DUAL ELIGIBLE BENEFICIARIES

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Dual eligibles are individuals eligible for or enrolled in the federal Medicare program as well as the state Medicaid program (called either the AHCCCS or ALTCS programs in Arizona). The dual eligible population is typically comprised of elderly and/or disabled individuals. They tend to be among the poorest, sickest and most costly beneficiaries in these two programs.[1] Dual eligible individuals account for 16 percent of all Medicare beneficiaries but 25 percent of Medicare expenditures. They account for 18 percent of all Medicaid beneficiaries but 46 percent of all Medicaid expenditures.[2] Unfortunately, the current dual system of care for this vulnerable population frequently results in poorly coordinated care for those with complex medical conditions, consumer confusion in navigating these systems of care and provider cost shifting between the programs.

KEY REFORM CHANGES

- **Promotes integration of care delivery to dual eligible beneficiaries by:**
  - **Requiring federal government to take steps to improve coordination between Medicare and Medicaid.**
  - **Authorizing five-year state demonstration projects related to provision of care to dual eligible beneficiaries.**
- **Extends authorization of Medicare Special Needs Plans; requiring these plans to be NCQA-approved.**
- **Eliminates cost sharing for Part D drugs for at-risk dual eligible beneficiaries who are receiving Medicaid home and community-based services.**

The Patient Protection and Affordable Care Act (Act) lends support to ongoing efforts to improve healthcare policy relative to the dual eligible population. In particular, the Act includes a number of provisions that are directed at studying, planning and developing recommendations for more substantive national program changes in the future. Only a limited number of the Act's provisions directly impact how care is to be delivered to dual eligible individuals. These include the opportunity for individual state Medicaid programs to implement special Medicaid waiver demonstration programs[3] directed at caring for dual eligibles, the extension of Medicare Special Needs Plans (SNPs) until 2014 and the elimination of cost sharing for Medicare Part D drugs.

In Arizona, the dual eligible population makes up over 50 percent of the membership in the Arizona Long Term Care System (ALTCS) program.[4] Arizona has tried to align the delivery of care for its dually eligible members by requiring its ALTCS health plans to either become a SNP or establish a relationship with a Medicare Advantage plan. Despite these efforts, providing an integrated and well-coordinated system of care to dual eligibles continues to be an ongoing challenge in Arizona.

Unfortunately, the Act's provisions overall will have only a minimal impact on how Arizona delivers care to dual eligibles. The one exception is if Arizona is able to draw upon this renewed federal commitment to improve the systems of care for dual eligibles and obtain federal approval to implement a more fully integrated care model for dual eligibles through modifications to its current Medicaid 1115 demonstration project waiver.[5]

Improved Coordination for Dual Eligible Beneficiaries

With regard to the dual eligible population, the Act's primary focus is the exploration of strategies for moving national healthcare policy toward a service delivery system that will:

- Promote well coordinated care
- Streamline the administration requirements associated with management of these dual systems of care

Responsibility for this effort is assigned to the federal Department of Health and Human Services (HHS). Specific requirements of the law include the following:

- Immediate establishment of the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services (CMS). The purpose of this Office will be to integrate benefits under the Medicare and Medicaid programs and improve the coordination between the federal government and states for dual eligibles. Along with specifically prescribed goals and areas of responsibilities that address quality and access, coordination of care, simplification of processes and elimination of cost shifting, CMS is required to submit an annual report to Congress containing recommendations for legislation that would improve care coordination and benefits for dual eligible beneficiaries.
- Need for consultation and coordination on the impact of Medicaid and Medicare program policies on dual eligibles between the recently established Medicaid and CHIP Payment and Access Commission (MACPAC) and the longer standing and highly influential Medicare Payment Advisory Commission (MEDPAC). In carrying out their duties, MACPAC is required to regularly solicit input from the states as well as coordinate and consult with the Federal Coordinated Health Care Office.
- Testing of payment and service delivery models for the Centers for Medicare and Medicaid Innovation that is to be established within CMS by January 2011. Potential models this new Center may test include state-operated models that provide fully integrated care to dual eligible individuals or include an all-payer payment system for medical care provided to state residents, including dual eligibles.
- Completion of two studies by the HHS Inspector General: one on the availability in Medicare Part D formularies of drugs commonly used by dual eligibles, and the second on the prices of drugs under Medicare Part D compared to the Medicaid program, including the impact price discrepancies have on dual eligibles.

