Managed Care for Dually Eligible Beneficiaries: Key Program Design Choices for States

Prepared by
Paul Saucier

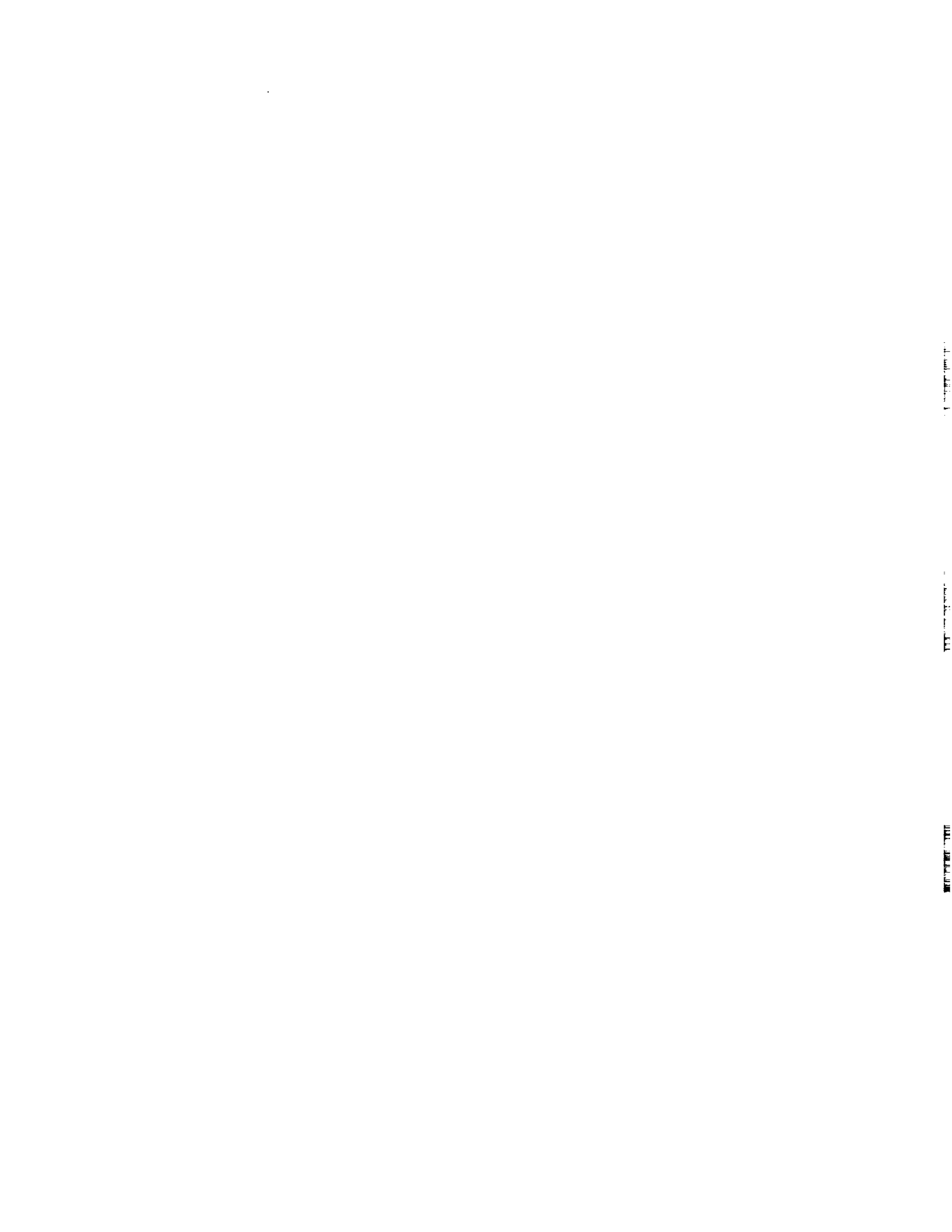
September

1996

NATIONAL ACADEMY *for* STATE HEALTH POLICY

The Third in a Series of Papers on Dual Eligibility

This project was made possible through a grant from The Pew Charitable Trusts with additional support from The Henry J. Kaiser Family Foundation, Center for Vulnerable Populations



