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Federal and State Initiatives to Integrate Acute and Long-Term Care: Issues & Profiles

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Summary

Over the past two decades, Congress has considered a variety of proposals to improve the financing and delivery of long-term care. One such approach is to better coordinate the acute and long-term care services needed by many of the 7 million Medicare beneficiaries who also qualify for Medicaid. These “dual eligibles” are not only disproportionately poor but are also more likely than other beneficiaries to be age 85 or older, under age 65 and disabled, non-white, female, alone, in only fair or poor health, cognitively and functionally impaired, and suffering from many chronic ailments and diseases. The \$106 billion in public spending attributed to this population in 1995 was one-third of all spending by Medicare and Medicaid combined.

Dual eligibles are served by two financing programs (Medicare and Medicaid), administered under different authorities (the federal and state governments), that, for the most part, cover different services (acute and long-term care). Many believe that this bifurcation of responsibility has helped create a fragmented service delivery system, fraught with administrative inefficiencies and incentives to shift costs. To achieve integration, most federal and state initiatives have relied on managed care organizations to directly provide or arrange to provide health and social services through affiliated providers for a prepaid, fixed monthly payment (or capitation). The intent is to use managed care mechanisms as vehicles for integrating financing, service delivery, and administration. The Program for All-Inclusive Care of the Elderly (PACE) is an example of a federal initiative that capitates both Medicare and Medicaid. Minnesota Senior Health Options, the Wisconsin Partnership Program, and the Continuing Care Network Demonstration are examples of state initiatives that do the same. Other federal initiatives include the Social HMO (S/HMO) demonstration, which capitates Medicare acute and long-term care services, and EverCare, which coordinates with Medicaid but capitates Medicare only.

While comprehensive reform has been considered, Congress has primarily taken an incremental approach to long-term care. Though Medicare-Medicaid integration programs serve a comparatively small number of dual eligibles, they provide options Congress may consider when formulating future policy. Possibilities for congressional consideration may include streamlining the federal waiver approval process necessary for programs, relaxing Medicare and other impediments to state programs, developing new care coordination mechanisms and payment methodologies, facilitating unified Medicare and Medicaid program administration, and supporting care management in fee-for-service Medicare and Medicaid.

Though the number of integration programs has grown, there are a variety of reasons why states might exclude dual eligibles from their Medicaid managed care efforts and why dual eligible enrollment in Medicare HMOs has been quite low. These include doubts about managed care’s appropriateness for vulnerable populations, lack of plan availability, selective enrollment, inadequate risk adjustment, and statutory and regulatory impediments. Given these issues, some have proposed relying on care management to integrate care without capitation.

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Federal and State Initiatives to Integrate Acute and Long-Term Care: Issues and Profiles

Introduction

Congress has considered a variety of proposals to improve the financing and delivery of long-term care. While comprehensive reform has been considered, Congress has primarily taken an incremental approach when addressing long-term care issues. Recent proposals, for example, would provide tax credits for families of individuals with long-term care needs, offer tax deductions for individuals who purchase private long-term care insurance, fund caregiver support services through the Older Americans Act, and link the provision of additional federal nursing home dollars to quality of care improvements.¹ Another strategy supported by Congress as well as the Clinton Administration and the states has been the development and implementation of programs that integrate acute and long-term care services for frail elders and disabled adults. This report discusses such efforts with an eye toward providing Congress with the necessary information with which to consider future action in this area.

Federal and state initiatives to integrate acute and long-term care usually focus on Medicare beneficiaries who also qualify for Medicaid (i.e., the “dual eligibles”). Compared to other beneficiaries, the nation’s approximately 7 million dual eligibles are especially vulnerable and have high medical care costs. They also face additional problems that arise from their being served by two separate programs (Medicare and Medicaid), administered under two different authorities (the federal and state governments), that, for the most part, cover two different types of services (acute and long-term care). Many believe that the bifurcation of responsibility in caring for dual eligibles has resulted in a fragmented health services delivery system, fraught with administrative inefficiencies and incentives to shift costs. They argue that reform is necessary if this population is going to be served more cost-effectively.

The primary vehicles suggested for reform are managed care organizations that: (1) directly provide, or arrange to provide, health and long-term care services through affiliated providers; and (2) receive a prepaid, fixed monthly payment, or capitation, in exchange for assuming full responsibility for all covered benefits. Although these entities often include health maintenance organizations (HMOs) that have traditionally covered only acute health care services, the general goal of reform is to use managed

¹For further information, see CRS Report RL30254, *Long-Term Care: The President’s FY2001 Budget Proposals and Related Legislation*, by Carol O’Shaughnessy, Bob Lyke, Carolyn Merck.

care mechanisms to integrate Medicare and Medicaid financing (through prepaid, fixed monthly payments or capitations, and broad, flexible benefits), service delivery (through comprehensive provider networks and care coordination), and administration (through unified program requirements and oversight). Care management without capitation has also been proposed as an approach to achieving integration.

In exploring integration of acute and long-term care, this report begins by characterizing the dually eligible population and describing the problems associated with meeting their health and social service needs in an uncoordinated system. It continues by analyzing the advantages of using capitation and care management as the vehicle for integrating those services and by discussing concerns about care integration strategies. It concludes by profiling nine federal and state programs that to varying degrees integrate the acute and long-term care services that Medicare-Medicaid dual eligibles often require. These are:

- ! *Federal initiatives* such as the Program for All-inclusive Care of the Elderly (PACE), which capitates both Medicare and Medicaid acute and long-term care services for dual eligibles, and the Social/Health Maintenance Organization (S/HMO) and EverCare demonstrations, which capitate Medicare benefits only²;
- ! *Comprehensive state demonstrations* such as Minnesota Senior Health Options, the Wisconsin Partnership Program, and the Continuing Care Network Demonstration of Monroe County New York, which, like PACE, capitates both Medicare and Medicaid benefits; and
- ! *Capitated state Medicaid demonstrations* such as the Arizona Long-Term Care System, Oregon Health Plan, and Florida's Community-Based Diversion Pilot Project, which capitate Medicaid only, but actively pursue various Medicare coordination strategies.

Proposals that explore using care management techniques to integrate Medicare and Medicaid service delivery without capitation are also discussed briefly. The report concludes with the observation that although federal and state initiatives to integrate acute and long-term care for dual eligibles only serve a relatively small percentage of this population, they provide a set of options which Congress may want to examine when formulating long-term care policy in the future.

Dual Eligibles Defined

The term dual eligibles refers to individuals who qualify for both Medicare and Medicaid. Persons qualify for Medicare because they are either age 65 or older, or under age 65 and disabled and receiving Social Security disability insurance (SSDI) for 2 years. Persons qualify for Medicaid because they are either aged, blind, or disabled and meet the income and asset requirements for Supplemental Security

²The S/HMO program also has the authority to capitate Medicaid covered benefits, though this occurs in limited circumstances.

Income (SSI) assistance,³ or because they are “medically needy,” having “spent down” their income and assets to pay for their medical or long-term care costs to state determined levels. The majority who qualify for Medicaid are eligible for full Medicaid benefits. Others, however, are only eligible for Medicaid coverage of some portion of their Medicare premiums and cost-sharing. This latter group includes Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs), and others termed Qualifying Individuals (1) and (2) (QI-1s and QI-2s).⁴

Characteristics. In 1998, the Medicare program covered 39.8 million beneficiaries, including 34.7 million individuals age 65 and older (87.2%) and 5.1 million disabled individuals under age 65 (12.8%). Of the 7.0 million (17.5%) Medicare beneficiaries who were also eligible for full Medicaid benefits and/or for Medicaid payment of Medicare cost-sharing requirements, 4.9 million (71.3%) were over age 65. Data from the 1998 Medicare Current Beneficiary Survey indicate that dually eligible Medicare beneficiaries are particularly vulnerable compared to persons who qualify for Medicare only (see **Table 1**). Not only are they disproportionately poor, by definition, but they are more likely than non-dually eligible Medicare beneficiaries to be frail elders age 85 and over and disabled individuals under age 65. They are also more likely to be minority, female, unmarried, institutionalized, alone, less educated, report fair or poor health, and suffer from functional and cognitive impairments such as limitations in instrumental and basic activities of daily living.⁵ Except for arthritis and cancer, dually eligible beneficiaries are also more likely to suffer from most chronic ailments and diseases. Almost half of all Medicare beneficiaries with Alzheimer’s disease (49.0%) are dually eligible.

³In 2001, an individual qualifying for SSI must have countable income less than \$530 per month, and assets of less than \$2,000.

⁴*QMBs* have monthly incomes below 100% of the federal poverty level and assets less than \$4000, and receive Medicaid coverage for Medicare Part B premiums, as well as for any Medicare deductibles and coinsurance. *SLMBs* have incomes below 120% of the federal poverty level and assets less than \$4000, and receive coverage for their Medicare Part B premiums only. *QDWIs* lost their Medicare Part A benefits due to a return to work but have monthly incomes below 200% of the poverty level and receive Medicaid coverage of their Part A premiums. *QI-1s* have monthly incomes below 135% of the federal poverty level and can receive coverage for their Medicare Part B premiums. *QI-2s* have monthly incomes below 175% of the federal poverty level and receive coverage for a portion of their Medicare Part B premiums. The *QI-1* and *QI-2* categories were introduced by the Balanced Budget Act of 1997, which placed an annual cap on the amount of money available. To fund premiums, a state is only required to cover the number of persons to bring its spending on these groups in a year up to its allocation. The continuation of coverage for these latter two groups is authorized in law through the end of 2002.

⁵Instrumental activities of daily living are tasks necessary for independent community living, and include the following: shopping, light housework, telephoning, money management, and meal preparation. Activities of daily living are activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, toileting, and transferring from a bed to a chair.

Expenditures. Not surprisingly dual eligibles use a disproportionate share of resources relative to their numbers. The 1995 per capita health expenditures for dual eligibles (\$16,854), for example, was close to two and a half times higher than for non-dually eligible Medicare beneficiaries (\$7,031).⁶ Dual eligibles consume more spending than their share of recipients. Although they constituted only 16% of Medicare beneficiaries in 1995, dual eligibles accounted for approximately 30% of total Medicare expenditures (\$53 billion).⁷ Although only 17% of Medicaid recipients, dual eligibles accounted for approximately 35% of Medicaid expenditures (\$53 billion). Overall, the \$106 billion consumed by this population was *one-third of total spending* by both the Medicare and Medicaid programs combined in 1995.

Table 1. Comparison of Medicare Beneficiaries by Dual Eligibility Status, 1998

Characteristics	Duals	Non-Duals
Total Beneficiaries	7.0 million	39.8 million
Income Less Than \$10,000	73.8%	18.3%
Age 85 and Older	18.1%	9.9%
Under Age 65 But Disabled	28.8%	9.4%
Non-White (Hispanic, Black, Other)	38.5%	14.1%
Female	63.2%	54.6%
Unmarried	77.1%	41.0%
Institutionalized	20.9%	2.2%
Living Alone If in Community	39.4%	29.2%
Less than 12 Years of Education	61.6%	31.2%
Fair/Poor Self-Reported Health	53.4%	25.1%
1+IADL or ADL Limitation	76.4%	42.9%
Upper Extremity Limitation	57.5%	36.3%
Mobility Limitation	68.8%	42.7%
Urinary Incontinence	33.6%	20.5%
Multiple Chronic Conditions	81.3%	70.5%
Hypertension	53.5%	52.3%
Diabetes	21.6%	15.1%
Arthritis	52.0%	54.0%
Osteoporosis/Broken Hip	15.9%	14.5%
Pulmonary Disease	19.4%	13.2%
Stroke	14.8%	10.0%
Alzheimer's Disease	12.0%	2.8%
Parkinson's Disease	2.6%	1.3%
Skin Cancer	6.2%	17.0%
Other Type of Cancer	13.8%	16.7%

Source: HCFA Analysis of the 1998 Medicare Current Beneficiary Survey

IADL=Instrumental Activity of Daily Living

ADL=Activity of Daily Living

⁶Murray, Lauren A., and Andrew E. Shatto. Dually Eligible Medicare Beneficiaries. *Health Care Financing Review*, v. 20, no. 2, 1998. p. 131-140. Data from the 1995 Medicare Current Beneficiary Survey.

⁷Health Care Financing Administration (HCFA). *A Profile of Dually Eligible Beneficiaries*. Prepared for the National Health Policy Forum, May 6, 1997.

The share of state Medicaid budgets consumed by the dual eligibles can be very dramatic. In 1995, for example, the percentage of total state Medicaid spending devoted to dual eligibles in each of the six New England states far exceeded their percentage of each state's Medicaid population. In Connecticut, Massachusetts, and New Hampshire, for instance, dual eligibles constituted approximately 20% of each state's Medicaid recipients but accounted for more than half of spending.⁸

In 1999, Medicaid long-term care expenditures for the total Medicaid population reached \$63.2 billion or 35.2% of total Medicaid expenditures.⁹ Most of that spending (74%) was devoted to institutional services (i.e., nursing home care plus intermediate care facilities for the mentally retarded). Much less (26%) was directed toward community-based services (i.e., personal care, home and community-based waiver services (HCBS), and home health care). These 1999 figures represent only the latest point in a decade of unprecedented Medicaid program growth. Between 1988 and 1999, the annual compound rate of growth in Medicaid expenditures was 12.0% for all of Medicaid, and 9.5% for Medicaid long-term care.¹⁰ Though Medicaid program growth has been driven largely by factors such as inflation in medical care costs, eligibility expansions, and the provision of additional services, the aging of the population and the higher rate of chronic disease and disability that it entails, has also played a small but increasingly significant role in driving program expenditures. The graying of the baby boom generation (76 million strong) will only exacerbate this trend.

Projections. June E. O'Neill, former Director of the Congressional Budget Office (CBO), has argued that increased longevity, together with a large increase in the size of the retired population and slow growth in the number of workers, will dramatically expand the burden of federal long-term care expenditures in the coming decades.¹¹ Between 2000 and 2020, the number of individuals age 65 and older is projected to increase by almost 50% (from 35.5 to 52.6 million), while the number of individuals age 85 and older is projected to increase by 26% (from 4.6 to 5.8 million, reaching more than 14 million by 2050).¹² At the same time, the number of disabled elderly persons with at least one ADL or IADL limitation is expected to grow by 42% (from 5.2 to 7.4 million), in large part due to the dramatic growth in the number of individuals 85 and older. Based on demographic projections that indicate significant

⁸New England States Consortium. *Dual Chart Book: Dually Eligible Beneficiaries in New England*. [<http://neconsortium.org/chrtbook.htm>.] Visited June 15, 2000.

⁹Burwell, Brian. *Memorandum: Regarding Medicaid Long Term Care Expenditures in FY1999*. The Medstat Group, April 25, 2000. Using data from HCFA Form 64 Reports.

¹⁰Ibid. Though high, these figures mask an especially explosive period between 1988 and 1993 when Medicaid grew at an annual compound rate of 19.6% and Medicaid long-term care grew at 12.9%. Spending has since slowed, however. Between 1993 and 1999, annual compound increases in total Medicaid and Medicaid long-term care expenditures dropped to 5.6% and 6.4% respectively.

¹¹U.S. Congress. House. Committee on the Budget. *Long-Run Budgetary Impacts of an Aging Population*. Testimony by June E. O'Neill, Director, Congressional Budget Office, March 13, 1996.

¹²*The Long-Term Care Financing Model*. The Lewin Group, Inc., 2000.

growth among the oldest old and the growing ranks of the population that will be chronically ill and disabled, the Lewin Group has projected that Medicare and Medicaid expenditures for long-term care services *for the elderly* will more than double between 2000 and 2025 (see **Table 2**). It is likely that an increasingly disproportionate share of these resources will be consumed by dually eligible individuals, since they are more likely than non-duals to be among the populations requiring long-term care.

Table 2. Projections of Medicare and Medicaid Expenditures for Long-Term Care Services for the Elderly, 2000-2025

(in billions, in 1999 dollars)

	2000	2025	% Increase
Total	\$98.1	\$207.9	112%
Medicare	\$19.3	\$40.6	110%
Medicaid	\$35.9	\$71.6	99%

Source: *The Long-term Care Financing Model*. Preliminary estimates prepared by the Lewin Group, Inc., for the Office of the Assistant Secretary for Planning and Evaluation (OASPE), DHHS, 2000.

Serving Dual Eligibles: Separate Systems

Given their disproportionate share of disease and disability, dual eligibles often require a continuum of acute and long-term care services that meet their changing health and social service needs, including services delivered in the home and the community. The Pepper Commission defined long-term care as “an array of services needed by individuals who have lost some capacity for independence because of a chronic illness or condition. Long-term care consists of assistance with basic activities and routines of daily living such as bathing, dressing, meal preparation, and housekeeping. It may also include skilled and therapeutic care for the treatment and management of chronic conditions.”¹³

Different programs and levels of government have been assigned primary responsibility for financing, planning, and administering the care that dual eligibles require. Dual eligibles, in particular, are served by two programs (Medicare and Medicaid), administered under different rules by different authorities (the federal and state governments), that, for these persons, cover different categories of services (acute and long-term care). Delivery of these two basic types of services, moreover, has been delegated to different organizations and delivery systems. Whereas most acute care services are provided within hospitals and physicians’ offices, most federal and state funded long-term care services are provided by nursing homes and community-based health and social service organizations. Though the Health Care

¹³A *Call for Action, The Pepper Commission: U.S. Bipartisan Commission on Comprehensive Health Care. Final Report*, September 1990. p. 90.

Financing Administration (HCFA) administers both programs at the federal level, states have been granted primary administrative responsibility for the Medicaid program. While Medicaid provides coverage for both acute and long-term care services, Medicaid long-term care coverage is especially significant largely because dual eligibles can rely on Medicare as the primary payer for acute care services. The basic problem, some argue, is that neither Medicare nor Medicaid has responsibility for the entire system.

Medicare. For dual eligibles, Medicare is the main payer for primary and acute care services. It is federally financed and administered by HCFA and consists of Part A, the Hospital Insurance Program, and Part B, the Supplementary Medical Insurance Program. Part A provides coverage for inpatient hospital services, up to 100 days of post-acute care in a skilled nursing facility following a hospital stay, home health services for persons who need skilled nursing care, and/or therapy services, and hospice services; Part B provides coverage for physicians services, outpatient hospital services, laboratory services, durable medical equipment, some home health care, and other medical care. Unlike Medicaid, Medicare's role in funding long-term care is very limited.

