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RESOURCE PAPER

Limitations in Medicare Managed Care Options for Integration with Medicaid

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*Funded by the Center for Health Care Strategies, Inc.
under The Robert Wood Johnson Foundation's
Medicaid Managed Care Program*

March 2003

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Acknowledgements

The authors would like to thank the project's superb technical advisor, Tina Nye, Vice President, Account Services, Government and State Medicaid Programs, AdvancePCS. They would also like to thank the state officials from Arizona, Texas, Colorado, and Minnesota as well as Evercare of Texas, LLC, Maricopa Integrated Health Systems, UCare, and Kaiser Permanente for their contributions to this project.

Executive Summary

Persons who are eligible for Medicare and Medicaid use a wide array of health care services, depending on their age, health status, and whether they have chronic health care needs. The dually eligible tend to have more serious and complex medical, social, and long-term care needs than other Medicare and Medicaid beneficiaries. As a result, they generate higher health care costs and must often navigate within a complicated set of multiple payers and providers. For these reasons, federal and state policy-makers have turned to managed care as a means to deliver primary, acute, and long-term care services for dual eligibles and to integrate the sources of financing for this care.

This paper focuses specifically on the problems states and health plans face when attempting to create a Medicare managed care program that can be integrated with Medicaid managed long-term care. It describes the issues that arise when two options – the Program for All-Inclusive Care for the Elderly (PACE) and Medicare demonstration waiver authority – are used to create integrated programs. This paper also explores whether Medicare+Choice provides states and health plans with a successful avenue for designing integrated programs.

- **PACE.** PACE is an integrated managed care program for the frail elderly offered in 18 states. The program offers many advantages to states interested in finding a mechanism for integrating Medicare and Medicaid financing streams through managed care. PACE providers receive a special risk-adjusted payment to provide care to their clients and enhanced regulatory flexibility to market exclusively to dual eligibles.
- **Medicare demonstration waiver authority.** Some states have requested Medicare demonstration waivers. These states have borrowed certain features of PACE including integrated Medicare and Medicaid financing, marketing, and care, as well as the PACE risk-adjusted rate for the frail elderly. In addition, demonstration waivers allow states to serve not only the frail elderly who meet a nursing facility level of care, but all persons who are dually eligible.
- **Medicare+Choice.** Some plans and states have recently considered using the Medicare+Choice program as another approach to integrating care for dual eligibles. Medicare+Choice plans integrate care with Medicaid benefits without applying for Medicare waivers and plans can serve a large number of dual eligibles through a network of providers.

Methodology

Our investigation centered on the experiences of four health plans that operate or have considered operating an integrated program for persons eligible for both Medicare and Medicaid. Among those interviewed were a plan that initially considered offering a plan focused on dual eligibles, but subsequently decided to forego that option, and a plan

participating in the Medicare demonstration waiver program Minnesota Senior Health Options (MSHO). We also interviewed two Medicare+Choice providers and supplemented the health plan interviews by talking with the plans' corresponding state officials. We did not attempt to assess whether care provided by these programs differs from that of the care provided under fee-for-service programs.

Findings

States and plans interested in offering an integrated managed care program to their dual eligibles face significant challenges. Although three Medicare managed care options exist – PACE, Medicare demonstration waivers, and the Medicare+Choice program – each has serious limitations.

- **PACE.** The PACE program's use is limited to a small group of elderly who qualify for nursing facility level of care within the PACE site's service area. This restriction, which allows beneficiaries to receive care only at one PACE site, limits the volume of beneficiaries that can be served. The federal PACE law also limits permanent participation to organizations with not-for-profit status. This restricts states' ability to create large numbers of programs that can reach a significant number of dual eligibles in their state.
- **Medicare demonstration waiver authority.** Medicare demonstration waivers require lengthy review from the United States Department of Health and Human Services (DHHS) and other agencies prior to their approval and implementation. This has limited the number of states that are willing to develop these types of programs. In addition, the Centers for Medicare and Medicaid Services (CMS) has not clearly stated whether it will approve any more of these waivers due to the costs associated with the additional PACE risk-adjuster.
- **Medicare+Choice.** Medicare+Choice regulations do not permit health plans to specialize and focus on dual eligibles alone. Plans must offer their benefits to every Medicare beneficiary who elects to enroll in their health plan. In addition, Medicare+Choice plans cannot merge Medicare and Medicaid marketing materials to attract dual eligibles and clarify the unique circumstances these beneficiaries may experience. Finally, Medicare+Choice plans, unlike PACE and Medicare demonstration waivers, do not receive additional risk adjustments for dual eligibles living in the community.

Future Policy Directions

Given the limitations of the current PACE and Medicare managed care models for dual eligibles, federal policymakers could construct a managed care mechanism to integrate care for duals that combines the advantages available through the current Medicare and Medicaid program options. Policymakers should consider creating a new Medicare managed care mechanism that can be paired with Medicaid managed long-term care.

This program should offer higher payment rates that reflect the complex care needs of dual eligibles and specifically delineate the services plans must provide to duals. Policy makers could also consider allowing additional flexibility under Medicare+Choice for plans that wish to focus exclusively on dual eligibles.

If the federal government creates a significant, flexible, and financially viable Medicare managed care option, states still must assume primary responsibility for initiating, designing, and implementing these programs in concert with their Medicaid programs. The burden of responsibility is significant. In addition to improving Medicare, the federal government has a continuing responsibility to prod reluctant states toward delivery system improvements for dual eligibles and to assist motivated states in reaching their goals.

Introduction

Approximately six million individuals in the United States are eligible for both Medicare and some form of Medicaid coverage.¹ In 1999, these “dual eligibles” were estimated to be about 15 percent of both 39.6 million total Medicare beneficiaries and 40.4 million total Medicaid beneficiaries.² Persons who are eligible for Medicare and Medicaid use a wide array of health care services, depending on their age, health status, and whether they have chronic health care needs. The dually eligible tend to have more serious and complex medical, social, and long-term care needs than other Medicare and Medicaid beneficiaries. As a result, they generate higher health care costs and must often navigate within a complicated set of multiple payers and providers.³ For these reasons, persons who are dually eligible have long been the primary focus of policies and projects designed to merge, through managed care, the delivery of their primary, acute, and long-term care services and the sources of financing for this care.

The complexity of care delivery for persons who are dually eligible – poor people often with complex medical conditions and social needs – has prompted many state and federal analysts as well as policy makers to search for ways to better coordinate their care. The goal of these efforts is to integrate the point of delivery for acute and long-term care and also to coordinate a variety of services that are provided by different delivery systems. The primary avenue for fulfilling this goal has been to use managed care as the integrated delivery system for Medicare and Medicaid financing streams. The concept – at its simplest – is that a managed care organization receiving a capitated payment for both Medicare and Medicaid services will lead to the alignment of care delivery and financial incentives.

¹ *Key Facts: Medicaid's Role for Low-Income Medicare Beneficiaries*, The Kaiser Commission on Medicaid and the Uninsured, January 2002.

