions.

Specifically, dually eligible beneficiaries in managed care need to understand which services are covered by any plans in which they are enrolled, which may be complicated by the differences between the standard Medicare or Medicaid benefit and those of the beneficiaries' specific plans. In the case of Medicaid MCO enrollment, beneficiaries also need to understand which of their Medicaid services are covered by the plan and which are carved out, remaining under Medicaid FFS or provided by a separate behavioral health plan. In addition, as discussed in Sections 3 and 7, Medicaid MCO enrollees face special circumstances regarding their use of Medicare providers. If enrollees go out of their Medicaid MCO network, as is their right under their Medicare benefit, they may face coordination of care and benefit problems with their

Medicaid MCO-covered benefits. When enrolled in an M+C plan, dual eligibles, as with all enrolled Medicare beneficiaries, need to understand that they must seek all of their Medicare-covered services from that plan.

4.3 Available Information Sources and Their Efficacy

Dually eligible beneficiaries receive information about their health coverage through marketing materials, member handbooks, and other printed materials from a variety of sources, including:

- health plan materials and member service departments;
- State government agencies, such as Medicaid (Medical Assistance), State Health Insurance Assistance Programs (SHIPs), and Departments of Aging;
- Federal government agencies (e.g., CMS); and
- other nongovernmental agencies and organizations such as AARP.

Many of these materials are available both in print and on the Web. In addition, health plans provide member service staff available by telephone to answer specific questions as they arise. Despite the number of potential information sources, we found none to be designed specifically for dually eligible beneficiaries. Focus group findings also indicate that while beneficiaries receive a variety of information materials, they are not useful in helping beneficiaries navigate the complex health care system created by combining Medicare and Medicaid benefits. In addition, federal policies impede the dissemination of dual-specific marketing materials by M+C plans, and the lack of coordination across Medicare and Medicaid also results in burdensome processes for plans seeking approval of marketing information. As a result (as detailed in Section 3), beneficiaries may be going without services to which they are entitled, and many pay copayments or deductibles for which they should not be liable.

We provide information about Web-based consumer information materials, member handbooks, health plan marketing materials, and member services at the individual health plans. We also provide background information about federal and state regulations that affect the information available for dually eligible beneficiaries.

Table 4-1 summarizes the materials reviewed for this report. It is important to recognize that although the internet is not necessarily a primary source of information for beneficiaries, it is used by intermediaries—family, friends, and others who may assist beneficiaries with answering questions and helping to make health care decisions. In 1998, McCormack, et al. found that insurance companies, agents, and/or health plans were the most informative sources for both new and experienced Medicare beneficiaries (McCormack, et al., 2001). In addition, many of the materials we reviewed on the Web are also available in print and are frequently disseminated to beneficiaries.

4.4 Findings

The information available on the CMS website is targeted primarily toward beneficiaries who are only receiving Medicare. The website has little information to help beneficiaries understand dual eligibility and none about how managed care enrollment in either M+C or Medicaid plans affects dual eligibles.

Although McCormack, et al. showed that about one in ten beneficiaries used the Medicare website to obtain information, these data were collected nearly 4 years ago. McCormack and her colleagues predict that “use of this information source is likely to grow as the baby-boomer generation ages into Medicare” (McCormack, et al., 2001). Moreover, intermediaries, including SHIPs, may rely on the CMS website to obtain the most up-to-date information and download publications such as *Medicare and You*. Publications that until recently had to be acquired in hard copy format through the mail or by going to a social security office are now available on the internet in offices, homes, and libraries. As a result, while the internet may not be widely used directly by dually eligible beneficiaries, it is nonetheless an extremely important source of information.

We were unable to locate any information materials that specifically targeted dually eligible beneficiaries. Moreover, many beneficiary-oriented information guides, such as *2002 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*, lack important information about how benefits or copayments may be different for dually eligible beneficiaries than for Medicare-only beneficiaries.

Many of these materials contain sections to which information on benefits for dually eligible beneficiaries could easily be added. For example, *Your Medicare Rights and Protections* includes a section that discusses ABNs (Advance Beneficiary Notice). Discussing how Medicare is obligated to notify beneficiaries regarding which services may not be covered would be a natural segue to how beneficiaries may be eligible for additional benefits and coverage (i.e., Medicaid) that might cover additional services.

The CMS website includes Medicare and Medicaid information for consumers. However, there is an obvious difference in the presentation of the information directed at Medicare beneficiaries versus Medicaid beneficiaries. The material available for Medicare beneficiaries is much more accessible by the average person, while material for Medicaid beneficiaries is much more difficult to access. When the terms “Medicare,” “dual eligibility,” or “dually eligible” are searched on the CMS Medicaid website, no links are retrieved. Other available information is highly technical and does not answer basic questions regarding how to access or pay for health care. Although the website includes links designated as “information for consumers,” the information is highly technical and appears to be more suitable for researchers or program administrators.

Below, we present key findings from our review of information materials available to dually eligible beneficiaries.

4.4.1 Information for Medicare Beneficiaries is Suited to Elderly; Information for Medicaid Beneficiaries is Suited to Families with Children

Information for Medicare beneficiaries (e.g., *Medicare and You*) has a tone that targets elderly beneficiaries. This assertion is based on the observation that the graphics generally include images of elderly persons. Likewise, names of M+C plans, such as “Senior Partners,” suggest that the plans are for those over age 65. Although current marketing regulations prohibit such age-specific names for M+C plans, it may take time for Medicare beneficiaries under 65 to recognize this change.

In contrast, information for Medicaid beneficiaries has a tone that targets families with children. For example, the cover page of one health plan’s marketing brochure touts, “If you receive Medicaid: Get more health care benefits at no cost to you!” and has images of children with teddy bears and features a cartoon mascot named “Doc Leo.” Although the majority of Medicaid beneficiaries are children, disabled or elderly persons may be put off by information materials that depict Medicaid beneficiaries as children and pregnant women with low incomes.

4.4.2 State-Based Medicaid Websites Offer Some Links, but Little Useful Information for Dual Eligibles

Review of Medicaid websites for the states included in our case studies revealed little useful information. Often, the websites referred users to the CMS website.

The California Department of Aging website, like components of the CMS website, mentions that low-income elders may be eligible for Medicaid and provides links to the State Health Insurance Assistance Program and to the Medical Assistance program, but does not explain how these coverages would work together or address coordinating Medicare and Medicaid benefits for those enrolled in managed care.

Like other SHIP websites, Oregon’s website provides information about Medicaid eligibility criteria, but not about coordinating Medicare and Medicaid in managed care. It also inaccurately defined the federal poverty level as \$716 per year (rather than per month). This information could cause potential beneficiaries to believe they were ineligible.

Pennsylvania’s Department of Aging did include one question and answer (shown below) regarding dual eligibility on their Medicaid managed care website. As shown, the information focuses on enrollment requirements and the beneficiary’s right to go to any Medicare provider. While informative, the information is limited. The website also offers a number to call for information, instructs beneficiaries to call member services at their health plans with questions or problems, and links to the public assistance offices. There is no information about how Medicare copayments or deductibles are handled or other information about coordinating Medicare and Medicaid benefits.

Example from Pennsylvania’s Department of Aging Website

Q: I have Medicare coverage. Do I have to enroll in HealthChoices?

A: If you have both Medicare and Medical Assistance (MA) coverage, your Medicare benefits do not change in HealthChoices. But, the way you get your Medical Assistance benefits is different.

In order to use your Medical Assistance benefits, you need to pick a HealthChoices health plan and PCP. When you need a service that is not covered by Medicare, you go to your HealthChoices doctor for that service.

When you use a service covered by Medicare, you can go to any provider that takes Medicare. You do not have to get these services through your HealthChoices plan. You will get your prescription drugs through your HealthChoices health plan if you are eligible for MA prescription benefits. After you have enrolled in a plan, call the plan to find out what pharmacies to use for your prescription drugs.

The Florida Department of Health and Human Services provides links to information about Medicare and Medicaid, but does not provide specific information for dually eligible beneficiaries.

4.4.3 Regulatory Coordination is Lacking, Extending to the Type of Approval Plans Needed for Plans’ Marketing and Other Materials

Plans providing both M+C and Medicaid managed care must obtain approval of their marketing materials and member handbooks from Medicare and Medicaid. In addition to health plans’ added burden inherent in having to acquire separate approvals, the state and federal requirements may differ. As a result, dually eligible beneficiaries may receive inaccurate information. These inaccuracies set the stage for beneficiaries’ paying more out of pocket than necessary or not receiving necessary services altogether, as we discuss below and in Section 3.

4.4.4 Current Federal Requirements and State Practices Impede the Dissemination of Important Information for Dual Eligibles

Dually eligible beneficiaries may receive information regarding at least four sources of health care benefits: Medicare FFS, M+C, Medicaid with a managed care plan, and Medicaid without a managed care plan. Given this level of complexity, dually eligible beneficiaries require information that is relevant to their specific situation. Many dually eligible beneficiaries receive benefits information from each program and the beneficiary faces the onerous task of synthesizing and integrating this information. As we discuss in Section 4.5, the focus groups revealed that beneficiaries may not be able to meet this challenge. As a result, dually eligible beneficiaries may pay more out of pocket than necessary for covered services and experience problems with coordination of care.

Current federal requirements promulgated under the Balanced Budget Act of 1997 state that all Medicare beneficiaries must receive the same information, a requirement that overlooks

the legitimate differences in coverage between dual eligible beneficiaries and “Medicare-onlies.” These regulations affect the information that may be provided to beneficiaries and includes restrictions on information in marketing materials, mailings to beneficiaries, and member handbooks. For example, M+C organizations are not allowed to include information explaining that dually eligible beneficiaries are not liable for any copays or deductibles in the M+C Explanation of Benefits. This is based on the requirement that M+C plans provide consistent marketing information to help consumers compare the benefits offered across plans. However, even though nearly 20 percent of Medicare beneficiaries are dually eligible, the Medicare regulations (and their interpretation by the CMS regional office staff) assume that all Medicare beneficiaries have the same coverage, and hence the same copayment requirements. As a result, beneficiaries may pay for services for which they are not liable, or choose not to enroll in an M+C plan because of an incorrect impression that they will face higher copays than under Medicare fee-for-service when combined with their Medicaid benefits. In other words, the requirements for standardized information do not take dual eligibility into account.

At the time of our site visits, CMS regional office staff had denied permission to a plan seeking to mail out dual-specific information for its dually eligible members. The plan had wanted to inform these beneficiaries that they are not liable for M+C copays or deductibles, and to remind them to be sure to show their Medicaid card at the point of service in order to have their M+C copays waived. This decision was based on the regional office staff’s interpretation of federal requirements to provide a consistent benefit package to all Medicare beneficiaries. Waiving copayments or deductibles for dual eligibles was interpreted as a discriminatory practice because it meant that some M+C members within the same M+C product were being treated differently than others. While the plan and the regional office continued to negotiate this issue, an opportunity was lost to include the information in a routine mailing to its members.

4.4.5 Member Service Staff are An Important Source of Information for Beneficiaries

Member service staff are another source of information for managed care members. The plans we visited invest substantial resources in these services, including large telephone banks, information systems for staff to draw upon, and staff training and supervision. Plans serving dually eligible beneficiaries include those with M+C only, Medicaid only, and those with both. The possible combinations can vary by county even for members of the same plan. Hence, customer service for dually eligible beneficiaries is complex. Staff need to have information about all the combinations possible for their members, what the combined benefits are in each combination, what the plan’s responsibility is according to the member’s enrollment combination, and up-to-date information about each member’s eligibility (i.e., M+C organizations must have up-to-date information about Medicaid status). Meeting some of these needs is dependent on access to information from the state or from CMS (see Section 6), while addressing other needs depends on the plan’s own practices (e.g., what information is available about additional coverages on the electronic files available to member services staff?). Unfortunately, even within plans that enroll dual eligibles in both Medicare and Medicaid products, member services representatives may not have access to what benefits members may receive through both Medicare and Medicaid products and information on how these benefits coordinate. Health plan practices varied as to whether information about dual eligibility was available on the electronic files accessed by their member services staff.

In our earlier work evaluating the impact of the Oregon Health Plan on dually eligible beneficiaries, we conducted beneficiary focus groups of individuals under age 65 with physical, developmental, or psychological disabilities (Walsh, et al., 2000). In contrast to the over-65 dually eligible beneficiaries in the past and current project's focus groups, many of the beneficiaries with physical disabilities, and some of those with psychiatric disabilities, had a detailed understanding of their benefits and many were active self-advocates. At that time, dually eligible beneficiaries with disabilities described several problems with the accuracy of information from member services. Beneficiaries described situations where the customer service number differed on the M+C and Medicaid MCO cards, and the staff answering each of those lines only understood one of the two benefits, even though the beneficiaries were simultaneously enrolled in both. Hence, beneficiaries were told by M+C customer services staff that they were not eligible for a service that was indeed covered by the Medicaid MCO plan, and vice versa. In addition, participants in those groups reported that member services staff sometimes misunderstood the concept of Medicare as the primary payer. This policy means that Medicare pays first for services covered by both Medicare and Medicaid, while Medicaid covers Medicare cost-sharing requirements and also covers in full any additional services covered under a state's Medicaid plan. Beneficiaries reported that member services staff misunderstood this concept to mean that the Medicare benefit dictated all covered services, and was the first payer for services covered by both. As a result, dually eligible beneficiaries enrolled in both the M+C and Medicaid MCO products within the same health plan were denied Medicaid-covered services.

In our interviews with plan staff in the current project, health plans had taken several measures to address this issue. The plan had eliminated product-specific member services staff, and provided all member services staff with training in the M+C products, the Medicaid MCO products, and in dual eligibility. Other plans also reported cross-training member services staff and providing intensive training and supervision.

4.5 The Beneficiary Experience

Despite the investment in print materials, Web-based materials, and member services, our focus groups and interviews with health plan staff indicate many problems with beneficiary understanding of each coverage, of their dual eligibility, and of the specific requirements of managed care enrollment. In this section, we summarize our findings regarding sources of consumer information gleaned from the beneficiary focus groups. We will describe some of these issues in additional detail in subsequent sections of this report.

4.5.1 Dually Eligible Beneficiaries do Not Understand Their Dual Coverage or How Their Benefits Should be Coordinate

To evaluate the focus group participants' understanding of their coverage, we facilitated a discussion by presenting the following introduction and asking a series of questions:

Let's talk a little bit about your experience with your health plan(s) and with Medicare and Medicaid.

Different health plans work with Medicare or [*whatever it is called in each study state*], or with both, to provide health care services to people enrolled in these programs. Medicare is the federal program that covers health care services for the elderly, the disabled, and those who have end-stage renal disease. Medicaid [*whatever it is called in each study state*] helps cover certain health care services and prescription drugs for those who have low incomes. Do you know which type of plan you are enrolled in? Are you enrolled in a Medicare managed care plan, a Medicaid managed care plan, or one that combines the two, or do you not know?

- How do you know which kind of plan it is? [*remember from enrollment, someone told me, etc.*]
- Is there anyone who belongs to more than one plan, and has more than one insurance card? [*How many insurance cards do you have?*]
- Is one of those your [*Use name of the plan*] card?

In response to this series of questions, focus group participants could identify the names of plans in which they were enrolled, but did not know which benefit (Medicare, Medicaid, or both) was covered by their plan(s). In addition, most focus group participants generally did not understand what it meant to be dually eligible and many could not identify what coverages they had. When asked, most participants acknowledged that their dual eligible benefits had not been explained to them. One man enrolled in a California M+C plan described how he called member services but that nobody was able to explain his dual eligibility to him. Other focus group participants thought that perhaps information was available in their benefits booklet but that they did not remember. This notion further reflected the difficulty of members who received membership materials from M+C plans as well as Medicaid managed care plans.

In this focus group discussion and when discussing their various medical cards and experience with copayments (see Section 4.5.2), it was clear that most participants lacked the fundamental knowledge that Medicare was their primary payer or how to assure they received all the benefits to which they were entitled. This lack of knowledge is consistent with issues discussed by the health plan representatives. In virtually every plan, questions about coordination of benefits was one of the common issues brought to customer service representatives by members and their families.

4.5.2 Identification Cards for Health Plans Can Conflict and Confuse Beneficiaries

To make the discussion of coverage concrete, we asked the focus group participants to show us their various cards and asked the following questions:

- When do you show these cards?

- What do you use each of these cards for?
- Which card do you use the most?
- Have you had problems using any of these cards?
- In general, what type of services does [*Insert plan name*] cover? What about your other coverage [*other card*]? What types of services are covered?
- Did [*Insert plan name*] ever give you a different card than the one you have now? What was the difference between the two cards?

Some participants mentioned that their out-of-pocket expenses varied from one provider to another depending on which card they showed. In one group, participants mentioned showing the Medicare and Medicaid identification cards and having no copayment, while those who showed only one card had a copayment. Two of these participants mentioned that their doctors told them that they could not use their other card so these participants no longer presented both cards at the time of service. “When I went to the doctor, I showed them both and he said then we accept this one and I won't need the health card anymore. So I threw the other one away and I pay a copay of \$5.” Another participant explained that he only used one card, but had to pay for prescriptions. “My card states that I shouldn't be paying for medications but yet when I show it to them they make me pay either \$5 or \$10.”

4.5.3 Beneficiaries Vary in Their Ability to Use Managed Care Member Handbooks as an Information Source; Many Criticize the Complexity of the Information

Some participants enrolled in M+C plans reported that they received materials that contained some useful information. “We know what kinds of doctors are [covered] or what doctors are in the plan...there are tabs in the booklet so...it's easy to find what you're looking for.” However, materials often contained information that was hard to follow and understand. As one focus group participant explained, “The booklets are written in medibureaucratspeakese.” Another quipped, “You need a ouija board to figure it out.”

