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Major Changes for Individuals Who Are Dually Eligible

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Key Resources

Issue Briefs

- Advocates' Guide for Evaluating State Dual Eligible Integration Demonstration Proposals, available here.
- Model Standards for Dual Eligible Integration Demonstrations, available here.
- Comments on California Proposal for a Dual Eligible Integration Demonstration, available here.

Coming in November's Health Advocate:

An explanation of Section 1115 Waivers

This issue of the *Health Advocate* provides background on individuals eligible for both Medicare and Medicaid ("dual eligible beneficiaries") and identifies key issues as many states expand managed care to this diverse population.

Introduction: Who qualifies for Medicare and Medicaid?

Medicare provides critical healthcare access for the elderly and people with disabilities. However, Medicare has holes that cause serious problems for low-income enrollees. Medicare premiums and cost-sharing deter access and Medicare coverage excludes some critical services. To fill these gaps, many low-income seniors and people with disabilities turn to Medicaid. Nearly 9.4 million Medicare enrollees qualify for some level of Medicaid coverage, including 7.2 million fully eligible for both programs.[1]

So is double coverage twice as good? Not exactly. Medicare pays for services such as clinician visits, acute care, home health aides, post-hospitalization skilled nursing, and prescription drugs. Medicaid's more comprehensive service package includes additional services such as long term supports and services, some transportation needs, and assistance paying Medicare premiums and cost sharing. For services that both programs cover, Medicaid covers outstanding costs after Medicare pays its share. By law, dual eligible beneficiaries retain all the legal rights of each program. In practice, however, the Medicare and Medicaid bureaucracies do not always integrate smoothly. Differing requirements and standards often lead to logistical headaches, uncoordinated care, and problems accessing services.

Quality integrated and coordinated care is especially critical because dual eligible beneficiaries experience higher than average levels of chronic conditions and other illnesses. Their diverse healthcare needs include many long term supports and services.[2] Consequently, dual eligible beneficiaries' health expenses exceed other Medicaid and Medicare populations. Nationwide, they represent 15% of Medicaid beneficiaries but account for 38% of expenses.[3] The combination of poor care coordination, complex health needs and high health costs made dual eligible beneficiaries a prime target for health reform.

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[1] Another 2.2 million have "partial" dual eligibility where Medicaid only assists with Medicare premiums and cost sharing. Kaiser Family Foundation, *Dual Eligible Beneficiaries, 2009*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=303&cat=6&sub=76 (last visited Sept 25, 2012).

[2] The threshold for full dual eligibility is very low, with most states income limits from $675 to $900 per month.

[3] Kaiser Family Foundation, *Dual eligible beneficiaries Share of Medicaid Spending (in millions), 2009*, http://www.statehealthfacts.org/comparemaptable.jsp?ind=299&cat=6.

Affordable Care Act Reforms

The Affordable Care Act (ACA) sought to promote better integration by creating the Medicare-Medicaid Coordination Office (MMCO). To improve quality and reduce costs for dual eligible beneficiaries' care, MMCO has launched two major initiatives: 1. "realigning" historic differences between Medicare and Medicaid; and 2. testing new models of care that "integrate" Medicare and Medicaid services into a unified coverage vehicle.[4]

Realignment

MMCO's realignment initiative has identified 29 specific problems over six categories: coordinated care, fee-for-service benefits, prescription drugs, cost sharing, enrollment and appeals. For example, Medicaid and Medicare have different standards for obtaining a wheelchair. Medicaid covers wheelchairs for use in and out of the home while Medicare covers *only* in-home wheelchairs. Many dual eligible beneficiaries experience problems when the Medicaid agency erroneously applies the Medicare standard and denies a wheelchair not exclusively for in-home use. Sometimes the Medicaid billing system rejects the claim until Medicare has been billed, even if the service (such as a wheelchair for out-of-home use) is not covered by Medicare. Other common alignment problems include issues with drug formularies, Medicare's inadequate prior authorization procedures, and overlapping due process rules. While some states have developed workarounds for such misalignments, MMCO seeks systemic solutions.

Integration

The MMCO initiative garnering the most attention centers on integrating the care delivery system for dual eligible beneficiaries. In fall 2010, MMCO, in conjunction with the Center for Medicare & Medicaid Innovation, requested state proposals to design integrated care management programs for dual eligible beneficiaries. States could choose between managed fee-for-service (FFS) or capitated managed care. Managed FFS offers a small fixed payment to a designated care coordinator to facilitate each enrollee's care team. Capitated managed care pays insurers a fixed per member per month fee to cover all plan services. The managed FFS model, which tweaks rather than overhauls existing delivery systems, has generated less controversy among consumer advocates.