² *Feder. Medicare/Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations*, The Kaiser Commission on the Future of Medicaid, May 1997.

³ O'Brien and Rowland. *Medicare and Medicaid for the Elderly and Disabled Poor*, The Kaiser Commission on Medicaid and the Uninsured, May 1999.

There are many theoretical benefits for using managed care as a mechanism to integrate financing streams. First, by putting the managed care plan at risk for both Medicare and Medicaid services, integrated capitation gives the plan a greater incentive to reduce unnecessary or redundant care, thereby improving the cost-effectiveness and efficiency of care delivery. Integrated financing also curtails cost shifting between the two programs and allows savings accrued from acute care management to help finance long-term care or other care needs.⁴ Second, managed care can be used to develop a strong relationship between an enrollee and a care coordinator, who is responsible for both monitoring the enrollee's health status and referring them to other appropriate providers when necessary. Care coordinators also facilitate medical and non-medical support services that dually eligible persons often require and ease transitions between such services when needed.⁵

Despite the benefits of integrating acute and long-term care through managed care, a relatively small number of programs have successfully integrated acute and long-term care through managed care. The majority of these programs operate under the national Program for All-Inclusive Care for the Elderly (PACE). In addition to PACE, two states recently have designed and implemented integrated care demonstration programs which are operating under a combination of Medicare demonstration waivers and Medicaid managed care. Most recently, at least one plan and state have attempted to integrate funding using the Medicare+Choice program and Medicaid managed care. Unfortunately, these few programs do not serve the majority of dual eligibles nationally. As a result, most dual eligibles continue to receive their care from a confusing array of providers and delivery systems.

The purpose of this paper is to present the problems states and health plans face when attempting to create a Medicare managed care program that can be integrated with Medicaid managed long-term care. It describes the issues that prevent the PACE program option, the Medicare demonstration waiver authority, and Medicare+Choice from achieving widespread use as integrating mechanisms for integrated care programs. The paper concludes with recommendations for future efforts to integrate care.

Methodology

This paper relies primarily on interviews with three plans and their corresponding state officials:

1. Evercare of Texas, LLC, a Medicare+Choice provider and Medicaid managed care plan participating in Texas STAR+PLUS on behalf of Blue Cross/Blue Shield of Texas.
2. Maricopa Integrated Health System (MIHS), a Medicare+Choice provider and Medicaid managed care plan providing acute and long-term care services in Arizona.

⁴ Ibid.

⁵ Ibid.

3. UCare, a managed care plan providing services under the Medicare demonstration programs: Minnesota Senior Health Options (MSHO) and Minnesota Disabled Health Options (MnDHO).

The Medicare+Choice plans were selected for in-depth interviews because they are the only managed plans in the country that provide both Medicare+Choice and Medicaid managed acute and long-term care services to dual eligibles. We believed these plans and their corresponding states would have a unique perspective on the advantages and disadvantages of using Medicare+Choice to serve dual eligibles. UCare was selected because it chose to provide integrated services to dual eligibles under a Medicare demonstration waiver after recognizing the limitations of Medicare+Choice. This paper relies secondarily on an interview with Kaiser Permanente in Denver, Colorado. Kaiser was selected because it has contemplated a variety of integrated care options and is currently working to become a subcontractor to a local PACE provider.

The interviews focused on the advantages and disadvantages of the different Medicare managed care options. We specifically asked MIHS and Evercare of Texas to identify the major operational obstacles they encountered while using Medicare+Choice, and how they may have overcome them. We also asked these plans and the corresponding state officials to explain why they did not attempt to develop integrated care programs using the PACE or demonstration waiver approaches. More plan and program details are available in Appendices One and Two.

Background

Persons who are eligible for both Medicare and Medicaid fall into two categories:

1. Medicare beneficiaries eligible only for Medicaid coverage of their Medicare cost-sharing (Medicare Part B premiums and co-payments).
2. Medicare beneficiaries eligible for full Medicaid coverage.⁶

The first group – Medicare beneficiaries receiving only Medicaid coverage for Medicare cost sharing – are a small subset of all persons who are dually eligible.⁷ Their incomes are too high to qualify them for full Medicaid coverage in their state. However, federal law requires states to cover Medicare Part B premiums for Medicare beneficiaries below 120 percent of the poverty level and premiums, co-payments, and deductibles for Medicare beneficiaries below 100 percent of poverty.⁸

⁶ In some cases, a state may choose to offer Medicaid coverage to people with incomes above the levels at which the state is mandated to provide Medicare cost-sharing and premium coverage to Medicare beneficiaries (120 percent of poverty). States can offer optional Medicare cost-sharing coverage to people above this income level and often choose to do so.

⁷ O'Brien and Rowland, *op. cit.*

⁸ *State Coverage of Medicare Cost-Sharing For Additional Low-Income Medicare Beneficiaries*, 42 U.S.C. 1396u-3, § 1933 (1999).

This paper addresses care coordination and financing issues related to coverage of the second group – Medicare beneficiaries who qualify for the full Medicaid benefit package. For these people, Medicare pays for most acute care services and Medicaid functions like a Medigap insurer. Medicaid pays for Medicare cost-sharing, prescription drugs, and other services traditionally not covered by Medicare (i.e., transportation, vision and dental screenings, etc.).⁹ Many dual eligible enrollees receive Medicaid coverage for long-term care services as well, including an array of community-based long-term care services such as enrollment into a home- and community-based waiver, delivery of personal care services, home health, or some combination of all three.¹⁰

Medicaid also pays for “wrap-around” acute and post-acute care when a person who is dually eligible exhausts Medicare benefits or the benefits provided do not conform to Medicare coverage rules (i.e., a skilled nursing facility stay without prior hospitalization). In instances where Medicare and Medicaid both cover a service (i.e., physician care, hospitalization, etc.), Medicaid is the “payer of last resort” requiring providers to seek payment from Medicare first and then bill Medicaid for any remaining balance (see Figure 1).¹¹

Figure 1

| Medicare | Medicaid— Acute Care Services | Medicaid— Long-Term Care | Medicaid— Wrap-Around Services |
|---|--|--|---|
| <ul style="list-style-type: none"> • Inpatient hospital • Skilled nursing facility care • Home health • Hospice care • Physician services | <ul style="list-style-type: none"> • Inpatient hospital • Prescription drugs • Transportation • Dental care • Medicare cost-sharing | <ul style="list-style-type: none"> • Personal care services • Home and community-based services • Nursing facility care | <ul style="list-style-type: none"> • Physician services* • Inpatient hospital* • Skilled nursing facility care** • Home health*** |
| <p>* Medicaid covers physician and inpatient hospital services once Medicare benefits are exhausted.</p> <p>** Medicare fully covers 20 days of skilled nursing facility care and partially covers 80 additional days. Medicaid wrap-around for these 80 days and Medicaid pays any days over 100.</p> <p>*** Medicare covers 100 days of home health post-institutional care under Part A and additional visits under Part B. Medicaid pays the remaining non-Medicare covered visits.</p> | | | |

Therefore, a person who is dually eligible could be someone participating in a Medicaid home- and community-based waiver program and also receiving physician and hospital coverage from Medicare, drug coverage from Medicaid, and for whom Medicaid is paying Medicare Part B premiums and Medicare copayments. While the dual eligible may be receiving these services through Medicare fee-for-service and Medicaid fee-for-service,

⁹ Anthony, Shroer, Caroll, and Meyer. “Appendix F,” *Medicaid Managed Care for Dual Eligibles: State Profiles*, The Kaiser Commission on Medicaid and the Uninsured, October 2000.