Medicaid. For the majority of dual eligibles who receive full benefits, Medicaid provides coverage for acute care and other services not included in the Medicare benefits package (e.g., prescription drugs and medical transportation). More importantly, though, for a chronically ill and disabled population, Medicaid provides coverage for long-term care, including nursing home care and home and community-based services. Because of substantial flexibility granted to states in implementing Medicaid, there are essentially 56 separate Medicaid programs covering each of the 50 states, U.S. territories, and the District of Columbia.

Other Programs. A variety of other federal programs also support long-term care services, including home and community-based services funded through the Older Americans Act, the Social Services Block Grant, the Department of Veterans Affairs, and various housing programs administered by the Department of Housing and Urban Development. There are also additional state programs. All but two states (Alabama and Mississippi) had state-only funded home and community-based care programs for older persons in 1996, for instance.¹⁴ Though not nearly as large as Medicare or Medicaid, these additional programs play a role in serving the long-term care needs of dual eligibles and others who do not meet the eligibility criteria of Medicare and/or Medicaid. They make care coordination even more difficult, however.

¹⁴Kassner, Enid, and Loretta Williams. *Taking Care of Their Own: State-Funded Home and Community-Based Care Programs for Older Persons*, no. 9704. AARP, Public Policy Institute, Washington, DC, September 1997.

Divided Responsibility: Implications

Many believe that the bifurcation of responsibility for caring for dual eligibles between Medicare and Medicaid (and sometimes other programs) has helped create a fragmented service delivery system, fraught with administrative inefficiencies and incentives to shift costs from one payer to the other.

Fragmentation. Because of their greater degree of disability and frailty, dual eligibles often must access multiple health and social services from both the acute and long-term care sectors. Some argue, however, that the separate funding and service delivery systems of Medicare and Medicaid typically require that patients and their families try to obtain care from a confusing assortment of badly coordinated providers and care settings, which have no incentives to interact given divided financing responsibility. Inconsistent practices and poor communication, along with separate medical record systems, pose significant barriers to meeting the total care needs of individual patients. Seldom does one provider assume responsibility for coordinating care and assuring its continuity. Thus, despite their greater need for continuity, dual eligibles are less likely than other Medicare beneficiaries to report having a consistent source of care.¹⁵ According to a study published in 1993, they are also less likely to receive specific types of preventive care, follow-up, and testing, and though they use more health services generally, they are less likely to receive timely, appropriate care relative to disease-specific standards.¹⁶

In addition to its implications for patient health, fragmentation may also increase system costs by complicating coordination across service providers and care settings. For example, patient discharges from expensive acute care facilities may be delayed unnecessarily because appropriate care in a nursing facility or patient's home could not be arranged. Some, moreover, believe that incentives built into the current system promote the overutilization of expensive institutional care and the underutilization of less expensive home and community-based care services – which are also more preferred by beneficiaries.

Administrative Inefficiency. Federal and state administrative rules for contracting, enrollment, marketing, reimbursement, oversight, data collection and quality standards are different for Medicare and Medicaid. The resulting inconsistencies and overlapping requirements, some argue, complicate caring for dually eligible beneficiaries as providers and payers must maintain parallel administrative systems for the two programs. In particular, providers often need to conduct multiple assessments, develop multiple protocols, and establish multiple records for a single patient during a single episode of care.

¹⁵According to the 1995 Medicare Current Beneficiary Survey, dual eligibles were less likely than other Medicare beneficiaries to report seeing a particular doctor and more likely to report using the emergency room. See: HCFA. *A Profile of Dually Eligible Beneficiaries*. May 6, 1997.

¹⁶Merrell, Katie, David C. Colby, and Christopher Hogan. Medicaid Beneficiaries Covered by Medicaid Buy-In Agreements. *Health Affairs*, v. 16, no. 1, 1997. p. 175-184. Based on claims from 1992 and 1993 for a 1% sample of beneficiaries.

Though difficult to measure, some researchers have indirectly estimated the costs of such administrative inefficiencies. For example, one group of investigators found that most of the higher Medicare costs of dual eligibles relative to other beneficiaries was due to demographic, health, and disability factors. Controlling for these factors reduced the cost gap from 282% to 45% of the average beneficiary's costs. The authors suggest that much of the remaining difference (45%) could be attributable to the inefficiencies associated with providing care under two separate programs.¹⁷

Cost-Shifting. It has long been widely acknowledged that overlap in coverage between two programs serving the same population creates opportunities for cost-shifting as a way for each program to limit its financial liability. Because Medicare is entirely federally funded, for example, states have incentives to ensure Medicare is billed for as many services as possible – a practice known as “Medicare maximization” that states say is consistent with Medicare’s role as the primary payer of physician and other acute care services. For those services for which both Medicare and Medicaid are major payers, moreover, such as nursing facility and home care, opportunities and incentives for cost-shifting by providers are particularly strong as they seek to maximize payment or limit their liabilities. Incentives such as these may have contributed to the explosive growth in Medicare home health expenditures between 1988 and 1997, which has been attributed, in part, to home health care agencies first billing Medicare for needed care before turning to Medicaid.

Others fear that where two programs cover the same population and no single entity is accountable for all patient care, reimbursement incentives may play a disproportionate role in influencing treatment decisions at the expense of the patients’ best interests. To maximize reimbursement under Medicare’s prospective payment system (PPS), for instance, which pays hospitals a fixed amount for each episode of patient care, facilities have an incentive to discharge patients as quickly as possible to long-term care settings in the home or nursing home, which are eventually paid for by Medicaid.

Medicare-Medicaid System Reform Goals

In view of perceived problems in the way acute and long-term care services for Medicare-Medicaid dual eligibles are financed, administered and delivered, some observers argue that reform of the health care delivery system is required if this population is going to be served more cost-effectively. Among the most commonly articulated goals of reform are to:

- ! **Eliminate fragmented service delivery**, while promoting enhanced continuity of care and more simplified access to services;
- ! **Develop community-based options** that promote beneficiary independence through the use of the most cost-effective, least restrictive care settings (i.e., reduce institutional care in favor of home and community-based care);

¹⁷Liu, Korbin, Sharon K. Long, and Cynthia Aragon. Does Health Status Explain Higher Medicare Costs of Medicaid Enrollees? *Health Care Financing Review*, v. 20, no. 2, 1998. p. 39-54.

- ! **Make benefits more flexible** and responsive to the diverse and changing needs of individual beneficiaries;
- ! **Promote improvements in care quality** and beneficiary outcomes; and
- ! **Control costs** through greater emphasis on prevention and primary care, reduced incentives to use institutional care, fewer opportunities to cost-shift, streamlined administration and oversight, and less reliance on cost-based reimbursement systems.

Managed Care as a Vehicle For Integration

Integration means different things to different people. For purposes of this report, it refers to the process of unifying two previously separate systems into one – in this case, acute and long-term care financing, administration, and service delivery for dual eligibles. From the perspective of beneficiaries, a fully integrated system would provide easier access to appropriate, seamless care, with acute care providers coordinating with long-term care providers and vice versa.¹⁸ What are now multiple systems would look and act as one. Perhaps the most frequently proposed vehicle for integration has been managed care.

Managed Care Basics

A recent CRS report defined managed care as a payment system or delivery arrangement through which health plans attempt to control or coordinate the use of services by their enrollees.¹⁹ Particular managed care arrangements range from managed fee-for-service systems using case management, utilization review, and other utilization control strategies, to managed care organizations that combine utilization management activities with a variety of risk-sharing arrangements. While traditional unmanaged fee-for-service plans simply reimburse independently operating providers for services rendered, managed care organizations directly provide or arrange to provide for health care services through affiliated physicians, hospitals, and other providers.

Managed care organizations also assume varying degrees of risk for the care that they provide. Those assuming full risk receive a prepaid, fixed monthly payment or capitation rate in exchange for which they are responsible for all member services. Unlike fee-for-service systems that create incentives for providers to order additional, possibly unnecessary, excessive, and duplicative services, managed care organizations typically rely on prospective reimbursement, which creates incentives for providers to minimize spending by, theoretically, controlling inappropriate utilization and promoting early intervention. Common utilization management activities employed

¹⁸Wiener, Joshua M. and Jason Skaggs. *Current Approaches to Integrating Acute and Long-Term Care Financing and Servicing*, no. 9516. Public Policy Institute, AARP. December 1995.

¹⁹For additional information see CRS Report RS20259, *Managed Care Fact Sheet*, by Jean P. Hearne. July 9, 1999. See also CRS Issue Brief IB98017, *Patient Protection and Managed Care*, by Jean P. Hearne. Updated June 6, 2000.

by managed care organizations include case management, utilization review, mandatory second opinions, preauthorization, and member copayments. Managed care plans may also negotiate discounted rates with their provider networks, select low-cost providers, or give participating providers a financial stake in the cost of the services that they order.

In 1997, more than 60% of the U.S. population, or 165.7 million Americans, including 75% of insured employees, belonged to Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Provider Sponsored Organizations (PSOs), and a host of other managed health care plans. Though not nearly as common, enrollment of Medicare and Medicaid recipients in managed care has also grown over the course of the last decade. Dual eligibles may enroll in managed care through either Medicare, Medicaid, or both.

Medicaid Managed Care Enrollment

States generally rely on two types of managed care under their Medicaid plans, including “risk-based” programs in which health plans assume full or partial risk for at least some Medicaid covered services, and primary care case management programs (PCCMs), in which states pay individual health care providers (a physician or other licensed health professional) a small monthly fee in return for managing health care services for a defined population. According to a survey by the National Academy for State Health Policy, by 1998, 54.4% of all Medicaid recipients (16.7 million) were enrolled in managed care, up from 23.0% in 1994, with approximately three times as many Medicaid beneficiaries enrolled in risk-based as opposed to PCCM programs.²⁰ The scope of services covered under a risk contract, in particular, may range from a single service such as mental health to a comprehensive package that includes all Medicaid covered benefits. Forty-eight states (all but Alaska and Wyoming) and the District of Columbia had some form of managed care program that year. While the number of states with risk-based programs grew from 27 to 45 between 1990 and 1998, the number of states with PCCM programs grew from 19 to 29.²¹

Medicaid law prohibits states from requiring dual eligibles to enroll in managed care. Compared to other eligible groups (e.g., poverty-level pregnant women and children) populations with complex needs are less likely to be enrolled in managed care. Enrollment of dual eligibles in Medicaid managed care depends in part on individual state Medicaid program policies. In 1998, for instance, only 23 of 45 states with comprehensive risk programs enrolled community-based elderly Medicaid recipients.²² Of these 23 states, only nine operated statewide programs that included this population. Medicare-Medicaid dual eligibles and Medicaid long-term care recipients are much more likely than other groups not to be enrolled in managed care (i.e., excluded) or permitted to disenroll from an otherwise mandatory program (i.e.,

²⁰Pernice, Kaye N., and C. Pelletier H., eds. National Academy for State Health Policy. *Medicaid Managed Care: A Guide for States, Fourth Edition*. March 1999. Portland, ME.

²¹Ibid.

²²Ibid.

exempted). Of the 45 states with risk-based managed care programs in 1998, for example, 73% excluded or exempted dual eligibles (31 and 4 respectively), 82% excluded or exempted community-based long-term care recipients (36 and 3 respectively), and 87% excluded or exempted institutionally-based long-term care recipients (39 and 1 respectively).

Medicare Managed Care Enrollment

Medicare beneficiaries are entitled to enroll in Medicare+Choice²³ plans as long as they live in areas served by those plans. In September 2000, 16.4% of Medicare beneficiaries (6.2 million) were enrolled in one of 261 Medicare+Choice plans, up from 3.3% in 1990.²⁴ While Medicare HMO enrollment has grown, it still lags behind Medicaid, (which has more than 50% of its beneficiaries enrolled in managed care). Unlike states, which may make Medicaid managed care enrollment mandatory for most populations, or acquire special waivers to do so for others (e.g., dual eligibles), the federal government cannot require Medicare beneficiary enrollment in managed care. This is because Medicare beneficiaries have a statutory right under the Social Security Act to choose the providers from which they receive care, a requirement that cannot be waived. Relative to other Medicare beneficiaries, however, dual eligible enrollment has especially lagged. Only 4.7% of dual eligibles enrolled in a Medicare HMO in 1998, compared to 17.4% of non-duals.²⁵

A Managed Care Approach to Integration

Despite state reluctance to enroll dual eligibles in managed care, most initiatives to integrate acute and long-term care for this population build on existing managed care arrangements to meld together components of the Medicare and Medicaid programs, including financing, benefits, providers, administration, and oversight. This report considers three broad policy goals articulated by system reform advocates: financial integration, service delivery integration, and administrative integration.²⁶

²³The Balanced Budget Act of 1997 replaced the existing Medicare HMO program established under the Tax Equity and Fiscal Responsibility Act of 1982 with a new program, Medicare+Choice, which expanded the array of service delivery options available for Medicare risk contracting, including health maintenance organizations, preferred provider organizations, provider sponsored organizations, private fee-for-service plans, and medical savings accounts. It should be noted that dual eligibles were specifically excluded from medical savings account plans. For additional information see CRS Report 98-90, *Medicare Risk-Contract HMO and Medicare+Choice Private Plan Options*, by Beth C. Fuchs, and Jack Hoadley.

²⁴CRS Report RL30702, *Medicare+Choice*, by Hinda Chaikind and Madeleine T. Smith.

²⁵HCFA analysis of the 1998 Medicare Current Beneficiary Survey.

²⁶Booth, Maureen, Julie Fralich, and Paul Saucier. The Muskie School of Public Service, University of Southern Maine, and the National Academy of State Health Policy. *Integration of Acute and Long-Term Care for Dually Eligible Beneficiaries through Managed Care*. August 1997. Medicare/Medicaid Integration Project Technical Assistance Paper No. 1. This section builds on a more extended discussion reported in this study. For purposes of this CRS

(continued...)

Financial Integration. For financial integration to take place, the funds used to pay for care need to be pooled together. The most common approach suggested for doing so is capitation, which, as stated earlier, pays contracting entities a fixed fee in advance to provide a range of services. In a fully integrated system serving dual eligibles, a single contractor would receive combined Medicare and Medicaid capitation payments in exchange for assuming complete responsibility for the full range of Medicare and Medicaid acute and long-term care benefits. Unlike fee-for-service systems, which pays for each covered benefit provided, fully capitated entities would, in theory, have the financial incentive to coordinate/integrate delivery of all needed acute and long-term care services. Advocates also argue that because managed care organizations are at risk financially, they would have an incentive to emphasize preventive services, to reduce hospitalization, and to substitute low-cost settings for high-cost settings when appropriate (e.g., nursing facility care for hospital care, community care for nursing home care). In fact, some believe that savings resulting from reduced acute care utilization (i.e., hospitalization) could be used to fund expanded long-term care benefits, and that full capitation would also eliminate incentives to shift costs because the use of a fixed payment to cover all services eliminates the need to consider which program is paying.

Service Delivery Integration. For full integration to take place, service delivery integration is also required. As a first step, proponents suggest the development of comprehensive delivery systems with access to the complete array of health and social services necessary to meet the complex needs of dual eligibles. Ideally, an integrated network would combine traditional health care providers, such as physicians, hospitals, and nursing homes, with community-based organizations with experience caring for the chronically ill and infirm at home or in the community. Supportive residential options such as assisted living might also be included.

Advocates point out, however, that simply forming an expanded provider network does not guarantee that services will be integrated. Additional steps need to be taken to ensure that coordination takes place. Possible strategies include: (1) case management systems that facilitate communication and promote smooth transitions across providers and settings; (2) assignment of a primary care provider or team leader through whom beneficiaries access additional network services; (3) interdisciplinary care teams that possess the varying skills required to meet the diverse needs of individual members; and (4) centralized member records that ensure timely access to beneficiary information.

Administrative Integration. For advocates, the last piece of the integration puzzle is to eliminate the administrative inefficiencies associated with using multiple payers and delivery sources in an uncoordinated system. Administrative integration, in particular, would involve a single set of Medicare and Medicaid program requirements, including the way contracts are administered, enrollment takes place,

²⁶(...continued)

report the categories used by Booth, et al. are compressed. According to Booth, et al., fully integrated systems are those that provide for integrated financing, broad and flexible benefits, far-reaching delivery systems, care integration, unified program administration, and overarching quality systems.

data are reported, and quality management and oversight occur. Rather than requiring plans to enter into separate contracts with Medicare and Medicaid, for example, a fully integrated program would employ a single contract for plans serving participants in both programs. In addition to helping to create a single point of accountability for all Medicaid and Medicare benefits, use of a single contract would reduce duplication and resolve important differences across the two programs.

To minimize the amount of paperwork and confusion resulting from separate Medicare and Medicaid membership in the same plan, an integrated system would also collapse the enrollment systems of the two programs into a single process for the beneficiary. Moreover, to better track utilization across payment sources, administrative integration would authorize the collection of a complete set of encounter-level data (i.e., data gathered each time the beneficiary is seen, no matter what the funding source). Through more consistent standards, fewer redundant requirements, and better coordination among overlapping oversight authorities, Medicare and Medicaid quality management activities would also be rationalized.

Federal and State Initiatives Serving Medicare-Medicaid Dual Eligibles

The federal government and several states have developed a number of pilot initiatives aimed at integrating acute and long-term care services for Medicare-Medicaid dual eligibles. Nine are reviewed in this report. (See **Appendix A** and **B** for detailed program profiles). They include:

- ! *Federal initiatives* such as the Program for All-inclusive Care of the Elderly (PACE) which capitates Medicare and Medicaid, as well as the EverCare demonstration and Social Health Maintenance Organization Demonstration (S/HMO) which capitates Medicare only²⁷;
- ! *Comprehensive state demonstrations* such as Minnesota Senior Health Options, the Wisconsin Partnership Program, and the Continuing Care Network Demonstration of Monroe County New York, which, like PACE, capitates both Medicare and Medicaid benefits; and
- ! *Capitated state Medicaid demonstrations* such as the Arizona Long-term Care System, Oregon Health Plan, and Florida's Community-Based Diversion Pilot Project, which capitate Medicaid only but actively pursue various Medicare coordination strategies.