Participants may require assistance in interpreting materials. Participants reported that family or physicians sometimes helped them to understand information materials.

“I don't understand some of the stuff that's written in there, you know? But my niece does and I have my envelope, and it's right there, and she'll say to me, 'Well, has this happened? That happened?' I say, 'I don't know, Fran.' So she gets the book and she refers to that book to find out different things that she wants to know. So they are helpful if you understand them.”

This comment is noteworthy not only because it indicated beneficiaries may have difficulty using materials but because it reflects the importance of intermediaries in reviewing and interpreting benefits information.

Some participants in managed care plans described how they tried to obtain information or clarification from member services, with varying degrees of success:

“I got coupons for [my health plan] stating that my copayment would be \$20 a month and I didn't understand why because until now I had only \$10 copayment. So I went to the membership services—she was very nice and she says, ‘Oh, that's a mistake. They shouldn't send you that’.”

Although this beneficiary's reported interchange reflected a positive interaction between herself and her health plan, it also reflects an underlying problem: dually eligible beneficiaries can receive conflicting or incorrect benefits information.

4.6 Recommendations

There is a clear need for dual specific information for beneficiaries and those who advocate for them. This information needs to cover a wide range of topics and various scenarios in which dual eligibles may find themselves. The information also needs to be tailored to the specifics of the various combinations of managed care and FFS and how those vary by state or even within states.

Below, we present our recommendations to the Federal government, states, and plans for improving the information availability to dual eligibles.

4.6.1 Recommendations for the Federal Government

- Provide information specific to dually eligible beneficiaries in CMS documents and require, or at least permit, MCO materials (e.g., marketing materials, member handbooks, and special mailings) to address topics specific to dually eligible beneficiaries in M+C plans.
- Include topics relevant to dually eligible beneficiaries in documents' table of contents.
- Provide training to CMS regional office staff (both Medicare-oriented staff and Medicaid-oriented staff) regarding dual eligibility generally and in relation to various managed care arrangements.
- Provide information on the CMS Medicaid website that is consistent with that provided to Medicare beneficiaries.
- Improve the coordination within CMS at the national level to improve policies and programs that affect dually eligible beneficiaries.
- Provide information that is more inclusive of nonelderly Medicare beneficiaries.

4.6.2 Recommendations for States

- Handbooks for Medicaid plan beneficiaries need to have clear information about how enrollment in the plan coordinates with or affects Medicare benefits, and whether the individual has access to additional services under Medicare outside the Medicaid plan. This information would have to be state-specific.
- Materials approved by CMS should be deemed acceptable by states. Materials approved by CMS on the federal side are not automatically deemed acceptable by the individual states. This policy makes it more burdensome for dually eligible beneficiaries to receive timely and potentially useful information.
- Information for Medicaid beneficiaries should be designed to appeal to elderly and disabled beneficiaries—not just to children and pregnant women.

4.6.3 Recommendations for Plans

Plans vary in the way they train member services staff, the information available on member ID cards, and how members access member services. Best practices we observed include:

- Entering dual eligibility information into the data bases accessed by member services staff.
- Training member services staff on issues specific to dual eligibility, from both the M+C and Medicaid plan perspective (if the plan has both lines of business).
- Issuing cards that clearly indicate special status regarding copayments and deductibles that are different for dual eligibles than for other members.

Table 4-1
Summary of materials reviewed

Source	Title	Type (i.e., printed, electronic, etc.) ¹	Agency (author)	Year	Mentions Medicaid/ dually eligible	Targeted to lay readers/ beneficiaries	Comments
	Medicare and You 2002	Printed (from website)	CMS	2002	Yes	Yes	Mentions Medicaid as a program available for some persons of low income. Refers readers to state medical assistance office. Dual eligibility or Medicaid is not mentioned specifically in the table of contents but is included in the index.
Federal government	Evidence of Coverage: Your Medicare Health Benefits and Services as a Member of [Name of MCO or Plan] January 1-December 31, 2002	Printed	CMS	2002	Yes	Yes	EOC fails to mention many instances in which Medicaid may play an important role in benefits. Neither table of contents or Appendix A (Reference list of important words in this booklet) do not mention Medicaid by name.
	2002 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy	Printed (from website)	CMS	2002	Yes	Yes	Mentions Medicaid as a program available for some persons of low income. Refers readers to state medical assistance office. Dual eligibility or Medicaid is not mentioned specifically in the table of contents but is included in the index.

(continued)

Table 4-1
Summary of materials reviewed (continued)

Source	Title	Type (i.e., printed, electronic, etc.) ¹	Agency (author)	Year	Mentions Medicaid/dually eligible	Targeted to lay readers/beneficiaries	Comments
Federal government	Your Medicare Rights and Protections	Printed (from website)	CMS	2001	No	Yes	Discussion of ABN (Advance Beneficiary Notice) (p. 10) would be an excellent point to mention Medicaid and how some Medicare services may be available through other programs.
	Understanding Your Medicare Choices	Printed (from website)	CMS	2000	No	Yes	Discussion of out-of-pocket expenses would be excellent point to mention Medicaid and how Part B and other medical expenses may be covered for persons of low income through other programs.
	Medicare and Other Health Benefits: Your Guide to Who Pays First	Printed (from website)	CMS	2000	No	Yes	Although this publication described how Medicare works with group health insurance, no-fault or liability insurance, Veterans' benefits, workers' compensation, TRICARE, Federal Black Lung Program, and COBRA, no mention is made of Medicaid.
	New Rules for Switching Medicare Health Plans	Printed (from website)	CMS	2001	No	Yes	Publication could be extremely confusing for those in Medicaid managed care and other dually eligible beneficiaries.

(continued)

Table 4-1
Summary of materials reviewed (continued)

Source	Title	Type (i.e., printed, electronic, etc.) ¹	Agency (author)	Year	Mentions Medicaid/ dually eligible	Targeted to lay readers/ beneficiaries	Comments
Federal government	What is Medicaid and Who Does it Cover?	Electronic	CMS	2002	Yes	Yes	Website refers readers to state medical assistance. Does not explain dual eligibility, per se.
	Who is Eligible for Medicare?	Electronic	CMS	2002	No	Yes	No mention of Medicaid or means to pay for Part B or other medical expenses that are uncovered by Medicare.
	Medicare Managed Care Manual (section 40.5 Conducting Outreach to Dual Eligible Membership, Rev. 4, 10-01-01)	Electronic	CMS	2002	Yes	No	Describes process Medicare managed care plans may use to conduct outreach to enrollees who are potentially eligible for Medicaid.
State Government	Medicare + Choice: Questions and Answers about Medicare	Electronic	CA Dept. of Aging	2002	Yes	Yes	Following discussion of out-of-pocket expenses, mention is made that persons of low income may be eligible for Medicaid. Links are provided to the SHIP and Medical Assistance.
	Healthy Horizons	Electronic	PA Dept. of Aging	2002	Yes	Yes	Briefly describes Medicaid managed care plan for Medicare dually eligible beneficiaries. Links are provided to the Department of Public Welfare County Assistance Office.

(continued)

Table 4-1
Summary of materials reviewed (continued)

Source	Title	Type (i.e., printed, electronic, etc.) ¹	Agency (author)	Year	Mentions Medicaid/ dually eligible	Targeted to lay readers/ beneficiaries	Comments
State government	Medicare and Health Insurance for Elders	Electronic	FL Dept. of Health and Human Services	2002	Yes	Yes	Provides links to additional information on Medicare and Medicaid. Does not provide specific information for program participants who are dually eligible.
	Senior Health Insurance Benefits Assistance: Medicaid for Medicare	Electronic	OR Senior Health Insurance Benefits Assistance	2002	Yes	Yes	Described what is covered under Medicaid. Erroneously defines FPL as \$716 per <i>year</i> instead of month. This could cause potential beneficiaries to believe they were ineligible.
Private	Medicaid	Electronic	AARP	2002	Yes	Yes	Describes basics of Medicaid. Provides links to CMS website to locate local medical assistance office.
	Benefits Check Up	Electronic	National Council on the Aging	2002	No	Yes	Uses information provided by user, e.g., income, disability, place of residence, to identify state and federal programs for which older adults may be eligible.
	Medicare HMO Marketing in the Information Age	Printed (from website)	Medicare Rights Center (Dallek, G.)	1999	No	No	Reviews problems with the marketing of Medicare HMOs. No mention is made of unique problems of dually eligible beneficiaries.

(continued)

Table 4-1
Summary of materials reviewed (continued)

Source	Title	Type (i.e., printed, electronic, etc.) ¹	Agency (author)	Year	Mentions Medicaid/ dually eligible	Targeted to lay readers/ beneficiaries	Comments
Private	Module 4: Coordination with Low-Income and Other Programs	Printed	SHIP Manual	2000	Yes	No	Provides general information for SHIP counselors who are working with dually eligible beneficiaries.
	The Guidebook to Kaiser Permanente Services (Southern California)	Printed	Kaiser Permanente	2000	No	Yes	Basic information not targeted to Medicare or Medicaid beneficiaries.
	Senior Partners Health Partners Medicare Plan 2001 Evidence of Coverage	Printed	Senior Partners	2001	No	Yes	Doesn't mention correct copay information for dually eligible beneficiaries. Name of health plan may not appeal to disabled beneficiaries.
	Senior Partners Health Partners Medicare Plan 2001 Summary of Benefits	Printed	Senior Partners	2001	No	Yes	Doesn't mention correct copay information for dually eligible beneficiaries. Name of health plan may not appeal to disabled beneficiaries.
	If you receive Medicaid: Get more health care benefits at no cost to you!	Printed	Physicians Healthcare Plans		No	Yes	Marketing brochure. Images appear suited to beneficiaries with young children. Features cartoon images of children and mascot "Dr. Leo."

¹"Printed" indicates materials that are available in printed, i.e., hard copy, form. "Printed (from website)" indicates those printed materials that, while available in printed form, were downloaded from a website. "Electronic" refers to those materials that are only available from websites.

SECTION 5 MEDICARE COST SHARING

“I was a corporate attorney [before becoming disabled]. That means I have specialized expertise in dealing with mindless bureaucracy, but I could not figure out this system.”¹

Medicaid eligibility is intended to help low-income Medicare beneficiaries with the Medicare cost sharing requirements. According to plans and beneficiaries, implementation and common practices do not accomplish this goal as consistently as intended. The result can be inappropriate charges to beneficiaries, underpayments to providers, or additional payments made by plans for which they are not reimbursed. In addition, while Medicaid automatically pays the Medicare Part B premiums for dual eligibles, this is not the case for M+C premium charges, which are covered at the discretion of each state. In this section we first present a discussion of issues and recommendations regarding M+C premium policies, followed by a discussion of Medicare copays and deductibles for dually eligible beneficiaries enrolled in M+C plans, and end with a discussion of the issues related to copays and deductibles for dual eligibles enrolled in Medicaid plans.

5.1 Medicare and M+C Premiums for Dually Eligible Beneficiaries

5.1.1 Background

Table 5-1 provides information about the various components of Medicare coverage, the associated premiums, and the role of state Medicaid agencies in paying those premiums for dual eligible beneficiaries. Medicare coverage is composed of two parts with separate premiums: Part A and Part B. Part A, for inpatient care, has no premium for beneficiaries with at least 40 quarters of employment that qualifies them to receive Medicare. Individuals without the minimum required work history can buy into Part A or, if they are eligible for Medicaid, their states can purchase Part A coverage for them. Medicare Part B, which covers physician services and outpatient care, is optional. Non-dual eligibles pay for Part B coverage through monthly deductions from their Social Security checks, while states pay for Part B coverage for their full-benefit Medicaid beneficiaries, QMBs, and SLMBs. In 2002, the monthly Part B premium cost was \$54. In addition to these basic Medicare premiums, M+C plans are permitted to charge premiums for enrollment in their plans. States are not required to pay these premiums, but are permitted to pay them on behalf of their full-benefit dual eligibles.

Historically, there have been substantial differences in the monthly payments from CMS to M+C organizations, based on historic differences in FFS costs by county. These payment differences are due to variations in practice patterns and provider payment levels. The discrepancies have had several effects: (1) counties with very low rates have little or no M+C penetration; (2) M+C organizations could offer more generous benefit packages in high payment counties compared to lower payment counties; and (3) in counties with higher rates, M+C organizations could offer additional benefits with little or no additional premiums.

¹ Quote from a focus group composed of dually eligible beneficiaries under age 65, under HCFA Contract No. 500-94-0056.

**Table 5-1
Medicare and M+C premiums**

Insurance premium	Covered services	Cost/month	Source of payment
Medicare Part A	Inpatient care	\$0 (for those with 40 quarters or more of Medicare covered employment) \$175 (for those with 30-39 quarters of Medicare covered employment) \$319 (for those who have less than 30 quarters of Medicare covered employment)	None required for those with enough quarters paid into the Social Security system. Medicaid covers for SSI and QMBs, where payment is required applicable. (Referred to as Part A Buy-In)
Medicare Part B	Physician services and outpatient care	\$54	Beneficiaries pay through monthly deductions to their Social Security checks. Medicaid covers for SSI, QMBs and SLMBs.
M+C	Full Medicare benefit (Parts A and B), and any additional services at the discretion of the M+C plan	The premiums range from \$0 to more than \$100, as determined by the M+C plan	Beneficiaries or state Medicaid agency could choose to pay for full-benefit dual eligibles.

Source for 2002 Premiums: <<http://www.medicare.gov/Basics/Amounts2002.asp>> and <<http://www.medicare.gov/MPPF/home.asp>>.

Individual M+C organizations may provide a variety of plans, each with a different benefit package and premium. “Basic” plans offer the same benefits as traditional Medicare but generally have a different copayment and deductible schedule, while other plans incorporate additional services such as prescription drug coverage. M+C plans may charge monthly premiums to cover the costs of any additional benefits, or include these benefits without any extra charge to attract enrollees. Plans without a premium charge are often referred to as “zero premium” plans. Prior to 2001, most M+C organizations in any particular market area had at least one zero premium M+C plan. Zero premium plans are the most appropriate M+C plan for dually eligible beneficiaries to choose since their Medicaid coverage serves as wrap-around coverage for any additional benefits. Zero premium plans are also the only affordable M+C option for low-income beneficiaries (dual eligibles and non-dual eligibles, alike), and had created

an easy enrollment mechanism for dual eligibles without requiring any involvement from their state Medicaid agency.

Some categories of dual eligibles benefit from enrollment in M+C plans. QMB-only and SLMB-only beneficiaries may receive additional services offered by M+C plans, and SLMBs also benefit from any reduction in copays or deductibles relative to traditional, FFS Medicare. As low-income beneficiaries, the opportunity to enroll in an M+C plan may provide an affordable alternative to Medigap coverage, especially in plans providing a prescription drug benefit. In addition, where staff model HMOs exist, enrollment is required to access plans' provider networks. It is less clear why full-benefit dual eligibles enroll in M+C plans, as their joint coverage would, at least theoretically, provide ample coverage, unless they reside in a state with a very limited Medicaid benefit. States clearly benefit when full-benefit dual eligibles enroll in M+C plans because the plan is likely to cover expenses that would otherwise be covered by Medicaid (e.g., some preventive services and prescription drugs). In addition, state liabilities for copayments are decreased if M+C procedures decrease utilization of emergency rooms, hospitalization, or costly tests such as MRIs. Both states and beneficiaries also benefit to the extent that enrollment in M+C leads to improved care coordination or medical management.

However, the number of zero premium M+C plans has decreased substantially since 2000, even for "basic" M+C coverage (Achman and Gold, 2002). The loss of zero premium M+C plans has created a new problem for dually eligible beneficiaries, states, and the M+C plans because dually eligible beneficiaries cannot afford to pay these premiums. At the same time, states are not required to pay M+C premiums on behalf of their dually eligible beneficiaries. Without M+C, QMB-only and SLMB-only beneficiaries may receive fewer preventive services and their Medicare services are not subject to utilization management, potentially increasing costs, and the associated Medicaid copayments and deductibles. To the extent M+C plans cover additional benefits beyond traditional Medicare, a loss of M+C enrollment for full-benefit dually eligible beneficiaries translates to increased Medicaid costs for states.

Our site visits began in the fall of 2000, when many plans were preparing to charge premiums for the first time. We provided information about this issue to CMS at the time, as did one of the M+C organizations directly. In this section, we will describe the issues brought to CMS's attention by that plan and the resulting federal and state policy changes that occurred.

5.1.2 Findings

Charging premiums was a new development in some market areas, so plans, states, and CMS did not have experience or systems in place to deal with issues pertaining to premiums and dually eligible beneficiaries. The associated problems have implications for beneficiaries, plans, and states.

The loss of zero premium products, without a premium subsidy by a state Medicaid agency, affects both potential and existing M+C members. Dual eligibles who might otherwise consider enrolling in an M+C plan would be deterred by the cost. The willingness of any plans to "forgive" the premium payments for dual eligibles, even if approved by CMS, could not be communicated to potential enrollees as it was interpreted by CMS as discriminatory treatment of non-dually eligible beneficiaries (see Section 4). Without the knowledge that their premiums might be forgiven, beneficiaries could not take this into account when considering enrollment.

Worse, perhaps, is the situation of individuals already enrolled in M+C who receive notices of the new premium structure and no information about the special circumstance of dual eligibility. Although beneficiaries may not be held liable or disenrolled for lack of payment, they may still receive bills for the premiums, see explanations of coverage that do not take dual eligibility into account, and hence disenroll from their plans. For these individuals, continuity of care may be disrupted.