¹⁰ Ibid. And Wiener et al., “State Variation in the Growth of Medicaid Home and Community-Based Services in Seven States,” *Health Care Financing Review*, Spring 2002, p. 90.

¹¹ Feder, op. cit.

alternatively he or she could be enrolled in one of the following delivery system combinations:

- Medicare managed care and Medicaid fee-for-service.
- Medicare fee-for-service, Medicaid managed care.
- Separate Medicare managed care and Medicaid managed care organizations.

If a person who is dually eligible is enrolled in Medicaid managed care and needs long-term care services as well, most likely these long-term care services are “carved out” of Medicaid managed care and are provided on a fee-for-service basis. In this instance, a dually eligible enrollee would be receiving Medicare services on a fee-for-service basis, some Medicaid services such as prescription drugs, cost-sharing, and other wrap-around services from Medicaid managed care, but all long-term care services such as any community-based services or nursing home care from Medicaid fee-for-service. Not surprisingly, these conflicting delivery systems and multiple payers lead to fragmented services, uncoordinated care, and duplication of coverage, not to mention confusion and frustration for dual eligible persons and their families.¹²

Some of this confusion is caused by conflicting financial incentives across the payers and delivery systems. With the primary responsibility for financing dual eligible care falling on two different payers (Medicare and Medicaid), there is an incentive for applying payment policies that shift as much of the financial burden on the other program as possible (referred to as “cost-shifting”). When a dually eligible individual is enrolled in managed care for one program and fee-for-service for another, the incentives for cost-shifting can be even more intense. In such an environment, providers with the ability to direct care may not emphasize the most appropriate service and care setting for the beneficiary but rather may select services for dual eligibles based on which program will pay.¹³

The following presents the views of states and plans on the advantages and disadvantages of the three main options for combining Medicaid and Medicare benefits (PACE, Medicare demonstration waivers, and Medicare+Choice) through managed care.

Program for All-Inclusive Care for the Elderly

PACE is an integrated managed care program for the frail elderly. Although PACE started as a demonstration program in 1990, the Balanced Budget Act (BBA) of 1997 allows states to offer PACE programs without applying for a special demonstration waiver. It uses an interdisciplinary team approach to provide care in an adult day health

¹² O’Brien and Rowland, op.cit.

¹³ Anthony, et al., op.cit.

center. Care provided within the center is supplemented by in-home and referral service in accordance with participants' needs.¹⁴

The PACE program offers many advantages to states interested in finding a mechanism for integrating Medicare and Medicaid financing streams through managed care. Some of the key advantages include:

- **Medicare Payment.** A risk-adjusted capitation rate results in payments to PACE providers that are higher than payments would be under Medicare+Choice for frail elderly living in the community (enrollees who qualify for a nursing home level of care but do not live in a nursing home). Where Medicare+Choice rates are not adjusted for the higher costs associated with community-dwelling frail elderly, the current PACE rate methodology does. The PACE rate adjustor for this group is 2.39 times higher than the base Medicare+Choice rate.
- **Regulatory Requirements and Administration.** The PACE authority overrides many Medicare and Medicaid regulatory requirements so that operational aspects of the programs such as marketing and program oversight are integrated and unified. Benefits offered under the PACE program can be described to prospective enrollees as PACE benefits – not as separate Medicare or Medicaid benefits. The Center for Medicare and Medicaid Services administers the Medicare portion of the PACE program separately from Medicare+Choice so that issues such as effective enrollment dates and payments can be aligned with the individual state's Medicaid program.¹⁵
- **Care Coordination and Integration of Services.** PACE programs provide coordination through a unique interdisciplinary medical and social services team. Participants in PACE benefit from access to the entire range of care and services including all needed preventive, primary, acute, and long-term care services.¹⁶
- **Federal Demonstration Waiver Approval is Unnecessary.** States interested in developing dual eligible programs do not need a federal demonstration waiver to implement PACE programs. The BBA provided the statutory authority necessary to implement a PACE program without a federal Medicare or Medicaid waiver review process.

The flexibility allowed in PACE programs has led to long-lasting and strong programs in many areas. For example, in Denver, the Total Long Term Care PACE site offers a long-running, successful program. The strength of its program led another area plan, Kaiser

¹⁴ National PACE Association. *What is PACE?* Available at: http://www.natlpacessn.org/content/what_pace/#services.

¹⁵ Program of All-Inclusive Care for the Elderly (PACE), 42 U.S.C. 1396u-4, § 1934 (1999).

¹⁶ *Ibid.*

Permanente, to attempt to establish itself as a subcontractor to Total Long Term Care for specialty acute care services and prescription drugs. These two providers are now working together to create such an arrangement.

However, the permanent program status granted by the BBA has not resulted in a large PACE program expansion beyond the original demonstration program.¹⁷ Plans and states we interviewed identified several reasons for their lack of interest in the PACE model as an integrating mechanism for Medicare and Medicaid. These include:

- **Limited Eligibility.** PACE enrollment is restricted to the elderly who need a nursing home level of care (as determined by the state according to its Medicaid nursing home eligibility criteria). Therefore states cannot use the PACE program if they want to enroll persons who are dually eligible with lesser levels of need. In addition, states cannot use the PACE program to serve people under age 55 with disabilities.
- **Non-Profit Providers.** PACE providers under the permanent PACE program were authorized as not-for-profit under the BBA.¹⁸ PACE is a full-risk model that requires relatively high overhead to operate. Many community-based not-for-profit organizations may not be able to accept this risk. However, for-profit PACE sites can operate only as demonstration sites. States that want to create a PACE program under contract with a for-profit entity must seek federal approval as a demonstration site.
- **Delivery System.** The strength of the PACE model – an interdisciplinary team approach to care – requires enrollees to get all of their primary care and much of their other care through frequent visits to adult day care centers.¹⁹ Enrollees must elect to change all their providers, including their primary care physician, to PACE providers. Some states believe this delivery system model would be perceived as too restrictive by beneficiaries and would prevent a PACE site in their state from attracting as much enrollment as they would like.
- **Voluntary Enrollment.** Enrollment into a PACE program is entirely voluntary for both Medicaid and Medicare benefits. PACE, like Medicare+Choice or Medicare demonstration projects, does not permit individuals who are dually eligible to be mandatorily enrolled in managed care for their Medicare benefits. In addition, a state may not mandatorily enroll someone into the PACE program for his or her Medicaid benefits. The PACE enrollees must choose to enroll in PACE for both Medicare and Medicaid benefit packages. Some states may view this aspect of the program

¹⁷ As of August 2002, there are 21 operational PACE or pre-PACE sites nationwide. The BBA allows for more than 80 sites nationwide. 42 CFR Part 460.24 and <http://www.cms.gov/pace/>.