Implementation of dual eligible programs such as these require HCFA approval of waivers of certain Medicaid and Medicare program rules. A Medicaid waiver, in particular, allows states to waive certain federal requirements in order to operate specific kinds of programs. The Medicaid requirements that may be waived are statewideness (requirement that services be available statewide), comparability of services (requirement that duration, amount and scope of services in the state be

²⁷The S/HMO program also has the authority to capitate Medicaid covered benefits, though this only occurs in limited circumstances.

similar for all covered groups), and freedom-of-choice (requirement that Medicaid recipients be free to choose their own providers). These waivers are usually referred to according to the section of the Social Security Act under which they are authorized. Extant Medicaid waiver authorities include 1115 “research and demonstration” waivers, 1915(b) “freedom-of-choice” waivers, and 1915(c) home and community-based services waivers. States may also use one non-waiver authority, 1915(a), to establish voluntary managed care programs. (See **Appendix C** for details.)

States have traditionally sought 1915(b) or 1115 waivers when considering mandatory Medicaid managed care programs. Others have combined a 1915(a) (allowing states to establish voluntary managed care programs), or 1915(b) waiver (allowing states to establish mandatory managed care programs) with a 1915(c) waiver which allows them to expand available services to include non-medical, social, and support services that allow individuals who otherwise would have required nursing facility care to remain in the community. Those explicitly incorporating Medicare services into their managed care efforts have also sought Section 222 Medicare waivers which allow them to contract with plans that are not Medicare risk contractors and to alter the way such contractors are paid. Waiver applications are reviewed and approved by HCFA.

Though the nine programs profiled in this report use varying approaches and combinations of waiver authorities, general similarities exist in their strategies for integrating financing and service delivery (see **Table 3**). While financial integration involves capitation of Medicare and/or Medicaid benefits, service delivery integration typically involves comprehensive provider networks, case management, and interdisciplinary teams of providers. Less effort, however, has been made to integrate Medicare and Medicaid administratively. Only PACE and MSHO include provisions to integrate Medicare and Medicaid data reporting requirements, while only MSHO has integrated provider contracting and member enrollment processes.

Table 3. Examples of the Way Profiled Programs Pursue Medicare/Medicaid Integration

Program	Financial	Service Delivery	Administrative Integration
Program for All-Inclusive Care of the Elderly (PACE)	Medicare and Medicaid Capitation. Acute and Long-Term Care Services	Community Organizations. Provider Teams	One set of encounter level data to HCFA
Social HMO (S/HMO) Demonstration	Medicare Capitation. Medicaid Capitation (where applicable). Acute and Some Long-Term Care	HMOs and Long-Term Care Organizations. Case Managers	_____
EverCare Demonstration	Medicare Capitation. Acute Care Only	HMOs. Provider Teams. Case Managers	Medicare only
Minnesota Senior Health Options (MSHO) Demonstration	Medicare and Medicaid Capitation. Acute and Most Long-Term Care	HMOs and Geriatric Care Systems. Care Coordinators	Single contract, enrollment process, and data reporting requirements
Wisconsin Partnership Program Demonstration	Medicare and Medicaid Capitation. Acute and Long-Term Care	Community Organizations. Provider Teams	_____
Continuing Care Network (CCN) Demonstration	Medicare and Medicaid Capitation. Acute and Long-Term Care	Integrated Network. Provider Teams	_____
Arizona Long-term Care System (ALTCS) Demonstration	Medicaid Capitation. Long-Term Care and some Acute Care	County and Private Health Plans. Case Managers	_____
Oregon Health Plan (OHP) Demonstration	Medicaid Capitation. Some Acute Care	Health Plans. Care Coordinators	_____
Florida's Community-Based Diversion Project	Medicaid Capitation. Long-Term Care and Some Acute Care	HMOs. Case Managers	_____

Though similarities exist in some of the general integration strategies used, program specifics vary greatly. The following three sections discuss these differences in the context of federal initiatives, comprehensive state demonstrations, and capitated state Medicaid demonstrations.

Integration Through Federal Initiatives

Under this approach dual eligibles voluntarily enroll in a managed care organization participating in one of three federal initiatives: the first and second generation incarnations of the S/HMO demonstration, the EverCare demonstration, and the PACE program (which the Balanced Budget Act of 1997 made a permanent benefit category under Medicare and an optional benefit states can offer under Medicaid). All three programs operate under Section 222 Medicare demonstration waivers and all three capitate Medicare acute care benefits. Although PACE and S/HMO also operate under Section 1115 Medicaid waivers, S/HMOs serve a much broader cross-section of Medicare beneficiaries than PACE (i.e., they target Medicare beneficiaries generally) and, therefore, enroll comparatively few dual eligibles. PACE, on the other hand, requires that enrollees be certified for nursing home care and targets persons who are or would be eligible for Medicaid and on whose behalf the state makes another capitated payment, generally to cover long-term care services not covered by Medicare. The EverCare program, by contrast, focuses exclusively on Medicare-eligible nursing home residents.

Though EverCare does not cover long-term care, its providers work closely with nursing homes to coordinate acute and long-term care services. The goal of EverCare, in particular, is to use physician-nurse practitioner teams as a way to reduce the need to hospitalize nursing home residents. By emphasizing the delivery of primary, preventive, and other outpatient services within the nursing home, EverCare attempts to save Medicare money and reduce the dislocation trauma associated with being transferred from the nursing home to the hospital. Under EverCare, the per enrollee monthly capitation paid by Medicare is equal to 97.8% of the Medicare county rate for Medicare+Choice plans. Approximately 11,300 nursing home residents are being served at six EverCare demonstration sites. An evaluation is due at the end of 2001.

Unlike EverCare, PACE provides coverage for a broad array of long-term care services. The primary goal of PACE is to use interdisciplinary case management, adult day care, and other home and community-based care services to prevent the institutionalization of extremely frail elders. Case management teams, in particular, consist of physicians, nurses, social workers, dietitians, physical and occupational therapists, activity coordinators, and other health and transportation workers. Under PACE, the per enrollee monthly capitation paid by Medicare is equal to 2.39 times the Medicare county rate amount for Medicare+Choice plans. Calculation of the monthly Medicaid rates varies by state and is subject to negotiation between each PACE provider and state Medicaid agency. Member premiums are charged when appropriate. There are currently 7,000 enrollees at 26 PACE sites in 14 states.

HCFA's evaluators of the PACE demonstration found that compared to people who applied to PACE but later declined to enroll, PACE enrollees were less costly as indicated by lower health expenditures in the 6 months prior to applying to the PACE program.²⁸ This led evaluators to conclude that PACE sites are experiencing

²⁸Irvin, Carol. *Evaluation of the Program of All-Inclusive Care for the Elderly (PACE)*
(continued...)

favorable selection, or the disproportionate enrollment of healthier than average applicants (i.e., those individuals who were referred, screened, and willing to consider program services). Controlling for prior utilization and other factors, they also found that PACE enrollees, after enrollment, had lower hospital and nursing home use, a higher probability of survival, better self-reported health status, higher satisfaction, and lower levels of functional impairment. Though statistically significant impacts were found with respect to each of these outcomes, PACE's impact on medical utilization tended to be longer lasting (i.e., more than 1 year after enrollment) than its impact with respect to self-reported health status, satisfaction, and function (i.e., less than 1 year after enrollment).²⁹ While evaluators found that Medicare capitation payments were much lower than expenditures would have been had PACE enrollees continued to receive care in the fee-for-service sector, they found that capitated payments made by Medicaid were greater than projected fee-for-service costs. Overall, however, no statistically significant difference was found between combined Medicare and Medicaid fee-for-service costs and the total (Medicare and Medicaid) capitation rates received by PACE program sites.³⁰

Compared to PACE the goal of the S/HMO demonstration is more limited. Rather than attempting to fully integrate a wide range of acute and long-term care services, it assesses the feasibility of adding a limited chronic care benefit to the typical package of Medicare HMO services. While the three first generation S/HMO sites (S/HMO-I) focus care coordination exclusively on those enrollees certified for nursing facility care, the lone second generation site (S/HMO-II) focuses it more broadly on individuals with high-risk conditions, evidence of impending disability, or at high-risk for hospitalization. This latter site also uses a more geriatric-oriented model of care, including greater reliance on interdisciplinary teams of providers.

Under S/HMO, the per enrollee monthly capitation payment paid by Medicare is equal to 105.3% of the county rate for Medicare+Choice plans. Plans in both S/HMO generations, moreover, adjust payment for high risk enrollees. First generation sites' payments are adjusted for the demographic characteristics of the enrollee, e.g., higher capitation payments are made for persons in nursing homes than for those in the community. The lone second generation plan, on the other hand, risk-adjusts Medicare payments using impairments in activities of daily living and instrumental activities of daily living, as well as the prevalence of adverse medical conditions. In addition to Medicare payment, S/HMOs also receive Medicaid payments when appropriate (currently only one site has a formal agreement with the state to receive Medicaid capitation payments for dually eligible enrollees). They may

²⁸(...continued)

Demonstration: Determinants of Enrollment Among Applicants to the PACE Program, Final Report. Prepared for the Health Care Financing Administration. HCFA Contract no. 500-96-0003/T04. Cambridge, MA, Abt Associates, Inc. January 1998.

²⁹Chatterji, Pinka. *Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) Demonstration: The Impact of PACE on Particular Outcomes, Final.* Report Prepared for the Health Care Financing Administration. HCFA Contract no. 500-96-0003/T04. Cambridge, MA, Abt Associates, Inc. June 1998.

³⁰Forthcoming report under review at HCFA. Based on personal communication with HCFA staff.

also charge member premiums. Currently, more than 84,000 individuals are enrolled at the program's four sites.

An evaluation of S/HMO-I took place between 1985 and 1989. Evaluators concluded that while it succeeded organizationally in offering long-term care to frail enrollees, it failed to achieve an adequate degree of coordination between acute and chronic care services. Lack of communication between physicians and other participants, especially case managers, was largely to blame.³¹ This finding is one reason why those planning S/HMO-II opted to use multidisciplinary teams of providers to assess, plan, and manage care. Moreover, financial losses and high expenditures (relative to fee-for-service Medicare) among a number of high risk groups during the demonstration's early years also led investigators to suggest refinements to S/HMO operations.³²

Like PACE, S/HMO-I sites experienced favorable selection, in this case, the disproportionate enrollment of healthier than average Medicare beneficiaries. Using prior utilization and health status, in particular, the evaluators found that S/HMO enrollees tended to be healthier than those in traditional fee-for-service Medicare. They also found evidence of favorable disenrollment, where frail and impaired members were more likely to disenroll than healthier members.³³ The impact of S/HMO-I on outcomes was mixed. While the evaluators concluded that S/HMOs performed HMO functions well for the healthy and acutely ill, they concluded that S/HMOs did not perform well for impaired or acutely ill enrollees with chronic impairments. Though there was no overall difference in mortality rates (standardized for case mix) between S/HMO enrollees and fee-for-service Medicare beneficiaries. Moreover, frail individuals had a higher probability of dying in S/HMOs than in fee-for-service Medicare.³⁴ While unimpaired S/HMO enrollees reported generally higher satisfaction than comparable fee-for-service Medicare beneficiaries, impaired enrollees reported lower satisfaction than impaired fee-for-service beneficiaries in all areas but finance and benefits (where they were more satisfied).

Overall, S/HMOs serve comparatively larger enrollments than PACE and EverCare because the latter two programs are limited, in part, by the need to deliver essential program services at particular sites (i.e., adult day care centers for PACE and nursing homes for EverCare). Though the PACE and S/HMO programs were

³¹Harrington, Charlene, Marty Lynch, and Robert J. Newcomer. Medical Services in Social Health Maintenance Organizations. *The Gerontologist*, v. 33, no. 6, 1993. p. 790-800.

³²Newcomer, Robert, Kenneth Manton, Charlene Harrington, Cathleen Yori, and James Vertrees. 1995. Case Mix Controlled Service Use and Expenditures in the Social/Health Maintenance Organization Demonstration. *Journal of Gerontology: Medical Sciences*, v. 50A, no. 1. p. M35-M44.

³³Harrington, Charlene, Robert J. Newcomer, and Steve Preston. A Comparison of S/HMO Disenrollees and Continuing Members. *Inquiry*, v. 30, 1993. p. 429-440.

³⁴Manton, Kenneth G., Robert Newcomer, Gene R. Lowrimore, James C. Vertrees, and Charlene Harrington. Social/Health Maintenance Organization and Fee-for-Service Health Outcomes Over Time. *Health Care Financing Administration*, v. 15, no. 2, 1993. p. 173-202.

designed to serve as models for states, the role of the states in designing and managing federal demonstration programs such as these has been limited.

Integration Through Comprehensive State Demonstrations

Under this approach, a dually eligible beneficiary voluntarily enrolls in one of a growing number of state administered demonstrations that capitate both Medicaid and Medicare benefits. Particular programs include Minnesota Senior Health Options (MSHO), the Wisconsin Partnership Program, and the Continuing Care Network (CCN) Demonstration of Monroe, County New York (which will begin operating in 2001). In addition to goals of controlling costs and reducing administrative complexity, all intend to delay institutionalization through the provision of expanded home and community-based care options.

All three operate under Section 222 Medicare waivers. While Wisconsin Partnership currently operates under a Section 1115 Medicaid waiver, MSHO recently substituted a Section 1915(a)/1915(c) combination for the Section 1115 waiver under which it was originally authorized. CCN is also authorized under a Section 1915(a)/1915(c) combination. There are currently 3,569 enrollees in MSHO and Section 822 in Wisconsin Partnership.

Though all enroll dually eligible elders, Wisconsin Partnership also enrolls younger disabled adults, while Minnesota intends to do so in the future. While Wisconsin focuses exclusively on individuals deemed eligible for nursing facility care, MSHO and CCN cast their nets more broadly, enrolling both impaired and unimpaired beneficiaries. In addition to dual eligibles, CCN also enrolls Medicare-only beneficiaries, who receive a limited chronic care benefit as part of enrollment in the program and who may purchase extended long-term care coverage privately.

To provide services, CCN has contracted with a single managed care organization that features a comprehensive network of acute and long-term care service providers. Though most Medicaid benefits are included in the New York demonstration, some, such as prescription drugs, remain in the fee-for-service system. Minnesota, on the other hand, has contracted with HMOs which have in turn subcontracted with Geriatric Care Systems to provide all or part of the MSHO benefits package, including all acute care, home and community-based waiver services, as well as 180 days of Medicaid nursing facility coverage (which, after 180 days, Medicaid pays on a fee-for-service basis). To provide all acute and long-term care services, Wisconsin Partnership, by contrast, has contracted with community-based organizations with experience serving elderly and disabled individuals living in the community.

Interestingly, MSHO is the only program to receive waivers allowing it to combine the purchase of Medicaid and Medicare services into a single contract managed and overseen by the state. All other dual eligible initiatives, including the Wisconsin Partnership Program and CCN, require that plans enter into two contracts, a Medicaid managed care contract with the state and a Medicare contract with HCFA. MSHO believes that use of a single contract has allowed it to better resolve important differences between the Medicaid and Medicare programs than if separate contracts had been used. For example, it has enabled MSHO to merge the enrollment

processes, membership materials, and grievance procedures of the two programs. Medicare and Medicaid capitation payments are always pooled at the plan level rather than the state level, even in Minnesota.

Plans in all three programs receive capitation payments from Medicare and Medicaid. Like PACE, the per enrollee monthly capitation paid by Medicare under Wisconsin Partnership is equal to 2.39 times the Medicare county payment rate amount for Medicare+Choice plans. To create incentives for plans to use home and community-based services rather than institutional services and to provide disincentives for the favorable selection of healthier than average individuals, MSHO and CCN base reimbursement, in part, on impairment, paying more for impaired individuals living in the community than unimpaired individuals living in the community. In doing so, both programs employ separate capitation rates for the following subgroups: nursing home residents, unimpaired community residents, community residents eligible for nursing facility care, and nursing home conversions.³⁵ Impaired community enrollees in the Minnesota program receive 2.39 times the Medicare county rate amount for Medicare+Choice plans along with a Medicaid payment component equivalent to the average monthly payment for elderly home and community-based waiver services. CCN, on the other hand, intends to use the results of functional assessments to risk-adjust Medicare and Medicaid payments according to impairment level.

While MSHO requires that each enrollee have access to a care coordinator, both Wisconsin Partnership and CCN use interdisciplinary teams of providers to manage care. Wisconsin partnership also has an especially strong emphasis on client involvement in decisionmaking, including choice of provider, services and setting.

All three programs cater to limited service areas and enrollments. Though comparatively few of each state's dual eligible population is served by MSHO, Wisconsin Partnership, and CCN, the limited scope of these programs has facilitated each state's ability to put together provider networks capable of delivering a comprehensive array of acute and long-term care services. It has also facilitated their ability to recruit health and social service organizations with experience serving elderly and chronically disabled adults living in the community. All three programs will be studied as part of a multi-state evaluation performed by researchers at the University of Minnesota. The results are due in 2005.

Integration Through Capitated State Medicaid Demonstrations

Under this option a dually eligible beneficiary enrolls in a capitated Medicaid demonstration that coordinates with either capitated or fee-for-service Medicare. These demonstrations include mandatory, statewide Medicaid managed care programs such as the Arizona Long-Term Care System (ALTCS) and Oregon Health Plan (OHP), or small, voluntary programs such as Florida's Community-Based Diversion Pilot Project, which serves selected metropolitan areas or counties. While the ALTCS

³⁵Nursing home conversions refer to individuals who have been discharged into the community after nursing facility stays of more than 6 months in the MSHO program and 5 months in the CCN demonstration.

currently enrolls 28,993 individuals, including close to 19,000 elderly and physically disabled persons, enrollment in OHP stands at 349,500, including 50,000 elderly and physically disabled dual eligibles. There are 501 individuals enrolled in the Florida sites.

Both Arizona and Oregon use Section 1115 “research and demonstration” waivers to require most state Medicaid recipients to enroll in managed care. While recipients certified for nursing home care receive integrated acute and long-term care services under the ALTCS, the OHP does not formally cover long-term care. Instead, OHP contractors are required to hire “exceptional needs coordinators” (ENCCs) whose responsibilities include coordinating OHP-covered acute care benefits with long-term care services furnished in the fee-for-service system. Florida’s Community-Based Diversion Pilot project, on the other hand, uses a Section 1915(c) home- and community-based services waiver to add community-based long-term care to the acute care benefits already covered by existing Medicaid contractors.