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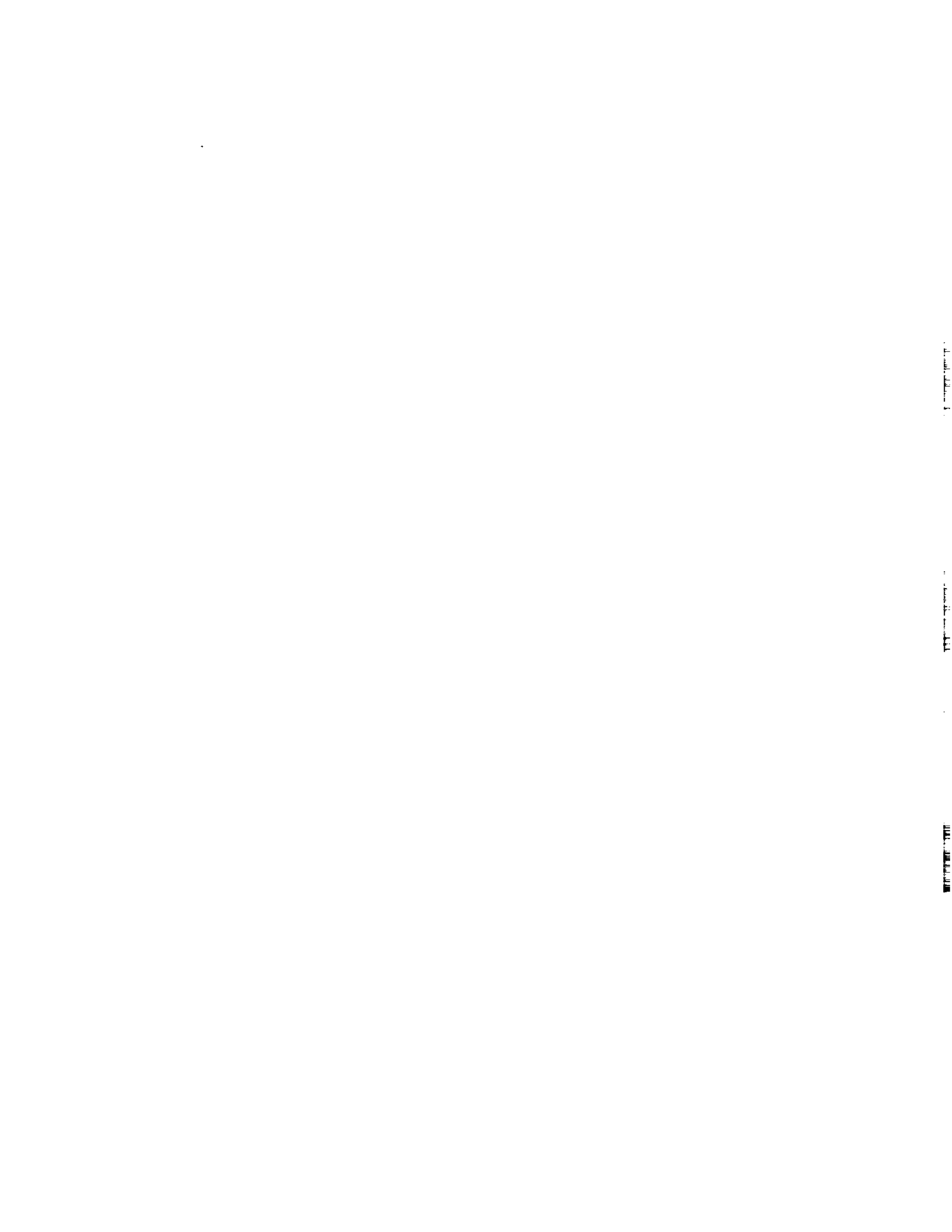

The Dual Eligibility Series

This is the third and final in a series of papers on dual eligibility supported by The Pew Charitable Trusts, with additional support from The Henry J. Kaiser Family Foundation, Center for Vulnerable Populations.

The first paper, *Managing Care for Older Beneficiaries of Medicaid and Medicare: Prospects and Pitfalls* (September, 1994), describes the fragmentation of care experienced by dually eligible elderly persons, and explores the potential benefits and disadvantages of integrating the two funding streams for dually eligible persons.

The second paper, *Federal Barriers to Managed Care for Dually Eligible Persons* (August, 1995), describes federal policy barriers that make the integration of Medicaid and Medicare difficult.

This paper outlines a series of design choices facing states as they fashion managed care programs for dually eligible beneficiaries.

With support from The Commonwealth Fund, The National Academy for State Health Policy will produce a new series on dual eligibility over the next several months.

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Acknowledgements

This paper grew out of a technical assistance meeting held in Austin, Texas by The National Academy for State Health Policy to provide expert advise to its dual eligibility planning grantees in Texas and Maryland. Participants at the meeting were Maureen Booth, National Academy for State Health Policy; Mabel Chen, Arizona Health Care Cost Containment System; Lou Glasse, Older Women's League; Charles Hawley, Sisters of Providence Health System; Charles Liem, Florida Department of Elder Affairs; Dann Milne, Colorado Department of Health Care Policy and Financing; Robert Mollica, National Academy for State Health Policy; Trish Riley, National Academy for State Health Policy; Kathleen Schuler, Minnesota Department of Human Services; and several project personnel from Maryland and Texas. Key project leaders from Texas were Cathy Rossberg and Amy Orum. The Maryland project was led by Ilene Rosenthal and Stephanie Hull.

Several additional state officials have been generous with their insights and experiences in designing managed care programs for dually eligible people. They include Meryl Adelson of Massachusetts, Francis Finnegan of Maine, Thomas Hamilton of Wisconsin, Lynn Martinez of Arizona, Pamela Parker of Minnesota, Carla Williams of New York and Joel Young of Oregon.

We very much appreciate the time and thought that key HCFA officials contributed to clarifying the issues in this paper and in the entire dual eligibility services.

Through its support of planning grants for dually eligible elderly persons in Maryland and Texas, The Pew Charitable Trusts made the Austin meeting, this paper and several other dual eligibility activities possible over the past two years.

Through its sponsorship of The Center for Vulnerable Populations, The Henry J. Kaiser Family Foundation made it possible for us to include discussion regarding non-elderly persons in this paper.