Plan administrators we interviewed had varying perspectives on whether they would be willing to forgive the premiums from dual eligibles, if permitted to do so by CMS. Some plans consider the higher capitation payments from CMS for dual eligibles to be adequate without charging premiums for these enrollees, particularly given the administrative savings realized by eliminating the costs associated with disenrolling beneficiaries for nonpayment. Other plans were concerned about the loss of potential revenue if states refused to pay premiums on behalf of dually eligible enrollees. The administrative burdens and costs caused by members' falling behind in premium payments include compliance with the mandated notification process, complicated by Medicare regulation requiring three continuous months of nonpayment before a plan can disenroll any beneficiary.

M+C plans that made efforts to provide information to their dually eligible members encountered bureaucratic difficulties.

Several M+C plans we visited had tried to provide dual-specific guidance to their dually eligible members about premiums and copays. However, at the time of this study, CMS regional office staff had prohibited any information materials notifying dually eligible beneficiaries that they are not liable for premiums, copays, or deductibles. CMS staff believed that it would be “discriminatory” to treat some Medicare beneficiaries differently from others.

Plans need up-to-date information about Medicaid status waive premiums for dually eligible beneficiaries or collect premiums from Medicaid.

Current lags in Medicaid status information lead to retroactive reconciliations between the plans and CMS regarding capitation payments, a feasible but burdensome process for MCOs. However, retroactive reconciliation is not an acceptable approach for plans and beneficiaries regarding premiums, because having to pay a premium at all would discourage dually eligible beneficiaries from enrolling in M+C organizations or result in disenrollment.

Based on information provided by M+C plans and this project, CMS determined that plans could allow dually eligible beneficiaries to remain enrolled even if in arrears for premiums.

As they prepared to terminate their zero premium products, some plans contacted CMS to determine whether they would need to attempt to collect private premium payments from dually eligible enrollees, because the plans knew this would lead to disenrollment. CMS determined that these M+C plans would need to attempt to collect the private premiums, but that beneficiaries' failure to pay did not mean that plans would need to disenroll them. This arrangement, although only addressing part of the issue, was necessary because M+C regulations forbid discrimination in marketing among different classes of beneficiary enrollees (i.e., having different benefits or charges based on beneficiary characteristics).

State Medicaid departments have the option to pay all M+C premiums through their state plans, but the requirements of this option may make it undesirable.

States that would exercise this option must agree to pay all M+C premiums for dually eligible beneficiaries enrolled in any M+C plan. In other words, a dually eligible beneficiary could select any of the variously generous and variously priced M+C products available in their area and the state would be liable for the premiums. To date, only Alabama has chosen to routinely include M+C premiums. Among the M+C plans we visited, some were receiving state payments for premiums for their dually eligible members, while others were not.

California now pays M+C premiums to some plans on behalf of dually eligible beneficiaries. Such arrangements are authorized by M+C regulations (42 CFR 422.106).

Because the State of California did not want to include M+C premiums as part of the State Medicaid plan, they talked with several plans about whether and how California might pay private M+C premiums for specific managed care products. States are not required to pay private premiums; however, they may negotiate with M+C plans to arrange payment of M+C premiums for specific products. The State of California entered into arrangements with some M+C plans, which took effect in 2001. The state agreed to pay the private M+C premium on behalf of the QMB-Plus (full-benefit) dually eligible enrollees as it anticipated the premium support would be lower than the increased pharmacy expenses the state would incur if these beneficiaries disenrolled from M+C plans. The agreement did not include any state funding for M+C copayments such as those charged at physicians' offices on a per visit basis.

Negotiations of this type between M+C plans and states are authorized by the M+C regulations (42 CFR 422.106). The regulation enables states to negotiate with M+C plans in the same ways that are available to employer group health plans with respect to establishing special benefit plans for dually eligible beneficiaries. States are able to negotiate premiums, cost sharing, and any Medicaid benefit under the state plan under a contract between the M+C plan and the state, as long as the basic Medicare benefits and coverage are maintained per the requirements of M+C. By 2002, California had entered into contracts with as many as eight M+C plans operating in various counties in the state. The California Premium Payment Program assisted 48,000 dually eligible beneficiaries to enroll in M+C plans through these contracts. The state contracts with the various M+C plans only in counties where the plans continue to offer pharmacy benefits. The 2002 contract expanded the pharmacy packages to include generic-only formularies as well as generic and brand-name pharmacy benefit packages. The state was willing to pay increased M+C premiums on behalf of dually eligible enrollees because it continued to believe that Medicaid pharmacy costs in FFS would exceed the cost to the state through the Premium Payment Program. The State and the participating M+C plans will re-evaluate these contracts and determine on a year-to-year basis whether it is in their interest to negotiate a contract. Neither the State nor M+C plans appear to have considered any potential value in negotiating arrangements that would facilitate the coordination of care between Medicare and Medicaid programs for those dual enrollees participating in both programs.

5.1.3 Recommendations

- In the absence of zero premium products, states should give serious consideration to paying M+C premiums on behalf of full-benefit dually eligible beneficiaries for whom the state would otherwise have more financial exposure. This can be accomplished following the approach taken by California, based on CFR 422.106.
- M+C organizations should be allowed to exempt dually eligible enrollees from paying premiums, and should be permitted to include this information in their marketing materials. Indeed, following our site visits in one state, this issue has been partially addressed by CMS: M+C organizations may now choose whether or not to disenroll dually eligible members for premium nonpayment. However, if neither CMS, the plans, nor the states are allowed to inform dually eligible beneficiaries of this exemption, then beneficiaries are likely to disenroll or decide not to enroll at all when premiums are announced.
- CMS should revisit the issue of whether it is indeed discriminatory to include information in their marketing materials, such as the Explanation of Benefits, informing dually eligible beneficiaries that they are not liable for premiums, copayments, or deductibles.

5.2 M+C and Medicare Copays and Deductibles for Dually Eligible Beneficiaries

5.2.1 Background

Traditional FFS Medicare coverage includes substantial beneficiary copays and deductibles. For example, the deductible for each hospital stay in 2002 was \$812, and there were additional daily copays for stays beyond 60 days. In addition, outpatient services carry a 20 percent copay for each visit. While M+C copays and deductibles are substantially lower than those in FFS, approximately \$5 or \$10 per physician visit, these rates of cost-sharing have been rising. The average M+C enrollee paid \$219 for copays and deductibles in 2001, and those in poor health paid \$614 (Achman and Gold, 2002), almost the entire monthly income of an individual eligible for QMB status (\$759 in 2002). Hence, even these nominal copays are burdensome for low-income beneficiaries or those with chronic conditions and may be a barrier to needed care. Indeed, legislation was introduced in 2001 to eliminate Medicare cost sharing requirements to improve access to preventive services for Medicare beneficiaries with chronic conditions (Medicare Chronic Care Improvement Act of 2001, S. 1589).

Under federal policy, full-benefit dually eligible beneficiaries and QMBs are not liable for these cost-sharing requirements because Medicare copays and deductibles are covered under their Medicaid benefit (practices regarding the level of payment vary across states, as permitted under the Balanced Budget Act of 1997; see Mitchell and Haber, 2002). However, in our meetings with plan administrators and in the beneficiary focus groups, we learned that providers and plans have difficulty getting Medicaid to reimburse them for the copays and deductibles, and that beneficiaries are sometimes charged inappropriately for these amounts. Provider and plan staff also report that they have difficulty getting these payments from Medicaid either because the state does not cover the copays, the state cannot determine what the copayment amount

should be, or the individual payments are too small to warrant billing costs. The obstacles are especially problematic for small providers. While provider claims to Medicare under FFS generate crossover claims to Medicaid, this does not occur in M+C. While some plans would be happy to submit bills on behalf of their providers, only plans that are licensed as providers themselves are eligible to submit bills to the state.

In the following sections, we present findings from the beneficiary focus groups, the plan perspectives, and our recommendations.

5.2.2 Focus Group Findings

- M+C members are often charged copays for which they are not liable.
- Lack of beneficiary understanding of dual coverage, and misinformation on member cards contribute to inappropriate copayment charges.

Examples of the Beneficiary Experience

The experience of one administrator in a national M+C organization extends to her own family as well as to the members in her plan. “My aunt has had Medicare and Medicaid for several years, and was hospitalized this year. Somehow, she was personally charged over \$800 by the hospital—the standard hospital deductible—and she paid it! I have been working for several months with the state and the hospital, trying to get the hospital to refund her the money and bill the state instead.”

Ms Jones, now in her 70s, first became a member of her managed care organization through her employer. When she became disabled, she continued her membership, and has been a Medicare member of that MCO for many years. She has also received Supplemental Security Income (SSI) and Medicaid for most of that time. Her M+C card indicates copays for outpatient services. Throughout her enrollment, she has always been charged copays by her M+C plan providers, including the plan’s own pharmacy, and has paid them. “I didn’t know until today that my Medicaid card was good for anything the plan covered.” (Paraphrased.)

M+C members are often charged copays for which they are not liable. Misinformation on M+C member cards contributes to these inappropriate charges to beneficiaries.

Beneficiaries and providers receive information about copayment and deductible liabilities from various sources, but beneficiaries’ medical cards, including health plan membership cards, are what they rely upon on at the point of service. As a result, our focus group discussions about copays and deductibles centered around the types of medical cards each beneficiary held, and how they used those cards. Dually eligible beneficiaries have a collection of insurance cards, including their basic Medicare card (which they keep even if enrolled in an M+C plan), their Medicaid card, and the member card associated with any managed care organizations to which they belong. They also may have cards associated with pharmacy discount programs, Medicare supplemental insurance coverage, and social welfare benefits such

as food stamps. As shown in Table 5-2, a typical dually eligible beneficiary may have as many as four different Medicare, Medicaid, and managed care cards.

Table 5-2
Beneficiaries may have as many as four separate insurance cards
for their Medicare and Medicaid benefits

Medicare and Medicaid managed care enrollment combinations					
	M+C and Medicaid FFS	M+C and Medicaid MCO within one health plan	M+C and Medicaid MCO in separate health plans	FFS for both Medicare and Medicaid	Medicare FFS and Medicaid MCO
Medicare card	X	X	X	X	X
M+C card	X	X	X		
Medicaid card	X	X	X	X	X
Medicaid MCO card		Varies by plan	X		X

The standard Medicare card, which beneficiaries sometimes know as their “red white and blue card,” indicates whether a Medicare beneficiary has Part A and/or Part B coverage, but it does not indicate whether the beneficiary is dually eligible or is enrolled in a managed care organization. State Medicaid “cards” (be they full page papers issued monthly in Oregon, or plastic cards infrequently replaced, as in Florida) usually do include the eligibility category, although that information may be magnetically encoded on the card rather than legibly imprinted. Magnetically encoded strips have several benefits: they are an efficient way to provide billing information for providers, can be retained even as eligibility status or coverage changes, and can include additional state benefit information (such as food stamp benefits). However, magnetic encoding is also problematic as neither beneficiaries nor small providers without the needed decoding equipment can identify the Medicaid eligibility category by looking at the card.

In addition to the standard Medicare and Medicaid cards, dually eligible beneficiaries enrolled in managed care plans have member cards for each plan in which they are enrolled. Those enrolled in both Medicare and Medicaid managed care, even within the same organization, may have two separate member cards, one for each plan. For example, in Oregon, Kaiser issues a single member card, encoded with information about which plan or plans the member is enrolled in (e.g., M+C only, or M+C and Medicaid managed care plan), while Providence issues separate cards for M+C and Medicaid enrollment even to beneficiaries enrolled simultaneously in both. In Florida, where simultaneous enrollment in both M+C and Medicaid managed care plans is prohibited in the same organization, a beneficiary may have an M+C card from one organization and a Medicaid managed care member card from another organization.

We asked focus group participants to show us their cards; for those in M+C plans, we examined the copay information on their M+C member cards. Some participants had “zero” listed as the copayment amount, others had copayments ranging from \$5 to \$45 for primary care physician visits, prescription medicines, and emergency room visits. While copays would be appropriate for SLMBs (for whom Medicaid only covers the cost of Medicare Part B premiums), QMB and full-benefit dual eligibles participating in the focus groups also had M+C cards that indicated deductibles for which they are liable.

M+C member cards can indicate erroneous copay information for several reasons. Data available from CMS is not always up to date (see Section 6) or if the plan’s policy is to issue the same information on all M+C member cards regardless of dual eligibility. Indeed, lags in this information combined with beneficiaries’ movement on and off of Medicaid is one of the reasons cited by some plans for issuing separate cards for their M+C and Medicaid managed care products. Plans issue new cards to reflect dual eligible status previously unknown to the plan, or because the beneficiary recently became Medicaid-eligible.

We asked focus group participants to tell us if they had ever received new cards from their managed care organizations. Focus group participants reported receiving new cards reflecting a change in primary care provider or in the copayment amount listed on the card. The latter could occur as a result of changes in the plan’s copayment structure or in beneficiaries’ dual eligible status, or if an M+C enrollee also enrolls in the Medicaid plan offered by the same MCO. Some participants did not know why they got a new card.

Examples of the Beneficiary Experience

“With mine, it [refers to the copay] started out as zero, and then they added a five the next time.” **[Enrollee in both M+C and Medicaid managed care within the same health plan. No copay should be charged.]**

“**When** I changed doctors, I got a new card.” **[Enrollee in both M+C and Medicaid managed care within the same MCO.]**

“And they sent me a new card. I just moved . . . but I had to call and tell them to send another one because they sent the wrong address.” **[M+C enrollee, Medicaid FFS.]**

“I got one card but then later on they changed something on it, and they mailed me a new card and told me to cut my other one up and throw it away.” **[Medicaid MCO enrollee, Medicare FFS.]**

“I have no idea what the reason was to change this card, but they sent me another card and I destroyed the other one.” **[Medicaid MCO enrollee, Medicare FFS.]**

Regardless of any copay indicated on an M+C card, full-benefit and QMB dually eligible beneficiaries should be able to receive M+C covered services without a copay by showing their

Medicaid cards. However, this depends on provider practices and whether providers accept Medicaid as well as Medicare, as well as beneficiary understanding of their benefits. The following quotations are from beneficiaries enrolled in both M+C and Medicaid plans simultaneously, none of whom should be liable for copayments for Medicare services:

Examples of the Beneficiary Experience

“When I went to the doctor, I showed them both and he said then we accept this one and I won't need the health card anymore. So I threw the other one away and I pay a copay of \$5”

“My card states that I shouldn't be paying for medication but yet when I show it to them they make me pay either \$5 or \$10.”

“I do (pay a copay) and I only show the (M+C Plan) card.”

“They told me to give them both cards, but my doctor only uses (the Medicaid plan card) for her patients.”

“They just take (the M+C plan) card and I pay the \$10 copay.”

Beneficiary understanding of how their joint coverage works, or at least of the importance of showing all of their cards at every encounter, is clearly important as plans may not have accurate information about dual eligibility. In other words, even if the M+C card indicates a copayment, showing the Medicaid card or Medicaid MCO member card to the provider should result in the copayment being charged to Medicaid or the Medicaid MCO, not to the beneficiary. However, beneficiaries clearly vary in their understanding of how the cards work together, and not all realize it is important to show all insurance cards at every provider contact. In these focus groups, as in groups we conducted under other related CMS projects, the variation in beneficiary understanding was striking, and more knowledgeable beneficiaries explained to their peers what they should be doing to avoid being charged inappropriate copayments.

Examples of the Beneficiary Experience

“I’ve got two separate ones [i.e., cards] but for the same plan. [The M+C and Medicaid managed care cards] are different, but if you have [the M+C plan] you use [that card]. But when you go to the doctor if you have a copay. At the pharmacist you could have a copay. Show them your [Medicaid managed care] card and you don’t have to pay that money.”
[M+C and Medicaid Managed Care within the same MCO.]

“No copay. I have not paid [copays] to my doctor, any doctor. And I do not pay copays [for] medicine.” **[M+C enrollee, Medicaid FFS.]**

“If there is something that [the M+C plan] does not cover, then [the Medicaid plan] picks it up.” **[M+C and Medicaid Managed Care within the same MCO.]**

“I just showed the card once to my doctor . . . my [M+C] card. I only have one.” **[M+C enrollee, Medicaid FFS.]**

“[The Medicaid managed care card] pays for my medicine . . . and [the M+C card] I take when I go to the doctor.” **[M+C enrollee, Medicaid FFS.]**

“I don’t have to show the white MediCal card but only in the pharmacy. If I don’t show it in the pharmacy, they gonna bill me the full amount.” **[M+C enrollee, Medicaid FFS.]**

“They require two now. They insist. If you don’t have your MediCal card, they might not. If somebody’s very rude there, they won’t serve you.” **[M+C enrollee, Medicaid FFS.]**

“Yes, I have two and also have [a] problem each time I go. I have to show them each time, otherwise I don’t get service.” **[M+C enrollee, Medicaid FFS.]**

“My card states that I shouldn’t be paying for medication, but yet when I show it to them they make me pay either \$5 or \$10. If you see my card, it says no money for medications. See on the end where it shows no money?” **[Enrollee in both M+C and Medicaid managed care in the same MCO.]**

(Because of a previous bad experience as a Medicaid beneficiary) “I refrain from even showing them the (Medicaid card). I pay \$7 for my medication and I have to pay mine (copay) to my physician.” **[M+C enrollee, Medicaid FFS.]**

Consistent with differences in Medicare and Medicaid coverage, participants in the focus groups (both M+C and Medicaid managed care) in both states reported using their cards to obtain several different types of services according to which card covered each service. Physician and hospital services are primarily paid for by their M+C plans, while showing the Medicaid card is important to cover the copays or deductibles. However, pharmacy coverage depends on the M+C plan benefit package, and dental care is covered by Medicaid, if at all. Whether the M+C plan covers DME and home health care (in total or as the primary payer) varies by plan, service and duration. Beneficiaries described showing both their M+C and Medicaid cards for each of these services. While few of the focus group participants reported use of mental health services, at least one reported successfully showing her cards and having no copay for individual and group therapy. In some cases, if the participant had been a patient at a physician's office or a customer at a pharmacy for some period of time, they did not show both cards, stating that the information was already in the system.