Though none of the three programs profiled capitate Medicare, aspects of each increase the likelihood of coordination. All three, for example, contract with at least one managed care organization which also participates in the Medicare+Choice program, giving at least some dual eligibles the option of receiving capitated Medicaid and Medicare benefits from the same plan. For those electing to remain in fee-for-service Medicare, moreover, Arizona and Oregon have received waivers from HCFA allowing them to limit their Medicare cost-sharing obligations to services delivered through their Medicaid plans³⁶; that is, the state will cover Medicare cost-sharing amounts only when Medicare covered services are provided by a capitated plan that also has a contract with the state Medicaid program. (All other state Medicaid programs must pay Medicare premiums, deductibles, and coinsurance for Medicare beneficiaries who qualify for full Medicaid benefits, no matter where those beneficiaries receive their care). Arizona’s and Oregon’s special cost sharing restrictions, on the other hand, have provided dual eligibles with strong incentives to use the same providers for both Medicaid and Medicare. Given HCFA’s reluctance to offer any more such waivers, however, other states must instead rely on consumer incentives, enrollment counseling and other strategies to persuade beneficiaries to use Medicaid network providers for Medicare services. Where ALTCS and OHP members choose to receive their Medicare services through enrollment in a Medicare+Choice plan, however, the states are still obligated to pay any beneficiary cost-sharing that might be required.

Rather than focusing on beneficiary choice of providers, Florida requires contractors to hire case managers whose functions include coordinating the delivery of all acute and long-term care services regardless of funding source. Where project enrollees have opted to receive their Medicare benefits on a fee-for-service basis, for example, case managers are responsible for actively pursuing coordination with their primary care physician even though that physician may be a non-Medicaid affiliated provider. How effective such coordination is, however, depends on how cooperative

³⁶Minnesota also has a similar waiver for its prepaid medical assistance program, i.e., its mandatory Medicaid managed care program.

out-of-network providers are, since they are paid by Medicare but unaffiliated with the Medicaid plan in which their patients are enrolled.

While the approach discussed in this section capitates Medicaid only, it provides enrollees with a wide pool of Medicare providers from which to choose. Through consumer incentives, enrollment education, and contracting with existing Medicare HMOs, it also affords states the opportunity to encourage dual eligibles to receive all of their Medicaid and Medicare benefits from the same plan. Some believe that this approach may be particularly attractive to states designing programs for broadly defined target groups and not just those certified for nursing homes. Others, however, doubt whether effective care coordination can take place unless requirements under both programs are formally synchronized and combined Medicare-Medicaid capitation occurs.

Of the three capitated Medicaid programs reviewed, evaluation results are available for Arizona and Oregon. An evaluation of the Florida program is currently in the planning stages. The evaluation of the ALTCS found an approximately 16% average annual reduction in what Arizona spent per capita for elderly and physical disabled long-term care Medicaid recipients from what would have been spent in a typical Medicaid program. Most savings arose from reduced hospital and nursing home use. While the plan experienced higher ambulatory and administrative expenditures, these were smaller than the savings due to lower utilization of institutional care – resulting in net savings to the plan.³⁷

The effect of the Arizona system on patient outcomes was mixed. Evaluators found that nursing home residents in the ALTCS were less likely to be offered an influenza vaccine than Medicaid nursing home residents in neighboring New Mexico. Medicaid nursing home residents in the ALTCS, moreover, were also more likely to experience other negative medical experiences (such as a decubitus ulcer, fever, and catheter insertion) than nursing home residents served by the New Mexico program. No significant differences, however, existed with respect to the incidence of patient falls or fractures resulting from the use of psychotropic drugs.³⁸

Evaluators of the acute care side of the Arizona Medicaid system found that SSI recipients in Arizona were less likely to report being very satisfied with their overall medical care compared to their counterparts in New Mexico. Arizona enrollees also reported being slightly less satisfied, on average, with waiting time, evening and weekend availability, information giving, courtesy and consideration. On the other hand, Arizona recipients reported slightly more satisfaction with ease and convenience and the costs paid out-of-pocket for medical care received.³⁹

³⁷McCall, N., C.W. Wrightson, J. Korb, et al. *Evaluation of Arizona's Health Care Cost Containment System Demonstration, Final Report*. Prepared for the Health Care Financing Administration. HCFA Contract No. 500-83-0027. San Francisco, CA, Laguna Research Associates. February 1996.

³⁸Ibid.

³⁹McCall, Nelda, Jay Deborah, and Richard West. Access and Satisfaction in the Arizona Health Care Cost Containment System. *Health Care Financing Review*, v. 11, no. 1, 1989.

(continued...)

Though an evaluation of the Oregon Health Plan has been undertaken, most findings pertaining to the elderly and disabled portion of the demonstration will not be made available until early 2001. Preliminary findings, however, indicate that separate enrollment of dually eligible beneficiaries in Medicare and Medicaid is extremely complex and time-consuming, and represents the greatest source of frustration among OHP plans.⁴⁰ They also indicate that while the ENCC program has resulted in creative and flexible service plans for some beneficiaries, their effectiveness has been limited by lack of consumer and provider awareness and variations in ENCC program operation as a result of latitude granted plans in implementing these programs.⁴¹

³⁹(...continued)
p. 63-77.

⁴⁰Mitchell, Janet B., and Paul Saucier. *Enrolling Elderly and Disabled Beneficiaries in Medicaid Managed Care: Lessons Learned from the Oregon Health Plan*. Prepared for the Health Care Financing Administration and the Office of the Assistant Secretary of Planning and Evaluation. Waltham, MA, Health Economics Research, Inc, 1999.

⁴¹Walsh, Edith G., Gregory Todd French, and Fred Bentley. *The Exceptional Needs Care Coordinator in the Oregon Health Plan Draft*. Prepared for the Health Care Financing Administration and the Office of the Assistant Secretary of Planning and Evaluation. Waltham, MA, Health Economics Research, Inc, 2000.

Concerns About Integrating Acute and Long-Term Care

Though the number of federal and state initiatives integrating acute and long-term care for dual eligibles has grown in recent years, there are a variety of concerns that federal and state policymakers face when developing such programs in the future. While some of these issues may be characteristic of managed care more generally, they are especially salient where vulnerable populations such as dual eligibles are concerned. They include:

- ! Doubts about managed care's appropriateness for vulnerable populations;
- ! Lack of managed care plan availability;
- ! Evidence of risk selection and concerns about inadequate risk adjustment; and
- ! Statutory and regulatory impediments to developing and implementing integrated care programs.

Doubts About Managed Care's Appropriateness for Vulnerable Populations

Managed care organizations covering acute health care services through a capitated payment arrangement have primarily served a relatively young and employed population. Most states, moreover, have focused their Medicaid managed care programs on children and non-disabled adults, while Medicare beneficiaries who choose to enroll in managed care tend to be healthier than beneficiaries not enrolled. Relatively few managed care plans, therefore, have had experience serving vulnerable groups such as the dually eligible elderly who often have special needs associated with chronic conditions, require continuous rather than episodic care, experience problems in navigating through multiple systems, and often lack social resources (e.g., informal caregivers). As a consequence, some doubt whether managed care organizations have the expertise or the willingness to take on the risks associated with providing the specialized services and long-term care required by predominately chronically ill and disabled populations.⁴² Furthermore, given the primarily acute and post-acute care experience of most plans, some fear the "over-medicalization" of long-term care services or the diversion of funds budgeted for long-term care if integration should take place.

Others, echoing concerns behind the recent passage of patient protection bills in both the House and Senate,⁴³ fear that financial incentives to do less under managed care may lead to the under-provision of appropriate services, resulting in access and quality problems. They are particularly wary that gatekeeper systems, limited provider networks, and other conventions used to limit care for younger, healthier enrollees may inhibit the appropriate access of chronically ill and disabled individuals

⁴²Friedland, Robert B., and Judith Feder. Managed care for elderly people with disabilities and chronic conditions; Managed Care and Older People: Issues and Experiences. *Generations*, v. 22, no. 2, 1998. p. 51.

⁴³For additional information see CRS Issue Brief IB98017, *Patient Protection and Managed Care: Legislation in the 106th Congress*, by Jean P. Hearne.

to specialist and other services.⁴⁴ The following discussion briefly reviews relevant research findings pertaining to issues of resource use, costs, quality of care, and satisfaction.

Resource Use and Costs. Though not in perfect agreement with the S/HMO evaluation, which highlighted plan losses and comparatively high expenditures levels for certain high risk groups, findings from the PACE and ALTCS evaluations, as well as an evaluation of the Medicare HMO program, indicate that managed care plans serving the elderly typically use fewer resources and operate more cheaply than traditional fee-for-service arrangements. While PACE and Arizona recipients had higher rates of ambulatory care utilization, for example, enrollees in both programs experienced lower hospital and nursing home use.

These findings are consistent with the results of the Medicare HMO evaluation, which found that although HMOs had the same number of hospital admissions and home health clients as fee-for-service Medicare, they had a lower average length of stay and 50% fewer home health visits.⁴⁵ Overall, the evaluators concluded that Medicare HMOs spent 10.5% less for hospital, physician, home health and skilled nursing care than what would have been spent for the same enrollees in Medicare's fee-for-service system. While Medicaid capitation payments under PACE were higher, moreover, Medicare capitation payments were found to be much lower than what would have been spent had members not enrolled. This latter result is reflected on the Medicaid side in Arizona, where Medicaid payments were significantly less than what would have occurred had a typical Medicaid program been in operation.

Quality of Care. Although existing evaluations indicate that managed care plans serving the elderly often operate less expensively and use fewer resources, quality of care findings have been mixed – often no different, but sometimes worse. While evaluators concluded that S/HMOs performed well for the healthy and acutely ill, for example, results indicated that they did not perform well for the impaired or acutely ill with chronic impairments. While no significant difference was found between Arizona's managed care-based system and New Mexico's traditional Medicaid program with respect to certain nursing home outcomes (e.g., patient falls or fractures resulting from the use of psychotropic drugs), Medicaid nursing home residents in Arizona were more likely to experience unfavorable results such as a decubitus ulcer, fever, and catheter insertion. Even the PACE evaluation, with its generally positive findings (with respect to mortality, self-perceived health status, and function), revealed that the project's impact on health outcomes tended to be more fleeting than its effect on utilization.

Results from the Medicare HMO evaluation and other studies are also mixed. For example, evaluators found that, depending on the indicator, the performance of Medicare HMOs with respect to joint pain, colon cancer, chest pain, and stroke were sometimes better but more often no different or worse than fee-for-service

⁴⁴Friedland and Feder, 1998.

⁴⁵For results from the Medicare HMO evaluation, see: Brown, R.S., D.G. Clement, and J.W. Hill. Do Health Maintenance Organizations Work for Medicare? *Health Care Financing Review*, v. 15, 1993. p. 7-23.

Medicare.⁴⁶ Others found that elderly HMO enrollees were more likely than fee-for-service beneficiaries to report a decline in physical health outcomes over a 4-year study period,⁴⁷ while another study concluded that the outcomes of home health care were better for Medicare fee-for-service than HMO patients when adjusted for case mix.⁴⁸

Satisfaction. Although researchers have generally found that elderly people rate their overall satisfaction with both HMO and fee-for-service care highly, HMO enrollees sometimes report being more satisfied with financial and coverage aspects than fee-for-service beneficiaries and less satisfied with other dimensions. While unimpaired S/HMO enrollees reported higher satisfaction than fee-for-service beneficiaries in all areas except interpersonal relations (where there was no difference), impaired enrollees reported lower satisfaction in all areas but finance and benefits (where they were more satisfied).

Compared to their counterparts in New Mexico, moreover, SSI recipients in Arizona's Medicaid program reported being less satisfied with their overall medical care as well as with particular aspects of care such as waiting time, information giving, evening and weekend availability, courtesy and consideration. Alternatively, Arizona respondents reported being slightly more satisfied with ease and convenience and costs paid out of pocket. Similarly, a comparison of Medicare HMO and fee-for-service beneficiaries found the former to be less satisfied with care processes, plan access, provider choice, and perceived quality and outcomes, but more satisfied with costs and less likely to report lacking coverage for needed services.⁴⁹ PACE enrollees, on the other hand, had a higher probability of being satisfied with their overall care arrangements compared to people who applied to PACE but later declined to enroll.

Lack of Plan Availability

In 1999, 28% of Medicare beneficiaries lived in areas not served by Medicare HMOs. Though 99% of beneficiaries living in central urban areas had a choice of plans, almost 90% of beneficiaries living in rural areas had no choice. Thirteen states also had virtually no Medicare HMO enrollment. The number of organizations participating in the Medicare+Choice program declined from 346 to 261 by September 2000. Since the implementation of the program, a large number of managed care plans have withdrawn or reduced the size of their service areas. In 1999, 907,000 Medicare+Choice beneficiaries were affected by plan withdrawals and

⁴⁶Brown, et al., 1993; Clement, D.G., S.M Retchin, and R.S. Brown, et al., 1994. Access and Outcomes of Elderly Patients Enrolled in Managed Care. *JAMA*, v. 271. p. 1487-1492.

⁴⁷Ware, Jr., J.E. M.S. Bayliss, and W.H. Rogers, et al., 1996. Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems: Results from the Medical Outcomes Study. *JAMA*, v. 276. p. 1039-1047.

⁴⁸Shaughnessy, P.W., R.E. Schlenker, and D.F. Hittle. Home Health Care Outcomes Under Capitated and Fee-for-Service Payment. *Health Care Financing Review*, v. 16, 1994. p. 1870221.

⁴⁹Brown, et. al., 1993.

service area reductions. In 2000, another 327,000 beneficiaries were affected. For 2001, the estimate is 934,000, although some plans may choose to return to the program as a result of the passage of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.⁵⁰ Declining plan participation due to mergers and withdrawals has taken place in the Medicaid managed care market as well. Though the total number of participating risk plans grew from 275 in 1994 to 375 in 1998, the average number of plans per state with comprehensive risk plan enrollment declined 15%, from 9.8 to 8.3.⁵¹

At this point in time, there are questions about the ability and willingness of Medicare+choice plans to serve sparsely populated areas with low numbers of potential subscribers and undeveloped provider infrastructures. Plan withdrawal from both the Medicare and Medicaid managed care markets, on the other hand, is hard to interpret, though two interrelated issues come to the forefront: risk selection and payment.

Evidence of Risk Selection and Concerns About Inadequate Risk Adjustment

Evidence indicates that managed care plans serving the elderly experience favorable selection or the disproportionate enrollment of beneficiaries who are healthier, on average, than fee-for-service beneficiaries. Favorable selection has been extensively documented for Medicare HMOs.⁵² It has also been documented with S/HMO and PACE (at least with respect to people who applied to PACE but later declined to enroll). To the extent that favorable selection takes place, it may stem from a reluctance on the part of sicker individuals to disrupt long standing relationships with providers in the community. Although Medicare law prohibits favorable selection on the part of participating plans, they may encourage enrollment of healthier beneficiaries through selective marketing, or avoid enrollment of frail beneficiaries, by, for example, downplaying their reputation for serving chronically ill individuals.

Given evidence of favorable selection, HCFA believes that it has overpaid Medicare HMOs. Despite such perceived overpayment, however, health plans exhibit a continued reluctance to serve Medicare beneficiaries. There are a number of possible reasons, including fears by health plans of unlimited liability for care, weak demand, and underpayment by HCFA for frailer than average Medicare beneficiaries.

⁵⁰For further information, see CRS Report RL30707, *Medicare Provisions in H.R. 5661: Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000* by Hinda Chaikind, Sibyl Tilson, Jennifer O'Sullivan, Carolyn Merck, and Madeleine T. Smith, and

⁵¹Kaye, et al. *Medicaid Managed Care*. March 1999.

⁵²For example, see: Lichtenstein R. Thomas J.W., J. Adams-Watson, et al. Selection Bias in TEFRA At-Risk HMOs. *Medical Care* 1991, v. 29. p. 318-31. Brown, R.S., and J.W. Hill. The Effects of Medicare Risk HMOs on Medicare Costs and Service Utilization. In Luft, H.S., ed. *HMOs and the Elderly*. Ann Arbor, Michigan, Health Administration Press, 1994. Riley G., Tudor, C., Y. Chiang, et al. Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994. *Health Care Financing Review*, v. 17, 1996. p. 65-76.

Dissatisfaction with the way capitation rates are set is a significant factor underlying all these concerns.

To ensure that the federal government is not overpaying for healthier than average Medicare beneficiaries and that plans are receiving adequate payment to care for frailer than average ones, capitation rates can be adjusted for beneficiary risk. The mechanism for doing so is called risk adjustment, which is a process of setting capitation rates that reflect health status – paying plans more to care for ill beneficiaries and less to care for healthy ones. Prior to the BBA, HCFA adjusted Medicare’s capitation rates to managed care plans using certain demographic factors. In particular, HCFA used the the average adjusted per capita cost (AAPCC) methodology. Under the AAPCC, Medicare’s rates were based on county level fee-for-service expenditures adjusted for age, sex, disability status, institutional status, Medicaid eligibility, and working aged status. It is widely acknowledged that these factors do an extremely poor job of adjusting for risk. In fact, it has been shown that demographics explain only 1% of the variation in individual beneficiaries’ health care costs.⁵³ Because demographic factors are poor predictors of future health care use, inadequate risk adjustment has led to overpayments for healthier than average Medicare HMO enrollees and underpayments for frailer than average ones.

Recognizing certain inadequacies in payment methodology, the BBA mandated that HCFA develop and implement a method for risk adjustment based on health status. The new methodology,⁵⁴ which HCFA began to phase in January 2000, adjusts Medicare capitation payments using enrollee’s inpatient hospital diagnoses in the previous year, if any, as well as traditional demographic factors.⁵⁵

Though the new risk adjustment system may perform much better than the old system, there are still concerns that it, nonetheless, may underestimate the costs of caring for people with disabilities and overestimates the costs of caring for people without disabilities. As a consequence, DHHS has temporarily excluded plans participating in programs enrolling frail populations from implementing the new risk adjustment system. Six of these plans are profiled in this report, including PACE, S/HMO, EverCare, MSHO, Wisconsin Partnership, and CCN. These will continue to be reimbursed under special arrangements established before the new reimbursement methodology went into effect.