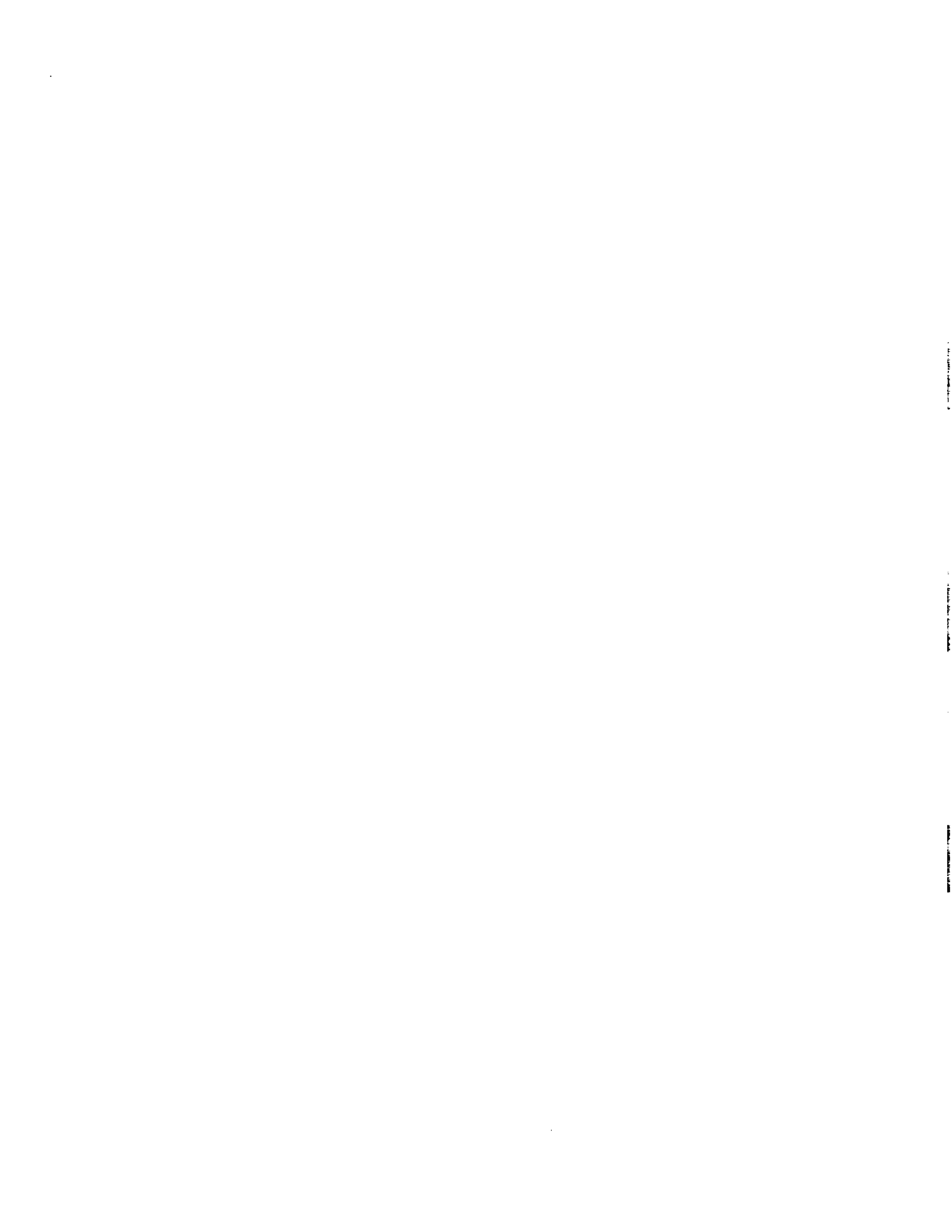
Forward

A little over two years ago, with the support of The Pew Charitable Trusts, we at The National Academy for State Health Policy began a series of activities regarding managed care and its potential application to dually eligible people. Early on, we sensed that states and the federal government had significantly different perspectives on this issue, even though they share responsibility for the health care of people who are eligible for both Medicaid and Medicare.

Roughly 5 million persons nationwide are estimated to be dually eligible. From a federal perspective, 5 million represents less than 15% of the nearly 40 million Medicare beneficiaries. Given the significant growth projected in the Medicare program in the coming decades, state concerns about dual eligibility may seem like a bit of carping. But for states, these 5 million people represent nearly all elderly Medicaid beneficiaries and a significant portion of younger Medicaid beneficiaries with disabilities. Furthermore, a significant portion of dually eligible people use long term care services, and states suspect those services could be delivered more effectively if they were integrated, or at least closely coordinated with the primary and acute services that are overseen by Medicare-reimbursed physicians.

Through painstaking discussion, states and HCFA have learned much about each other's perspective on this topic, and with growing interest on the part of HCFA, states, foundations and others, we are likely to have much more discussion and experimentation in the near future.

Drawing on the experience and discussion to date, this paper outlines some of the key dual eligibility program design choices facing states today.



1. Early Questions

Starting with the End: What are the Goals?

Managed care is a means to an end, not an end unto itself. This obvious statement can get lost easily in the current public sector rush toward private sector approaches. What might a state want to achieve by enrolling dually eligible persons into managed care? Most states hope to improve care and control expenditures simultaneously.