“There may be some procedures and the doctors have to use one or the other cards, you know, they look at them. If it's a certain thing they use (the M+C card), if not they use the Medicaid plan card.”

5.2.3 Plan Findings

The managed care plans we interviewed for this project participated voluntarily and generously provided us access to many of their staff. There was no mandate related to a federal or state evaluation requiring them to talk with us at all, and some plans we approached declined the opportunity to participate. The participating plans saw this project as an opportunity to bring to light challenges they face in serving dually eligible beneficiaries as a population group and in relation to state or federal regulations, information systems, or disjunctures between the two. In every plan, we were impressed with the personal and organizational commitment to quality care for dually eligible beneficiaries.

Copayments for M+C plan services was a hot topic in these interviews. One senior administrator greeted us with an immediate disclaimer: “We are out of compliance regarding copayments and we don't know what to do about it. Our dually eligible members are often being charged copayments by our providers and we don't have the systems in place or the information we need to correct this.” (Paraphrased.)

- CMS's standardized marketing materials do not permit inclusion of any dual-specific information to educate beneficiaries about copay liability; neither is there any information about this on the CMS website.
- CMS regional offices have turned down requests by plans to provide dual-specific information about copays and deductibles in mailings to members, citing a requirement in the CFR intended to prohibit plans from treating some beneficiaries differently than others.

- Many M+C organizations have no system in place to reimburse providers (if appropriate) for copays, or to bill state Medicaid programs for these copays.
- Smaller providers especially have trouble; they are reluctant or are unwilling to submit bills to Medicaid in their states for copays and deductibles. While provider claims to Medicare generate crossover claims to Medicaid under traditional Medicare, this does not occur in M+C.
- Some states have copay requirements for Medicaid benefits. This may apply to either Medicaid FFS or Medicaid managed care. These copays are generally small (i.e., \$1 or \$2). M+C enrollees may be required to pay the Medicaid copayment amount in lieu of a larger M+C copayment.

M+C organizations lack timely information regarding dual eligibility. As a result, members may not be treated as dually eligible in their first months of enrollment, and their member cards may not reflect their dual eligible status. In this instance, the burden is on the beneficiary to “show all their health cards” at the point of service.

The M+C organizations we met with were aware that dually eligible members were often being charged inappropriately for copayments, and were concerned about this issue. The information they shared with us sheds some light on the factors contributing to the problem, including gaps in the enrollment information available to the plans from CMS, state practices and regulations, and provider practices.

As we described in Section 3, M+C plans do not have a timely source of data regarding which of their enrollees are dually eligible, what type of dual eligibility they have, and for what time periods individual enrollees are dually eligible. These problems are due to delays in entering new Medicaid eligibles data into the state MIS systems and in the states passing that information on to CMS. In addition, the federal data do not include type of dual eligible. Indeed, CMS staff determined it was not possible to identify QDWIs for whom no enhanced M+C capitation is intended so CMS continues to pay the dual eligible capitation rate to M+C plans for these beneficiaries. While type of dual eligible is not important to the plans for most capitation payments, it is key to whether the beneficiary has any liability for copayments and deductibles. M+C plans need accurate information about dual eligibility status to print or encode the correct copay information on their dual eligible members’ cards. Plans are prohibited from asking about dual eligibility on enrollment applications, to ensure that the plans do not implement selective enrollment practices. M+C plans that also have a Medicaid product may have access to state data bases to identify dual eligibility status among their M+C enrollees, even those who are not enrolled in their Medicaid plan.

Requesting one’s insurance cards is standard procedure for provider office staff. However, frontline staff, such as medical office receptionists and pharmacy clerks, may not realize that these beneficiaries are not liable for these copays or know to ask them whether they have “another insurance card,” after receiving the M+C card. As described below even those that do request the cards may encounter difficulties receiving reimbursement for copayments.

There are barriers to providers' accessing copayments from states.

- IPA plans are not licensed as Medicaid providers, so providers cannot submit to the plans for payment because the plans cannot bill Medicaid in turn.
- Individual providers in IPA systems, or those providing either subcontracted services or carved-out services, must have a Medicaid provider number in order to submit bills for payments.
- Smaller providers do not have the means to submit Medicaid bills electronically, so submitting for small copays is costly.
- In one state included in our study, the Medicaid department has put a block on payment for all services to dual eligibles enrolled in M+C plans, adding an additional level of burden for providers trying to collect the copays and an administrative burden for the M+C plans. The block is intended to prohibit beneficiaries from accessing duplicate services using the two payments (e.g., fill two prescriptions for the same drug, one under their M+C benefit and one using their Medicaid cards). To override this block on the Medicaid card, the M+C plan must inform the state by fax to remove the block and the provider must then submit payment manually. In addition, the payment can only be submitted after state has processed the override before submitting the bill otherwise the bill will be denied.
- Staff model plans with both M+C and Medicaid products do have Medicaid provider numbers that can be used to submit claims for M+C copays for their members who are Medicaid FFS. However, in at least one state, there is no mechanism for these plans to submit these claims electronically. As dually eligible beneficiaries have particularly high pharmacy utilization (representing 35 to 50 percent of one plan's FFS claim volume), the plans need to be able to recover these copays. Billing for these copays manually, as currently required, is burdensome.

Even if all systems were in place, policy issues may leave the providers and beneficiaries in a “no-copayment” zone, due to the Balanced Budget Act and rate negotiations between plans and providers.

While it is clear that full-benefit dual eligibles and QMB-only dual eligibles are not liable for Medicare copays under FFS or M+C, states are not always liable either. When the Medicaid rate for a service is equal to or less than the Medicare payment, states are not obligated to pay the Medicare cost-sharing. Table 5-3 shows how the Medicare fee schedule works for dually eligible beneficiaries in several scenarios. Column A shows the base case, in which Medicaid pays the full Medicare copayment for a dually eligible beneficiary. The usual and customary charge recognized by Medicare for an outpatient service is \$100 a provider is allowed to bill 80 percent—in this example, \$80—to Medicare, and Medicaid is charged a \$20 copayment. However, if the Medicaid fee for the same service is less than \$80 (Column B), the state is not obligated to provide a copayment to the Medicare provider. In a state with a Medicaid rate of \$85 (not shown), the state could choose to limit the copayment to \$5, the difference between the Medicare rate and the Medicaid rate. Indeed, there is evidence that limiting Medicaid

reimbursement for Medicare copayments results in decreased access to Medicare providers for dually eligible beneficiaries (Mitchell and Haber, 2002).

Most M+C copayments are less than those under Medicare FFS. Column C (Table 5-3) provides an example in which the M+C pays providers the same amount as Medicare FFS. For non-dual eligibles, the provider accepts \$85 as total payment. However, plans often negotiate a lower rate based on volume, as shown in Column D.

Table 5-3
Sample comparison of copayment charges in FFS and M+C

	A	B	C	D
	Base case Medicare FFS charge \$100 Medicaid FFS allowable charge \$100	Medicare FFS charge \$100 Medicaid FFS allowable charge ≤ 80	M+C using Medicare fee schedule, and lower beneficiary copayment	M+C with lower negotiated rate and lower copayment
Medicare payment	\$80	\$0	\$80	\$75
Copayment charged	\$20	\$20	\$5 (should be zero for full benefit and QMB dual eligibles)	\$5 (should be zero for full benefit and QMB dual eligibles)
State liability (if invoking BBA regulation)	\$20	0	0	0
Dual eligible liability	\$0	0	0	0
Total received by provider for dually eligible beneficiaries	\$100	\$80	\$80	\$75

We have found that beneficiaries are confused about cost sharing in several CMS studies, including the evaluation of Oregon’s section 1115 Medicaid waiver (Walsh, French, and Bentley, 2000), and the evaluation of the QMB and SLMB programs (Walsh, Hoover and Haber, 2002). In these studies, dually eligible beneficiaries enrolled in M+C organizations report that they have been paying copays routinely, often over the course of many years. Copayment charges are not only burdensome for these beneficiaries; they can also become a barrier to needed services, as explained by one focus group participant: “As far as my medications, I haven’t taken any of them. I’ve dropped them because of the copayment. Because I can’t afford the copayment.”

5.2.4 Recommendations

The challenge faced by plans, states, and CMS is to provide the information and processes necessary to assure that full-benefit dually eligible beneficiaries and QMBs are not charged Medicare copayments, while providers receive the payments they are entitled to with minimal administrative burden to the providers and the states.

Recommendations to Plans

- Beneficiaries need cards that contain clear information about their dual eligibility status and liability for any copays and deductibles. One integrated card seems better than two separate cards for MCOs that provide both M+C and Medicaid managed care, with replacement cards sent for individuals whose status changes.
- Dual status and its implications need to be included in M+C organizations' member services computer screens.

Recommendations to the Federal Government

- Beneficiary education materials available from CMS need to be revised to explain that dually eligible beneficiaries are not responsible for M+C cost-sharing.
- CMS needs to ensure that plans receive timely and accurate information about the dual eligibility of each M+C enrollee.

Recommendations to States

While dually eligible beneficiaries themselves are not legally liable for M+C copays, it is not clear who is. Under M+C, providers accept a negotiated rate from the plan, which they expect to be supplemented by copayments from the beneficiaries. Under the Balanced Budget Act of 1997, states have the right to limit Medicare copayments if the Medicaid FFS rate for a service is lower than the Medicare rate or lower than the Medicare rate plus the full copayment amount. If states are willing to pay M+C copayments, then providers need an efficient way to bill the state.

Selected Options

- M+C plans could pay a supplemental payment to the providers for services rendered to dual eligible enrollees, and either (1) collect that money from the state; (2) receive a supplemental capitation from the state under CFR 422.106; or (3) absorb the added expense as related to the higher capitation rates that M+C organizations receive for dually eligible enrollees.
- Theoretically, states could pay providers the copays directly. However, this may not be feasible. Not all Medicare providers are contracted with the state as Medicaid providers, nor do they have an efficient way to submit these bills to the state. State specific issues would need to be addressed, such as California's practice of "turning

off” access to Medi-Cal payments for dually eligible beneficiaries enrolled in M+C plans.

5.3 Dual Enrollment Issues: M+C and Medicaid Managed Care within a Single MCO

States permitting or encouraging simultaneous enrollment in M+C and Medicaid managed care within a single MCO expect that this arrangement promotes close coordination between the two benefits, in a way that might be similar to the Program of All Inclusive Care for the Elderly (PACE). PACE is a special type of MCO that receives capitation payments from both Medicare and Medicaid for frail beneficiaries at risk of institutionalization (or, for a small percentage of their enrollees, Medicare capitation payments combined with private payment for the Medicaid portion of the service package). However, unlike PACE participants, dually eligible beneficiaries enrolled in a regular M+C organization and its companion Medicaid plan are not actually enrolled in a single, integrated plan coordinating their benefits and their medical care. Rather, they are enrolled in two separate managed care plans and may have separate membership cards for each. In part, this is a natural result of differing M+C and Medicaid enrollment policies (such as accretion dates). The possibility also exists of an individual dropping out or becoming ineligible for one plan while remaining in the other, as in the case of a person choosing to disenroll from the M+C plan or losing his or her Medicaid coverage. When such an enrollee receives separate membership cards, the M+C cards may not identify the member’s special copay status associated with dual eligibility. As a result, like dually eligible beneficiaries in all of the other possible combinations of Medicare and Medicaid managed care and FFS, these beneficiaries are sometimes inappropriately charged M+C copays and deductibles by their providers.

5.4 Medicare Copays and Deductibles for Medicaid MCO Plans

5.4.1 Background

In the case of dual eligibility, the Medicaid benefit can be thought of as a public “Medigap” policy that covers Medicare cost-sharing, some additional services not included in the Medicare benefit, and continued payment for services after the Medicare benefit is exhausted. When dual eligibility is considered from this angle, enrollment in a managed care organization for wrap-around coverage seems unnecessary. Such MCO plans have little opportunity to manage care or costs initiated under the primary coverage, unless beneficiaries accept management of all of their health care needs by the Medicaid MCO. Interviews with Medicaid MCO staff also revealed a variety of cost-sharing issues and problems encountered by Medicaid MCOs, beneficiaries and providers when a dual eligible receives Medicare on a FFS basis and is enrolled in a Medicaid MCO.

5.4.2 Medicaid MCO Responsibility for Medicare Cost-sharing

Like the Medicaid agencies of the states in which Medicaid MCOs operate, these health plans have limited responsibility for Medicare copayments and deductibles. While Medicaid MCOs may choose to provide copayments, they are not obligated to pay cost-sharing to providers in their networks if the Medicare payments exceed their established Medicaid MCO rates. For nonparticipating providers (i.e., Medicare providers that are not in the Medicaid

MCO's network), Medicaid MCOs would be responsible for paying copayments or deductibles if the Medicare payment is less than the state Medicaid payment rate. While Oregon's and Arizona's waivers allow Medicaid MCOs to deny copayments to out-of-network Medicare providers, CMS has not approved this in any other state and does not intend to do so. Thus, in most states, dual eligibles enrolled in Medicaid MCOs have the right to access Medicare providers without regard to whether the provider participates in Medicaid at all or in their Medicaid MCO, and without prior authorization by a Medicaid MCO. However, their providers have limited ability to recoup the anticipated Medicare copayments.

Medicaid MCOs are also responsible for charges incurred after the Medicare benefit has been exhausted (e.g., for prolonged hospitalizations) and for items that a Medicare provider has prescribed that are covered by the Medicaid benefit package but not by Medicare (e.g., outpatient prescription medications).

5.4.3 Findings

Medicaid MCO staff identified several challenges inherent to this process resulting in confusion for their enrollees, administrative burdens for the MCOs and for providers related to Medicare cost-sharing requirements.

Providers inappropriately charge beneficiaries for Medicare cost-sharing.

As we heard in the focus groups, some providers are incorrectly charging dual eligibles for copayments under this arrangement, as they are for M+C enrollees. Without knowledge of Medicaid MCO enrollment, providers may assume that beneficiaries are not dually eligible, let alone enrolled in a Medicaid MCO. In general, as several plans emphasized, beneficiaries have to inform providers of their multiple coverages as there is no other reliable mechanism. While plans instruct their own providers to inquire about multiple coverages in their contracts, newsletters, and other communications, the plans report that providers are inconsistent in following through with this practice. In addition, the plans have no contact with providers outside their networks unless a specific problem comes to their attention.

Plan staff described several reasons why beneficiaries may not inform a Medicare provider of their enrollment in a Medicaid MCO. As indicated by one of the focus group participants, some beneficiaries want to avoid stigma associated with being a Medicaid recipient at all. Many beneficiaries do not understand how Medicaid managed care works or the relationship between their various coverages. Finally, beneficiaries may knowingly be exercising their right to access providers outside the Medicaid MCO network. It is also conceivable (although we have no evidence supporting this hypothesis) that some providers knowingly charge the beneficiaries if the copayment will not be reimbursed by the Medicaid MCO or it is not cost-effective for the provider to submit a bill. Medicaid MCOs did report instances in which they either reimbursed a beneficiary for copayments or instructed the provider to do so (the latter is only feasible if the provider is part of the Medicaid MCO's network).

Problems associated with the receipt of Medicare services without prior authorization from the Medicaid MCO.

As is their right, dually eligible beneficiaries may access any type of Medicare provider, and Medicare provider, regardless of Medicaid MCO enrollment, (e.g. for primary care, specialty care, home health, or inpatient services). This may include receiving services without prior approval from Medicare providers who are in the Medicaid MCO network, or going outside the Medicaid MCO network completely.

When beneficiaries receive services without prior approval, the plan has lost the opportunity to manage the care (see Section 7, Care Coordination and Case Management), yet the plan may still be responsible for paying copays and deductibles which can be substantial. For example, 20 percent of the fee schedule payment for magnetic resonance imaging services is several hundred dollars. In addition, the Medicaid MCO may be responsible for medications or services prescribed by a Medicare provider but covered by the Medicare benefit, also without having the opportunity to manage the associated care or costs.

Problems associated with using out-of-network providers.

When beneficiaries go to Medicare providers outside of the Medicaid MCO network (nonparticipating, or “nonpar” providers), the situation is more complex. As with participating providers, there are issues with copayments and deductibles and lost opportunities to manage care. In addition, any “nonpar” provider has not been through the Medicaid MCO’s credentialing process. The use of such providers concerned plans we interviewed for two reasons. First, the plans were concerned that their members might receive services from providers whose quality is suboptimal. One plan provided the example of a member experiencing serious complications as a result of knee surgery conducted by a Medicare provider who would not have passed the plan’s credentialing process. Second, the Medicaid MCOs believe they can be held liable for poor outcomes associated with any service for which they made any payment, even if they did not authorize the service and it was performed by a nonparticipating provider.