⁵³Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy. Volume I: Recommendations*. March 1998.

⁵⁴The new methodology is known as the Principle Inpatient Diagnostic Cost Group (PIP-DCG) model. PIP-DCG and its eventual successor are known as claims-based models since they used diagnostic information from claims submitted by providers to estimate the expected costs of enrollees. Under the Balanced Budget Refinement Act of 1999, transition to health status-based risk adjustment will be based on a blended percentage of 10% risk adjusted payment and 90% demographically adjusted payment in 2000 and 2001, and not more than 20% risk adjusted in 2002.

⁵⁵For additional information, see: CRS Report RL30587, *Medicare+Choice Payments*, by Hinda Chaikind, and Madeleine Smith.

Currently, some plans choose not to serve vulnerable populations because they do not want to take on the full risk of caring for potentially resource intensive groups such as the dually eligible elderly. This observation has raised interest in partial capitation, which pays plans using a blended capitated/fee-for-service arrangement in exchange for providing or arranging to provide covered services.⁵⁶ Under partial capitation, plans receive a percentage of the full capitation rate for each enrollee along with a percentage of the fee-for-service rate for each service delivered. Plans, for example, may contract with Medicare or Medicaid at 60% of their usual full capitation rates and receive 40% of the Medicare and Medicaid fee schedule for each service provided to enrolled beneficiaries. By reducing financial risk, some believe partial capitation may encourage more plans to serve dual eligibles as well as blunt any incentives to risk-select or under-provide appropriate services. Because partial capitation still contains fee-for-service elements, however, it does not contain as strong an efficiency incentive as fully capitated systems. It also does not provide as large a prepaid pool with which to fund extra services often needed by this population.

Statutory and Regulatory Issues Regarding Integration

Before plans can decide whether to participate in managed care programs aimed specifically at Medicare-Medicaid dual eligibles, the federal and state governments must first create these programs. States have been particularly enthusiastic in this regard, believing that they must be allowed to manage the care of dual eligibles if they are going to control health care costs. To overcome many administrative inefficiencies associated with using multiple payers in an uncoordinated system, state policymakers believe that such management needs to include Medicare as well as Medicaid. Though integrating acute and long-term care through managed care has indeed been one of three noteworthy strategies pursued by states to control Medicaid long-term care spending,⁵⁷ states cite a number of statutory and regulatory barriers that have severely hampered the development and implementation of Medicare-Medicaid integration programs. Many of these perceived obstacles relate to Medicare and Medicaid program rules.⁵⁸ They include:

- (1) **Medicare Freedom of Choice:** Medicare beneficiaries currently have a statutory right to choose the providers from which they receive care. If states want to integrate Medicare into a managed care program for dual eligibles, therefore, enrollment must be voluntary, at least for the Medicare portion of their benefits.

⁵⁶For a more extended discussion, see: Newhouse, J. Reimbursing Health Plans and Health Providers: Efficiency in Production Versus Selection. *Journal of Economic Literature*, September 1996. p. 1236-1263.

⁵⁷Wiener, Joshua M. and David G. Stevenson. Long-Term Care for the Elderly and State Health Policy. *New Federalism: Issues and Options for States* Series A, no. A-17. The Urban Institute, November 1997.

⁵⁸For a recent discussion on these and other implementation issues, see: U.S. General Accounting Office. *Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*. GAO/HEHS-00-94. Report to the Special Committee on Aging, U.S. Senate. August, 2000.

- (2) **Medicare Lock-In:** Currently, dual eligibles electing to receive their Medicare benefits in a managed care plan may choose to leave that plan on a month-to-month basis. Guaranteed beneficiary enrollment of only 1 month makes Medicare participation less desirable for managed care plans than if beneficiaries had to remain enrolled (i.e., locked in) for longer periods of time. States, on the other hand, may establish longer lock-in periods under Medicaid. Medicare, however, will move toward a 3-month annual open enrollment period with effective plan lock-in for 9 months beginning in 2003. It is expected that longer guaranteed enrollment or lock-in periods for both Medicare and Medicaid should increase the number of plans willing to participate in both programs simultaneously.
- (3) **Medicare Cost-Sharing:** As noted earlier, only three states (Arizona, Oregon, and Minnesota) have received permission from HCFA to limit their Medicare cost-sharing obligations to services delivered through their Medicaid plans. All other states are required to provide for Medicaid payment of Medicare cost-sharing (i.e., premiums, deductibles, and coinsurance) whether or not dual eligibles who qualify for full Medicaid benefits elect to obtain care through their state's Medicaid network of providers. If a dually eligible Medicaid recipient obtains Medicare covered services from a primary care physician unaffiliated with their state's Medicaid network, for example, most states are still required by HCFA to cover Medicare coinsurance and deductibles. Because HCFA allows Arizona, Oregon, and Minnesota to limit Medicare cost-sharing to services provided by their Medicaid networks, dual eligibles in those states have strong incentives to use the same providers for both Medicare and Medicaid since they would have to pay more out-of-pocket to use non-Medicaid affiliated providers. HCFA has expressed an unwillingness to allow any more states to do the same, since the agency now believes it infringes on Medicare beneficiaries' freedom-of-choice. For the foreseeable future, therefore, all other states must continue to meet their Medicare cost-sharing obligations no matter where dual eligibles receive their Medicare services.
- (4) **Independent Medicare and Medicaid Budget Neutrality:** Waiver rules require that managed care programs serving the dual eligible population be budget neutral (i.e., they cannot cost the federal government more than traditional fee-for-service programs). If both Medicare and Medicaid waivers are sought for an initiative, the Office of Management and the Budget (OMB) requires that they be neutral with respect to Medicare and Medicaid independently. It is not enough to show budget neutrality for both programs combined. Critics argue that evaluating federal spending for Medicare and Medicaid separately ignores the interaction between Medicare and Medicaid costs and limits state flexibility to design cost-effective programs.⁵⁹ They argue that OMB should look at combined Medicare and Medicaid costs to assess whether

⁵⁹National Chronic Care Consortium. Regulatory Barriers to Integration. *Serving the Dually Eligible Tool Kit*. 1999.

a program is cost-effective for society and not focus on budget neutrality for separate programs.

- (5) **Waiver Process:** Many states have found the process of obtaining waivers difficult and time-consuming. Unclear waiver authority for dual eligible demonstrations, they argue, has resulted in inconsistencies in granting waivers as well as protracted waiver discussions between HCFA and a number of states – some lasting upwards of 3 years. They propose that federal policy in this area be clarified, including the implementation of a 90-day review process and support for a broad range of cost-effective demonstrations tailored to the market conditions of particular states.⁶⁰

Care Management in the Fee-for-Service System: An Alternative to Capitation

Concerns about capitation along with other barriers to managed care have led some observers to focus on care management as a way to integrate acute and long-term care services for dual eligibles. Care management may be defined as a process that coordinates the provision of acute and long-term care services across health and social service professionals and settings of care, including, but not limited to: needs assessment, prior approval, care communication, coordination, and risk assessment.⁶¹ To varying degrees it is used to coordinate care by most health care organizations, including hospitals, medical groups, insurance companies, home health agencies, community-based social service agencies, public agencies, senior housing communities, and health plans.

Although the various managed care initiatives discussed in this paper use a variety of financing and service delivery arrangements, all rely on some form of care management. PACE, EverCare, Wisconsin Partnership, the Continuing Care Network Demonstration, and the lone second generation Social HMO site all use teams of providers to manage patient care. The Oregon Health Plan, on the other hand, employs Exceptional Needs Care Coordinators to coordinate Medicaid acute and long-term care benefits, while Florida's Community-Based Diversion Pilot project requires that case managers coordinate care regardless of funding source. Minnesota Senior Health Options, first generation Social HMOs, and the Arizona Long-term Care System also assign case managers to program recipients.

Part of the advantage of combining care coordination with Medicare-Medicaid capitation, supporters argue, is that it provides case managers with the necessary authority and flexibility to develop and implement care plans that effectively meet the

⁶⁰U.S. Congress. Senate. Special Committee on Aging. Testimony by Mark Meiners before the Senate Committee, April 29, 1997.

⁶¹*Case Management for the Frail Elderly: A Literature Review on Selected Topics.* Developed by the National Chronic Care Consortium in cooperation with the Minnesota Department of Human Services, Senior Health Options Project under a grant from the Robert Wood Johnson Foundation, 1997.

medical and social service needs of individual clients. Some observers argue, however, that greater coordination need not involve capitation of all Medicaid and Medicare benefits, nor need it involve enrollment in managed care organizations.

The BBA illustrated these differing views by enacting provisions sympathetic to both philosophies. While the BBA promoted capitated arrangements with PACE and Medicare+Choice, it also authorized the Medicare Coordinated Care demonstration to evaluate private-sector models of care coordination. Because care coordination has not traditionally been a large part of fee-for-service Medicare, the aim of this demonstration will be to assess the cost-effectiveness of making monthly payments for coordinated care services that manage fee-for-service expenditures under Parts A and B of Medicare.⁶² Demonstration design and applications procedures were published on July 28, 2000.⁶³ HCFA plans to announce selected projects by early 2001.

The 4-year demonstration, which is to include nine sites (five urban, three rural, one in Washington, D.C.), is based on a review of 29 private-sector programs chosen because they serve chronically ill adults and show evidence of reductions in hospital admissions or total medical costs.⁶⁴ The review, which was submitted to HCFA on March 22, 2000, identifies two main types of coordinated care, including disease management, which target patients whose main problem is a particular medical diagnosis, and case management, which targets patients who suffer from social and medical vulnerabilities that place them at a high risk for costly, adverse medical events and poor health outcomes. The authors note that none of the programs required physicians to hire new staff, install new equipment, or reorganize their practices. Nor did they lock patients into predefined networks of providers. All included the following three steps:

- (1) **Assessing and Planning:** Involves identifying all important problems and goals and drawing from a comprehensive arsenal of proven interventions to produce a clear, practical care plan that addresses these problems and lists these goals;
- (2) **Implementing and Delivering:** Involves (a) operationalizing and delivering the interventions included in the plan, (b) building ongoing relationships with providers, patients, and their families, and (c) educating patients about their conditions and appropriate self-care; and
- (3) **Reassessing and Adjusting:** Involves (a) performing periodic reassessments to determine if interventions are working, (b) promptly

⁶²Health Care Financing Administration. *Medicare Coordinated Care Demonstration*. [<http://www.hcfa.gov/ord/coorcare.htm>.]

⁶³HCFA. Medicare Program; Solicitation for Proposals for the Medicare Coordinated Care Demonstration. *Federal Register*, v. 65, no. 146, July 28, 2000. p. 46466-46473.

⁶⁴Chen, Arnold, Randall Brown, Nancy Archibald, Sherry Aliotta, and Peter D. Fox. *Best Practices in Coordinated Care*. Submitted to the Health Care Financing Administration. Contract No: HCFA 500-95-0048 (04). Mathematica Policy Research, Inc., March 22, 2000.

modifying the plan of care in response to any new barriers or problems, or in response to patient improvement or decline, and (c) making oneself accessible to patients for either routine or urgent issues.⁶⁵

It is expected that demonstration sites will develop care coordination procedures based on the findings of this report. Although the demonstration does not expand on Medicare's covered benefits – other than the provision of coordinated care services for targeted beneficiaries – project sites may use a portion of the payments received for care coordination services to offer additional services designed to remove barriers to prompt medical care, including but not limited to community-based services, transportation, medications, non-covered home visits, and equipment.

Though few of the programs studied for HCFA's review may have had trouble executing their care coordination programs, it is generally reported that case managers and physicians often find it difficult to establish meaningful working relationships. There are a variety of reasons why it may be difficult to promote physician participation, including but not limited to independent physician working styles, lack of face-to-face communication, time pressures, and general unfamiliarity with care coordination.⁶⁶

Though it is only recently being considered in the context of fee-for-service Medicare, care management has been applied to fee-for-service Medicaid for more than 20 years. Some analysts suggest taking advantage of state experience in managing Medicaid-covered benefits under their primary care case management (PCCM), 1915(c) home and community-based service (HCBS) waiver, and other programs. As discussed earlier, states may use 1915(b) "freedom of choice" waivers to establish PCCM programs that pay individual health care providers a small monthly fee in return for managing health care services for a defined population. Under PCCM programs, primary care providers act as gatekeepers, authorizing access to additional Medicaid services. Under a Section 1915(c) waiver, on the other hand, states may offer optional Medicaid-financed HCBS to individuals with long-term care needs. One of the services states may choose to provide under an HCBS waiver is case management, which they often use for purposes of developing care plans and overseeing the quality of care provided under their waiver programs. In 1998, close to 60% of 230 HCBS waiver programs surveyed included case management, making it among the most common service for all major targeted populations, including the elderly, developmentally disabled, children and adults with disabilities, and people with AIDS/ARC.⁶⁷

Another impediment in achieving integration under the current system is that Medicaid case manager authority is restricted to Medicaid benefits. They do not have

⁶⁵Ibid.

⁶⁶For more information, see: *Case Management for the Frail Elderly: A Literature Review on Selected Topics*. Developed by the National Chronic Care Consortium in cooperation with the Minnesota Department of Human Services, Senior Health Options Project under a grant from the RWJ Foundation, 1997.

⁶⁷*Home and Community-Based Waivers: A Look at the States in 1998*. Washington Memo. American Public Human Services Association, 1999.

the authority to authorize Medicare-covered services. Though they may use their own initiative to develop care plans that make use of certain types of Medicare services, they have no control over Medicare provider behavior and thus cannot ensure that services delivered are consistent with what was ordered. One option would be to create service delivery networks especially designed for the diverse needs of dual eligibles that would grant Medicaid case managers the authority to develop care plans involving Medicare services, to authorize Medicare as well as Medicaid services, and to substitute non-covered services for Medicare services if found to be cost-effective.⁶⁸ One analyst suggests that such an approach may be one way to hold Medicare providers accountable for meeting the needs of dual eligibles, while protecting states and beneficiaries from incentives to shift costs to Medicaid by inappropriately institutionalizing dual eligibles in need of long-term care.⁶⁹ Alternatively, the Medicare program may benefit from the appropriate substitution of low-cost for high-cost settings and the reduced use of expensive acute care services as a result of case manager familiarity with the health care needs of chronically ill dual eligibles. However it may be operationalized, care coordination without capitation is another option considered by advocates of integrating acute and long-term care services for dual eligibles.

Policy Implications

Congress has considered a variety of proposals to improve the financing and delivery of long-term care services. While comprehensive reform has been considered, Congress has primarily taken an incremental approach when addressing long-term care issues, including the development and implementation of federal and state initiatives to integrate acute and long-term care services for frail elders and disabled adults. Though programs such as PACE, S/HMO, and MSHO serve a comparatively small number of the nation's dual eligibles, they may provide models that Congress may want to consider when formulating long-term care policy in the future.

Before taking action in this area, however, Congress may want to consider a variety of issues, including doubts about managed care's appropriateness for serving vulnerable populations. In particular, many worry that incentives under managed care to control utilization may have deleterious effects on patient welfare and quality—especially for frail recipients. Given the recent nature of most integration programs, however, there is currently a dearth of evaluation evidence to support or reject this claim definitively. Of the nine programs reviewed for this report, for instance, only the PACE, first generation S/HMO, ALTCS, and OHP programs have been evaluated thoroughly. While innovative state programs such as MSHO and

⁶⁸Hausner Tony, Julie Gaus, and Mary Larkson. *Managed Long-Term Care*. HCF Long-Term Care Work Group, October 31, 1994.

⁶⁹Feder, Judith. *Medicare/Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations*. Kaiser Commission on the Future of Medicaid. Washington, DC, May 1997.

Wisconsin Partnership have yet to be independently evaluated, other programs, such as CCN, are only now being implemented.

Despite the lack of a rich body of evaluation research, proponents strongly believe in the efficacy of using managed care to integrate acute and long-term care financing, service delivery, and administration under Medicare and Medicaid. In particular, they see managed care as a way to eliminate fragmentation, develop community service options, make benefits more flexible, promote quality of care improvements, and control costs. At the same time, however, they also point to a number of statutory and regulatory requirements inhibiting the development and implementation of these programs. These include requirements to obtain federal waivers that allow states to enroll dual eligibles in managed care programs that are budget neutral to the Medicare and Medicaid programs independently.

Given the concerns expressed by both advocates and opponents to using managed care to integrate acute and long-term care for Medicare-Medicaid dual eligibles, congressional action in this area might include an examination of one or more of the following possibilities put forward by various health policy experts.

- ! Streamlining the waiver approval process, or eliminating the need for states to obtain waivers altogether;
- ! Allowing states to show budget neutrality for Medicare and Medicaid combined rather than each program individually;
- ! Restricting the right of some Medicare beneficiaries to choose the providers from whom they receive care;
- ! Accelerating the implementation of longer Medicare lock-in provisions;
- ! Allowing all states, and not only a few (Oregon, Arizona, and Minnesota) to limit Medicaid payment of Medicare cost-sharing to dual eligibles who elect to obtain care through their state's Medicaid networks of providers;
- ! Promoting the development of care coordination mechanisms, including case management and centralized data systems;
- ! Facilitating unified Medicare and Medicaid program administration, including contracting, enrollment, and oversight;
- ! Using alternative payment mechanisms, such as partial capitation, which reduce plan risk, thereby promoting participation in programs targeted toward potentially resource-intensive groups;
- ! Spurring the development of better risk adjustment methodologies to guard against overpayment for healthy beneficiaries and underpayment for frail and disabled beneficiaries;
- ! Developing incentives that encourage health plans to participate in both Medicare+Choice and Medicaid managed care simultaneously;
- ! Continuing and expanding existing federal initiatives such as PACE, S/HMO, and EverCare until more research evidence becomes available;
- ! Directing additional resources toward evaluation of existing programs; and
- ! Supporting the development of Medicare- or Medicaid-based care management options independent of capitation.