¹⁸ Program of All-Inclusive Care for the Elderly (PACE), 42 U.S.C. 1395eee, § 1894 (1999).

¹⁹ National PACE Association, op.cit.

as a disadvantage if they are interested in requiring that long-term care and other Medicaid services be delivered through a managed care delivery system.

As a result of these concerns, PACE sites are operating in only 18 states and PACE enrollees account for a small part of the dually eligible population.²⁰ Arizona, for example, examined PACE to potentially integrate care for persons who are eligible for Medicare and Medicaid, but believes the program would not allow for the wide participation necessary.

Medicare Demonstration Waiver Authority

As an alternative to PACE, some states have requested Medicare demonstration waivers in order to merge Medicare and Medicaid funds and services through managed care. These states have been interested in borrowing certain features from the PACE model but prefer to diverge from some aspects of PACE to suit local needs and interests.

The Medicare demonstration waiver authority allows the DHHS and CMS to conduct demonstrations that test new payment methodologies. These waivers can be used to pay entities not otherwise contracting with Medicare, or to change the payment methodology for entities, such as Medicare HMOs, that already receive Medicare payments.²¹ Medicare demonstration waivers may be used in combination with Medicaid waivers to capitate financing from both programs to a single managed care organization. The combined capitated payments create the financial flexibility and incentives necessary for integrated delivery of the most appropriate and cost effective mix of services. In addition to changes in payment methodology, CMS also often allows exemptions from certain Medicare regulatory requirements, such as rules related to integration of Medicaid and Medicare marketing materials.

Medicare demonstration waivers offer many advantages to states interested in finding a mechanism for integrating Medicare and Medicaid financing streams through managed care. Some of the key advantages include:

- **Medicare Payment.** The major advantage of a waiver is that it enables plans to receive a risk adjusted payment similar to the one provided through the PACE model. Like the PACE model, dual eligible demonstration waivers tend to provide an increase in capitated payments for enrollees who are nursing home certifiable but living in the community.²² For example, the Medicare risk adjustor approved for Minnesota Senior Health Options is 2.39 times the base rate – as it is in the PACE program. UCare of Minnesota, a plan participating in the MSHO demonstration believes that, without such an enhancement, its participation would be financially infeasible.

²⁰ PACE Homepage www.cms.gov/pace/

²¹ This Medicare demonstration authority is available under Section 222 of Public Law 92-603.

²² Testimony before the Special Committee on Aging, U.S. Senate: *Medicare and Medicaid: Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues* (GAO/T-HEHS-97-119, April 29, 1997).

- **Regulatory Requirements and Administration.** Similar to PACE, Medicare demonstration waivers give states and plans more flexibility to operate than if they were Medicare+Choice providers. They allow integration and unification of important operational aspects of the Medicare and Medicaid programs. In the context of a payment waiver, CMS will allow the demonstration program to combine marketing materials, and better coordinate administrative requirements for both Medicaid and Medicare.

Pam Parker, the chief architect of the MSHO demonstration, has said that the ability to merge Medicare and Medicaid regulatory requirements is almost as important to the operation of MSHO as the Medicare payment changes.

- **Delivery System Design and Eligibility Flexibility.** Under Medicare demonstration waivers, states have more design flexibility than PACE. First, unlike the PACE program, waiver programs may enroll all persons who are dually eligible, not just those who require a nursing home level of care or those who are elderly. Second, the programs may provide services in enrollees' homes, adult day care centers, assisted living, or other care settings. Third, a state could design a demonstration where the dually eligible enrollees are required to receive their Medicaid benefits through a managed care organization rather than fee-for-service. Finally, a state could contract with a for-profit managed care organization whereas the permanent PACE program requires that PACE providers be not-for-profit.²³

The advantages of the Medicare waiver option led to a great deal of interest among states in the mid-to-late 1990s, but the difficulties of designing a demonstration from scratch and the extensive review process has prevented waivers from proliferating.²⁴ Currently, there are only four approved dual eligible demonstration waivers: in Minnesota, Wisconsin, New York (recently rescinded), and Massachusetts. Of these, only waivers in Minnesota and Wisconsin are implemented and operating.²⁵ The following describes problems with Medicare demonstration waivers in more detail:

- **Federal Demonstration Waiver Approval is Required.** The most significant barrier to pursuing a demonstration waiver is the federal approval process. The Executive Branch (the Department of Health and Human Services, Centers for Medicare and Medicaid Services, and the Office of Management and Budget) is responsible for approving Medicare demonstration waiver requests. Congress provided the waiver authority to these agencies so they would have flexibility to test new payment approaches. The agencies must

²³ Program of All-Inclusive Care for the Elderly (PACE), 42 U.S.C. 1395eee, § 1894 (1999).

²⁴ Ibid.

²⁵ GAO Report, *Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*, Report to the Special Committee on Aging, U.S. Senate, August 2000, GAO/HEHS-00-94.

ensure that the waivers they approve do not exceed this authority. The agency spends a great deal of time reviewing waiver applications and negotiating terms of waivers with the applicants.

One important aspect of this review is ensuring that the waivers do not increase costs to the federal government, that they are budget neutral. Prior to the enactment of the Balanced Budget Act of 1997, integrated programs required Medicaid 1115 waivers and Medicare waivers. Budget neutrality was required for both the Medicaid 1115 waivers and the Medicare waivers. The BBA loosened Medicaid managed care and permitted states to create integrated programs without Medicaid waivers or by using Medicaid waiver authorities with less stringent budget neutrality requirements (i.e., 1915 (b)). While the Medicaid budget neutrality requirements are no longer a barrier to most integrated programs, concerns about Medicare costs remain a large issue in reviewing waivers. CMS and the Office of Management and Budget (OMB) must be certain that any increase in payment to managed care plans under the waiver (i.e., the PACE risk adjuster) is offset by savings in Medicare fee-for-service. Such certainty is difficult given that the PACE risk adjuster theoretically represents the average cost of frail duals in fee-for-service. Unfortunately, no one can know, in advance, whether there will be systematic selection of less costly frail duals into the integrated programs. These considerations are an important part of the waiver review process and can contribute to a lengthy negotiation between states and the federal government.

- **No Waiver for Regulatory Changes without Payment Changes.** CMS has not determined whether its demonstration waiver authority should be interpreted narrowly to mean that a state or plan may not receive regulatory flexibility without also receiving a waiver to alter Medicare's payment methodology or whether it should be interpreted more broadly to allow for regulatory flexibility without alterations to Medicare payments. To date, the agency's interpretation has been very narrow and requires payment waivers. For example, MSHO could not merge marketing, enrollment, and administrative functions of Medicare and Medicaid without also operating under a change in Medicare payment methodology. Until CMS broadens its interpretation, states do not have the option of creating a seamless administrative program without also undertaking the time-consuming process associated with a payment change.