Managed Care for Dually Eligible People: Goals

Improve Consumer Outcomes	*Control Expenditures*

Objectives potentially falling under both goals include, but are not limited to, the following.

Managed Care for Dually Eligible People: Objectives

Reduce Service Fragmentation through integration or enhanced coordination of primary and acute services (funded by Medicare) and long term services (funded by Medicaid)
Make Benefits More Flexible and responsive to individual needs
Reduce Cost Shifting between Medicaid and Medicare
Reduce Institutional Care in favor of community-based care

While managed care is a potential means to achieving these objectives, some program designs will favor certain objectives over others. Without a strong foundation of program goals and objectives, designers may find it difficult to face the numerous program decisions that present themselves when building a program for dually eligible persons.

Facing Reality: What is Possible?

Though some designs may be more ideal than others, the unique conditions that exist in any state will influence design choices. Considerations include the following:

- **Broader state policy context.** Is the state in the midst of a §1115 waiver initiative? If so, how do dually eligible people fit in? Is there a strong desire to develop large, statewide programs? Is it important to establish a program quickly? Has the Governor publicly discussed overall health care goals for the state? Has the state embarked on a particular health care purchasing strategy that must be considered? Does the state have a reinventing government initiative? How would the state's home- and community-based waiver program be affected? Is it a high priority to control long term care costs in the Medicaid program?

- **Political context.** Is the Legislature likely to support managed care for dually eligible persons? Are unrelated managed care controversies (e.g., drive-through deliveries) likely to create political obstacles for any new managed care initiative? What are constituents, including consumers, providers and managed care organizations, likely to support? Are important program agencies (aging, disability) participating in and likely to support program development efforts?

- **State and private managed care infrastructure.** How extensive is state government's experience with risk-based managed care? Does the state have existing relationships with managed care organizations, and would it like to build on those relationships? What is the managed care penetration rate in the private sector? Does the state have any TEFRA plans (Medicare HMOs)? If so, have they expressed any interest in contracting with the state?

Selecting the Target Group: Who will the Program Serve?

Who are the dually eligible beneficiaries in your state, and which ones of them will be served by this program? As the national discussion of dual eligibility has evolved, the term "dually eligible" has become shorthand for any Medicaid beneficiary who is elderly or has a disability or chronic condition. This is an unfortunate development, suggesting homogeneity of a very large group that is actually comprised of several distinct subgroups.[1]

Dually eligible people have one thing in common: they are eligible for Medicaid and Medicare benefits simultaneously.[2] Some are dually eligible by virtue of age; others because of a disability. Some are quite sick; others are healthy. On the other hand, a dually eligible individual can be very similar to another individual who

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[1]For a discussion regarding various approaches to defining target groups of people with disabilities, see Tobias et al. Defining the Target Population: Policy and Program Development Issues. Boston: Medicaid Working Group. 1995.

[2]People can become dually eligible in a number of ways. See Appendix A in Federal Barriers to Managed Care for Dually Eligible Persons. Portland, ME: National Academy for State Health Policy. 1995.

qualifies only for Medicaid. For example, two working-aged persons may have similar disabilities and both qualify for Medicaid through SSI, but one may not qualify for Medicare because of insufficient work history. Program designers face several overlapping choices, some of which are included on the following chart.

Target Group Considerations

Characteristic	Selected Target Group Options
1. Eligibility Status	1-A. Dually Eligible Only 1-B. Dually Eligible *and* Medicaid-only Persons with Similar Needs 1-C. All Medicaid Eligible, including Dually Eligible
2. Age	2-A. 65 or Older 2-B. Adults Under 65 2-C. Children 2-D. Combination of Above
3. Long Term Services Status	3-A. Nursing Facility (NF) Certified Only 3-B. NF Certified *and* Others not Certified
4. Type of Condition	4-A. Physical 4-B. Developmental 4-C. Mental (including Dementia) 4-D. Other

Determining the Scope of the Program: What Does the Capitation Include?

Efforts to enroll dually eligible persons into managed care have been associated with the full integration of primary, acute and long term services. However, a number of states have enrolled dually eligible persons into managed care programs in which capitated payments include only some portion of Medicaid (usually primary and acute) with the remaining portion and all of Medicare remaining fee-for-service. A number of variations are possible, some of which are shown on the following chart.

What's In and What's Out?

Option	Capitated	Fee-for-Service
A	• Medicaid Primary and Acute	• Medicaid Long Term Services • Medicare
B	• Medicaid Primary and Acute • Medicare	• Medicaid Long Term Services
C	• Medicaid Primary, Acute and Some Long Term Services • Medicare	• Medicaid Additional Long Term Services
D	• Medicaid All	• Medicare
E	• Medicaid All • Medicare	
F	• Medicaid Partial (variety of options)	• Medicaid Remaining Portion • Medicare

For states opting for a partially capitated system, attention should be devoted to the development of mechanisms that discourage cost shifting to the fee-for-service sector. For example, in Wisconsin, utilization targets have been established for services that remain fee-for-service, and contractors are financially penalized if they exceed the targets.

2. Approaches and Vehicles

Choosing A Basic Approach: Coordination or Integration?