Appendix A. Summary of Federal and State Initiatives for Integrating Acute and Long-Term Care for Medicare-Medicaid Dual Eligibles

Programs Characteristics	Federal Initiatives			Comprehensive State Demonstrations			Capitated Medicaid Demonstrations		
	PACE	Social HMO	EverCare	Minnesota Senior Health Options	Wisconsin Partnership Program	Continuing Care Network Demonstration	Arizona Long-Term Care System	Oregon Health Plan	Florida's CBDPP
# Enrollees	7,000	84,004	11,300	3,569	822	—	28,993	349,500	501
Medicare Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory	Mandatory	Voluntary
Statewide	No. Sites in 14 states.	No. Sites in 4 states.	No. Sites in 10 markets in 7 states.	No. Serves 7 county metropolitan area.	No. Serves 5 counties.	No. Serves only Monroe County, New York.	Statewide	Statewide	No. Sites in Palm Beach and Orlando.
Target Population	Aged 55 or older and eligible for nursing facility care.	Medicare eligible. To receive long-term care in first generation S/HMOs, must be aged 65 or older and eligible for nursing facility care.	Medicare eligible nursing home residents.	Medicare and Medicaid eligible seniors aged 65 or older.	Medicaid or Medicare-Medicaid eligible. Eligible for nursing facility care. Aged 55 or older, or 18-65 & disabled.	Eligible for Medicare only or both Medicare and Medicaid. Age 65 or older.	Enrollees must have family incomes below 300% of SSI Standard. Eligible for nursing facility care.	All Medicaid recipients, including elderly and disabled dual eligibles.	Dually eligible for Medicaid and Medicare. Aged 65 or older, and eligible for nursing facility care. Must also meet other clinical criteria.
Contractors	26 sites, mainly free standing community organizations.	3 S/HMO-I and 1 S/HMO-II sites. Uses both HMOs and long-term care organizations.	6 demonstration and 3 non-demonstration HMOs run by United-Health Group.	4 HMOs that subcontract with Geriatric Care Systems that provide for the continuum of care.	3 community organizations. 2 serve 55+ population, 1 serves 18 to 65 population, and 1 serves both.	1 plan, ViaHealth, that includes both acute and long-term care providers in its network.	2 county plans (1 of which is also a Medicare + Choice plan) and 5 plans chosen through a competitive bidding process.	15 fully capitated plans (4 of which are also Medicare+ Choice plans).	3 HMOs (2 of which are also Medicare+ Choice plans).
Benefits Covered	All Medicare and Medicaid acute and long-term care.	All Medicare basic benefits, expanded HMO benefits (e.g., prescription drugs), and limited long-term care.	All Medicare acute care.	All Medicare and Medicaid acute care, Medicaid home & community-based waiver, and 180 days of Medicaid nursing home coverage.	All Medicare and Medicaid acute and long-term care.	All Medicare acute care. Most Medicaid acute and long-term care for dual eligibles. Medicare only enrollees receive limited chronic care benefit.	All Medicaid acute and long-term care. Medicare acute care if sought from enrollee's Medicaid plan.	All Medicaid acute care. Medicare acute care if sought from Medicaid plan. Long-term care remains fee-for-service Medicaid.	All Medicaid acute and long-term care. Medicare acute care if sought from enrollee's Medicaid plan.

Program Characteristics	Federal Initiatives			Comprehensive State Demonstrations			Capitated Medicaid Demonstrations		
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Payment Mechanism	Capitation= Medicaid, and 2.39 X Rate for Medicare+ Choice plans. Also Member Premiums where appropriate.	Capitation= 105.3% X Medicare+ Choice rate adjusted for nursing facility eligibility in S/HMO-I; function in S/HMO-II. Also Medicaid and Member Premiums.	Capitation= 97.8% X Medicare+ Choice Rate. Long-term care paid by Medicaid or Out-of-Pocket.	Uses 4 rates. Capitation= Medicaid, and 100% (or 2.39) X Medicare+ Choice Rate. After 180 days, nursing facility care paid for on a fee-for-service basis.	Capitation= Medicaid, and 2.39 X Medicare+ Choice Rate.	Uses 4 rates. Capitation= Medicaid, and Medicare+Choice Rate. Nursing facility eligible rate adjusted for function. Medicare only enrollees can purchase extended long-term care coverage privately.	Capitation paid by Medicaid. Medicare usually fee-for-service but capitated if recipient enrolls in a Medicare+ Choice plan.	Capitation paid by Medicaid. Medicare usually fee-for-service but capitated if recipient enrolls in a Medicare+ Choice plan.	Capitation paid by Medicaid. Medicare usually fee-for-service but capitated if recipient enrolls in a Medicare+ Choice plan.
Care Coordination	Uses adult day care & interdisciplinary teams of providers.	In S/HMO-I, care coordination used for nursing home certified only. In S/HMO-II, used for high risk enrollees, also team-based.	Emphasizes physician-nurse practitioner teams and case managers.	Requires that each enrollee have access to a care coordinator.	Uses interdisciplinary teams of providers. Emphasizes client involvement	Requires 24-hour access to case management. Also relies on multi-disciplinary teams of providers.	Uses case managers and state assessment teams.	<i>Exceptional Needs Care Coordinators</i> coordinate acute and long-term care providers.	Uses case managers to coordinate care regardless of funding source.
Legal Authority	Section 1115 and 222 waivers. BBA 1997.	Section 1115 and 222 waivers.	222 waiver.	1915(a)/(c) and 222 waivers. Had an 1115.	1115 and 222 waivers.	1915(a)/(c), and 222 waivers.	1115 waiver.	1115 waiver.	1915(c) waiver.
Operating Status	<u>1971</u> : On Lok. <u>1990</u> : PACE.	<u>1985</u> : S/HMO-I. <u>1997</u> : S/HMO-II.	<u>1987</u> : 1 st site. <u>1994</u> : 1 st demo.	Enrollment began in 1997.	Full capitation in 1999.	Enrollment set for 2001.	<u>1982</u> : Acute Care. <u>1988</u> : Added Long-Term Care.	<u>1994</u> : OHP. <u>1995</u> : Added the elderly/disabled.	Enrollment began in 1998.

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Independent Evaluation Findings	Lower nursing home and hospital use; Higher survival, satisfaction, health status, and function; Favorable selection; Medicare cost-savings; Higher Medicaid costs.	<u>S/HMO-I</u> : Little acute-long-term care coordination; Plan losses and higher expenditures among certain groups; Favorable selection; Mixed outcome and satisfaction effects. <u>S/HMO-II</u> : In 2002 evaluation is due.	HCFA sponsored evaluation due by December 31, 2001.	Part of HCFA sponsored multi-state evaluation due in 2005.	Part of HCFA sponsored multi-state evaluation due in 2005.	Part of HCFA sponsored multi-state evaluation due in 2005.	Lower hospital and nursing home use; Medicaid cost-savings; Mixed satisfaction effects; No difference/ worse process of care findings; Worse outcomes for nursing home residents.	Separate Medicare and Medicaid enrollment found complicated. ENCCs effective for some but limited awareness and cross plan variation. Other findings expected early 2001.	Florida legislature mandated independent evaluation. Still in planning stages.

Appendix B: Detailed Program Profiles

Program for All-inclusive Care of the Elderly (PACE)⁷⁰

PACE is modeled on the system of care developed by On Lok Senior Health Services in San Francisco, California during the early 1970s.⁷¹ PACE is a fully capitated managed care program that provides a comprehensive array of acute and long-term care services to frail elderly persons living in the community. To be eligible an individual must be age 55 years or older, reside in a PACE program service area, and meet state criteria for nursing home eligibility. PACE is a voluntary program in which most enrollees are eligible for both Medicare and Medicaid. Prior to the expansion provided in the Balanced Budget Act (BBA) of 1997, there were 12 program sites in addition to On Lok. At the present time, there are 26 sites in 14 states serving approximately 7,000 individuals under combined Medicare and Medicaid capitation payments. There are also eight pre-PACE sites that operate under Medicaid capitation only. Most sites are sponsored by freestanding community-based organizations. All operate as not-for-profit entities. All emphasize onsite geriatric care in adult day care centers. Site-by-site enrollment tends to be low, ranging from 45 to 748, with a median enrollment of 142.

Fully operating PACE sites are financed through prepaid, capitated payments from Medicare and Medicaid. Together, these payments are required to be less than what would have otherwise been paid for a comparable frail population not enrolled under a PACE program. The monthly capitation paid by Medicare is equal to 2.39 times the Medicare county rate amount for Medicare+Choice plans. Calculation of monthly Medicaid rates varies by state and are subject to negotiation between each PACE provider and the state Medicaid agency. In establishing rates, most states first identify a population hypothetically similar to PACE (e.g., nursing home residents, waiver program participants) and calculate that group's average per capita fee-for-service spending. This amount is subsequently discounted to reflect anticipated savings from improved care coordination and timely provision of primary care and

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⁷¹On Lok started providing services in 1971 and was established as a federal demonstration in 1972. In 1983, it received a federal demonstration waiver allowing it to receive monthly capitation payments from Medicare and Medicaid (P.L. 98-21, Section 603). The Consolidated Omnibus Reconciliation Act of 1985 made On Lok's program permanent (P.L. 99-272, section 9220). The Omnibus Reconciliation Act (OBRA) of 1986 authorized On Lok replication projects at up to 10 sites (P.L. 99-509, Section 9412) with the first replication site being implemented in 1987 in East Boston. OBRA 1990 subsequently increased the number of PACE demonstration sites to 15 (P.L. 101-508, Section 4744). The Balanced Budget Act of 1997 made PACE a permanent benefit category under Medicare and an optional benefit states can offer under Medicaid (P.L. 105-33, Sections 4801, 4802, and 4803).

other services. In 2000, monthly capitation rates ranged from \$1,902 to \$4,589 for Medicaid, with a median rate of \$2,371, and \$972 to \$1,713 for Medicare, with a median rate of \$1,234. Medicare beneficiaries who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount. No deductibles, coinsurance or other type of Medicare or Medicaid cost-sharing may be applied.

In exchange for Medicare and Medicaid capitation payments, PACE sites are at full risk for all primary, acute, and long-term care services covered by these programs. At its core, the PACE model features the provision of adult day, health care and interdisciplinary case management. Adult day care, in particular, is the key service used for monitoring plan participants and coordinating and delivering all medical and social service benefits. These services are managed by interdisciplinary teams of physicians, nurses, social workers, dietitians, physical and occupational therapists, activity coordinators, and other health and transportation workers. The specific functions of these teams include assessing enrollees' needs, developing care plans in consultation with patients and their families, and delivering services across acute and long-term care settings. Some sites also manage subsidized housing developments though housing is not funded under either the Medicare or Medicaid capitation.

BBA 1997 made PACE a permanent benefit category under Medicare and a state plan optional benefit under Medicaid. It also authorized the total number of PACE sites to grow from 15 to 40 in the first year after the law's enactment, with an additional 20 sites authorized in each succeeding year. Since authorizations are cumulative – unused authorizations carry over from 1 year to the next – 80 PACE sites are authorized under current law. Though only public and non-profit entities may qualify as PACE providers, the BBA also authorized up to 10 for-profit entities to serve as PACE sites during a 4-year demonstration project. No later than 4 years after the law's enactment, the Secretary of the Department of Health and Human Services (DHHS) is required to report to Congress on the quality and cost of providing services through PACE. This report is due in 2001.

Prior to the BBA, PACE sites operated under dual Section 1115/222 Medicaid/Medicare waivers. On Lok and the original 12 replication sites have 3 years from the day the HCFA issued its regulations (November 24, 1999)⁷² to make the transition to permanent status (November 2002). Newer sites, implemented after the BBA but before HCFA issued its regulations, have 2 years (between August 1999 and November 2001).

HCFA's evaluation contractor found that compared to people who applied to PACE but later declined to enroll, PACE enrollees were less affluent, more familiar with adult day care facilities, and more willing to change providers to enroll in a program that provides for all health care needs. Though PACE enrollees were more dependent in instrumental activities of daily living, they were, nonetheless, less costly as indicated by lower health expenditures in the 6 months prior to their application to

⁷²*Federal Register*, v. 64, no. 226. p. 66234-66304. 42 USC 1302 and 1395. 42 CFR Parts 460, 462, 466, 473, and 476.

the PACE program. This last finding indicates that PACE sites may be experiencing favorable selection of healthier than average applicants.⁷³

Compared to people who applied to PACE but later declined to enroll, PACE enrollees have experienced a lower probability of hospital and nursing home use, an increased probability of survival, a higher probability of reporting being in good or excellent health, a higher probability of finding life to be satisfying, a higher probability of being very satisfied with overall care arrangements, and a lower probability of having a functional impairment. Though statistically significant impacts were found with respect to each of these outcomes, PACE's impact on medical utilization tended to be longer lasting than its impact with respect to self-reported health status, satisfaction, and function. The authors contrast these generally favorable findings with the lack of significant impacts identified for home and community based services programs generally.⁷⁴

HCFA's evaluators also found that the capitated payments made by Medicare were much lower than costs would have been had PACE enrollees continued to receive care in the fee-for-service sector. In particular, capitated payment was 38% less than projected fee-for-service reimbursement in the first 6 months following enrollment and 16% lower than projected reimbursement in the 7 to 12 months following enrollment.⁷⁵ Building on these results, a forthcoming study, currently under review at HCFA, concludes that in the first year following enrollment, projected fee-for-service Medicare costs were considerably higher than the Medicare portion of PACE's capitated payment, while projected fee-for-service Medicaid costs were lower than the Medicaid portion of the capitation rate. Overall, however, no statistically significant difference was found between combined Medicare and Medicaid fee-for-service costs and the total Medicare plus Medicaid capitation rate received by PACE.

Social Health Maintenance Organization Demonstration (S/HMO)⁷⁶

Using capitated financing and varying degrees of care coordination, the S/HMO demonstration adds chronic care and other services to the traditional Medicare benefits package. In particular, S/HMOs, like other Medicare HMOs, provide coverage for all standard acute care services in addition to expanded benefits, such as prescription drugs and eyeglasses. What distinguishes S/HMOs from other Medicare HMOs is the package of long-term care services that they provide, including limited nursing home benefits and a wide range of home and community-based

⁷³Irvin, 1998.

⁷⁴Chatterji, 1998.

⁷⁵White, 1998.

⁷⁶Contact: Thomas Theis, Social Science Research Analyst, Health Care Financing Administration, Demonstration and Data Analysis Group, Division of Demonstration Programs, 7500 Security Boulevard, C4-17-27, Baltimore, Maryland 21244-1850. Phone: (410) 786-6654. FAX: (410) 786-1048. E-Mail: [Ttheis@HCFA.gov]

services, such as homemaker services, adult day care, personal care, and medical transportation.

Two generations of S/HMOs have been authorized by Congress.⁷⁷ The first-generation (S/HMO-I), which began operating in 1985, included four sites, two of which were HMOs that added long-term care services to their existing service packages and two of which were long-term care providers that added acute-care services. Three of the original first-generation sites continue operation, including one HMO-based plan, Senior Advantage II in Portland, Oregon, and two long-term care-based plans, ElderPlan in Brooklyn, New York and Senior Care Action Network (SCAN) in Long Beach, California. A fourth Minneapolis-based plan ceased operations in 1994. Though HCFA awarded planning grants to six prospective second-generation sites (S/HMO-II) in 1995, only one of these, Senior Dimensions, in Las Vegas, Nevada, achieved operational status. For a variety of reasons, including lack of infrastructure, loss of personnel, and reluctance to adopt a risk-based payment methodology, the remaining plans chose not to participate.

As of July 2000, total enrollment in the S/HMO demonstration was 84,004, including 48,592 in the three remaining S/HMO-I sites and 35,412 in the single S/HMO-II site. Like PACE, enrollment in a S/HMO is voluntary and members may disenroll at anytime. Unlike PACE, which focuses almost exclusively on frail elderly individuals dually eligible for Medicare and Medicaid, S/HMOs serve a broader cross-section of the healthy and functionally impaired elderly living in their service areas. In fact, in order to reduce financial risk, first-generation S/HMOs were initially allowed to use health status screening to limit the number of nursing home certifiable enrollees to the proportion found in the general population. Individuals applying above that level were placed in a queue and enrolled as space became available.⁷⁸ S/HMOs serve very few dual eligibles.

While all S/HMO members are eligible for Medicare's basic package of primary and acute care benefits, as well as any expanded benefits that plans choose to provide, access to care coordination and chronic care benefits are more restricted. In first-generation S/HMOs, in particular, these latter benefits are limited to nursing home certifiable enrollees only. S/HMO-II plans, on the other hand, target these services on the basis of individual need rather than nursing home eligibility status. All three

⁷⁷The Deficit Reduction Act of 1984 (P.L. 98-369, Section 2355) authorized the first-generation of Social HMOs. The authority for these sites was subsequently extended through 1992 with the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203, Section 4018(b)), through 1995 with OBRA 1990 (P.L. 101-508, Section 4207(b)(4)), and through 1997 with Section 5079 of P.L. 103-66. OBRA 1990 also authorized a second-generation of Social HMOs (P.L., 101-508, Section 4207(b)(4)). The Balanced Budget Act of 1997 (P.L. 105-33, Section 4014) further extended it through 2000, while the Balanced Budget Refinement Act of 1999 (incorporated in to P.L. 106-113, Section 531) extended the program yet again.

⁷⁸Kane, Robert L., Rosalie A. Kane, Michael Finch, Charlene Harrington, Robert Newcomer, Nancy Miller, and Melissa Hulbert. S/HMOs, The Second Generation: Building on the Experience of the First Social Health Maintenance Organization Demonstrations. *Journal of the American Geriatrics Society*, v. 45, 1997. p. 101-197.

S/HMO-I sites – Senior Advantage II, ElderPlan, and SCAN – place annual caps on their chronic care benefits of \$12,000, \$7,800 and \$7,500 respectively. Custodial nursing home benefits under all four plans are quite limited.

In exchange for assuming risk for all covered services, S/HMOs receive monthly Medicare capitation payments equivalent to the Medicare county rate amount augmented by an additional 5.3% which is supposed to cover the long-term care services that S/HMOs provide. Plans in both S/HMO generations adjust these rates for high risk enrollees. Payments to S/HMO-I sites are adjusted for the demographic characteristics of the enrollee, e.g., higher capitation payments are made for persons in nursing homes than for those in the community. S/HMO-II plans, on the other hand, receive risk-adjusted payments based on impairments in activities of daily living, instrumental activities of daily living, and prevalence of medical conditions. For dual eligibles, S/HMOs also receive payments from Medicaid. Premiums and co-payments are also allowed and may be paid out-of-pocket by beneficiaries or by their Medicare supplements. The S/HMO-I sites also have the authority to capitate Medicaid covered benefits, though this occurs in limited circumstances. Currently, only one site has a formal agreement with the state to receive Medicaid capitation payments for dually eligible enrollees.