As a result of these problems, persons eligible for Medicare and Medicaid who are enrolled in demonstration waiver programs account for a small portion of the total dual eligible population. The number of demonstration waivers are unlikely to increase substantially enough to make integrated Medicare managed care programs available to a large portion of the dual eligible population.

Medicare+Choice

The Balanced Budget Act of 1997 created the Medicare+Choice program. The program was created to increase beneficiary participation in managed care and contain Medicare costs.²⁶ In some markets, Medicare+Choice enrollees receive traditional Medicare benefits and some value-added benefits, such as prescription drug coverage, when they pay a monthly premium. Despite recent withdrawals from the Medicare+Choice market by health plans, an estimated 5.6 million beneficiaries will have received care through managed care in 2001, a significant portion of these beneficiaries were dually eligible for Medicare and Medicaid.²⁷

In light of the limitations that have arisen under PACE and Medicare waivers, some plans and states recently have considered using the Medicare+Choice program as another approach to integrating care for dual eligibles. Some plans and states believe Medicare+Choice may be the most feasible option available at this time and in the near future to integrate care for this population. The advantage of Medicare+Choice is that it avoids limitations that arise under PACE or Medicare waivers.

- **A Federal Demonstration Waiver is Unnecessary.** Like PACE, a state may design a dual eligible program using Medicare+Choice without seeking a federal demonstration waiver. The lengthy approval process associated with a demonstration waiver is probably the most important reason a state or plan would choose Medicare+Choice over a demonstration waiver.
- **Medicare+Choice Offers More Flexibility than PACE.** While Medicare+Choice imposes strict regulatory requirements (discussed below), it does not require that a plan restrict eligibility to duals who are of a nursing home level of care or elderly dual eligibles. It also does not limit care delivery or physician networks to certain settings like PACE. Medicare+Choice plans have the ability to develop large physician networks and beneficiaries have a greater choice of providers than under PACE.

While many states and plans have been interested in using Medicare+Choice as the integrating mechanism for their dual eligible programs, we found only two Medicaid plans that actually offer Medicare+Choice products as well as Medicaid managed acute and long-term care. These plans are Maricopa Integrated Health System in Arizona and Evercare of Texas. While MIHS serves many dual eligibles within its total enrollment, it is neither trying to target dual eligibles exclusively nor specifically integrate its Medicare+Choice product with its Medicaid long-term care product. Only Evercare is attempting to create an integrated care program focused exclusively on its dual eligible population. For this reason, we relied heavily (although not exclusively) on our interview with Evercare of Texas to learn about the limitations of using

²⁶ *The Medicare Program: Medicare+Choice*, The Kaiser Family Foundation, June 2002.

²⁷ *Ibid.*

Medicare+Choice to integrate care. In particular, we focused on the nonfinancial limitations that affect a plan's ability to operate an integrated dual eligible program. (See Text Box A for brief descriptions of these plan's and the state programs under which they operate.)

Text Box A

Maricopa Integrated Health System (MIHS)

Maricopa Long Term Care Plan (LTC)

MIHS offers Medicaid long-term care benefits through Maricopa LTC.

LTC takes financial risk for full range of Medicaid long-term services, including all nursing home care and home and community-based services.

Care coordination (state mandated) provided by LTC and links duals with Maricopa Senior Select, or other Medicare+Choice products or Medicare fee-for-service.

Maricopa Senior Select Plan

MIHS offers Medicare+Choice through Maricopa Senior Select Plan.

Maricopa Senior Select Plan serves duals eligibles and non-dual eligibles.

Current Medicare+Choice benefits include up to \$200 on brand name drugs and unlimited generics.

This drug benefit and zero premium attract Medicare beneficiaries to its plan.

Evercare

Star+Plus

Evercare offers Medicaid long-term care benefits through Star+Plus, which is operating under a Medicaid 1915 (b) (c) combination waiver.

Texas mandates Medicaid managed care enrollment into Star+Plus for most elderly and disabled people living in Harris County.

Services include home and community-based services through a managed care network, short-term nursing facility care (up to 120 days), and personal attendant services.

Care coordination based on Evercare's long-term clinical delivery model. Primary Care Team (nurse practitioner, in house community RN, and family physician) create a coordinated care plan for frailest members.

Medicare+Choice

Recently certified as Medicare+Choice provider.

Evercare will be coordinating Medicare acute care benefits with Medicaid long-term care benefits offered through Texas Star+Plus.

Planning on fully integrating these services for dual eligibles through a team of clinicians, lead by a nurse practitioner.

Frailest members will receive in-home assessments and a personalized care plan, which will include Medicaid long-term care services, Medicare acute needs, and other services, but prescription drugs are not included.

The following are the key limitations Evercare, MIHS, and other stakeholders identified:

- **Inadequate Payment for a High Cost Population.** Several Medicaid plans we interviewed that were interested in better serving their dual eligible populations chose not to become Medicare+Choice providers because the program's payment rates were inadequate for this high-risk population. These plans point out that, unlike the PACE and waiver programs, Medicare+Choice does not pay the 2.39 risk adjustment factor for community-dwelling duals that need nursing home level of care. This limits the number of health plans willing to focus on dual eligibles and their unique health care needs. In addition, unlike PACE and Medicare demonstration waivers, Medicare and Medicaid capitation payments are still made separately to plans such as Evercare and MIHS. Separate payments discourage integration of services and administrative functions.
- **Inability to Enroll Dual Eligibles Exclusively.** Unlike the PACE authority and the Medicare demonstration waivers, Medicare+Choice plans cannot enroll dual eligibles exclusively. In order to protect Medicare beneficiaries, anti-discrimination clauses in the Medicare+Choice regulation require plans to accept all Medicare beneficiaries who elect to enroll in their health plan. Allowing plans to enroll dual eligibles exclusively may benefit this population. Research shows that in programs (PACE and MSHO) where dual eligibles are enrolled exclusively, consumer satisfaction and outcomes are better.²⁸ Plans, like Evercare of Texas, may perform better if they provide Medicare acute care benefits exclusively to the population with which they already have significant experience (i.e., Medicaid beneficiaries) rather than expanding their mission to serve relatively healthy people eligible for Medicare only.

Without the ability to waive the Medicare+Choice regulation enrollment clauses, Evercare of Texas is attempting to limit the number of non-duals that enroll through several mechanisms. They are offering no traditional value-added Medicare benefits (such as prescription drugs) and are charging an \$80 monthly premium to non-dual enrollees. Dual eligibles, enrolled in Evercare of Texas and STAR+PLUS are provided typical value-added benefits like prescription drugs through its Medicaid managed care program and STAR+PLUS pays the monthly premium (for an additional description of these strategies, see Text Box B).