5.4.4 Recommendations

It is not clear that Medicare FFS coupled with Medicaid MCO achieves any savings or other state policy goals. If a state does wish to enroll dually eligible beneficiaries who are already enrolled in M+C organizations in Medicaid MCOs, it might best achieve its goals by coordinating directly with M+C organization under CFR 422.106, rather than enrolling its dually eligible beneficiaries in unrelated Medicaid MCOs. CFR 422.106 grants states the authority to offer additional benefits (such as wrap-around benefits) through an M+C organization, as well as paying cost-sharing for M+C benefits. However, at this time, even if a state chose to use this mechanism, participation would be burdensome for the MCO. MCOs wishing to use this approach to add benefits for dually eligible beneficiaries or to pay cost-sharing on behalf of their dually eligible members are obligated to meet all of the state’s Medicaid managed care contract regulations. States might consider deeming CMS-approved M+C organizations as approved for Medicaid managed care.

CHAPTER 6

ENROLLMENT AND ELIGIBILITY DATA ISSUES

Providing the appropriate benefits and care coordination for dually eligible beneficiaries requires accurate information about dual status and any concurrent enrollments in other plans. During our site visits, it became evident that neither M+C plans nor Medicaid MCOs have access to this basic, 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 out of date. The lack of coordinated eligibility and enrollment information, combined with time lags that occur within each data system, are problematic for plans, providers, and beneficiaries. In this section we identify key issues by plan type (M+C, Medicaid MCO, and plans with both), describing the data sources and flow of eligibility and enrollment information.

6.1 M+C Plans

M+C organizations do not have access to accurate and timely information about Medicaid status or Medicaid MCO enrollment. This is problematic even in health plans that have both M+C and Medicaid managed care plans, and hence access to state enrollment and eligibility data. Beneficiaries may be approved for Medicaid, QMB, or SLMB status several months before the data are entered into the CMS system and available to the M+C plans. This lack of information has implications for plans, beneficiaries, and individual providers.

- M+C plans do not receive the appropriate capitation payment from CMS until the dual status of their members is established. While retroactive adjustments correct these differences, pursuing these reconciliations is a substantial administrative burden on the M+C plans.
- Until the M+C plan receives the information from CMS that the beneficiary is also covered by Medicaid, the beneficiary will be charged for copays and deductibles for which the beneficiary is not responsible. No mechanism exists for identifying copayments made by beneficiaries directly to providers or requiring that providers return inappropriate copays or deductibles that they have collected.
- Without knowing that enrollees have additional coverage, M+C case management staff and primary care doctors miss the opportunity to coordinate with Medicaid-covered services unavailable to Medicare-only beneficiaries.
- Some health plans pay their primary care providers in proportion to the individual capitation payments received from CMS. In these plans, primary care providers receive a lower-than-indicated capitation payment for members who have not yet been identified as dually eligible beneficiaries. This situation may lead providers to more strictly limit services provided to these members than they would otherwise.

6.1.1 How Do M+C Plans Identify Dually Eligible Members?

M+C plans rely on information in the Medicare Enrollment Data Base (EDB) to alert them of any special status, including Medicaid status, End Stage Renal Disease, and Hospice enrollment. Plans also ask new members to identify additional insurance coverage, including Medicaid, on their enrollment forms. (M+C Plans are not permitted to ask about Medicaid coverage in the application forms, to ensure the plans do not discriminate against Medicaid beneficiaries in the enrollment process.) However, the data in the EDB may not be up to date, and beneficiaries do not always know what their coverage is.

The process of applying and being approved for dual eligibility has several steps, each of which can lead to delays in entering the information into the EDB, and in getting the information from the EDB to the Monthly Membership Reports (MMRs) available to each M+C plan. There can be a lag between the time the individual applies and becomes enrolled. QMB-only status becomes active the first of the month following approval, while full Medicaid eligibility is approved retroactively to the date a completed application is submitted, although approval may take several weeks. Once an individual is approved, dual status also depends on a Medicaid case worker to update the state's information system. State systems then download eligibility information to Medicare, and the details provided vary by state. Delays can occur at each stage of the process, resulting in a cumulative delay of 3 to 4 months between the date of dual eligibility approval and the information appearing on the EDB.

Plans generally consider M+C enrollment tentative, pending checking against an electronic data base to verify Medicare eligibility, correct demographic information and to check if they are already enrolled in another plan. This electronically available information also includes dual status, but only to the extent the Medicare data are current. If there are any inconsistencies between the information provided by the beneficiaries and the information in this report, the plan has the opportunity to correct the information before submitting the M+C enrollment data to Medicare.

At M+C enrollment, beneficiaries have the opportunity to self-identify as Medicaid beneficiaries. Plans report that beneficiaries seem to know if they have full Medicaid benefits, but are less likely to identify themselves as QMBs or SLMBs. M+C plans report accepting beneficiary-provided information about dual eligibility as accurate at the time of enrollment however, plans check dual status against the MMRs they receive from CMS. These MMRs generated by CMS, contain information about demographic characteristics and dual eligibility. In addition, these data include beginning and ending dates for any special status, which can be used retroactively to correct payment information. While the MMR indicates dual eligibility, it does not distinguish between full-benefit dual eligibles, QMBs, SLMBs or even QI-1's and QI-2's. As only full-benefit (QMB-Plus and SSI beneficiaries) and QMB-only beneficiaries receive assistance with Medicare copayments and deductibles, and only full-benefit dual eligibles receive additional services, this information is important for benefit and care coordination, as well as to ensure the M+C plan is receiving appropriate capitation payments.

M+C plans also reported that members with Medicaid lose their eligibility with some frequency. It is not clear whether this is the result of problems with recertification requirements or if there are actually a substantial number of dual eligibles whose income and assets increase

beyond the eligibility criteria. Unlike TANF recipients, who may return to work or marry, most dual eligibles are on fixed incomes and are unlikely to acquire additional asset. Hence, it is unlikely that many lose actually become income or asset-ineligible. M+C plans routinely check Medicare data for lost Medicaid eligibility as well as for those who are newly or continuing dual eligibles.

6.2 Medicaid MCO Issues

Medicaid MCOs do not have access to accurate and timely information about beneficiaries' enrollment and disenrollment from M+C plans. This lack of information is particularly salient in states where certain combinations of plan enrollment are prohibited (e.g., if a plan is not allowed to simultaneously enroll a dually eligible beneficiary in both products, as in Florida and California). Without timely information about M+C enrollments, the Medicaid MCOs face several challenges that affect the plan, providers, and beneficiaries:

- Medicaid MCOs face an administrative burden to inform members of their unacceptable dual enrollment and, where applicable, offer the beneficiary choices about what enrollment to keep and which to drop.
- Medicaid MCOs must retroactively disenroll beneficiaries, resulting in cash flow problems for the plans, and generating ill will with beneficiaries and providers.

6.2.1 Issues for Medicaid MCOs

While any Medicare beneficiary can enroll in an M+C plan, regardless of dual eligibility, some dually eligible beneficiaries are not eligible to enroll in MCOs, or are restricted in their choices of MCOs in which to enroll. In addition, Medicaid MCOs receive different rates from states based on the presence or absence of Medicare coverage. Hence, Medicaid MCOs need current information about Medicare status and M+C plans enrollments. Problems also arise when beneficiaries enroll in “forbidden” combinations (i.e., when enrollment occurs in both the M+C and MCO products within one organization when that combination is not allowed or, conversely, in two separate plans in a market area that does not permit this enrollment combination). As Medicare selections take precedence, Medicaid MCOs bear the administrative burden associated with any incorrect enrollments. Thus, in Florida, plans described having to send beneficiaries a letter explaining the need to choose between enrollment in the M+C plan or the Medicaid MCO.

Although most states do not auto enroll dual eligibles in Medicaid MCOs, plan staff reported that state eligibility files do not always identify individuals as dual eligibles, hence ineligible for auto enrollment. In other situations, where enrollment in Medicaid MCOs is voluntary for dual eligibles, beneficiaries may choose to enroll if the Medicaid MCO has a more generous benefit package than the state Medicaid plan (e.g., covering more prescriptions per month).

Knowing whether a Medicaid MCO enrollee is dually eligible has important implications for payments from the state to the plan, and in some cases, from the plan to the primary care provider (if the PCP receives a monthly capitation payment rather than a negotiated FFS rate). Medicaid MCOs may have separate rate categories as follows:

- SSI without Medicare
- SSI with Medicare
- Part B only (Part B Medicaid Buy-In)
- Part A only (Part A Buy-In)
- Part A&B only (QMB)

Because the plan receives the largest capitation payment for those with SSI but no Medicare, and has the greatest clinical and fiscal responsibility in that case, it is problematic if dual eligibility is discovered after a beneficiary has been enrolled in a Medicaid MCO. In such cases, the state wants the plan to return the difference in capitation payments retroactively, and the plans want providers to bill Medicare for services previously provided. Plans report they are reluctant to push their providers for these payments.

Perhaps more often, a Medicaid MCO believes a person to be dually eligible who either has no Medicare coverage or does not have both Part A and Part B coverage. Unlike the M+C plans, Medicaid MCOs have no direct way to check the Medicare enrollment data. The plans rely on state information systems and on vendors who have Medicaid eligibility data.

6.3 Plans with Both M+C and Medicaid Managed Care Products

M+C and Medicaid MCOs that jointly enroll individual beneficiaries encounter problems coordinating accretion dates (the dates new enrollments become effective). For example, under Oregon's Medicaid managed care rules, new enrollments are effective within 1 week of signing the enrollment forms, whereas M+C enrollments for the same individuals are only effective at the beginning of the next month. As a result, an individual may be in the Medicaid plan before his or her enrollment in the M+C plan becomes effective, creating special challenges regarding benefit coordination. This is very confusing for beneficiaries, and burdensome for the health plans and providers.

SECTION 7 CARE COORDINATION AND CASE MANAGEMENT

Much of this report focuses on elements of coordinating Medicare and Medicaid benefits on a very basic level: the challenges managed care companies encounter identifying dual coverage, administering coordination of benefits (COB) rules appropriately, and assisting their members to understand their coverage. Yet one of the key policy goals for managed care implementation at both the federal and state level is to provide a structure that can enhance efficient and effective care delivery, and hence improve health outcomes. The structure and financial incentives of managed care are assumed to support this goal, and to improve health outcomes through improved processes of care. Although capitated financing creates incentives and the potential to increase efficiencies and improve care, it is not sufficient to achieve these objectives. These objectives can be achieved by coordinating care within the managed care system and across systems of care, and through individually focused case management.

Individualized case management or care coordination encompasses other types of support, beyond COB. As summarized in Table 7-1, such activities can include coordinating or facilitating in-plan services, linking members to other resources outside the plan's benefit package, flexible service authorization on a case-by-case basis, reviewing risk screening assessments to identify individuals in need of medical case management, and implementing disease management protocols.

Case management or care coordination is an evolving field. Entire organizations exist to define and set standards, and educate providers and health care systems about case management. The terms "case management" and "care coordination" themselves are defined in various ways, encompassing a range of activities including clinical management, assessment of service needs, coordination of services within a plan, and coordination with services outside the scope of the plan. While there is much interest in care coordination and case management, managed care organizations are inventing their own programs and strategies. During the site visits, we learned about some of the strategies used by M+C and Medicaid MCOs, and some of the challenges that they face. We asked about where care coordination and case management occur in their organizations, the range of activities care coordinators or case managers deal with, how cases in need of care coordination are identified, and how federally mandated health risk assessments are linked to any case management services. We asked specifically whether plans have programs geared especially to dually eligible beneficiaries, to what extent staff coordinating care are able to identify individuals who are dual eligibles, and whether dual eligibility itself is considered a risk factor or target group for case management. Focus group participants also shared their experiences.

Table 7-1
Potential care coordination and case management activities in managed care

Case management or care coordination activity	Example
Facilitate access to plan services	Assist with referral process Identify in-network providers
Resolve billing problems	Explain benefit Review denials
Disease management programs	Telephone calls to monitor health status and promote adherence to treatment plan Patient education programs Referrals to specialists Authorization of home health for early detection and prevention of chronic disease exacerbations
Refer to external agencies	Area Agency on Aging County transportation services Charitable organizations State pharmacy assistance programs
Coordinate with external agencies	Joint service plan development with mental health, long-term care, and social service agencies
Flexible authorization practices	Case by case determination of cost-effective substitutions or extensions of the published benefit package

7.1 Plan Findings

In this section, we first summarize the key findings and then provide detailed descriptions of case management and care coordination activities in M+C plans and Medicaid MCOs.

7.1.1. Key Findings

- Most plans do not target dually eligible beneficiaries specifically for care coordination activities. However, benefit coordination is commonly an issue for these beneficiaries. Due to their health status, dually eligible beneficiaries are likely participants in disease management or case management programs that address issues related to prescription drug, durable medical equipment (DME), home health, and long-term care utilization.

- Care coordination and care management activities are spread across many departments in managed care plans.
- The major care coordination activities are benefit coordination, utilization review and associated hospital discharge planning, and disease management programs. Member service departments and health risk assessments are two common entry points to care coordination and disease management.
- Plans vary in their ability to identify their dually eligible members, which contributes to care coordination problems.
- State policies can facilitate or create obstacles to effective care coordination regarding coordinating Medicare and Medicaid benefits, and in transitions to long-term care.

7.1.2 Where Do Care Coordination and Case Management Occur?

While most managed care plans have specific case management departments, care coordination activities occur in member services and utilization review departments, social medicine departments, quality improvement departments, at the provider level, and as part of special disease management activities. COB activities are handled by claims departments, sometimes in units specifically focused on this aspect of claims processing.

7.1.3 The Role of Member Services Departments

As the point of contact for beneficiaries or family members who have questions about coverage or bills received, member services or customer service departments play a pivotal role in COB (See Sections 3 and 5). In addition, as the point of entry to the plan for any type of assistance, member services staff play an important role in identifying individuals who may need to be referred to some type of case management or social service department. The volume of customer service calls is high. One large plan with Medicare, Medicaid, and commercial products receives 1,500 calls per day from Medicare beneficiaries, 2,000 per day from members in their commercial plans, and 700 from Medicaid beneficiaries (dual eligibles and nonduals combined). The same plan reported that 10,000 calls follow any mailings to their Medicare members.

None of the plans we visited had specialized member services staff for dually eligible beneficiaries; indeed, many plans are unable to identify this group or lack information about dual eligibility in the data bases accessed by member services staff. Even plans with both M+C and Medicaid MCO products were unable to provide a count of their members in both products within plan, let alone of dually eligible beneficiaries enrolled in another plan for one of their coverages or receiving those benefits on a FFS basis. Oregon M+C plans with companion Medicaid MCOs could identify their dually enrolled members, because dually eligible enrollees choosing to enroll in M+C are not allowed to enroll in an unrelated Medicaid MCO.

Even within the same plan, members enrolled in both M+C and Medicaid MCOs generally receive two separate membership cards, each with a different 800 number for customer

service that may place them in separate telephone queues. Except for the plans we visited in Oregon, plans with both coverages usually had separate member services staff specializing in either their Medicaid or Medicare products. One Oregon plan had integrated member services across both the Medicare and Medicaid products, another had converted to “cross training” all member services staff to work with all types of members. However, all plans we visited had provided special training for their member services staff regarding dual eligibility and the implications for coverage. The plans reported training their member services staff to understand that Medicare coverage is primary and that Medicaid coverage offers additional services beyond the Medicare benefit package, and to ask members whether they have any other health insurance. One plan had specifically trained its member services staff to discuss the need to present all health insurance cards at the point of service to ensure receiving all the benefits to which their members are entitled and to avoid inappropriate copayment charges.

In an earlier HCFA- and ASPE-funded project, we conducted focus groups composed of dually eligible beneficiaries under age 65, eligible by reason of disability. Those with developmental disabilities were unable to identify issues to bring to member services, and were reliant on care givers or advocates for this type of assistance. However, those with physical disabilities and some with psychiatric disabilities were able to describe their experiences with member services staff in detail. These beneficiaries reported plan staff misinterpreting Medicare as the primary payer to mean that they were only entitled to the Medicare benefit. In addition, they reported getting different responses to questions about their benefits, depending on whether they called the member services number on their M+C card or their Medicaid MCO card, even within the same health plan (Walsh, French, and Bentley, 2000).

While plans did not describe problems specific to dual eligibles, M+C plans did describe the most common calls to member services from their Medicare members, and reported that these are the same types of calls received from their commercial members. The most common topics listed by one plan include

- grievances about services received or denied;
- requests for information about enrollment, costs, and locating in-network specialists; and
- reconsideration for denials, most often ambulance, DME, or out-of-network (but within the service area) urgent care.

Another plan listed the following as the most common topics:

- changing primary care providers;
- questions about benefits, especially limited benefits such as;
- asking about status of referrals and authorizations;
- reacting to issues they have heard about in the media; and

- to have someone to talk to, due to loneliness.

In addition, member services staff are expected to identify the need to refer callers to specialized departments as needed (e.g., to a social medicine or social work department for grief or for financial problems with “big ticket” items, or to case management departments if clinical issues need to be addressed).

7.1.4 How Individuals Are Identified for Case Management

Case finding, identifying people who are in need of, or who would benefit from, case management is a key case management task. As described in the following sections, each of the plans we interviewed described several approaches to identifying members in need of care coordination or medical case management, in addition to referrals from member service staff. Except for one specialized program intended to identify *potential* dually eligible members, none of the case finding approaches specifically targeted dually eligible beneficiaries for care coordination or case management services.