To varying degrees, both S/HMO generations rely on care coordination to manage patient care. At S/HMO-I sites, however, care coordination has been limited to identifying, allocating, and managing long-term care services for members whose disabilities make them eligible for additional chronic care benefits. By their exclusive focus on nursing home certifiabiles and resulting systematic lack of geriatric attention toward other populations, some believe that the ability of case managers to coordinate care across the continuum of services in first-generation plans has been limited.⁷⁹ Taking these lessons into account, the lone second-generation site employs a more geriatric-oriented care model, including greater reliance on interdisciplinary teams of primary care physicians, specialists, pharmacists, dieticians, geriatricians, and nurse case managers. Moreover, these services are targeted more broadly toward those with high-risk conditions, evidence of impending disability, or who are at high-risk for hospitalization. Case managers are also encouraged to coordinate more closely with primary care providers for whom protocols have been developed to ensure adequate attention to geriatric problems.

Congressional authorization for the S/HMO program has been extended several times, with the most recent series of extensions beginning with the BBA of 1997, which extended the program through 2000. The BBA also expanded the number of persons who could be served at each site from 12,000 to 36,000 and directed the Secretary of DHHS to submit to Congress a plan for making S/HMOs an option available to beneficiaries under the Medicare+Choice program, a report which HCFA expects to deliver to Congress by the end of 2000. The Balanced Budget Refinement Act (BBRA) of 1999 further extended the program's authorization. It is now scheduled to end 18 months after the Secretary submits the transition report required by the BBA (sometime in 2002). The BBRA also extended the due date for the final report on the second generation S/HMO project to 21 months after submission of the

⁷⁹Ibid.

transition report to Congress (again, sometime in 2002), and it increased the aggregate maximum limit on participants at all sites to 324,000 individuals.

Between 1985 and 1989 the S/HMO-I demonstration was evaluated for HCFA by researchers associated with the University of California, San Francisco. While S/HMO-I succeeded organizationally in offering long-term care to frail enrollees, it reportedly failed to achieve an adequate degree of coordination between acute and chronic care services. This was attributed largely to lack of communication between physicians and other participants, including case managers and community-based long-term care providers. Even at the end of the 5-year evaluation period, many physicians serving S/HMO enrollees were unaware of the program's package of chronic care benefits.⁸⁰ This finding is one reason why the lone second generation site uses multidisciplinary teams of providers to assess, plan, and manage care. Financial losses and high expenditures during the program's early years among a number of high risk groups (relative to fee-for-service Medicare) also led investigators to suggest a need to refine S/HMO operations.⁸¹

Like PACE, S/HMO-I sites experienced favorable selection. Using prior utilization and health status, the evaluators found that S/HMO enrollees tended to be healthier than those in traditional fee-for-service Medicare. They also found evidence of favorable disenrollment, where frail and impaired members were more likely to disenroll than healthier members.⁸²

The impact of S/HMO-I on outcomes was mixed, with more favorable results experienced by healthier enrollees and less favorable results experienced by frail and chronically ill enrollees. Manton and colleagues, in particular, concluded that S/HMOs performed HMO functions well for the healthy and acutely ill as indicated by similarity in outcomes for certain case-mix groups between S/HMO enrollees and fee-for-service beneficiaries who joined an HMO during the course of their study. Alternatively, they concluded that S/HMOs did not perform well for impaired or acutely ill enrollees with chronic impairments. Though there was no difference in case-mix standardized mortality rates between S/HMO enrollees and fee-for-service Medicare beneficiaries, frail individuals had a higher probability of dying in S/HMOs than in fee-for-service Medicare.⁸³ While unimpaired S/HMO enrollees reported higher satisfaction than unimpaired fee-for-service Medicare beneficiaries in all areas except interpersonal relations (where there was no difference), impaired enrollees reported lower satisfaction than impaired fee-for-service beneficiaries in all areas but finance and benefits (where they were more satisfied). They also reported lower satisfaction levels than unimpaired S/HMO enrollees.⁸⁴

⁸⁰Harrington, et al. Medical Services in Social Health Maintenance Organizations, 1993.

⁸¹Newcomer, et al., 1995.

⁸²Harrington, et al. A Comparison of S/HMO Disenrollees, 1993.

⁸³Manton, et al., 1993.

⁸⁴Newcomer, et al., 1994.

EverCare⁸⁵

The EverCare program serves Medicare beneficiaries who are permanent nursing home residents. Through physician-nurse practitioner teams, the program emphasizes the delivery of primary, preventive and other outpatient services within the nursing home as a way to: (1) save Medicare money by shortening or preventing hospital admissions; and (2) reduce the medical complications and patient dislocation trauma associated with hospitalization. EverCare is available in 10 markets in six states. The demonstration replicates at six sites the original EverCare program, which began serving the Minneapolis-St. Paul area in 1987. Replication sites include Boston, Atlanta, Baltimore, Colorado (Denver and Colorado Springs), Arizona (Phoenix and Tucson), and Tampa-St. Petersburg. In addition to these six demonstration programs, two non-demonstration sites recently began operating in New York and Ohio.

EverCare was authorized as a demonstration in 1994 under section Medicare 222 waivers granted to EverCare, now a division of Ovations, a subsidiary of UnitedHealth Group, Inc. (formerly United HealthCare Corporation). Enrollment in the demonstration is voluntary and began in 1995 in four demonstration sites and expanded in 1996 and 1997 two others. Together, demonstration and non-demonstration sites serve approximately 16,550 residents cared for by more than 500 primary care physicians and 160 nurse practitioners in more than 450 nursing homes. Approximately 11,300 are being served by the six demonstration programs. EverCare is being evaluated for HCFA by researchers at the University of Minnesota. Results are expected December 31, 2001.

Particularly important to the EverCare model are geriatric and other nursing practitioners and physician assistants who serve as primary caregivers and whose functions include performing assessments, scheduling clinic and physician visits, developing care plans, working closely and in consultation with physicians, coordinating with nursing facility staff, and overseeing hospital admissions. EverCare's nurse practitioners also work closely with case managers whose functions include determining eligibility and authorizing and ensuring that requested services fall within the Medicare benefits package. Case managers also help nurse practitioners find geriatric providers who are willing to care for residents within the nursing home.

Under the demonstration, EverCare receives a fixed capitation payment from Medicare for each nursing home resident enrolled in the program. Capitation payments, which began at 100% of the AAPCC at the start of the program, were subsequently reduced to 95% and then 93% during the course of the demonstration. Today, this translates to 97.8% of the Medicare county rate for Medicare+Choice plans. Under its capitation, EverCare is responsible and at full risk for all Medicare-covered services, whether provided inside or outside of the nursing home. Room and

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board as well as the custodial costs of nursing home care are usually paid by Medicaid or paid out-of-pocket by residents themselves.

To encourage more active physician involvement in patient care, EverCare often reimburses at higher rates for nursing home than for office visits and pays for physicians' participation in care planning and family conferences. To promote care within the nursing home, EverCare provides nursing facilities with additional reimbursement, known as intensive service days (ISD) payments, for the added personnel costs associated with caring for residents who otherwise would have been transferred to a hospital. The EverCare demonstration is scheduled to run through 2001. HCFA expects to receive its evaluation results by December 31, 2001.

Minnesota Senior Health Options (MSHO)⁸⁶

In April 1995, Minnesota became the first state to receive combined Medicaid 1115 and Medicare 222 waivers to implement an integrated service program for dual eligibles. This program, Minnesota Senior Health Options (MSHO), combines Medicare and Medicaid financing to integrate acute and long-term care services for dually eligible seniors residing in the seven-county Minneapolis-St. Paul area. It is offered as a voluntary option to Minnesota's mandatory Medicaid managed care program, PMAP (Prepaid Medical Assistance Program), in which elderly dual eligibles are required to enroll for their Medicaid services. Not only do these waivers allow the state to contract with entities not eligible to be Medicare+Choice plans, including smaller HMOs and Community Integrated Service Networks, but they also make MSHO the only program to receive approval from HCFA to consolidate all Medicare and Medicaid managed care requirements into a single contract managed and overseen by the state. In addition to helping to create a single point of accountability, use of a single contract has allowed MSHO to reduce duplication and resolve important differences across Medicare and Medicaid. For example, it has enabled MSHO to merge the enrollment processes, membership materials, and grievance procedures of the two programs.

MSHO currently contracts with three health plans, Metropolitan Health plan, Medica, and UCare Minnesota. Under their MSHO contracts each health plan receives separate monthly capitation payments from HCFA and the Minnesota Department of Human Services for each member. In exchange for these two capitation payments, MSHO plans are responsible for all covered services, including all Medicare services and all Medicaid services, including all PMAP services, all home and community-based waiver services, and 180 days of nursing facility care for community enrollees. After 180 days, plans must still provide other needed services, but nursing home reimbursement is handled on a fee-for-service basis outside the capitated rates. To create incentives for plans to use residential and home and community-based services rather than institutional services, MSHO employs multiple

⁸⁶Contact: Pamela Parker, Minnesota Senior Health Options, Department of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3854. Phone: 651-296-2140. FAX: 651-297-3230. E-Mail: [Pam.Parker@state.mn.us]

rates for nursing home residents, nursing home certifiable conversions,⁸⁷ as well as nursing home certifiable⁸⁸ and non-nursing home certifiable community participants.

On the Medicaid side, the Minnesota Department of Human Services provides each MSHO contractor with a monthly per capita payment per enrollee, which includes: (1) Medicaid covered acute and ancillary services; (2) 180 days of Medicaid nursing facility care; and (3) home- and community-based waiver services for the elderly.⁸⁹ After 180 days of nursing facility care, nursing facility per diems are paid through the present fee-for-service system directly by the state.

On the Medicare side, HCFA provides each plan with the Medicare county rate for Medicare+Choice plans (equivalent to 95% of the AAPCC) for community and institutional enrollees. For the frail elderly living in the community who meet criteria for nursing home placement (i.e., nursing home certifiable conversions, and nursing home certifiables), the Medicare+Choice rate is multiplied by the PACE risk adjuster of 2.39. MSHO is currently exempted from Medicare's new claims-based risk adjustment methodology.

MSHO has encouraged participating plans to develop new partnerships with long-term care providers and counties in order to better serve seniors. As a result, the program's three plans have contracted with newly formed Geriatric Care Systems to provide all or part of the MSHO benefit package. These systems have been sponsored by long-term care providers who contract with clinics for primary care services, as well as by health plans and hospital-based organizations which share risk with long-term care providers. Several operate at full or partial risk.

MSHO requires that each enrollee have access to a 'care coordinator' whose responsibilities include assisting with developing care plans, arranging access to services, working closely with primary care physicians, and facilitating communication among enrollees, family members, and providers. Coordinators may be social workers, geriatric nurse practitioners, or registered nurses, and may be employed by clinics, care systems, or health plans. Coordinators must balance their roles as gatekeepers and patient advocates.

As of August 1, 2000, MSHO's three participating plans served 3,569 dually eligible seniors residing in the seven-county metro area. Enrollment in MSHO is voluntary, and participants may disenroll after 30 days. Enrollment began in February 1997. As of May 1, 2000, HCFA granted MSHO's request to transfer authority for the Medicaid portion of its program from its 1115 Medicaid waiver to a joint 1915(a)/1915(c) combination. Pending HCFA approval, MSHO plans to expand its focus to include dually eligible, disabled adults between the ages of 18 and 64 as of January 1, 2001. MSHO is being evaluated for HCFA as part of a multi-state study

⁸⁷Individuals discharged into the community after nursing facility stays of more than 6 months.

⁸⁸Individuals deemed eligible to receive care in a nursing home according to state criteria, but kept out due to the provision of community-based and other services.

⁸⁹More specifically, the monthly capitation includes the PMAP capitation for Medicaid acute and ancillary services, a 180-day Medicaid Nursing Facility Add-on which covers the historical rate of expected nursing home admissions, and the average or two times the average Elderly Waiver payment, as appropriate per MSHO policy.

being conducted by researchers at the University of Minnesota. Results are due in 2005.

Wisconsin Partnership Program⁹⁰

Wisconsin Partnership is a fully capitated program that integrates health and long-term care services for qualifying older adults age 55 and older and disabled individuals between the ages of 18 and 65 with chronic conditions and illnesses. It emphasizes client involvement in decision making, including choice of provider, services, and setting. It also emphasizes the use of interdisciplinary teams of physicians, nurses, and social workers to develop care plans and to coordinate across service modalities. Participants often keep their own physicians, who are typically added to the program's network of providers if they do not already belong. To join, prospective enrollees must be Medicaid-eligible or dually eligible for Medicare and Medicaid. Qualifying beneficiaries must also be certified as eligible for nursing facility care. Enrollment in the program is voluntary, and participants may disenroll at any time.

Because the Partnership model emphasizes in-home service delivery, it employs community-based organizations which have experience serving elderly and disabled individuals living in the community. The program began phase-in operations in 1995, and currently has four sites serving residents in five Wisconsin counties – with a combined enrollment of 822 as of May 2000 (up from 598 the previous year). Two sites, Elder Care in Madison and Community Care for the Elderly in Milwaukee, also participate in the PACE program and serve older adults only. A second Madison site, Community Living Alliance, focuses on physically disabled adults in the 18 to 65 age range, though it continues to serve older enrollees who have aged in place (i.e., it serves individuals over the age of 65 who enrolled prior to turning 65). A fourth site, Community Health Partnerships in Eau Claire, enrolls both older adults and younger disabled individuals. While Elder Care began operating as a fully capitated program in January 1999, the other three programs were phased in over the first 5 months of that year.

In October 1998, the Partnership Program received a combined Section 1115/222 Medicaid/Medicare waiver from HCFA, allowing Partnership sites to receive capitation payments from both programs. Participating organizations, therefore, enter into two separate contracts, a Medicaid managed care contract with the Wisconsin Department of Health and Family Services, and a Medicare contract with HCFA. The Medicaid rate is based on the cost of nursing home care plus the average cost of additional Medicaid fee-for-service expenses for nursing home residents in the target group (i.e., the elderly or physically disabled), discounted by 5% to assure that the state achieves cost savings. The Medicare rate is based on the Medicare county rate for Medicare+Choice plans (equivalent to 95% of the AAPCC) multiplied by the PACE risk adjuster of 2.39. In exchange for monthly capitation payments for each enrollee, contracting organizations are responsible for all primary,

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acute, and long-term care services covered by Medicare and Medicaid, including all home- and community-based waiver services. To ensure a comprehensive service delivery network, contracting entities may subcontract with hospitals, clinics, and other providers. The Wisconsin Partnership program is being evaluated for HCFA as part of a multi-state study being conducted by researchers at the University of Minnesota. Results are due in 2005.

Continuing Care Network Demonstration, Monroe County, New York⁹¹

Through combined Medicare and Medicaid capitation payments and integrated service delivery networks, the Continuing Care Network (CCN) demonstration of Monroe County, New York aims to integrate primary, acute, and long-term care services. The program, which will operate under a Medicare 222 waiver, as well as a 1915(a)/1915(c) Medicaid waiver combination was approved by HCFA in the fall of 1999. Enrollment will begin in 2001.

Over the course of its 5-year demonstration period the program intends to enroll at least 10,000 elderly beneficiaries, including 1,500 who had been certified for care in a nursing facility. To participate, enrollees must be age 65 or over, eligible for Medicare or Medicare/Medicaid, and reside in the program's service area. Upon voluntary enrollment in the demonstration, all participants will complete a screening questionnaire used to identify high-risk individuals. Those identified as high-risk will be assessed further using the DMS-1, a screening instrument that the State of New York currently employs to determine nursing home certifiability.

The participating plan will contract separately with the New York State Department of Health and HCFA for Medicaid and Medicare, respectively. In exchange for monthly capitation payments from each, the plan will be responsible for all services in the Medicare benefits package and most in the Medicaid package. Prescriptions drugs, for example, will be paid by Medicaid on a fee-for-service basis rather than through the capitation plan. To discourage biased selection the demonstration will employ a risk adjusted, multi-level capitated reimbursement system, which includes multiple rates for four population groups: community-based nursing home certifiables, nursing home residents, nursing home conversions,⁹² and unimpaired community residents. Rates will be adjusted for age, gender, and category of Medicaid eligibility (for unimpaired enrollees) or functional status based on DMS-1 score (for impaired community-based enrollees) when appropriate. ViaHealth will sponsor the contracting plan.

The base rate for Medicare will be the Medicare county rate for Medicare+Choice plans. For impaired beneficiaries living in the community (i.e., nursing home conversions, nursing home certifiables), this rate will be multiplied by 1.75, 2.98, and 3.92, respectively, for individuals determined to be mildly, moderately,

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⁹²Individuals discharged into the community after nursing facility stays of more than 5 months.

and severely impaired using the DMS-1 criteria. To compensate for the higher adjustors used for impaired community-based enrollees, the demonstration will employ lower adjustors for unimpaired beneficiaries living in the community. Providers will receive rates lower than existing Medicare HMO rates for unimpaired persons but higher rates that reflect the level of disability for those judged nursing facility certified. Rates for nursing facility residents will be based on the existing Medicare+Choice rate structure.

As with Medicare, Medicaid rates for community enrollees deemed eligible for nursing facility care will vary for mildly, moderately, and severely impaired individuals as determined by the DMS-1. Rates for unimpaired community-based enrollees will be based on historical fee-for-service expenditures, while rates for nursing facility residents and nursing home conversions will be based on facility-specific per diem rates that have been adjusted for case-mix.

All participants will be eligible for the full package of Medicare benefits. Medicaid participants will also be eligible for the full range of Medicaid acute and long-term care services, and, based on care management's assessment of need, could be eligible for social and environmental supports, social day care, the personal emergency response system (PERS), and congregate or home delivery meals. Non-dual eligibles (Medicare only) will be eligible for a limited chronic care benefit of \$2,600 per year, with a \$6,000 lifetime maximum. This benefit package will include home delivered meals, personal care, social day care, emergency response system, homemaker/chore services, and respite care. This group will also have the option of purchasing extended chronic care benefits on a capitated premium or private pay, fee-for-service basis. All enrollees will have 24-hour access to care management services. Plans will also use multi-disciplinary care management teams to coordinate services across providers, settings, and over time. These teams will be led by social workers for those with moderate risks and nurse practitioners or nurse specialists for medically vulnerable individuals. CCN is being evaluated for HCFA as part of a multi-state study being conducted by researchers at the University of Minnesota. Results are due in 2005.