Until recently, states with Medicaid managed care programs took one of two courses toward dually eligible persons. Either they 1) excluded them from the programs or 2) made an adjustment in their Medicaid capitations to reflect Medicare eligibility and took no further actions regarding Medicare. Many states are interested now in pursuing a far more active role to ensure that Medicaid and Medicare work well together for the maximum benefit of dually eligible persons. Although many variations exist, recent state approaches may be distinguished as attempts to coordinate or integrate Medicare and Medicaid services, as outlined on the following chart.

Two Basic Approaches to Dual Eligibility Programs

Approach	Distinguishing Feature
Coordination	• Emphasis on making two service systems appear and feel as one to the consumer. Examples: - Medicare and Medicaid enrollment remain separate, but contractor, state and HCFA develop coordinated enrollment process to approximate simultaneous entry into two systems - HCFA and state agree to share the Medicare and Medicaid data collected respectively by the two systems - HCFA and state maintain separate contracts for Medicare and Medicaid payments, respectively, but payments are made to the same MCO
Integration	• Emphasis on unifying two service systems into one. Examples: - HCFA authorizes state to enroll dually eligible persons into a single service system that includes both Medicare and Medicaid services - State collects (and shares with HCFA) Medicare and Medicaid data - A single contract covers both Medicare and Medicaid payments

Perhaps the most mature example of a coordination approach is Oregon's, in which the state, HCFA and managed care organizations (MCOs) have gone to great lengths to make the Oregon Health Plan (through which most Medicaid beneficiaries are enrolled in managed care) work well with the substantial TEFRA (Medicare HMO) market that exists in that state. Dually eligible beneficiaries who elect a TEFRA plan for Medicare have their Oregon Health Plan benefits delivered through that same plan, though the state has no direct role in the oversight of Medicare services. The MCO remains under contract and accountable to HCFA for Medicare services, and maintains a separate contract with the State for Oregon Health Plan services.

Minnesota Senior Health Options is pioneering an integration approach, in which HCFA will, in essence, allow the State to act as its agent for Medicare. This has allowed the State to solicit bids for a unified health system that encompasses both Medicaid and Medicare services. Following contract negotiations (which are underway at this writing), the State will execute a unified Medicare-Medicaid contract with one or more managed care organizations.

Transition Strategy: Is a Phased-In Integration Approach Possible?

New York, Wisconsin, Maine and other states are experimenting with transition approaches, in which a program begins as a coordination model with the intent to move to full integration over time. For example, Medicaid services are contracted by the state on a partially capitated basis. The Medicaid contractor is expected to bill for Medicare services on a fee-for-service basis as appropriate, but the state has no direct role in contracting for or overseeing the Medicare services. However, contractors enter into the arrangement with knowledge that the state plans to pursue waivers allowing a fully integrated approach. This strategy is attractive to some states for the following reasons:

- **Faster start up.** Assuming a partial capitation of Medicaid, it is possible to begin such a program without federal waivers, allowing faster start up; and

- **Learning time.** It provides a transition period for both the state and its contractors to gain experience and develop infrastructure. This may be particularly important when a state opts to use specialty contractors who may not have experience with managed care nor be able to qualify immediately as risk-bearing entities.

Picking a Vehicle: What Are the Options?

As managed care markets mature across the country, most states have a growing number of vehicles to consider. Each comes with advantages and limitations, and will be more or less attractive to a state depending on program objectives and, in particular, on whether a coordination or integration approach is favored. The following chart summarizes the pros and cons of various vehicles.

Managed Care Vehicles for Dually Eligible People (continues next page)

Vehicle	Reasons to Consider	Limitations for States
PACE	• Legal authority is well established and understood • Full Medicare and Medicaid capitation possible • Extensive experience exists, and support is provided by National PACE Assn. • Strong focus on long term services in community settings	• Availability of sites limited (though HCFA supports federal legislation to expand) • Population limited to those 55 or older who are nursing home certified • Sites serve small numbers of people (150 to 450) • Sites maintain separate Medicare relationship with HCFA
TEFRA Plans (Medicare HMOs), *Exclusively*	• Full Medicare and Medicaid capitation possible • May have valuable experience with Medicare beneficiaries • May offer extra Medicare benefits (e.g.; prescription drugs) • Possible without Medicare waivers (assuming a coordination approach) • Provides clear lock-in to plan (currently one month) and lock-in to network providers	• Not widely available; statewide coverage not likely • May not have sufficient experience with long term services • Medicare capitation (AAPCC) can change dramatically from year to year, affecting Medicare benefits; rate varies by county • May give undue bargaining leverage to TEFRA plans, contrary to some states' purchasing strategies • Does not allow state to build on existing relationships with non-TEFRA plans • State access to Medicare data unclear (assuming a coordination approach)

Vehicle	Reasons to Consider	Limitations for States
MCOs in General (*possibly including* TEFRA Plans)	• Full Medicare and Medicaid capitation possible (assuming Medicare waivers) • State may avail itself of the entire marketplace • State may build on existing relationships with non-TEFRA plans • State may choose MCOs with experience in long term and other needed services	• Requires demonstration status for full capitation; likely to be time consuming • Availability of Medicare lock-in for non-TEFRA plans unclear
Specialty Providers	• May have expertise needed by the target population • Can be used to help small providers make transition to managed care • May be appealing to consumers who have experience with the providers	• Full Medicare and Medicaid capitation not likely in the short run • Risk pool may be too small • May be inconsistent with some states' overall purchasing strategies
Partnerships between MCOs and Specialty Providers	• Combines providers' population expertise with MCOs' risk-bearing expertise • Full Medicare and Medicaid capitation possible • May make MCO more attractive to consumers	• MCOs or providers may resist such arrangements; state may need to act as broker • May be inconsistent with some states' overall purchasing strategies