At the state level, the Act provides the opportunity for individual states to apply for five-year Medicaid waiver demonstration program for dual eligible members, including programs (such as AHCCCS) that also serve non-dual eligibles. Through these demonstration programs, which are included as part of the current federal waiver processes (1115, 1915(b), 1915(c)), states would be able to obtain waivers from certain Medicaid requirements.

Arizona's Medicaid program, which currently operates under 1115 demonstration project waiver, includes both dual and non-dual eligibles. However, at this time Arizona does not have any specific waivers that are aimed at specifically addressing issues of care coordination for dual eligibles. Within the constraints of the current Medicaid and Medicare program frameworks, Arizona has laid a foundation for enhancing coordination for dual eligibles through the use of SNPs. (See following page.)

Despite these efforts, Arizona continues to face many of the same service delivery issues identified by national experts[6] – consumer confusion in navigating multiple systems, inability to manage all of individuals' care needs, lack of financial incentives to manage care effectively, inability to mandate enrollment for dual eligibles in the SNP, and misalignment of administrative, operational and regulatory processes. Given that the Act suggests a willingness by the federal government to look at new models for improving delivery of care to dual eligibles, this current environment may afford Arizona the opportunity to obtain certain waivers from CMS in order to further integrate the delivery of care to dual eligibles under a single entity (e.g., sharing in Medicare

savings attributable to integration, minimizing duplicative reporting requirements for the health plans, allowing mandatory enrollment in the same plans (ALTCS health plan and the companion SNP).[7]

KEY TAKEAWAYS:

- Arizona should identify strategies for improving the delivery of high-quality, well-coordinated care to dually eligible members enrolled in AHCCCS/ALTCS and, as part of the waiver demonstration renewal process, seek the approval needed from CMS to implement these strategies.
- Arizona should take an active leadership role in the national efforts to develop solutions for managing the care of the dual eligibles by providing input to the MEDPAC and working with those MEDPAC commission members who have working knowledge of Arizona and its unique Medicaid program.

EXTENSION OF SPECIAL NEEDS PLANS

Medicare Advantage Special Needs Plans (SNPs) are healthcare plans that have contracted with CMS and are focused on delivering Medicare benefits to the most vulnerable individuals, including dual eligibles, institutionalized individuals or individuals with severe or disabling chronic conditions. Under the health reform law, SNPs were authorized for another three years (until 2014), requiring any SNP serving dual eligibles to have by 2013 a fully-capitated contract with the state Medicaid agency to provide all Medicaid services, including long-term care. As part of the SNP extension, the Act also made two additional changes to the current operation of SNPs that include the following:

- Beginning 2011, the law allows CMS to pay frailty adjusters (increased payments based on health status) to SNPs for those dual eligible members if the SNPs have a fully-capitated contract with the state. However, recently CMS announced that it will not make this adjustment in 2011 due to lack of sufficient data to accurately determine frailty level. CMS expects to have a larger sample size to calculate these frailty levels for contract year 2012.[8]
- Beginning 2012, the law requires SNPs to be approved by the National Committee for Quality Assurance (NCQA) based on standards established by the Secretary of HHS. Since 2008, NCQA has been contracted with CMS to develop a strategy to evaluate the quality of care provided by SNPs. This phased assessment process utilizes defined Healthcare Effectiveness Data and Information Set (HEDIS) measures[9] as well as measures that evaluate structure and process requirements. All contracted SNPs are required to currently report annually their performance on the prescribed measures.