²⁸ MSHO Waiver Renewal Application, April 2001 and the National PACE Association, www.npaonline.org/content/research.

Text Box B

Medicaid Payment of Medicare+Choice Premium

- ❑ While non-dual eligibles wanting to enroll in Evercare's Medicare+Choice must pay a premium (\$80 per month) in addition to their Medicare Part B premium, Medicaid will pay this amount for dual eligibles (allowable under 42 CFR 422.106 of Medicare+Choice regulations). This allows Evercare to offer a zero premium Medicare+Choice plan to duals without offering it to non-dual eligibles.

Value-Added Medicare Benefits

- ❑ Evercare is not offering prescription drug coverage or other value-added Medicare benefits in its Medicare+Choice plan. These benefits are not necessary for dual eligibles receiving drug coverage and other typical value-added Medicare+Choice benefits through Medicaid. By charging non-duals a premium and offering no value-added benefits, Evercare will discourage enrollment of those covered only by Medicare. Many competing Medicare+Choice plans offer zero premiums to non-dual Medicare enrollees and some prescription drug coverage.

Utilization of Advocacy Networks

- ❑ The health plan will limit distribution of its Medicare+Choice marketing materials to communities with a high number of potential duals. It will also work with advocacy and community organizations interacting with low-income Medicare beneficiaries to educate them about Evercare's services.

Enrollment Broker Script

- ❑ Evercare has provided the state's enrollment broker with scripted information about their program. Based on a caller's request, they will be directed to 1-800-MEDICARE or Evercare's sales department. The primary trigger will be a caller request for information about greater prescription drug coverage.

- **Inability to Merge Marketing Materials.** Unlike PACE and demonstration waivers, Medicare+Choice plans cannot create marketing materials that describe the full range of integrated Medicare and Medicaid benefits the plan offers dual eligibles. Medicare+Choice marketing guidelines in the Medicare+Choice regulations and the Medicare Managed Care Manual require plans to inform Medicare beneficiaries about traditional Medicare benefits and any value-added benefits the health plan offers (e.g., prescription drugs). The materials cannot explain the added benefits a dual eligible may receive as a participant in both Medicare and Medicaid. For example, marketing materials cannot describe to dual eligibles that they are eligible for more than 100 days of nursing facility coverage (once Medicare and Medicaid benefits are combined). Dual eligible readers may mistakenly believe they are only eligible for 100 days (the standard Medicare-only benefit).

42 CFR 422.80 and Chapter 3 of the Medicare Managed Care Manual also require that premium costs, provider networks, and sub-networks are characterized as they are available for all Medicare beneficiaries. Therefore, a health plan such as Evercare of Texas cannot create marketing materials that explain how Medicare+Choice premiums are lower for dual eligibles because the plan cannot describe any product features uniquely available to dual eligibles.

Evercare of Texas believes that it may never attract dual eligibles to its plan if it cannot describe the full benefit available under its integrated care program. They

are hoping to compensate for this limitation in several ways, including help from advocates in publicizing their program and through scripted information that may be provided to dual eligibles through the state's enrollment broker.

- **Program Oversight.** Medicare+Choice plans that wish to focus on dually eligible beneficiaries must operate within the existing structure of federal and state regulations. In contrast, state agencies provide day-to-day oversight and administration of PACE providers and Medicare demonstration waivers. For example, Minnesota, with CMS oversight, monitors its MSHO plans for compliance with both Medicare and Medicaid regulations. PACE providers are monitored through a joint effort of state officials and CMS regional office representatives. However, in both cases, the state has a considerably larger role than CMS in monitoring the facilities, personnel, and training. The lack of unified program oversight increases the administrative burden on plans and decreases the likelihood that they will use Medicare+Choice as an integrating mechanism.

Future Policy Directions

As discussed above, managed care has much to offer as an integrating mechanism for the financing and delivery of acute and long-term care services to dual eligibles. In particular, managed care organizations employ professional staff whose purpose is to minimize confusion for beneficiaries and coordinate services such as primary and specialty physician care.²⁹

Unfortunately, states and plans interested in integrating Medicare and Medicaid managed care for their dual eligibles face two significant challenges. First, state officials must dramatically alter the financing and delivery of Medicaid health and long-term care services for dual eligibles. Moving these services and populations from fee-for-service to managed care requires state officials to overcome major challenges within their political and health care delivery systems. The recent fiscal crisis in states has made this task even more difficult for state officials. Second, in order to integrate the managed Medicaid services with managed Medicare, states must find a Medicare managed care option that meets their policy goals and is financially viable for their participating plans. Although three Medicare managed care options exist – PACE, Medicare demonstration waivers, and the Medicare+Choice program – each has serious limitations.

The following is a summary of each option's advantages and limitations:

- **PACE.** PACE offers enhanced payment rates, streamlined regulatory requirements, and the ability to focus on serving a specific population. Because PACE is a permanent program, new PACE programs do not require a long federal review process. Despite these advantages, the program's use is limited to elderly

²⁹ O'Brien and Rowland, *op.cit.*

dual eligibles who qualify for a nursing home level of care and many states would prefer to design programs that serve all dual eligibles including those under age 55. The permanent PACE program also is limited to not-for-profit managed care organizations. States would prefer the flexibility to contract with for-profit managed care organizations, but these are available only through demonstration authority. Finally, PACE requires that enrollees receive primary care services from adult day care centers where they have frequent contact with a team of providers.³⁰ While this approach ensures maximum care coordination, states would prefer more flexibility to design alternative service delivery systems and to provide services through other settings.

- **Medicare Demonstration Waivers.** Medicare demonstration waivers allow states the advantages of the PACE program including an enhanced payment rate, streamlined regulatory requirements, and the ability to serve dual eligibles exclusively. Medicare demonstration waivers allow states and plans to design programs that have broader eligibility than PACE and more flexible service delivery. Unfortunately, demonstrations require lengthy federal review to work out policy issues and payment rates. Federal approval is not guaranteed, in part because Medicare waiver authority is difficult to interpret and employ. Therefore, CMS has not approved a large number of integrated programs for dual eligibles under this demonstration waiver authority.
- **Medicare+Choice.** The advantage of Medicare+Choice is that, like PACE, it is a permanent program and does not require a lengthy federal review process as does a Medicare demonstration waiver. However, unlike PACE and Medicare demonstration waivers, Medicare+Choice does not permit plans to specialize and serve dual eligibles exclusively. It does not permit merged marketing materials that explain the full range of benefits available to dual eligibles. And, unlike PACE and Medicare demonstration waivers, Medicare+Choice does not provide additional risk-adjustment for dual eligibles who need a nursing home level of care but live in the community.

Because of these limitations, the majority of states are, so far, unlikely to design and implement dual eligible programs that integrate acute and long-term care services using Medicare managed care options such as Medicare+Choice, PACE, or demonstration waivers. As a result, relatively few of this country's dual eligibles have the option of enrolling in fully integrated services programs and continue to struggle on their own with a confusing array of acute and long-term care providers and services.