3. Medicare Waivers

Whether or not a state needs federal Medicare waivers to develop a managed care program for dually eligible people depends on the approach and vehicle a state wishes to use.[3] At one end of the spectrum is a fully integrated, fully capitated program requiring both Medicaid and Medicare waivers. On the other end is a partially capitated Medicaid program with fee-for-service Medicare, requiring no waivers. As described earlier, some states have adopted a transition strategy, in which they have initiated programs without waivers, with plans to further develop the programs pending successful receipt of waivers. States with short start-up deadlines will want to consider such a strategy: obtaining the novel and somewhat controversial Medicare waivers associated with integration models will take a minimum of several months, and could take years. Outside of PACE sites, the only state that has received Medicare waivers to conduct such a project is Minnesota, and it is unclear whether HCFA is prepared to proceed with similar experiments in other states. While the application of waivers in Medicaid managed care is by now fairly well understood, the use of Medicare waivers is less clear. The following discussion focuses on Medicare waivers in particular, but all of the Medicaid waiver issues applicable to Medicaid-only beneficiaries also apply to dually eligible beneficiaries.[4]

Is It Possible To Establish A Mandatory Program?

If a state wishes to include Medicare in a program for dually eligible persons, the program must be voluntary. This stems from the *unwaivable* Medicare requirement that Medicare beneficiaries have freedom to choose the providers of their choice.

It is possible, as in Oregon, to have a mandatory Medicaid managed care program that coordinates with Medicare for dually eligible persons, but the program must be constructed in a manner that allows enrollees to exercise their *Medicare* options. For example, if an Oregon Health Plan (OHP) member chooses a TEFRA plan for Medicare benefits, the member is enrolled in the same plan for OHP benefits. If the member opts for Medicare fee-for-service benefits, OHP still (with some exceptions) requires enrollment in managed care for Medicaid benefits.

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[3]This is largely an unchartered and evolving area. For a discussion of apparent possibilities under existing federal law, see: Saucier. Federal Barriers to Managed Care for Dually Eligible Persons. Portland, ME: National Academy for State Health Policy, 1995.

[4]For a comprehensive discussion and summary of Medicaid waiver options, see: Horvath and Kaye. Medicaid Managed Care: A Guide for States, 2nd Ed. Portland, ME: National Academy for State Health Policy, 1995.

Is Lock-In To A Managed Care Network Possible?

While lock-in to network is clearly possible in Medicaid managed care, its application to Medicare is more complicated. The only clear mechanism that exists for Medicare lock-in is the TEFRA program, in which a Medicare beneficiary agrees to be restricted to the TEFRA plan he or she joins on a month-to-month basis. Thus, one advantage of using TEFRA plans as a vehicle is the clear Medicare lock-in. What is not clear is whether a §222 Medicare waiver [5], which is technically limited to payment or reimbursement requirements of the Medicare law, can be employed to allow TEFRA-like lock-in outside of TEFRA plans.

Absent explicit lock-in, some states have fashioned *de facto* Medicare lock-in to Medicaid plans by limiting their payment of Medicare cost sharing (copayments and deductibles) to the Medicaid plan in which the dually eligible person is enrolled. This is a controversial policy, and HCFA, in recent waiver amendment negotiations with Arizona, has signaled that it will discourage this approach in the future. More promising for states is the possibility that §222, in certain contexts, may be used to achieve an explicit TEFRA-like lock in.

Is it Possible to Have Capitated Medicare Payments Outside of TEFRA?

Section 222 does allow waivers of Medicare requirements that are related to payment or reimbursement of Medicare services. Thus, a state may seek a §222 Medicare waiver (as Minnesota has received) for the purposes of making capitated Medicare payments to entities other than TEFRA plans. Of course, if a state wishes to limit itself to TEFRA plans, such a waiver may not be necessary, depending on other program features.

One of the reasons a state may wish to use non-TEFRA plans is the TEFRA composition rule, which has a higher non-public enrollment requirement that is impossible for some Medicaid plans to meet. At least 50% of a TEFRA plan's members must be members other than Medicare or Medicaid beneficiaries (the 50/50 rule). For Medicaid plans, only 25% must be non-Medicare or -Medicaid.

4. Long Term Services

To date, most Medicaid managed long term services programs have been developed separately from state primary and acute programs, and limited to people who have long term service needs at enrollment, as determined by state screening criteria for nursing home admission. This is the essential design of the Arizona Long Term Care System (ALTCS), the Wisconsin Partnership Program, and the New York Evaluated Medicaid Long Term Care Capitation Program. These programs assume that Medicare will be billed by the contractors on a fee-for-service basis, at least as an interim step toward a fully integrated program.

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[5]Refers to §222 of the Social Security Amendments of 1972. Alternatively cited as 42 USC §1395b-1.