The overall extension of SNPs is positive for Arizona, which has successfully used SNPs as a mechanism for bridging the two separate systems of care for dual eligibles for the past four years in the ALTCS program. As part of its contract, AHCCCS requires the ALTCS health plans to either 1) become a Medicare Advantage SNP or 2) develop a formal relationship with Medicare Advantage Plans or Medicare Advantage SNP. Currently, five of the nine ALTCS plans offer a SNP option to their members.[10] Approximately 40 to 50 percent of the dual eligibles in ALTCS/AHCCCS are enrolled in a Medicaid plan and SNP that are managed by the same health plan.

The two additional SNP provisions (frailty adjusters and NCQA approval) have the potential to positively impact the quality of care delivered to dual eligibles in Arizona. However, depending on how they are implemented, they also have the potential to impact the continual viability of SNP plans for dual eligibles in Arizona. Since the national trend is to ratchet down the payment to Medicare Advantage plans, the frailty adjuster is critical to ALTCS health plans that financially struggle under the current Medicare payment schedule to cover the costs associated with providing care to this more expensive Medicare population. Additionally, concern has been raised by some of the current SNP plans in Arizona over requirements to meet NCQA approval standards (e.g., will there be additional administrative requirements, and will the standards target caring for dual eligibles as opposed to caring for Medicare Advantage beneficiaries in general?).

KEY TAKEAWAYS:

- Arizona should continue to monitor the implementation of changes to SNPs, making sure the proposed solutions will appropriately support Arizona's service delivery system and the future viability of SNPs for dual eligibles in Arizona.
- Arizona should work in partnership with its current ALTCS health plans to make sure they are prepared to become NCQA-approved SNP plans in 2012.

ELIMINATION OF MEDICARE PART D CO-PAYMENTS FOR CERTAIN DUAL ELIGIBLE BENEFICIARIES

For the dual eligibles, Medicare pays for most of the prescription drugs that they need under the Medicare Part D program. Under healthcare reform, beginning in January 2012, dual eligibles that are at risk of institutionalization (i.e., receiving home and community-based services) will no longer be required to pay co-payments for drugs covered under Medicare. Previously this exemption only applied to low-income individuals who were residing in an institution, with all other dual eligibles being required to pay the following co-payments depending on income:

- For those with income at or below 100 percent of the Federal Poverty Level (FPL), the co-payment was $1.10 for generic and $3.20 for brand name drugs.
- For those with income above 100 percent FPL, the co-payment was $2.40 for generics and $6.00 for brand names.

While this change will expand the pool of dual eligibles who will be able to avoid out-of-pocket costs for Medicare drugs, those who are not at risk of institutionalization will continue to be required to pay for their Medicare Part D co-payments.

In Arizona, the majority of dual eligibles who are at risk of institutionalization (i.e. ALTCS) reside in home and community-based settings. Prior to the recession, ALTCS health plans paid the small co-payment for all Part D prescriptions. However, beginning in early 2009, these dual eligibles became responsible for making these payments for Medicare drugs (there is no co-pay requirement for any of the limited drugs a dual eligible may receive through Medicaid). In addition to benefiting these low-income members, this provision will also simplify the requirements for dual eligibles by eliminating the differences in prescription co-pay requirements between the Medicaid and Medicare programs. Unfortunately, those dual eligibles enrolled in AHCCCS health plans (those not at risk of institutionalization) will need to continue to pay for their Medicare drug co-payments.

KEY TAKEAWAYS:

- In 2012, ALTCS dual eligibles residing in a home or community-based setting will no longer need to pay co-payments for Medicare covered drugs.

ABOUT THE AUTHOR

Linda Huff Redman, PhD is an independent healthcare consultant with 14 years of experience advising organizations that serve low income populations on a broad range of healthcare related issues. Her expertise includes Medicaid program and provider organization restructuring, redesign of programs serving special need populations, federal fund maximization, managed care Medicaid RFP submittals, performance reviews, and federal waiver and strategic plan development. Previously, Dr. Redman spent eight years with Arizona's Medicaid agency (AHCCCS) as the Deputy Director.