Policy Change. In order for states and plans to offer more integrated programs to dual eligibles, federal policy-makers must make available for states a Medicare managed care mechanism that combines the main advantages available through each of the current

³⁰ Program of All-Inclusive Care for the Elderly (PACE), 42 U.S.C. 1395eee, § 1894 (1999).

options. Ideally, this new mechanism would incorporate the advantages of the PACE option, including:

1. Providing a special risk adjustment factor for the community-dwelling frail elderly population (those needing a nursing home level of care but living in the community).
2. Providing the flexibility to enroll dual eligibles exclusively, to market the program's integrated Medicare and Medicaid benefits, and to streamline other administrative functions.
3. Authorizing these changes through a permanent program that would require no protracted federal review process.

However, the new mechanism would combine these features with the specific advantages of the waiver program, which include:

1. Allowing states and plans to enroll all dual eligibles in integrated programs (including dual eligibles under age 55), not just those needing nursing home level of care (as in the PACE program).
2. Allowing flexibility for the location where primary care and community-based services are delivered and how they are coordinated.
3. Allowing states to contract with for-profit managed care plans, and to enroll dual eligibles in mandatory Medicaid managed care.

Therefore, a new mechanism that allows states to better integrate Medicare and Medicaid managed care would address both the financial and the nonfinancial limitations of the current options. However, as an alternative, policymakers could address only the nonfinancial limitations of the current options by providing more flexibility within the current Medicare+Choice program. This alternative would ensure a Medicare managed care mechanism that would include all of the advantages listed above except the special payment rate available under PACE and the waivers. The PACE adjuster of 2.39 has taken on new significance as CMS develops its new Medicare+Choice risk adjustment. Appearing in the Federal Register in March, this 61-disease group model also may contain a "frailty factor." However, it is unclear at this time whether CMS will use the PACE adjuster, some other factor, or none at all.

CMS lacks the authority to create the new program described above. Therefore, the policy changes described above would require Congressional action. The following describes these options in more detail and provides some considerations for each one:

A. Creating a New Medicare Managed Care Mechanism for Integrated Care Programs. This option would create a permanent program that combines the financing and regulatory benefits of PACE with the program design flexibility of demonstration waivers. To accomplish this goal, Congress could either create a new, permanent managed care program for all dual eligible Medicare beneficiaries similar to the PACE

program, or it could expand the current PACE criteria to include a broader set of beneficiaries and plans.

The new program would pay managed care plans a special rate for dual eligibles living in the community but needing a nursing home level of care. Like PACE, it would permit an integration of administrative functions such as marketing and would allow plans to specialize in serving dual eligibles by enrolling them exclusively. These plans, also like PACE, would be required to provide the full range of Medicare acute, and Medicaid wrap-around and long-term care services.

Expanding on PACE, all dual eligibles would qualify to enroll in the special plans, including those that do not require nursing facility level of care. The plans would have some flexibility to provide these services in a range of care settings and to use a variety of care coordination models. For-profit and not-for-profit plans that agree to provide the full range of services and to coordinate care would qualify.

Policy Considerations. The following are a few of the major policy considerations for this option:

- **Setting Medicare Payment Rates for High-Need Dual Eligibles Living in the Community.** The following are considerations for determining the appropriate risk adjustment amount for the new program. First, in setting the rate for this new program, Congress and/or CMS would have to decide whether to use the current PACE adjustment amount (2.39) for dual eligibles who need a nursing home level of care but live in the community. This factor has not been updated since the PACE demonstration began in 1990 and may not accurately reflect the current Medicare costs of this population. In conjunction with this decision and expansion of the program beyond small PACE sites, Congress and/or CMS would have to establish a common standard for determining nursing home level of care for dual eligibles. Finally, Congress and/or CMS would have to decide whether to pay Medicare+Choice rates for the rest of the dual eligibles who enroll in this program or to adjust these rates downward to account for the higher rate (2.39) paid for high need enrollees (this has been done in the demonstration waiver programs).
- **Certifying a Dual Eligible Plan for Participation in the New Program.** The following are considerations for defining which plans could participate in the new program. First, Congress would have to determine which services the plan would be required to provide. Second, Congress would have to decide whether to require that participating plans provide care coordination services and, if so, how extensive these services should be. Finally, Congress would have to determine how to draw from PACE and Medicare+Choice consumer protection requirements so that consumers are protected without compromising flexibility necessary to merge Medicare and Medicaid.

- **Financing Medicare Costs of a New Program.** Another consideration for Congress would be how to finance estimated new Medicare spending that results from a new program. Because the new program would pay PACE-type rates for high-need dual eligibles but would be more flexible, the Congressional Budget Office (CBO) may determine that the program will increase Medicare spending. If the CBO estimates an increase in Medicare costs from such a proposal, Congress would need to find savings to offset these costs.

B. Creating More Flexibility Under Medicare+Choice for Certain Plans. This option would maintain Medicare+Choice as an avenue for dual eligible integration programs. It would, however, correct Medicare+Choice's nonfinancial limitations by creating regulatory flexibility for certain plans. In order to accomplish this goal, Congress could give CMS explicit authority to waive certain Medicare+Choice requirements and allow plans to enroll dual eligibles exclusively. This option would correct the regulatory limitations of the current Medicare+Choice program, but would not correct the financial limitations. It would not provide special payment rates for high-need dual eligible enrollees, however it is possible the upcoming revised Medicare+Choice risk adjustment will.

This option would incorporate the following advantages of the demonstration waiver programs: 1) the ability to enroll all dual eligibles exclusively into integrated programs; 2) flexibility to market the program's integrated benefits and to streamline other administrative functions; and 3) flexibility to determine where community-based services are delivered and how they are coordinated. Unlike the demonstration waivers, CMS could approve special dual eligible plans under Medicare+Choice more quickly than it would if these plans also were seeking a special payment rate under the waiver authority. This option would allow plans willing to accept Medicare+Choice rates to specialize in serving dual eligibles and to integrate their Medicare services with Medicaid managed care.

Policy Considerations. The following are a few of the major policy considerations for this option:

- **Certifying a Plan to Receive Flexibility under Medicare+Choice.** The following are considerations for defining which plans would receive this regulatory flexibility. Like the first option, Congress would have to determine which services the plan would be required to provide in order to receive flexibility. Also like the first option, Congress would have to decide whether to require that participating plans provide care coordination services and, if so, how extensive these services should be.
- **Protecting Consumers.** A major consideration for Congress and CMS is how to protect consumers while waiving certain Medicare+Choice consumer protection requirements such as marketing and enrollment restrictions. Unlike payment demonstrations, which are monitored closely on an individual basis, Congress

would be authorizing CMS to use broad discretion and monitor less closely. In order to ensure adequate consumer protections for dual eligibles in integrated plans, Congress also should provide CMS with the authority to construct requirements that take into account the special circumstances of merging Medicaid and Medicare benefits under managed care. In summary, CMS will have the authority to waive Medicare+Choice requirements that do not lend themselves to merging the programs, but will be able to create new requirements that achieve the same consumer protection goals in the context of these special plans.