Managed Long Term Care: Typical Model to Date

Program A

Services	Target Group	Medicaid		Medicare
Primary and acute *only*	Those *without* long term service needs	Capitated for primary and acute	------------	Fee-for-service

Program B

Services	Target Group	Medicaid		Medicare
Primary, acute *and* long term	Those *with* long term service needs	Capitated (fully or partially) for primary, acute *and* long term services	------------	Fee-for-service

In this arrangement, a relatively well person who does not meet a state's nursing home admission criteria is enrolled in Program A, where the person stays until and unless long term service needs emerge. If long term services become necessary (as measured by a state's long term services screening tool), a person is disenrolled from Program A and enrolled in Program B.

In an alternative scenario, a person enrolls directly into Program B from the fee-for-service sector. Many people do not apply for Medicaid until they have long term service needs and, therefore, do not ever experience a state's primary and acute Medicaid managed care program.

Advantages of this approach include the following:

- **Explainable.** Relative to fully integrated models, it is easy to conceptualize and explain. For example, a state could propose converting its existing §2176 home and community-based waiver program (which serves the same target group) into a managed care program;

- **Budget neutral.** It makes budget neutrality easier to demonstrate, since existing long term service screens continue in force. The model provides little opportunity for long term services to be provided to beneficiaries who would not have qualified for them in fee-for-service Medicaid; and

- **Focus on long term services.** It allows a strong long term services focus (including an emphasis on experienced providers) to be built into a specialized program (Program B). Given the target group (people who qualify for nursing home services), long term services will be at the center, rather than the periphery, of the program.

This approach also comes with distinct disadvantages:

- **Integration not fully tested.** Because the target group is limited to people who have long term service needs, the approach does not accommodate a test of the hypothesis that integrated models can keep people healthy longer;

- **Limited accountability.** Those plans under contract for primary and acute Medicaid services only (Program A) are no longer responsible for a member when long term service needs develop (since the person will move to Program B), undermining the managed care concept of accountability over time; and

- **Shifting continues.** With Medicare remaining fee-for-service, the principal funding source for primary and acute care remains outside the system, continuing the opportunities for cost- and care-shifting that occur in the fee-for-service sector generally.

In an effort to address these shortcomings, dual eligibility programs under development, such as Minnesota Senior Health Options, Massachusetts Senior Care Organizations and the Colorado Integrated Care and Financing Project are all designing programs that eventually would integrate all Medicaid and Medicare services for mixed groups of people that include those who need long term services and those who do not. This approach is portrayed in the following diagram.

Managed Long Term Care: Emerging Integrated Model

Unified Program

Services	Target Group	Medicaid	Medicare
Primary, acute and long term	Mixed: those *with and without* long term service needs	Fully capitated	Fully capitated

This approach raises some challenging program design questions.

How Can Needed Long Term Services Expertise Be Incorporated?

Unlike a program dedicated to long term services users, a program with a mixed population will not necessarily have a strong long term services component, particularly if the contractor is more experienced in primary and acute care. States are taking different approaches on this issue, reflecting once again how local conditions and overall purchasing strategy must be incorporated into program design.

- **Brokering relationships.** In Maryland, the Office on Aging is developing a model, in cooperation with an HMO and aging services providers in Northwest Baltimore, in which the providers would establish a limited partnership for the purposes of providing geriatric expertise to the HMO's members.

- **Following the market.** By contrast, the Minnesota Department of Human Services is evaluating the capacity of prospective Senior Health Options contractors to provide long term services and will monitor those services, but will not direct the contractors to use particular long term services providers. That will be left to the marketplace.

Who Should Conduct Long Term Care Services Assessments And Care Management?

Several states have well-established systems for entry into the long term services system, with carefully considered roles for the state, counties, Area Agencies on Aging and community providers. Often, one or more of these entities has been established as a point of entry into the system, and is charged with conducting assessments and performing care management. Should these relationships continue in an integrated system? Should program contractors be entrusted with these important roles, given that assessment might be used to increase revenue (if they trigger higher payments) and care management might be used to limit services inappropriately to maximize profit? Again, states are taking different approaches.

- **Contractor responsible, with oversight.** Minnesota will make contractors responsible for assessments and care management, roles currently performed by counties. Contractors will have the option of subcontracting with counties for the services, or choosing a different process subject to audits by the county.

- **Brokered role for existing entity.** For its Integrated Care and Financing Project, Colorado has brokered an arrangement between Rocky Mountain HMO and the existing Single Entry Point (SEP) entity in the proposed service area (Mesa County Single Entry Point Agency). The state will pay the assessment and care management costs as part of its capitated payment to the HMO, which will in turn subcontract with Mesa County SEP for the services.

Who Should Have Assessments?

A key issue bearing on both quality and cost is how such a service can be targeted to those who need and desire it. On the one hand, if it is provided only to persons presenting advanced needs for long term services, it will not support a truly integrated approach, in which needs are identified and addressed early. On the other hand, if it is provided to all members, including those who have no unusual or ongoing needs, it will be prohibitively expensive and intrusive. One approach is to require contractors to perform ongoing screening as part of a good primary care program. Members identified as at-risk can then be referred for a more thorough

5. Assuring Quality

Interest in developing strong quality oversight has intensified as more and more dually eligible people have been targeted for managed care, but states will not find any ready made systems to adopt for this population, particularly for the sub-group with long term service needs.[6] Issues for state consideration include the following.