References

1 8.8 million dual eligibles drive nearly half of Medicaid funding and one quarter of Medicare spending. Bella, M. (2010, June 7). Innovative state initiatives in care management for dual eligibles. Hamilton, NJ: Center for Health Care Strategies. Retrieved July 30, 2010 from http://www.chcs.org/usr_doc/MBella_Duals_Innovations_060710.pdf

2 Saucier, P., Kasten, J., & Burwell, B. (2009, November). Medicaid contracts with Medicare special needs plans reflect diverse state approaches to dually eligible beneficiaries [Special Needs Plans and Long-Term Care issue Brief #3]. Washington, DC: Department of Health and Humans Services, Office of Assistant Secretary for Policy and Evaluation. Retrieved July 30, 2010 from http://aspe.hhs.gov/daltcp/reports/2009/SNPdual.htm

3 The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs (e.g., 1115, 1915(c) and 1915(b)). Each authority has a distinct purpose and distinct requirements.

4 In 2005, dual eligibles made up 57 percent of the ALTCS membership and 15.5 percent of the AHCCCS (acute care) program.

5 Under §1115 of the Social Security Act, the Secretary of Health and Human Services can allow states to "experiment, pilot or demonstrate projects which are likely to assist in promoting the objectives of the Medicaid statute." The statute authorizes the Secretary to waive compliance with any state Medicaid plan requirements, to develop plans that suit states' health-care needs and goals. Since Arizona began providing Medicaid on October 1, 1982, AHCCCS has been exempt from specific provisions of the Social Security Act, pursuant to a 1115 research and demonstration waiver.

6 Care, L.T. (2009, August). Health reform opportunities: improving policy for dual eligible [Focus on Health Reform]. Washington, DC: Kaiser Family Foundation. Retrieved July 30, 2010 from http://www.kff.org/medicaid/7957.cfm. See also Bella, M., & Palmer, L. (2009, July). Encouraging integrated care for dual eligibles. Hamilton, NJ: Center for Health Care Strategies, Inc. Retrieved July 30, 2010 from http://www.chcs.org/publications3960/publications_show.htm?doc_id=982564. Also, Saucier, P., & Burwell, B. (2007, January). The impact of Medicare special needs plans on state procurement strategies for dually eligible beneficiaries in long-term care. Cambridge, MA: Thomson Medstat. Retrieved July 30, 2010 from http://muskie.usm.maine.edu/Publications/MeicareSNP.pdf

7 To date only, a handful of states have implemented integrated care models for dual eligibles (e.g., New York, Massachusetts, Minnesota) in which the Medicaid health plans are required to offer SNP companion plans. Of note is California's recent submittal to CMS in June of a 1115 comprehensive demonstration project waiver, a component of which would provide for the full integration of funding and benefits for dual eligibles. See http://www.cdcan.us/medi-cal/Section1115Waiver/20100603-CMS%20Waiver%20Submission%20Ltr%206-3-10.pdf

8 Kaiser Family Foundation (2010, May). *Explaining health reform: key changes in the Medicare Advantage program* [Focus on Health Reform]. Washington, DC: Kaiser Family Foundation. Retrieved July 30, 2010 from http://www.kff.org/healthreform/8071.cfm

9 HEDIS is a tool used by health plans to measure performance on important dimensions of care and service. Because so many plans collect HEDIS data, and because the measures are so specifically defined, it is possible to compare the performance of health plans on an "apples-to-apples" basis and for health plans to use HEDIS results themselves to see where they need to focus their improvement efforts. HEDIS measures address a broad range of health issues such as asthma medication use, breast cancer screening, and comprehensive diabetes care. See: http://www.ncqa.org/tabid/187/default.aspx

10 Except for Pima Health System which formed a partnership with a SNP operated by Bridgeway Health Solution the county-operated ALTCS plans and the state-operated ALTCS plan for persons with developmental disabilities have not become SNPs. Paul Saucier notes that small provider organizations or counties may not be well suited to become a SNP due to administrative burden, financial reserves and the political hazard of passing financial risk on to county tax payers. Saucier, P., & Burwell, B. (2007, January). The impact of Medicare special needs plans on state procurement strategies for dually eligible beneficiaries in long-term care. Cambridge, MA: Thomson Medstat. Retrieved July 30, 2010 from http://muskie.usm.maine.edu/Publications/MeicareSNP.pdf

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