Health Risk Assessments— Federal regulations [42 CFR 422.112 (b)(4)(i)] require M+C plans to conduct health risk assessments for new members. This requirement has become one way that M+C plans systematically look for members who might benefit from case management services. An extensive review of current health risk appraisal (HRA) practices in Medicare has been conducted by researchers at RAND (Shekelle et al, 2002). This project was designed with a narrower focus to learn how health risk assessments were related to case management or care coordination activities for dually eligible beneficiaries. While some plans we visited considered their health risk assessment instruments proprietary, they did discuss the content in broad terms, the processes they used, and described how they used the information for follow-up.

In response to the federal requirements, M+C plans routinely send questionnaires to new enrollees, and some plans of both types conduct outreach calls to new members. The information from these surveys or welcome calls is used to identify anyone with an ongoing need for medications, oxygen, or other services that should be addressed without interruption, and to identify candidates for specific disease management programs. The most common approach to case finding from screening activities is identification of specific chronic conditions (e.g., identifying all new members with diabetes). This type of screening identifies individuals who might benefit from involvement in disease management programs. Diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease CAD, and asthma were most commonly the focus of disease management programs, and hence of HRA review. Only one plan we spoke to targets nutritional risk, two plans include possible depression as a target condition, and one includes renal insufficiency. Plans varied from including as few as three health-related questions in a welcome call, to mailing out a 96-item questionnaire (see below).

Plans also varied in how they review HRAs. While some plans use an electronic data analysis process, with algorithms used to flag candidates for disease management or further case management assessment, more commonly, staff review hard copies of assessment instrument as members return them to the plan. In one plan, member services staff review the information and refer cases to the utilization management department “if people say yes to anything” in the

screener. Another plan uses licensed practical nurses that are part of a quality improvement department to review each HRA for individuals who might need disease management. Most plans we interviewed use their own HRA instruments and staff to review the results, while one plan contracts out this activity to a vendor.

Plans generally reported passing the information on to the primary care provider (PCP), as useful information for the PCP and to file in the medical record. However, according to one plan, the industry average for responses to HRAs is 60 percent, so 40 percent of beneficiaries enrolling in M+C plans are not screened. In addition, some members fill out the HRA but do not come in to a physician's office for care. For these beneficiaries, there may be no medical record in which to file the completed HRA.

Utilization review and discharge planning— Utilization review staff identify beneficiaries in need of care coordination, case management, or disease management, prior to hospitalizations and in the discharge planning process. For example, when a member is precertified for an elective admission, such as a joint replacement, the utilization review staff may identify a need to coordinate with the community-based long-term care system to address the care needs of the member or the role the member plays as a caregiver for someone else. Similarly, discharge planning staff from the managed care plans replace the hospital discharge planners for their members. They coordinate post-acute care, including skilled nursing facility, rehabilitation facility, and home health care, arrange for oxygen, DME and medical supplies, and schedule outpatient follow-up care.

Utilization data analysis— Plans also analyze utilization data to flag individuals who might benefit from case management. Utilization is analyzed to identify high-cost cases, and as a means to identify individuals with specific chronic conditions associated with emergency room and hospital use, such as congestive heart failure. One plan reviewed hospital encounters to identify first coronary events for further review. Medicaid MCOs and M+C plans offering pharmacy benefits analyze pharmacy data for drugs associated with specific diagnoses (e.g., diabetes and asthma) or for polypharmacy.

Direct referrals to case management departments— While it is not clear to what extent members, families, providers and collaborating agency staff access case management staff directly, this option also exists in many plans. Some states, such as Oregon, have special care coordination requirements for their Medicaid MCOs. Beneficiaries access the Oregon Exceptional Needs Care Coordinators by way of member services, referral by community agency case workers, or the state ombudsman. Oregon developed a form and procedures specifically to promote communication between the community agency case workers in the long-term care system and Medicaid MCO care coordinators (for a detailed description, see Walsh et al., 2001). Plans reported calls from physicians to be most often about members with psychosocial issues or behavioral problems.

7.1.5 How Are Case Management Departments Staffed?

Given that case management activities are spread throughout various departments in both M+C plans and Medicaid MCOs, staffing levels are not easily determined or compared across plans. Plans reported a range from 1 M+C case manager (primarily registered nurses) for 2,000

enrollees, to 1 exceptional needs care coordinator for over 20,000 Medicaid beneficiaries (only some of whom technically qualify for that specialized assistance). One plan described having 4 senior case managers, and 23 others for a ratio of 1:10,000 across all types of enrollees. In this plan, the case managers are assigned to clinical pods associated with hospitals for concurrent review or with outpatient providers. The disease management case managers in that plan are outside of the pod system, and include 3 respiratory therapists for members with asthma. The remaining case managers are split between nursing and social work, working separately but conferring with each other as needed. How plans determine their staffing needs is variable. In general, plans either assign case managers to clinical groupings and determine how many they need based on those groupings, or they determine an appropriate patient load of active cases per case manager. As the case load increases, plans either add case management staff or ratchet down their case finding activities.

Some M+C plans also reported having case managers whose focus is on frail Medicare beneficiaries, many of whom are dually eligible. These beneficiaries become the target of case management for a variety of reasons. First, these beneficiaries are likely candidates for home health services, a set of services requiring specific approval by the plan. Second, based on the limits of the Medicare benefit, plan staff seek out other sources of care for their members, including home and community-based care or facility care for those unable to access adequate support in the community. In some instances, case managers develop ongoing relations with individual case managers in their state's long-term care system, and have developed extensive resource lists they can use to assist their members. For the M+C case managers working to assist members with complex medical or long-term care needs, dual eligibility is often a boon as these beneficiaries have access to benefits that most Medicare beneficiaries do not. However, in some states, where the Medicaid benefit is less generous (e.g., with limited prescription drug benefits), or where the home and community-based care system has waiting lists, M+C case managers struggle to provide their dually eligible members with the services they need.

Case managers working with frail elders described two particularly challenging situations. The first challenge relates to the limits of the community-based system. For example, in one state, M+C case managers described beneficiaries facing discharge from the hospital following major surgery to a home without so much as a loaf of bread, and long waiting lists for homemaker services and home-delivered meals. In states with more generous funding of home and community-based services, M+C and Medicaid MCO case managers and discharge planners are able to work out appropriate plans across organizations and agencies. The issue in states with more generous home and community-based care systems is determining the boundaries between the Medicare and Medicaid benefits, and the acute and long-term care systems (see Walsh, Kulas and Khatutsky, 2000, for a more detailed description of this issue.) The second challenge case managers face relates to beneficiary confusion about the distinction between acute and custodial care. Case managers frequently work with beneficiaries who neither understand the limits of the Medicare benefit, nor their own limits to manage safely alone in the community.

7.2 Examples of Care Coordination and Case Management Activities

In the following section, we describe the range of activities in some detail for two of the plans that we visited: one large M+C plan and a smaller Medicaid MCO.

Case management in an M+C plan—The medical director of a large M+C plan has used the CMS requirement to implement HRAs as part of a larger set of activities designed to identify individuals who might benefit from case management. This plan is concerned with identifying modifiable risk (i.e., medical conditions or other risk factors that are amenable to intervention through ambulatory care services). The plan uses a 96-item “home-grown” assessment tool that includes the SF36, nutrition screening questions, diagnoses, and utilization questions. An algorithm is applied to provide an overall risk score. The factors that lead to high risk scores include poor performance on psychosocial components of the instrument, a poor nutrition score, diabetes, CAD, CHF, COPD, or renal insufficiency. The plan then assigns members whose score falls into the highest 5 to 8 percent to case management.

The plan also looks for individuals needing case management based on information gathered by the utilization review staff in the process of precertifying members for elective inpatient admissions (i.e., individuals who will need discharge planning), and through data runs that flag members with emergency room utilization, ambulance use, or certain patterns of pharmacy utilization with a focus on high-cost cases. In addition, anyone can request case management; most commonly these requests come from members themselves, their families, or their physicians.

Members identified as candidates for case management by any of these means receive a call and a full telephone assessment from one of the 68 registered nurses in the case management department (1:2000 M+C members). In some situations, the case management department refers the member to the local Area Agency on Aging for a complete, in-home social work assessment paid for by the M+C plan. In other cases, where there are specialized medical problems such as end-stage renal disease, registered nurses with clinical expertise in that diagnosis work directly with the members.

Each RN in the case management department carries 75 to 125 cases, about 40 of which require ongoing involvement. These high-intensity cases need telephone contact at least weekly. These members’ clinical needs are often addressed through certified home health agency services, and include wound care, managing multiple comorbid conditions, complicated psychosocial needs, and education about managing their medical conditions. Generally, the case management staff focus on coordinating the covered benefits. While policy makers and some managed care administrators envision managed care as offering the opportunity for plans to provide more flexible service responses (e.g., make exceptions to the benefit restrictions if overall savings or improved outcomes result), this plan restricts services to those explicitly included in the benefit package to avoid setting precedents that the plan administrators fear will become problematic.

Case Management in a Medicaid MCO— According to this plan, the Medicaid department in its state mandates the use of case management for members with special needs, but does not define what constitutes a special-needs case. The plan has opted to use specific diagnoses, such as HIV or sickle cell anemia, or individuals who are technology dependent, as the targets of their case management activities. These conditions reflect the larger Medicaid enrollment, not conditions common in the dually eligible population. The plan does not have separate procedures for dual eligibles, but does include some diagnoses more common in the Medicare population.

The plan uses a 30-item HRA, which is included in the welcome call made to new members. The responses are entered into a database; new member information is reviewed by case management staff every 2 weeks; and high risk is determined based on having three or more chronic conditions, receiving home care services, or having any one of the following: asthma, diabetes, CHF, HIV, or sickle cell anemia. The plan also reviews monthly hospitalization reports to identify the most common diagnoses associated with hospitalization and determine whether to add a new diagnosis to the HRA.

Individuals also are identified through a variety of other means. Members are referred to case management if they have 10 or more prescriptions in a month. However, if the member is simultaneously enrolled in an M+C plan with a pharmacy benefit, the individual's full prescription drug utilization will not be visible to the Medicaid MCO. The plan also reviews member-specific utilization each month to identify those who have the top 1 percent of expenditures, and those who have multiple emergency room visits. Members are also referred to case management by member service staff, by referrals from a Medicaid department hotline, and from physicians.

Identifying Potential Dual Eligibles

When we asked plans about case management for dual eligibles, our focus was on medical management or care coordination for Medicare beneficiaries who already had been approved for Medicaid benefits, whether those benefits included full Medicaid services (SSI beneficiaries and those with QMB-Plus coverage); Medicaid buy-in for Medicare coverage (SSI beneficiaries, QMBs, and SLMBs); or coverage of Medicare copayments and deductibles (SSI beneficiaries and QMBs only). However, one large M+C plan we interviewed has a case management department comprised of experienced, bilingual social-work staff who conduct outreach activities to identify potential dually eligible beneficiaries. Focused particularly on QMBs and SLMBs, these case managers assist potentially QMB or SLMB-eligible members with the state application process, track their recertification dates and assist with the recertification process. The plan benefits by accessing increased capitation rates, and the members no longer have to pay Medicare Part B premiums, and, in the case of QMBs, may be eligible for state coverage of copays and deductibles. Indeed, we have since learned of several private companies to which M+C plans outsource this activity.

7.3 Case Management Issues

Regardless of how a dually eligible beneficiary comes into case management, coordinating services within the health plan and across systems is necessary to access the full range of health and social services that may be needed. 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 DME, home health, pharmacy, and LTC benefits, but only if plan staff, providers, or the beneficiaries are aware of the additional coverage. Due to the time lag between a beneficiary's being approved for Medicaid and that approval appearing in the CMS data, plans

may not know of a beneficiary's dual status. In addition, plans need to know whether a beneficiary is a full-benefit dually eligible, QMB-only, or SLMB-only beneficiary. The CMS data do not provide this detail.

The challenges to effective coordination of benefits are even greater for Medicaid MCOs serving dually eligible beneficiaries. 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, the Medicaid MCO staff we interviewed expressed frustration that they have no way to learn of these services before beneficiaries exhaust their Medicare benefits. Indeed, staff at one Medicaid MCO reported they often first learn that benefits are exhausted when the plan receives a bill for services already provided or the hospital is seeking prior approval to continue the beneficiary's stay. As a result, the Medicaid MCO has no opportunity to manage such episodes or direct their members to in-network providers. In general, as the secondary payer, Medicaid MCOs do not know the beneficiary's status (e.g., when the person is discharged from the hospital or what therapies the person is receiving).

The problems associated with being the secondary payer are costly for Medicaid MCOs and for their contracted providers. Reluctant to review a claim more than once because of the resources involved, one plan automatically pays bills if they do not know who the primary payer is. If they pay mistakenly, they go back to the provider and address the issue. Providers become frustrated when they are caught in the billing system for dually eligible beneficiaries, in both managed care and FFS. If they bill Medicare, they must wait for Medicare to deny the claim and then refile it with the Medicaid plan along with the Medicare denial. As a result of these provider-level reconciliations, participation in Medicaid MCOs can be seen as burdensome by providers as well as by the Medicaid plan.

Coordinating acute and long-term care—M+C plans do not restrict enrollment to community-residing beneficiaries, nor exclude those who receive home and community-based services. In addition, some states do include home and community-based waiver clients in their Medicaid managed care programs. For these plans, coordination issues arise between the acute and long-term care systems as long-term care services are not included as part of regular M+C plans, nor included in the benefit package in standard Medicaid MCOs. Thus, coordination with state long-term care agency personnel is another case management or care coordination activity for dually eligible members. Plans described working directly with the members, their families, and with the state agency personnel. These activities include referring members to state agencies, and negotiating with state agencies regarding the boundaries between certified home health services provided by the managed care plans and home care services provided through home and community-based waivers and other state-funded services.

Oregon's system requires special care coordinators in Medicaid MCOs to address issues that arise for SSI beneficiaries (dual eligibles and others) and other Medicaid beneficiaries receiving home and community-based or institutional LTC services. These Exceptional Needs Care Coordinators (ENCCs) play an important role as the point of contact for state long-term care agency staff to contact about care coordination issues, including both local case workers and the state Medicaid Ombudsman. The full range of duties of the ENCCs varies by plan, but in some cases they are responsible for authorizing certified home health agency services and DME.

As long-term care services are not included as part of regular M+C plans, nor carved into most Medicaid MCOs, coordination with state LTC agency personnel is another case management or care coordination activity for dually eligible members. Plans described working directly with members, their families, and state agency personnel. These activities range from referring members to state agencies to negotiating with state agencies regarding the boundaries between certified home health services provided by the managed care plans and home care services provided through home and community-based waivers and other state-funded services.

Transitions to LTC—As we previously described, 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 LTC or as they exhaust their Medicare benefits. M+C-contracted providers may not accept Medicaid, and providers serving dually eligible beneficiaries under Medicare FFS may not participate in a Medicaid MCO’s network.

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 HCBS 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. This can have several deleterious effects. First, the opportunity for a plan to manage the medical component of care and the opportunities for MCO case management or member services staff to assist beneficiaries is lost with disenrollment from the plan. Second, where the Medicaid MCO is a staff model plan, mandatory disenrollment causes the beneficiaries to cut their ties with their medical team, including PCPs, specialists, and ancillary service providers. Finally, as in other transitions, the plan may not learn of the facility move and may have paid for acute care services that occurred after the beneficiary became a nursing home resident and hence ineligible for MCO enrollment. As the state will require the plan to return the capitation received for the beneficiary who has become a facility resident, the plan is faced with trying to recoup payments already made to providers.

Issues for M+C enrollees transitioning to LTC—Under M+C, beneficiaries are not required to drop out of their plans due to LTC transitions, as long as the facility to which they move remains in the M+C plan’s service area. However, we identified different problems associated with coordination of care for dually eligible beneficiaries who are M+C plans and using LTC services.

An issue raised by one M+C plan is the conflict between managing care and the beneficiary’s right to select his or her PCP even when that physician does not attend patients in a particular nursing home. This M+C plan reported that its members who move into nursing facilities often choose to maintain their community physician, whereas the M+C plan would prefer the member to select a physician who routinely cares for members in that facility to promote quality care and to deal with the special clinical and administrative requirements of caring for these members.

In addition, many standard managed care practices conflict with the reality of service delivery in a 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 results in a clash between facility operations and managed care practices, and the inability of facilities to exert any influence over these vendors. For example, it is efficient and clinically effective for a facility to contract with a single laboratory company to serve all of its residents, and to use its own staff physical, occupational, and speech therapists. For the pharmacy or lab vendor to retain the nursing facility's business, they must be responsive to the needs of the facility. In addition, the volume at each facility makes daily or twice-daily lab pickups routine and cost effective for the vendor. Similarly, pharmacy vendors are responsive to the facilities needs.

Facilities with managed care enrollees may have to work with varying vendors depending on the contracts held by the managed care plans. These multiple vendors are less responsive to the needs of the facility, which no longer serves as their referral source. For example, vendors may make fewer lab pick ups or schedule rehabilitation therapies on a rigid schedule. A geriatrician we interviewed can no longer get STAT lab pickups for his nursing facility patients, whose regular schedule is to come to each facility only once a week. Those labs that will pick up more often add a \$50 surcharge for any service with less than 24-hour notice. He also reported that the pharmacies are not responding as they did previously, interfering with his ability to keep his nursing facility patients out of the hospital. (See Walsh, Kulas and Khatutsky, 2000, for a detailed description of this issue in Oregon.)