In April 2011 fifteen states received grants to design integrated care demonstrations.[5] Three months later MMCO issued another request and ultimately 26 states (including the original 15) submitted proposals. Most states opted for capitated models.[6]

Thoughtfully designed demonstrations promise to improve integration, streamline and synchronize administrative processes, and "rebalance" incentives in long term care to promote home-and community based services over nursing home care. Better care coordination and "rebalanced" long term care seek to generate savings while improving quality. However, the state proposals raised several red flags for consumer advocates.
Topping the list were states proposing to shift huge numbers of dual eligible beneficiaries into managed care plans with little or no experience meeting their complex health needs. Furthermore, the capitated model depends on evaluation metrics to ensure quality care, but very few validated measures specifically assess the complex services, such as long term care, that these new plans must provide.

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[4] A third initiative seeks to improve states' access to Medicare data for care coordination. Available at http://www.cms.gov/CMCSBulletins/downloads/Coordinated-Care-Info-Bulletin.pdf.
[5] The states are: CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, and WI.
[6] A map identifying these states and their proposed delivery model is available at: National Senior Citizens Law Center, *Dual Eligible Integrated Care Demonstrations: Resources for Advocates*, http://dualsdemoadvocacy.org.

Finally, to guarantee sufficient participation in the demonstrations, MMCO agreed to allow states to passively enroll dual eligible beneficiaries into managed care. Many older adults and persons with disabilities will not realize they have been auto-enrolled into a plan that may not include their existing providers or cover their medications. A similar approach in Medicare Part D implementation caused massive confusion and interruptions in care.[7]

During the spring of 2012, each state proposal underwent 30-day state and federal comment periods. Advocates submitted hundreds of comments commending strengths, expressing concerns and asking for specific details. MMCO has been generally responsive to advocates' concerns, including:

1. Relaxing the timeline so no capitated model will begin before spring 2013, and most will wait until 2014;
2. Increasing transparency by agreeing to post all proposals, memorandums of understanding (MOUs) and evaluation reports on a public website;
3. Requiring states to allow enrollees to opt-out of the demonstration with no "lock-in" period for Medicare; and
4. Regularly consulting with consumer advocates, including quarterly meetings.

Integration Demonstrations Going Forward

Currently, MMCO and participating states are negotiating Memorandums of Understanding (MOUs) detailing their respective responsibilities. In August, MMCO completed its first MOU with Massachusetts, which will phase in a capitated model beginning April 2013.

After completing an MOU, states adopting capitated models will select participating managed care plans. Each plan will undergo an MMCO readiness review that includes all the relevant standards for Medicare Advantage plans and additional requirements specific to the integration demonstrations. Participating plans will then negotiate three-way contracts with the state and MMCO.

Consumer health advocates continue to seek opportunities to establish stronger protections for dual eligible beneficiaries in these demonstrations. While advocates have no direct role in MOU negotiations or contracting, MMCO encourages feedback on completed MOUs and many states maintain ongoing stakeholder advisory groups. Some key consumer protection issues include:

1. Ombuds programs for capitated models;
2. Strict contractual language addressing key issues including provider network adequacy, the definition of medical necessity, enrollee due process rights, and care continuity;
3. A "best-of-both worlds" integrated due process system that guarantees enrollees all the rights afforded by both Medicare and Medicaid;
4. A secondary quality control system including reports on grievances and appeals (stratified demographically), enrollee experience interviews, and other measures to compensate for the lack of viable LTSS quality metrics; and
5. Ongoing stakeholder advisory boards to provide input on design, evaluation and implementation oversight.

[7] Vernon Smith et al, *Kaiser Family Foundation, The Transition of Dual eligible beneficiaries to Medicare Part D Prescription Drug Coverage: State Actions During Implementation* 1 (2006), at 5-7, http://www.kff.org/medicaid/upload/7467.pdf. *See also* Joyce C. West et al, *Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients During the First 4 Months of the Medicare Prescription Drug Benefit*, 164 Am. J. Psychiatry 789, (2007), http://ajp.psychiatryonline.org/data/Journals/AJP/3812/07aj0789.PDF.

Conclusion

Dual eligible beneficiaries present some of the most challenging and complex problems for Medicare and Medicaid health care administration. The risks of moving this population into new and untested capitated managed care require that MMCO takes extra care to bolster consumer protections and put on the brakes when proposals or implementation are insufficient. Advocates need to press states and HHS to keep a seat at the table and monitor rollout as these projects move forward.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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