Current Legislative and Executive Branch Activity

The following are recent legislative and executive branch activities that attempt to address some of the issues raised in this paper:

Medicare+Choice Risk Adjustment. As discussed previously, a new Medicare+Choice risk adjustment approach will be implemented in 2004.³¹ This model will be based on 61 disease groups and may include a “frailty factor.” CMS will disclose the details of the risk adjustment in March 2003. If the new model contains a generous frailty factor, Medicare+Choice plans may be more interested in pursuing dual eligibles and offering them specialized products. If the new model contains a limited factor or none at all, financial concerns will continue to discourage Medicare+Choice plans tailored to dual eligibles, despite Congressional action to reduce regulatory barriers to serving duals.

Pending Legislation. U.S. Rep. Jim Ramstad (Minnesota) introduced legislation in the 107th Congress, H.R. 2709, that would create specialized Medicare+Choice plans for special needs populations. This legislation would allow plans to target and restrict enrollment to dual eligibles, people living in institutions, and any other population the Secretary of HHS determines would benefit from enrollment in a specialized Medicare+Choice plan. It would also authorize the Secretary to waive Medicare+Choice requirements “which the Secretary finds to be impediments to a Medicare+Choice plan’s ability to optimize the care being provided to individuals enrolled in a specialized Medicare+Choice plan.”

This legislative proposal is similar to the second policy option described above but broader. It would permit flexibility under Medicare+Choice for plans serving a special population, which includes, but is not limited to dual eligibles. While the legislation specifies that plans would have the flexibility to enroll dual eligibles (and other special populations) exclusively, it does not specify any of the other regulatory requirements the Secretary should address in defining a special needs plan and leaves the determination of these requirements entirely to the Secretary. Further, it does not specify that plans receiving flexibility under Medicare+Choice and serving dual eligibles exclusively must be providing Medicare acute and Medicaid long-term care to its enrollees. For example,

³¹ CMS: Center for Beneficiary Services Letter. March 29, 2002.

it would allow exclusive enrollment for plans providing only Medicare benefits to dual eligibles. While this legislation would likely foster more integrated care programs, it is not narrowly tailored to this sole purpose.

This legislation was referred to the House Energy and Commerce Committee, Subcommittee on Health, and was attached to the Senate Medicare provider give-back bill during the 107th Congress. No similar legislation has been introduced in the 108th Congress.

Medicare and Medicaid Technical Advisory Group (TAG). The TAG consists of nine state representatives and works with CMS and the American Public Human Services Association to develop recommendations for future federal policy. The group focuses on the interaction between Medicaid and Medicare and how to integrate data systems, develop coverage and reimbursement policies, managed care, and quality assurance activities for programs serving dual eligibles.³² The group has been meeting since the fall of 2001 and could be critical in developing federal policies that are operational at the state and plan levels.

Recent PACE Interim Final Rule. The Department of Health and Human Services released a new interim final rule for PACE on October 1, 2002. Among other changes to the original PACE rule, Section 460.10 establishes a process for PACE organizations to request waivers of regulatory requirements in order to enhance flexibility for these organizations. While the change gives PACE organizations and states an ability to overcome some of the program's regulatory burdens, the new flexibility is limited to certain aspects of service delivery. PACE organizations cannot waive the focus on the frail elderly requiring nursing facility level of care, they must continue to provide comprehensive, integrated acute and long-term care services, use an interdisciplinary team approach, use capitated, integrated financing, and assume full financial risk.³³

These program revisions are a first step at loosening some of the restrictions that have limited the growth of PACE sites. They allow organizations to experiment with service delivery and staffing in an effort to improve the reach of PACE organizations in their respective communities. However, the new revisions do not go far enough in improving PACE organization's reach by allowing them to serve duals that do not meet nursing facility level of care. In addition, the flexibility under this rule is achieved through waivers, for which federal review can be a time-consuming and rigorous process.

³² National Association of State Medicaid Directors Medicare and Medicaid Technical Advisory Group, <http://medicaid.aphsa.org/tags/mmtag.htm>

³³ Program for All-Inclusive Care for the Elderly (PACE); Program Revisions. Federal Register Vol.67, No 190, 1 October 2002.

Summary

The goal of these policy options is to increase the availability of integrated programs so that more dual eligibles have options beyond traditional fee-for-service Medicare and Medicaid. These integrated programs offer the possibility of improved care coordination and more efficient service delivery but must be well designed and well monitored to ensure high quality care for the vulnerable population they serve. These options should be designed with significant flexibility and strong consumer protections.

A variety of factors have contributed to the lack of policy evolution in the area of integrated programs. The most significant factor is the conflict that has arisen between states, which need the ability to alter Medicare in order to design locally appropriate programs, and the federal government, which needs to preserve national uniformity in the federally run Medicare program. The tug-of-war between states and the federal government has hit its most intractable stalemate over the issue of Medicare managed care payment rates, with states lobbying for higher Medicare rates in order to attract an adequate supply of managed care providers and the federal government interested in guaranteeing no increase in spending within the Medicare program. This conflict has prevented the development of policy solutions that work well for the administrators of both Medicaid and Medicare. If the new Medicare+Choice risk adjustment model contains a generous frailty factor, the debate may be pushed forward and discussion of the regulatory barriers identified in this paper can begin.

While progress has been slow in creating full-fledged integrated care programs for dual eligibles, partially integrated approaches have evolved in the meantime. For example, in Arizona, any plan providing Medicaid long-term care must provide care coordination for its enrollees, even if their Medicare is delivered fee-for-service or through a different Medicare+Choice plan. Partial care coordination approaches like this one may ease some confusion and improve care for their dual eligible enrollees. Unfortunately, they are just beginning to evolve, are as few in number as fully integrated programs for the dually eligible, and the success of these programs remains untested.

The urgency of this issue grows as Congress considers a Medicare prescription drug benefit. The task dual eligibles currently face negotiating two sets of benefits and two systems will be even more daunting as their drug coverage – currently available through Medicaid only – gets divided between Medicare and Medicaid. Without thoughtful approaches to coordinating new coverage with the old, a Medicare drug benefit could impose an additional care coordination burden on this particularly vulnerable population.

This paper focuses on how the Medicare program has not provided a viable avenue through which states can merge Medicaid managed care with Medicare. It points out the need for Congress and CMS to develop policy solutions and enact changes that go beyond minor actions such as conducting workgroups and approving a few Medicare payment demonstrations. However, even if the federal government creates a significant,

flexible and financially viable Medicare managed care option, states must assume primary responsibility for initiating, designing, and implementing these programs. The burden of this responsibility is significant. In addition to improving Medicare, the federal government also has a continuing responsibility to prod reluctant states toward delivery system improvements for dual eligibles and to assist motivated states in reaching their goals.