To address the disconnects between standard managed care practices (e.g., having to use a contracted vendor for pharmacy, radiology, and other services) and the realities of nursing facilities (e.g., in which the pharmacy supplier may not be the plan's pharmacy vendor), one of the M+C plan's we interviewed allows primary care physicians who specialize in serving nursing facility residents to order services from out-of-plan providers. In addition, that M+C plan pays these physicians a higher capitation to account for the monthly physician visits required for nursing facility residents, and permits them to maintain a smaller panel.

Another M+C plan addresses these issues differently. This plan uses hospitalists (physicians who specialize in inpatient care) for acute-care stays and uses the same model to provide primary care to nursing facility residents. Members do not have the option of retaining their community physician if they wish to remain in this plan while residing in a nursing facility. During post-acute skilled nursing facility stays, the plan pays a contracted rate that includes ancillary service costs and pharmacy costs to the facility. However, when members become long-term residents of a facility, this plan requires their members to use the plan's laboratory services and pharmacy. If family members are not available to purchase medications for these facility residents, the plan's pharmacy mails the prescriptions and delivers any medications needed immediately.

7.4 Focus Group Findings

To learn about beneficiary perceptions and experience with case management and care coordination, we asked focus group participants a series of questions about case management and care coordination, and about activities that might be handled by case managers or care coordinators.

- Do you have a case manager or care coordinator?

- Where is this person from (plan, social services agencies, etc.)?
- What does your case manager or care coordinator do to help you? How often do you talk to or hear from the case manager or care coordinator?
- What kinds of things do you contact them about?
- What kinds of things do they contact you about?
- Who else helps you arrange to get health care services that you need?
- Does one person or agency coordinate all of your services? Does your regular doctor know about all the doctors and services that you use?
 - Is there anyone who helps you get the health services you need? Do you think this person serves as the central point of contact for health services that you receive? Do you wish there were such a person who kept track of all your health care services and needs?
 - Is there someone who knows about all of the different medications that you are taking?
 - Is there someone who helps arrange services like transportation or home health services for you?
- Who is this person?
 - **Probes:** Agency case manager, your doctor, someone at the managed care plan, family, Area Agency on Aging, etc.
- Does this person also know about all the medications that you take, or about all the different doctors or other providers that you see?
- How do you keep track of your medical appointments?
- How do you know when it is time for you to have a routine check-up, a flu or pneumonia shot, or screening exams (mammograms, colorectal exams, prostate screening exams, etc.)?

Focus group participants described various types of assistance that could be considered care coordination, care management, or disease management, but they generally could not identify from whom it was received and were not familiar with these terms. Participants had trouble identifying whether those helping coordinate care were employed by their health plans, by the local welfare office, or by some other community agency. While many described having received some type of help at a point in time, only a few focus group participants reported having a case manager or care coordinator specifically. They generally referred to that person as someone who would help them if they had questions about their plan.

The most common type of care coordination described by the focus group participants related to discharge planning after a hospital stay. Several participants described receiving home health services or transportation home from the hospital but not knowing how these services were arranged, and some of the services they describe might be those provided by a home and community-based care agency rather than their health plan. A member of the M+C group in Pennsylvania said, “Once home, they call you up right away and ask you what’s the best day to

come and they're going to give you maybe two visits a week." Another beneficiary said, "A social worker sets up visits with a nursing agency." Still another participant indicated that social services took care of everything that was needed upon discharge from the hospital. "I needed service—they sent them out. I needed somebody to help me with my bath and things when I had my knees worked on, and I got it." Several participants reported receiving help with health care coordination after being released from the hospital. One man in Pennsylvania reported that someone at the hospital arranged a hospital bed for his home, a nurse who came every 3 days, someone who helped him get washed up every morning, and someone else who cleaned his house. Focus group participants in California reported similar experiences. One beneficiary said, "Back when I was discharged from the hospital, the nurse had to come out and draw blood and they took care of that at the hospital."

Not everyone had positive experiences, even within the same plan. For example, another member of an M+C plan in Pennsylvania indicated that a social worker at the hospital had said that someone would be sent to help him but that no one ever came. As a result, he had to try to bathe himself after being discharged. Another M+C member in California said, "Yeah, [the social worker is there] to see if you need anything, you know. They haven't delivered 100 percent on what they said they were going to deliver and that goes for the same time when my mom was in the rest home. Saw the social worker there also. And also we've dealt with them, and they didn't deliver everything that they said they would." It is not clear whether the social workers described are associated with the managed care plans, with hospitals, or with community agencies.

The story told by one focus group participant illustrates simultaneously how some individuals' needs can go unmet and how plans can respond to identified needs. Using a supermarket cart instead of a walker, this beneficiary met his doctor on the street. It is not clear whether this need had gone undetected previously or whether there was a breakdown in the approval process. After their encounter, the doctor called the man's nurse, and he had his walker in 3 days. This beneficiary believed that he would never have received a walker if his doctor had not seen him out walking that day.

To a great extent, focus group participants had trouble distinguishing whether the assistance they receive is from their health plans or other organizations. For example, beneficiaries reported receiving help securing transportation, but it was not clear whether this service was provided through someone at the plan, through a separate program, or arranged in any way by their health plans. However, many participants in all of the focus groups reported gaining access to specialized transportation services at reduced costs. One participant in California said that the social worker from the health plan helped coordinate transportation when she needed it, but that it did not always work out. As she indicated, "One worker was trying to arrange transportation for my mom from her home to her primary care physician. And this was the social worker who gave me the number of who to call. Well, they [the transportation service] don't do that, so they say. The social worker's not aware that the information she's giving you is not valid."

Several people thought of their state case workers when asked about care coordination. For example, a participant in Pennsylvania indicated that, "They go over everything with your health and so forth that you've got. That's a case worker." Participants in each plan type discussed speaking with a case manager or case worker when they filled out an application for food stamps. However, it was not clear from the discussions that this person actually helped the

beneficiaries secure services. In fact, a few participants reported that the case worker was there to help them with their social security or applications for food stamps but not their health care needs. Others referenced home care agencies, such as the Philadelphia Corporation on Aging. As one caregiver explained, this agency taps into the state lottery money to help clients find different resources in the community. The caregiver said that they “help evaluate what it is you need, your financial situation, and then they hit the right organization.” They also provide a case worker. Another participant reported, “They could provide you with home health care, they provide diapers, they can provide meals, they can do a lot of things for you.”

While participants were often unclear about who helped coordinate their care, there was evidence of disease management or other types of case management activities occurring within the plans. Participants in the Pennsylvania focus groups, especially, made statements in this regard. One participant in the Pennsylvania M+C group indicated that he received a call from his plan after every cancer radiation treatment. Even though he did not specifically use the term “case management” or refer to this person as a case manager or care coordinator, it is likely that he was referred to case management at the plan as a result of his medical condition. Another participant in a Pennsylvania M+C plan described receiving disease management services, although he did not identify them by that name. He reported that his diabetes management nurse calls twice a month to check on him. She orders supplies if he needs them and even has them mailed to him. He noted, “If you get in touch with the right person at [the plan], you can get what you want.”

We also asked beneficiaries questions designed to identify other types of medical management they may have received. For example, we asked participants to talk about their medications and whether anyone helped them track their medications or their medical appointments. On average, beneficiaries in Pennsylvania reported having four prescriptions, those in California had a mean of five prescriptions, with the number across the focus groups ranging from zero to more than 10 medications daily. Most participants indicated that they relied on their physicians or pharmacist to help them track their medications, while many indicated that they kept track of their medications themselves. Participants also reported showing their doctors a list of medications when they were prescribed a new one and said that their doctors communicated with one another when prescribing medications. In general, these practices were reported consistently across plan types and across states, although there was no way to ascertain whether the health plans played a role in medication monitoring.

While most participants reported keeping track of their own medical appointments, several indicated that their doctors or health plans let them know when they were due for routine physicals or for a specific screening exam. Many women received a birthday card reminding them of their next mammogram; male participants reported that they waited until their yearly physical or irregularities in blood test results to have a prostate exam. Women indicated that reminder cards were sent to them by their health plans, implying that the plans have reminder systems in place to let people know they need to schedule preventive services. The same processes were followed for preventive services such as influenza and pneumonia vaccinations. Some participants also received newsletters indicating that it was time for them to get a flu shot, or when and where to go to receive one.

SECTION 8

SUMMARY OF STUDY FINDINGS AND RECOMMENDATIONS

In this section, we summarize our study findings and present recommendations for actions that might be taken to improve the administration and delivery of services to dually eligible beneficiaries.

8.1 Summary of Study Findings

Managed Care Arrangements Vary across Market Areas

The “managed” in managed care is meant to reflect the management of medical care by creating an administrative structure that focuses on providing cost-effective, well-coordinated services. We met with ten health plans—all committed to delivering quality health care to dually eligible beneficiaries—in four market areas. Our findings indicate that managing beneficiary-eligibility information and the consequences of incorrect information consume a substantial amount of health plan time and resources. These information gaps include:

- delays in the flow of dual-eligibility information between states, the Federal Government, and health plans;
- obstacles to accessing information about Medicaid status, including Medicaid MCO enrollment; and
- information about beneficiary liability for copays and deductibles at the beneficiary and provider levels.

Beneficiaries Lack Important Knowledge about Their Coverage

During focus groups conducted with dually eligible beneficiaries, we learned that they do not understand their various coverages, their dual eligibility, or the specific requirements of managed care enrollment. The findings regarding beneficiary confusion indicate a clear need for

- dual-specific information in Medicare and State consumer information sources;
- dually eligible beneficiaries to understand the importance of showing all their health insurance cards at every encounter;
- beneficiaries to have clear information on whether they are liable for any copayments; and
- beneficiaries to advocate for themselves, given the challenges inherent in improving health plan access to eligibility information.

Improving beneficiary knowledge is not an easy task, given the low educational level of many dually eligible beneficiaries, and the complexities of cost sharing. Plans seeking to address this issue encounter bureaucratic barriers. To achieve increased understanding, CMS and states

should consider revising the consumer information available at the state and Federal level, easing restrictions on health plan communication with beneficiaries to allow them to disseminate dually eligible-specific coverage information in their marketing materials, handbooks, and letters.

Plans Lack Necessary Information about the Status of Their Enrollees

The lack of timely enrollment and eligibility information available to health plans is both problematic and challenging to address. Findings in this area reveal, again, that the basic context in which managed care is being practiced for dually eligible beneficiaries has suffered from the lack of specific attention to the administrative details that might improve the service delivery environment in which M+C plans and Medicaid MCOs conduct business.

M+C plans do not have access to accurate and timely information about Medicaid status or Medicaid MCO enrollment. This lack of information has implications for plans, beneficiaries, and individual providers, including the following:

- M+C plans do not receive the appropriate capitation payment from CMS until the dual status of their members is established. While retroactive adjustments correct these differences, pursuing these reconciliations is a substantial administrative burden on M+C plans.
- Until the M+C plan receives the information from CMS that the beneficiary is also covered by Medicaid, the beneficiary will be charged for copays and deductibles for which the beneficiary is not responsible. No mechanism exists for identifying copayments made by beneficiaries directly to providers or requiring that providers return inappropriate copays or deductibles they have collected.
- Without knowing that enrollees have additional coverage, M+C case management staff and primary care providers miss the opportunity to coordinate with Medicaid-covered services unavailable to Medicare-only beneficiaries.
- Some health plans pay their primary care providers in proportion to the individual capitation payments received from CMS. In these plans, primary care providers receive a lower-than-indicated capitation payment for members who have not yet been identified as dually eligible beneficiaries. This situation may lead providers to more strictly limit services provided to these members than they would otherwise.

Medicaid MCOs also lack access to accurate and timely information about enrollment and disenrollment from M+C plans. Without timely information about M+C enrollments, the Medicaid MCOs face several challenges that affect the plan, providers, and beneficiaries:

- Medicaid MCOs face an administrative burden to inform members of their unacceptable dual enrollment and, where applicable, offer the beneficiary choices about what enrollment to keep and which to drop.
- Medicaid MCOs must retroactively disenroll beneficiaries, resulting in cash flow problems for the plans, and generating ill will with beneficiaries and providers.

M+C and Medicaid MCOs that jointly enroll individual beneficiaries also encounter problems, specifically in coordinating accretion dates (the effective date for a new enrollment), which creates special challenges regarding benefit coordination.

Some solutions might appear simple, such as enabling health plans to access Medicaid eligibility information online or for Medicaid plans to have access to systems that verify beneficiary M+C enrollment in specific health plans. However, actually solving these problems may be complicated, some improvements might require changes in regulations, permission for routine use and access to data systems, or even statutory changes. Perhaps the findings in this area may be instructive to policymakers, health plans, and providers in prioritizing administrative system changes that should be addressed and triaged according to the level of effort needed to make necessary changes.

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

This research raises questions about some of the existing managed care arrangements, and whether CMS and the states can develop approaches that better facilitate coordination of cost-sharing arrangements across the Medicare and Medicaid programs. During our site visits to plans in the four market areas, we learned the following:

- Charging premiums was a new development in some market areas, so plans, states, and CMS had no experience with or systems in place to deal with issues pertaining to premiums and dually eligible beneficiaries.
- M+C plans that made efforts to provide information to their dually eligible members encountered bureaucratic difficulties.
- Plans need up-to-date Medicaid status information to waive premiums for dually eligible beneficiaries or collect premiums from Medicaid.
- Based on information provided by M+C plans, CMS determined that plans could allow dually eligible beneficiaries to remain enrolled even if in arrears for premiums.
- State Medicaid departments have the option to pay all M+C premiums through their state plans, but requirements of this option may make it undesirable.
- California now pays M+C premiums to some plans on behalf of dually eligible beneficiaries.

California's decision to pay for M+C premiums for dually eligible beneficiaries allowed many to remain in M+C plans. Other states may wish to consider this innovative approach. In addition, California and other states may wish to examine further how to create Medicaid wrap-around coverage through the M+C plans that would encompass other aspects of cost sharing (i.e., copayments and deductibles) under current regulatory authority using CFR 422.106. If states took this approach, the billing requirements for providers could be streamlined by submitting a single bill to the M+C plan and receiving the total payments for which they have negotiated.

This arrangement makes more sense than enrolling dually eligible beneficiaries in two products within the same plan, and would perhaps alleviate some of the administrative burdens (for plans) and confusion (for beneficiaries and providers) associated with beneficiaries' being enrolled in separate M+C and Medicaid MCOs within the same organization.

Care Coordination and Case Management Activities Are Dispersed in Managed Care Plans

Managed care companies face challenges in identifying dual coverage, administering coordination of benefits rules appropriately, and assisting their members to understand their coverage. These objectives can be achieved by coordinating care within the managed care environment and across systems of care, and through individually focused case management. During the site visits, we learned about some of the challenges that M+C and Medicaid MCOs face:

- Most plans do not target dually eligible beneficiaries specifically for care coordination activities. However, benefit coordination is commonly an issue for these beneficiaries. Due to their health status, dually eligible beneficiaries are likely participants in disease management or case management programs that address issues related to prescription drug, DME, home health, and LTC utilization.
- Care coordination and care management activities are spread across many departments in managed care plans.
- The major care coordination activities are benefit coordination, utilization review and associated hospital discharge planning, and disease management programs. Member service departments and health risk assessments are two common entry points to care coordination and disease management.
- Plans vary in their ability to identify their dually eligible members, which contributes to care coordination problems.
- State policies can facilitate or create obstacles to effective care coordination regarding coordinating Medicare and Medicaid benefits, and in transitions to long-term care.

Two of the managed care arrangements we studied seem particularly problematic. First, it is not clear that states or beneficiaries are well served by enrolling dually eligible beneficiaries in Medicaid MCOs in combination with Medicare FFS. As we reported, this arrangement can only lead to care management if the beneficiary essentially ceases to use his or her Medicare FFS benefit independent of the Medicaid MCO. Beneficiaries cannot be required to do so, and may not understand the financial and care coordination implications of their decisions to go outside of the Medicaid MCO network. Second, enrolling dually eligible beneficiaries in separate and unrelated M+C and Medicaid MCOs does not promote coordination of care, but rather creates two unrelated administrative and billing structures to address COB issues. There may be additional disadvantages if the two unrelated organizations contract with different provider networks. In addition, beneficiary grievances and appeal processes become extremely complex in the context of two unrelated managed care contracts.

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

- Dually eligible beneficiaries are frequent LTC users. Current state policies, and various managed care practices, create discontinuities of care for dually eligible beneficiaries using long-term care services. Medicaid MCO enrollees are often required by their states to disenroll when they become LTC users, creating discontinuities of care. This is problematic for those receiving home and community-based services, as they would benefit from ongoing coordination. It is also problematic for those dually enrolled in a single, staff model plan for both M+C and Medicaid.
- For M+C enrollees in nursing facilities, managed care practices, such as contracting with a limited set of ancillary service providers, does not work well. Some plans allow PCPs specializing in nursing facility care to order out-of-network services.
- Beneficiaries moving into nursing facilities often wish to keep their community PCP, even if these PCPs do not serve facilities. Plans recommend that beneficiaries accept PCPs who specialize in serving nursing facility residents.

In most states, Medicaid MCOs are required to drop all long-term care users from their rolls, both facility and home and community-based service recipients. If dually eligible beneficiaries are enrolled in Medicaid managed care at all, perhaps they should not be dropped at this juncture. In addition, all plans—M+C and Medicaid MCOs—enrolling facility residents should consider using primary care physicians who specialize in serving these beneficiaries and allow these physicians to authorize the use of out-of-network ancillary services that serve the individual nursing facility.

8.2 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.