Arizona Long-Term Care System⁹³

Under the authority of a Section 1115 Medicaid “research and demonstration” waiver, Arizona implemented its acute care program, the Arizona Health Care Cost Containment System (AHCCCS) in October 1982. Following an amendment to this authority, the state added long-term care services in December 1988 through the Arizona Long-Term Care System (ALTCS), the only mandatory, statewide managed care program for long-term care currently in operation. In addition to developmentally disabled individuals, the ALTCS enrolls elderly and physically disabled adults with incomes up to 300% of the SSI eligibility level and who meet criteria for nursing facility care as determined by state assessment teams using Arizona’s pre-admission screening instrument. The ALTCS covers acute care services as well as care in nursing facilities for the mentally retarded and home and community-based care.

As of June 2000, the ALTCS enrolled 28,993 individuals, including 17,898 elderly and physically disabled persons and 11,095 developmentally disabled persons. Approximately 82% (14,755) of elderly and disabled enrollees were dually eligible for Medicare and Medicaid, close to 30% of whom (4,378) were enrolled in a Medicare HMO. To promote care coordination, each ALTCS member is assigned a case manager after enrollment in the program. Case managers are responsible for coordinating care with each member’s primary care provider and for identifying, planning, obtaining, and monitoring appropriate services to meet each member’s needs.

While the ALTCS capitates Medicaid coverage, it does not formally cover Medicare services. For those who choose to receive their Medicare benefits in the fee-for-service system, Arizona is only one of three states (Oregon and Minnesota are the others) to receive approval from HCFA to limit its Medicare cost-sharing obligations to services delivered through its Medicaid plans. All other states are required to provide for Medicaid payment of Medicare cost-sharing whether or not dual eligibles elect to obtain care through their state’s Medicaid network of providers. Because Arizona only pays for Medicare cost-sharing for dual eligibles who obtain Medicare covered services from its Medicaid network, dual eligibles have a strong incentive to use the same providers for both Medicaid and Medicare. For those ALTCS members who choose to receive their Medicare services through enrollment in a Medicare+Choice plan, however, Arizona is still obligated to pay any beneficiary cost-sharing that might be required.

Through a competitive bidding process, the ALTCS selects plans to serve each county and pays them a capitated rate in exchange for assuming full risk for all Medicaid-covered benefits, including primary and acute medical care, behavioral health services, nursing facility care, and home- and community-based care (e.g., homemaker, personal care, respite, transportation, assisting living, adult day care, home-delivered meals). Arizona’s Medicaid capitation includes a weighted average of nursing facility and home- and community-based long-term care costs as well as

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medical and acute care costs, behavioral health and case management costs. Rates are based on Arizona Medicaid rates, program contractor financial statements, service utilization data, and historical trends. Medicare is billed separately. Because of concerns about the cost-effectiveness of home- and community-based care, HCFA initially placed a cap on the percentage of the ALTCS budget that could be devoted to home- and community-based services for elderly and disabled members. This cap was gradually raised from 5% in 1988 to 50% in 1999. HCFA removed the cap on HCBS for elderly and physically disabled members effective October 1, 1999.

At the present time, seven program contractors provide care to the elderly and physically disabled in 15 Arizona counties, including two private plans and five county-operated programs. Only one of these providers, Maricopa County, also operates a Medicare+Choice plan. Originally, one contractor operated in each county and members had to enroll with the contractor in their county in order to receive services. While Arizona law mandated that the two largest counties, Maricopa and Pima, serve as program contractors in their respective counties, all others counties had the right of first refusal to participate as program contractors. If a county chose not to participate, the ALTCS sought competitive bids from private plans to provide the services within that county. As of October 1, 2000, all counties have contractors selected competitively, while one county (Maricopa) provides enrollees with a choice of plans (the county-based plan and two private plans). Starting October 1, 2001, however, Arizona will consider contracting with more than one plan to serve Pima County as well.

The ALTCS was evaluated for HCFA by researchers associated with Laguna Research Associates. Evaluators found an approximately 16% average annual reduction in what Arizona spent per capita for elderly and physical disabled long-term care recipients from what would have been spent in a typical Medicaid program. Most savings came from reduced hospital and nursing home use, which was less than offset by higher ambulatory and administrative expenditures.⁹⁴

Evaluators also found that nursing home residents in the ALTCS were less likely to be offered an influenza vaccine than Medicaid nursing home residents in New Mexico. Medicaid nursing home residents in the ALTCS, moreover, were more likely to experience a decubitus ulcer, fever, and catheter insertion than nursing home residents served by the neighboring program in New Mexico. No significant differences, however, existed between Arizona and New Mexico with respect to the incidence of patient falls or fractures resulting from the use of psychotropic drugs.⁹⁵

Focusing on the acute care side of the Arizona Medicaid system the evaluators found that SSI recipients in Arizona were less likely to report being very satisfied with their overall medical care compared to their counterparts in New Mexico. Arizona enrollees also reported being slightly less satisfied, on average, with waiting time, evening and weekend availability, information giving, courtesy and consideration. Alternatively, Arizona recipients reported slightly more satisfaction with ease and convenience and the costs paid out-of-pocket for medical care received. No

⁹⁴McCall, et al., 1996.

⁹⁵Ibid.

difference in the receipt of preventive care was found between Arizona and New Mexico SSI recipients.⁹⁶

Oregon Health Plan⁹⁷

Under the authority of a Section 1115 Medicaid waiver, the Oregon Health Plan (OHP), a statewide, mandatory Medicaid managed care program, was implemented in February 1994. OHP began enrollment of aged and disabled Medicaid recipients in January 1995, including Medicare-Medicaid dual eligibles. Though enrollment in Medicaid managed care is mandatory, Oregon provides beneficiaries with a choice of plans, that, in exchange for monthly capitation payments from Oregon's Office of Medical Assistance Programs (OMAP), are responsible for all Medicaid primary and acute care benefits. Unlike Arizona, long-term care services are not included in the capitated plan and are instead provided on a fee-for-service basis. As of January 1, 2000, the Oregon Health Plan had 349,500 enrolled individuals, approximately 50,000 of whom were dually eligible elderly and disabled adults.

Under Oregon's program, most Medicaid recipients receive their care through prepaid health plans. Three major types of managed care entities are used, including fully capitated health plans, dental care organizations, and mental health organizations. Although OHP emphasizes enrollment in fully capitated plans, primary care case management (PCCM) and fee-for-service coverage are also available on a case by case basis. Individuals may be exempted from managed care enrollment for a variety of reasons. These include: (1) availability of private supplemental insurance, typically a Medi-Gap policy provided by a former employer, (2) disruption of a critical patient-provider relationship, and (3) Native American heritage. For elderly, disabled, and other beneficiaries with complex care needs, local OHP enrollment counselors employed by local agencies responsible for aging and/or disability services may authorize PCCM or fee-for-service participation in Oregon's Medicaid program. Fee-for-service enrollment, is used as a last resort for those individuals whose existing providers do not belong to a fully capitated health plan, and whose primary care providers refuse to participate in the state's PCCM program. In 1998, 65.1% of dually eligible OHP beneficiaries were enrolled in a fully capitated Medicaid plan, up from 8.1% in PCCM, and 26.8% in fee-for-service Medicaid.⁹⁸

The Oregon Health Plan contracts with 15 fully capitated plans, of which four also participate in the Medicare+Choice program. While Oregon cannot mandate that Medicare beneficiaries receive their Medicare services through the state's network of Medicaid providers, dual eligibles who enroll in health plans with both Medicaid and Medicare risk contracts can receive all of their health care through plans capitated under both programs. In 1998, 34.6% of all dually eligible Oregon beneficiaries were

⁹⁶McCall, et al., 1989.

⁹⁷Contact: Joan M. Kapowich, Policy and Programs Section Manager, Office of Medical Assistance Programs, Department of Human Resources, 500 Summer Street, NE, 3rd Floor, Salem, 97310-1014. Phone: 503-945-6500. Fax: 503-373-7689. E-Mail: [joan.m.kapowich@state.or.us]

⁹⁸Mitchell and Saucier, 1999.

enrolled in Medicare HMOs with OHP contracts.⁹⁹ For those who chose to receive their Medicare benefits in the fee-for-service system, Oregon, like Arizona and Minnesota, has received approval from HCFA to limit its Medicare cost-sharing obligations to services delivered through its Medicaid plans. As a consequence, the 30.5% of dually eligibles remaining in fee-for-service Medicare but enrolled in a fully capitated Oregon plan have strong incentives to use their plan's Medicaid providers for their Medicare services needs. The remaining 34.9% dual eligibles are in other arrangements.¹⁰⁰

Plans are paid through actuarially determined Medicaid capitation rates based on plan encounter data, with separate rate categories for the elderly and disabled and for those with and without Medicare. These rates pertain to Medicaid primary and acute services only. Nursing home and home- and community-based services are reimbursed by Medicaid on a fee-for-service basis. How plans are reimbursed by Medicare depends on whether they are also a Medicare HMO. When the contractor is a Medicare HMO, the Medicare+Choice rate is used; otherwise, they are reimbursed on a fee-for-service basis.

To help elderly and disabled beneficiaries navigate managed care and to promote coordination between its long-term care program and the Oregon Health Plan, Oregon requires its contractors to hire "exceptional needs coordinators" (ENCCs), whose responsibilities include establishing a link between the state's medical and social service systems and acute and long-term care service providers. Other ENCC duties include identifying members with disabilities or complex medical needs, providing assistance to ensure timely access to providers and capitated services, coordinating services with providers to ensure consideration of unique needs in treatment planning, and assisting providers with coordination of capitated services and discharge planning. On average, plans receive \$6.02 per member per month to fund the ENCC role.¹⁰¹

An evaluation of the elderly and disabled portion of the OHP demonstration is being conducted by researchers at Health Economics Research, Inc. (based in Waltham, Massachusetts). Results are currently under review at HCFA and should be made available in early 2001. Preliminary findings indicate that separate enrollment of dually eligible beneficiaries in Medicare and Medicaid is extremely complex and time-consuming, and represents the greatest source of frustration among OHP plans.¹⁰² They also indicate that while the ENCC program has resulted in creative and flexible service plans for some beneficiaries, the effectiveness of ENCC has been limited by lack of consumer and provider awareness of the program and variations in ENCC program operation as a result of latitude granted plans in implementing these programs. Also the evaluators have pointed out that, "while some ENCC programs engage in creative case management, flexible service planning, and active liaison with

⁹⁹Ibid.

¹⁰⁰Ibid. In addition, 5.2% of dually eligible beneficiaries in Oregon were enrolled in a Medicare HMO and OHP fee-for-service, 8.1% in Medicare fee-for-service and OHP PCCM, and 21.6% in Medicare fee-for-service and Medicaid fee-for-service.

¹⁰¹Walsh, et al., 2000.

¹⁰²Mitchell and Saucier, 1999.

community agencies, others appear indistinguishable from traditional managed care services and utilization review departments.”¹⁰³

Florida’s Community-Based Diversion Pilot Project¹⁰⁴

Through the integration of medical and long-term care services, the aim of Florida’s Community-Based Diversion Pilot Project is to provide extremely frail seniors with an alternative to nursing home placement. Florida’s program focuses on dual eligibles 65 or older who reside in the project’s service area, have been certified for nursing home care, and meet additional clinical criteria, including: (1) some help needed with five or more activities of daily living limitations (ADLs); (2) some help needed with four or more ADLs plus supervision or administration of medication; (3) total help needed with two or more ADLs; (4) Alzheimer’s disease or other dementia diagnosis, plus some help needed with three or more ADLs, and/or (5) a degenerative or chronic condition diagnosis requiring daily nursing services.

After voluntarily enrolling in the program, participants are eligible to receive all of their Medicaid acute and long-term care services through one of three participating contractors, including two Palm Beach area plans (Beacon Health’s Independence Plan and Physicians Healthcare’s Summit Care Plan) and one Orlando-based plan (United HealthGroup’s Health and Home Connection). Since the two Palm Beach area sites are also Medicare+Choice plans, project participants may receive capitated Medicaid and Medicare benefits through the same provider, though the majority of Palm Beach enrollees have opted to remain in fee-for-service Medicare.

In exchange for a monthly capitation payment from the state, participating plans are at full risk for the following services: Medicaid nursing home care; 1915(c) home- and community-based waiver services (including adult day care, assisted living, homemaker, and respite care); and acute care benefits not covered by Medicare (including prescription drugs, Medicare cost-sharing, community mental health, dental, hearing, and visual services). Florida’s capitation payments include a medical and long-term care component equivalent to 75% of the fee-for-service nursing home rate and 92% of average fee-for-service claims, respectively. The medical payment component is developed using the Medicaid fee-for-service claims experience of Medicaid recipients age 65 or older who were assessed as nursing home certifiable. The long-term care component is developed using the statewide average cost of nursing home care less patient cost sharing responsibility. Beneficiaries receive their Medicare acute care benefits through separate enrollment in the Medicare program.

The project requires that participating plans employ case managers who perform assessments, develop care plans, and facilitate enrollee access to needed services. They are also responsible for developing and executing strategies to coordinate and integrate the delivery of all acute and long-term care services, regardless of funding source. Where project enrollees have elected to receive their Medicare services

¹⁰³Walsh, et al., 2000.

¹⁰⁴Contact: Judith Royce, Senior Management Analyst, Florida Department of Elder Affairs, 4040 Esplanade Way, Suite 235, Tallahassee, Florida 32399-7000. Phone: 850-414-2098. FAX: 850-414-2008. E-Mail: [roycej@elderaffairs.org]

within the fee-for-service system, for example, case managers must actively pursue coordination with enrollees' primary care physicians and other providers.

Authority for the Community-Based Diversion Pilot Project was obtained through a Medicaid 1915(c) waiver in 1997, which allows the state to add community based long-term care services to managed care organizations with existing Medicare or Medicaid risk contracts. Enrollment began in December 1998. As of February 2000, 501 persons were enrolled. An independent evaluation mandated by Florida's legislature is still in the planning stages.

Appendix C: Waiver Authorities

Existing waiver authorities (and one non-waiver authority) that have been used to authorize current federal and state dual eligible initiatives include:

- (1) **Section 1115 (of the Social Security Act) Medicaid waiver:** A Section 1115 “research and demonstration” waiver allows states to test major restructuring of the Medicaid program. It has been used for a variety of purposes, including making Medicaid managed care enrollment mandatory. States can use 1115 waivers to lock in enrollment in a managed care plan for 12 months if they provide enrollees with a choice of plans. The Balanced Budget Act (BBA) of 1997 granted states the flexibility to enroll most Medicaid recipients in mandatory Medicaid managed care without having to receive a waiver so long as they offer beneficiaries a choice between at least two managed care organizations or a primary care case manager. It explicitly excludes Medicare beneficiaries, children with special needs, and members of federally recognized American Indian tribes from mandatory managed care enrollment, however. As such, states will continue to need a Section 1115 or other waiver to enroll dual eligibles in mandatory Medicaid managed care. A Section 1115 waiver also allows states to cover non-Medicaid services, offer different service packages or combinations of services in different parts of the state, test new reimbursement methods, change Medicaid eligibility criteria in order to offer coverage to new or expanded groups, and contract with a greater variety of managed care plans.¹⁰⁵ This waiver is typically granted for periods of up to 5 years at a time.
- (2) **Section 1915 (b) Medicaid waiver:** A Section 1915 (b) “freedom-of-choice” waiver allows states to implement mandatory Medicaid managed care programs of both the risk-based (capitated) and primary care case management varieties. It also allows states to use savings generated by the waiver to fund expanded benefits for the populations served by these programs. Freedom-of-choice waivers are approved for 2 years and may be renewed at 2-year intervals.
- (3) **Section 1915 (c) Medicaid waiver:** A Section 1915 (c) home and community-based services waiver authorizes states to expand available services to include non-medical, social, and supportive services that allow individuals who otherwise would have required Medicaid-funded institutional care to remain in the community. Home and community-based waiver programs are initially authorized for 3 years and may be renewed at 5-year intervals.
- (4) **Section 1915 (a) Medicaid authority:** Though technically not a waiver authority, Section 1915 (a) of the Social Security Act allows states to

¹⁰⁵Prior to the BBA states had to obtain an 1115 waiver to engage in full-risk contracting with managed care plans that did not meet Medicaid’s 75/25 rule, which required that private (non-Medicaid) members constitute at least 25% of plan enrollment. The BBA eliminated this requirement.

establish voluntary managed care programs and only require approval of health plan contracts by HCFA's regional offices. (All waiver requests, by contrast, are reviewed in the central office). Under Section 1915 (a), health plans may provide a range of Medicaid services in addition to services not currently covered under states' Medicaid programs. Section 1915 (a) requests are not subject to the Office of Management and Budget's requirements that waiver programs be budget neutral to the Medicaid program (i.e., that Medicaid managed care programs not cost the federal government more than the traditional fee-for-service program).

- (5) **Section 222 Medicare waiver:** A Section 222 waiver is the only Medicare waiver available. It provides authority for Medicare demonstrations, and, in concert with such demonstrations, waiver of Medicare payment and administrative rules. A Section 222 waiver is required, for example, when states wish to contract with plans that are not Medicare risk contractors.¹⁰⁶ They are also required when states wish to alter the way Medicare risk contractors are paid. The creation of the Medicare+Choice program under the BBA expanded the array of service delivery options available for Medicare risk contracting to include HMOs, PPOs, and PSOs, among others, which may reduce the need for states to obtain Section 222 waivers to implement joint Medicaid-Medicare managed care programs for dual eligibles. The community-based long-term care organizations with which many states would like to contract are not included among the plans specified by the statute, however.

¹⁰⁶Prior to the BBA states had to obtain a 222 waiver to engage in full risk contracting with managed care plans that did not meet Medicare's 50/50 rule, which required that private members compose at least 50% of plan enrollment. The BBA eliminated this requirement.