Which Quality Standards Apply, Medicare's Or Medicaid's? Is The State Or HCFA Responsible For Oversight?

For programs using a coordination approach with no waivers, contractors will need to meet two sets of quality standards, and will be subject to oversight from both states and HCFA. In an integrated program, such as Minnesota Senior Health Options, it is possible, with waivers, for the state to develop and oversee a unified QA system with HCFA's approval.

Should Accreditation Be Required?

Accreditation can be a useful indicator of plan compliance with certain fundamental standards, but it is possible for a contractor to provide very high quality services without being accredited. States opting to use small or new contractors may find that the accreditation process is too costly and cumbersome for those entities. One option is to recognize but not require accreditation, with the state focusing its efforts on areas not addressed by the accreditors.

What Performance Measures Should Be Used?

Few have been developed to date that adequately address the needs of the population. Particularly elusive are measures that address larger quality of life issues, such as degree of autonomy. States currently developing programs that include long term services have found a need to develop and test measures of their own.

6. Payment Structure

Is A Single Capitation Possible? Is It Necessary?

Integrated programs for dually eligible people are often described as having a single capitation that pools Medicaid and Medicare funds. Technically speaking, no such payment system has been established to date, but a few programs have developed payment systems in which two capitated payments are received by contractors, one

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[6]For a focused discussion on quality issues in managed care for older persons and persons with disabilities, see: Booth. Assuring the Quality of Care in Managed Care Programs Serving Older Persons and Persons with Disabilities. (Forthcoming from the National Academy for State Health Policy). Much of this section was developed from discussions of earlier drafts by Booth.

for Medicaid and the other for Medicare. Funds are then pooled to provide the range of services needed by the dually eligible members. This is the arrangement employed in PACE, Minnesota Senior Health Options, and for certain members of the Oregon Health Plan.

As a practical matter, whether contractors receive funds in one payment or two is probably of little consequence, assuming the pooled funds may be used flexibly. What is important, though, is for states and HCFA to act jointly in the payment process. If a contractor is accountable only to HCFA for Medicare cost reports, a state will have no way of assessing whether it is paying an appropriate amount in its Medicaid capitation. For example, if a TEFRA plan is offering a limited drug benefit as part of its Medicare rate, how will a state know whether the benefit is actually provided on the Medicare side? The plan could instead show the drugs as a Medicaid cost, artificially inflating costs for future rate negotiations.

Should the AAPCC be Used for Medicare Payments?

Capitated Medicare payments are made to TEFRA plans on the basis of the adjusted average per capita cost, or AAPCC. The AAPCC is established annually by county, raising serious implications for Medicaid rates. The rates vary by county and can fluctuate dramatically from one year to the next. Generally, rates are lower in rural areas and higher in urban areas. States wanting to establish statewide programs for dually eligible people will have to accommodate the variance in Medicare rates from one county to the next. Also, if the AAPCC drops precipitously from one year to the next, the pressure will be on the state to make up overall revenue losses to the contractors.

HCFA is currently engaged in a number of Medicare pricing experiments, including competitive pricing and risk adjusted rate setting. For the time being, though, the AAPCC remains the standard payment method for Medicare managed care. Although Medicare payment methods can be waived with a §222 waiver (see section 3, above), the AAPCC has served as the basis of Medicare payments in PACE, Social HMOs and Minnesota Senior Health Options, and is the basis for discussion in several projects under development.

How Can Incentives to Provide Community-Based Long Term Care Services be Constructed?

States enjoy considerable flexibility in establishing Medicaid payments for dually eligible people. Some states report that some managed care plans are more interested in nursing home residents than in home- and community-based services users, because the captive audience in the nursing home is considered more responsive to good management of care. Typically, they also generate a higher rate than community-based beneficiaries. This suggests that states must do more than rely on

the pressures of capitation to encourage home and community based care and avoid inappropriate use of institutional care. Arizona and Minnesota have taken different approaches, both directed at this goal.

- **Blended rate.** In establishing rates for the Arizona Long Term Care System (which is limited to people who are certified as needing long term services), Arizona estimates the percentage of members who will be served in the community and those who will be served in nursing homes. It then pays a blended rate to contractors, and allows them to keep some savings if they successfully serve a higher portion than estimated in the community.

- **Rates varying by institutional status.** In Minnesota Senior Health Options, contractors will be paid according to where members reside upon enrollment, with higher payments made for nursing home residents. However, incentives for community based care will include a novel conversion payment, which will allow the higher nursing home rate to be paid for up to a year when members are moved from nursing homes into community settings.

7. An Uncertain Future

With both the Medicaid and Medicare programs under review in the Congress, states would be well advised to adopt flexible approaches to dually eligible persons. Of particular interest will be possible changes to Medicare managed care that could include abandonment of the AAPCC payment methodology, expansion of Medicare risk contracts to include provider sponsored organizations (PSOs) and other new players, elimination of the 50/50 composition rule, and extension of network lock-in from the current 1-month to as long as a year.

One thing is certain. Managed care will continue growing, both in Medicaid and Medicare. Together, states and HCFA will need to fashion joint strategies that result in the best value for dually eligible beneficiaries.