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APPENDIX A

Case Studies of Managed Care Arrangements for Dual Eligibles

Health Economics Research

Overview of Project

Goals

- To collect information about how state and federal regulations affect the ability of managed care plans and primary care physicians to coordinate benefits and care for Medicare/Medicaid dual eligibles.
- To compare the challenges and relative advantages of various managed care arrangements for dual eligibles (Medicare managed care only, Medicaid managed care only, or both).
- To learn about plan activities to coordinate benefits and care for dual eligibles.

Activities

- Meet with plan administrators and staff, and physicians, in four market areas with high concentrations of dual eligibles or high enrollment of dual eligibles in various managed care arrangements. We will be meeting with 2-3 plans in each market area.
- Four market areas are: Portland, Oregon; Los Angeles County, California; Miami, Florida, and Philadelphia, Pennsylvania. These four areas represent different state approaches to enrolling dual eligibles in managed care.
- Conduct focus groups of beneficiaries in three of the market areas.
- Reports to HCFA will integrate the information across these market areas, discussing types of plans and the challenges they face. While we will include a list of plans with whom we met, we will be discussing plan activities in aggregate. If we would like to identify a plan to highlight some of that plan's activities, we will contact the plan and request permission first.

I. General Questions

- What are the greatest challenges managed care organizations and primary care physicians face serving dual eligibles?
- How does current Medicare regulation affect your ability to serve this population?

- How does current Medicaid regulation affect your ability to serve this population?
- Have there been regulatory changes that have either facilitated or worsened your ability to serve this population?
- What have you implemented or changed over time to facilitate coordinating benefits or care to dual eligibles? Are there any you are considering or planning?
- Are there regulatory changes that you advocated for that were not implemented (either within the plan or with federal or state regulators)?
- Do you think of dual eligibles a discrete group, as members with two separate coverages, as Medicare members with an additional coverage, or some other way?

II. Coordinating Enrollment and Benefits

A. Enrollments and Information Systems

ALL PLANS

- Number and percent of duals by managed care product (e.g., total annual or average monthly, whatever is convenient to report).
- How are providers informed of member's status? How much do providers need to understand about dual eligibility?
- Do dual eligibles often lose their Medicaid coverage? If so, how does the plan find out and how does the plan respond?

For Plans with both Medicare and Medicaid products

- For plans with both Medicare and Medicaid products: how is enrollment and disenrollment in the two products coordinated? Are there problems based on lack of coordination of state or federal regulations? If there is a lag in processing one type of enrollment, how does the lag play out for members, the plan and for providers?
- In plans with both Medicare and Medicaid products, are there any dual eligibles who are in only the Medicare or Medicaid product? If so, why? If so, how are the benefits coordinated with fee-for-service benefits? If a member switches to a Medicare product at an HMO that does not participate in Medicaid, do you automatically disenroll the member from your Medicaid plan? If not, how does this play out?

- Are there members who are in one of your products for either their Medicare or Medicaid and enrolled in an unrelated plan for the other? If so, how do you know?
- Besides the lag time in Medicare enrollments, are there other problems in processing enrollments or disenrollments for dual eligibles? Are any such problems due to Medicare or state regulations?
- What does this “double” enrollment look like to the members? Do they receive two membership cards? Do members receive separate handbooks for the Medicare and Medicaid products? Does the plan provide any special materials explaining dual eligibility to their members?
- Is there an integrated MIS system for dual eligibles, or are they in two separate databases within the plan?

For plans with Medicare only

- How do you become aware of members’ Medicaid status?
- How do you become aware of dual eligible members’ enrollment in Medicaid plans, if any? How do you become aware of your members’ disenrollment from a Medicaid plan?
- Are there any lags between changes in members’ Medicaid status and your plan learning about those changes? If so, how do these lags affect the plan, your providers, or the members?

For plans with Medicaid only

- How do you become aware of dual eligible members’ enrollment in Medicare plans, if any? How do you become aware of your members’ disenrollment from a Medicare plan?
- How do you learn about changes in Medicare status, such as aging into Medicare or qualifying for Medicare based on disability?
- Are there lags in information about Medicare coverage or Medicare plan enrollment? If so, how does this affect your plan, your providers or members?
- Are there situations that require you to disenroll a dual eligible member, such as moving into a nursing facility? If so, do you view this as a problem?

B. Fiscal/Billing Issues/Provider Services

- Are there financial consequences to the plan of any lag time between Medicare and Medicaid enrollment or disenrollment (for plans with both products)?
- Are bills received for out-of-network services for dual eligibles? What types of services are these for? How are they handled?
- Are there other financial issues for the plan related to serving dual eligibles? For Medicare plans: does your state pay any premiums, copays or deductibles on behalf of dual eligible members? For Medicaid plans: are you responsible for any

Medicare copays or deductibles for members in either Medicare managed care or Medicare fee-for-service?

- Is there one provider network or separate provider networks for your Medicare and Medicaid products (for plans with both)?
- Do your Medicare providers have to agree to accept dual eligibles? If not, about what percent do not?
- What issues do your providers, especially primary care physicians, face serving dual eligibles?
- How does dual eligibility affect authorization and payment for post-acute care, DME and home health services?

C. Member Services

- What are the most common reasons that Medicare members call Member Services?
- Are there particular issues that come to Member Services from dual eligibles?
- How does Member Services handle membership in two products (for plans with both products)?
- How are Member Services staff organized and trained to address multiple coverage within the plan?
- How do Member Services staff understand Medicare being the primary payer?
- How does the plan track what kinds of issues come to member services? Does the plan track member services issues by certain member groups? Is dual eligible one of these groups?
- What criteria does Member Services use to refer calls on to medical case management or other departments?

III. Coordinating Care

A. Utilization Management and Case Finding for Case Management

What are the mechanisms used to find cases for case management, and which are most common? Is there any difference in case finding approaches or frequency for dual eligibles than for other Medicare or Medicaid members?

- Referrals from member services
- As part of hospital discharge planning
- Review of utilization to find high cost cases
- Response to calls from members or their families
- Response to calls from physicians
- Response to calls from other agencies
- Based on risk screening activities
- For members in certain clinical categories

- For members receiving long-term care
- Other ways?

Are there particular Utilization Management issues for dual eligibles? What are the greatest areas of concern about utilization for Medicare beneficiaries in general?

B. Case Management Organization

- Ratio of case management staff to plan members. Are case management staff organized by eligibility or clinical categories?
Average across lines of business
For Medicare members
For adult Medicaid members
For dual eligibles
For adult commercial members
- Case management staffing
MSW
RN
MSW/RN teams
- Location in organization
Utilization review dept
Separate department
- Is there a direct line available to members to case management department?
- What is the distinction between what is handled by Member Services and what is handled by case management?

C. Case Management Activities

What are the most frequent case management activities involving dual eligibles? Is this different than for other Medicare or Medicaid members? Can you quantify in some way what percent of your cases involve each of these activities? Are some of these activities handled by a different department?

- Coordination of Medicare and Medicaid benefits
- Working with physicians
- Facilitating referrals within plan
- Referring, arranging or coordinating with services outside the plan

- Discharge planning
- Explaining managed care to members (e.g., need for referrals, staying in network)
- Investigating problems with contracted providers
- Prior approval of DME, medical supplies or home health
- Developing or approving care plans that go beyond the usual benefit package

How do plans facilitate access to services that are not included in their contract? How do plans work with “carve out” Medicaid services, such as long-term care?

D. Risk Screening Activities

Are there any routine risk screening procedures for Medicare members? Alternatively, are there any risk screening activities under development? Has the plan implemented risk screening activities in the past and either revised or dropped them?

For current or planned risk screening activities:

- When are members screened? Upon enrollment? Annually? Some other way?
- What tool is used?
- What elements are covered?

Chronic conditions

Functional status

Pharmacy utilization

Other services received

Living arrangements

- How is risk screening conducted?
- Who reviews the information?
- What interventions are triggered by risk screening?
- What responses result in follow-up with the member?
- What responses result in follow-up with the primary care provider?

Does the plan have any system in place to monitor changes in health or functional status or living arrangements? How does the plan find out if a person moves to a nursing facility?

IV. Quality Improvement Activities

- Have you implemented or are you considering any quality improvement activities related to care coordination for dual eligibles or the Medicare or Medicaid

membership as a whole? How does the plan select quality improvement activities for dual eligibles?

- Do you have any disease management protocols in place that apply to Medicare members?
 - CHF
 - COPD
 - DM
 - Others
 - Any protocols specific to under 65 Medicare beneficiaries?
 - Any specific to dual eligibles versus all Medicare or Medicaid beneficiaries?

- Are disease management protocols or other quality improvement initiatives applied throughout the plan or only within selected practices or sites?

APPENDIX B

Focus group protocol

I. INTRODUCTION (5 minutes)

As participants arrive:

1. Welcome individually
2. Collect information sheet
3. Give incentive and collect signed receipt
4. Help with refreshments
5. Alert moderator to any access or communication needs

INTRODUCTION AND CONFIDENTIALITY

Welcome, and thank you for coming. My name is _____, and I will be leading the discussion today. This is _____, and s/he will be taking notes and asking questions now and then. We hope to learn a lot from what you have to tell us today.

This discussion is part of a study being done by Research Triangle Institute for the federal government. The purpose of the study is to learn about experiences of people like yourselves who use both a Medicaid plan and a Medicare plan to get their health care.

In the discussion today, I will be asking questions about your health plan and what your experience has been in getting the care that you need. We are interested in hearing about both good experiences and problems you may have had. The questions will be about your experiences and opinions. There are no right or wrong answers. Participation is voluntary and confidential, and you may refuse to comment on any question that is asked.

There is no need to raise your hand before speaking, but please don't talk while someone else is talking. Let them finish before you speak. I will ask the questions and keep the discussion moving along, but I want you to do most of the talking so I can hear what you think and how you feel about the things we are going to talk about.

After the group is over, we will be writing a report based on what we learn in this group and others like it. Nothing that identifies you will be included in the report, and your health care and benefits will not be affected by your participation in this group.

We will tape record the discussion to help us remember what you have to say. The notes and the tape will only be used by people working on the project, and will not be released to anyone else. We also ask that you respect the confidentiality of others in

the group. That means don't talk to anyone outside the room about what other people have said here today. Is that okay with everyone?

Logistics

The group will last until about __: o'clock. Can everyone stay that long? Did everyone return their short survey and collect your \$40 incentive? Did you sign the receipt?

Feel free to get up and move around if you need to, but it will be less distracting if only one person gets up at a time. There are restrooms located _____ . Help yourselves to more refreshments during the group.

Are there any questions before we get started?

Introductions (start tape recorder)

I'd like you start by asking you to introduce yourselves. Please tell us your first name, how long you've been enrolled in your health plan (s), and what one word describes your experience with your health plan.

BASIC KNOWLEDGE

1. CURRENT HEALTH COVERAGE (10 minutes)

Let's talk a little bit about your experience with your health plan(s) and with Medicare and Medicaid.

- Different health plans work with Medicare or MEDICAID (*whatever it is called in each state*), or with both, to provide health care services to people enrolled in these programs. Medicare is the federal program that covers health care services for the elderly, the disabled, and those who have end stage renal disease. Medicaid [*WHATEVER IT IS CALLED IN EACH STUDY STATE*] helps cover certain health care services and prescription drugs for those who have low incomes. Do you know which type of plan you are enrolled in? (a Medicare managed care plan, a Medicaid managed care plan, or one that combines the two, or do you not know?)
- How do you know which kind of plan it is? (*remember from enrollment, someone told me, etc*)
- Is there anyone who belongs to more than one plan, and has more than one insurance card? (*How many insurance cards do you have?*)
- Is one of those your _____ card? **USE NAME OF THE PLAN**

LOOK AT THE CARDS – check for information on deductibles and copays.

- Did PLAN NAME ever give you a different card than the one you have now? What was the difference between the two cards?
- When do you show these cards?
 - What do you use each of these cards for?
 - Which card do you use the most?
- Have you had problems using any of these cards?
- In general, what type of services does your [INSERT PLAN NAME] cover? What about your other coverage [other card]? What types of services are covered?

2. EXPERIENCE WITH SERVICE USE (20 minutes)

Now let's talk about the kinds of health care services that you use and how easily you are able to get access to those services.

- What kinds of health care services do you use?
 - Probe for primary care, specialty care, medications, lab tests, mental health, long term care, including home care, physical therapy, DME, etc.
- Do things go smoothly when you try to get the health care services that you need?
 - What helps things go smoothly?
 - What kind of problems have you encountered?
 - **Probe:** any problems getting your prescription drugs, seeing a specialist, getting durable medical equipment (hospital bed, walker, wheelchair), getting home health care, etc.?
- What did you do?
- Were the problems resolved? Who helped you resolve the problem?
 - **Probes:** member services, case managers, family members or friends, or other persons
- What happened? What did they do?

BENEFIT COORDINATION (30 minutes)

Now let's spend a few minutes talking about how well your health insurance works for you.

How do you know which coverage to use when you need health care? (How do you know *which card* to use when you need health care?)

- Do you ever have to pay any copays or deductibles? If some do and some don't, ask why there's a difference.
 - What are these co-pays or deductibles for? (the doctor's visit, for prescriptions or for other services)
 - Are these copays or deductibles ever waived? Does anyone ever say that you don't have to pay the bills?
 - Even though you're not paying copays and deductibles now, have you ever paid them while you were still in this plan?
- Do you ever get medical bills for services the plan doesn't cover (your visit to the doctor or specialist, co-pays, deductibles)? What type of providers do you get these bills from?

Probes:

- Do you ever have to pay for your prescription drugs?
- Do you get bills from your doctor?
- Do you get bills from the hospital or providers that you see while in the hospital?
- Anyone else?
- What do you do with these bills? (pay out-of-pocket, leave unpaid, or call the health plan)
- Do you ever need services that your plan (health insurance) doesn't cover? Have you ever needed to see a provider who is outside your plan's network? What did you do?
- What happens if you go outside your plan to see a doctor or other provider? Does your plan cover co-payments or deductibles for the providers you used outside the plan?
- If plan doesn't cover the bills for providers outside the plan, what do you do with the bills? Do you ever find out before hand that the plan will not cover the bills for providers outside the plan? What do you do if you're told that the plan won't cover those bills?

3. GENERAL PLAN ISSUES

INFORMATION ON PLAN BENEFITS (20 minutes)

I'd like to change the focus of the discussion a little and focus on your health care benefits and the types of services covered by your plan. By benefits I mean insurance coverage for your doctor visits, hospital stays, home health services, nursing home coverage and so on.

- Have you ever had a question about the benefits provided by your plan? How do you find out what is covered by your plan?
- Where did/do you get information (answers to your questions)? What happens when you try to get information about your plan coverage?

IF FAMILY OR SOMEONE ELSE IS GIVEN AS AN ANSWER PROBE:

- Where did/do they get the information?
- Do you ever use the member handbooks or other materials like comparison charts from your plans when you are looking for information? Are the materials helpful? Do the materials tell you anything about dual eligibility (having Medicare and Medicaid)? Do any of the other materials you have give you information about dual eligibility?
- What else do you use to get information about your [PLAN NAME] benefits?
- Have you ever called member services or customer service for information? What kinds of things did you call them about? Have you ever called specifically about how your two kinds of coverage work together?
- Has member services staff ever given you information about how your coverages should work together?
- Were they helpful?
- Does anyone else help you find out what your plan covers or how to get services you need?

Probes:

- Do you have a case manager or care coordinator? Does your case manager help you? What do they do? Where does this person come from?
- What about the person who handles plan enrollment? What do they do?
- How about your doctor or other health care provider?
- Do you get help from family or friends?

IF FAMILY OR SOMEONE ELSE IS GIVEN AS AN ANSWER PROBE:

- Where did/do they get the information?

4. CARE COORDINATION (30 minutes)

Now I'd like to hear how well your health insurance works for you.

- Do you have a case manager or care coordinator? (*refer back to earlier responses about case managers/care coordinators in section 2, but ask regardless of the previous responses*)
- Where is this person from (plan, social services agencies etc)?
- What does your case manager or care coordinator do to help you? How often do you talk to or hear from the case manager or care coordinator?
 - What kinds of things do you contact them about?
 - What kinds of things do they contact you about?
- Who else helps you arrange to get health care services that you need? (**PROBE:** family members, friends, social workers, care coordinators, etc.)
 - *Does one person or agency coordinate all of your services? Does your regular doctor know about all the doctors and services that you use?*
 - Is there anyone who helps you get the health services you need? Do you think this person serves as the central point of contact for health services that you receive? Do you wish there were such a person who kept track of all your health care services and needs?
 - **Probes:** How many doctors prescribe medications for you?
 - Is there someone who knows about all of the different medications that you are taking?
 - Is there someone who helps arrange services like transportation, or home health services for you?
 - Who is this person?
 - **Probes:** agency case manager, your doctor, someone at the managed care plan, family, Area Agency on Aging, etc
 - Does this person also know about all the medications that you are taking, or about all the different doctors or other providers that you see?
 - How do you keep track of your medical appointments?
 - How do you know when it is time for you to have a routine check-up, a flu or pneumonia shot or screening exams (like mammograms, colorectal exams, prostate screening exams, etc)?

5. GENERAL COMMENTS AND CLOSING (10 minutes)

We're almost done. I have just a few more questions.

- Overall, how do you feel the health care system is working for you?
- What do you think would make it easier for people like you, who are eligible for both Medicaid and Medicare, to use health services?
- You have told me about several ways that things have and have not worked well together. **PROVIDE A QUICK SUMMARY OF THESE.** Does that sound correct? Is there anything else that you would like to add?

That's all of the questions I have for you. I want to thank you again for coming and sharing your thoughts and experiences with us.