Business Opportunities in the Medicare Modernization Act for Community Affiliated Health Plans

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Table of Contents

EXECUTIVE SUMMARY

The Medicare Modernization Act (MMA), enacted on December 8, 2003, established a new prescription drug benefit for Medicare beneficiaries and launched far-reaching reform of the Medicare program. The MMA's provisions also have important long-term consequences for the Medicaid program, particularly for beneficiaries eligible for benefits under both Medicaid and Medicare.

Dual eligible beneficiaries are likely to be affected both by the establishment of the new Medicare prescription drug benefit, which will vary in a number of ways from their coverage under Medicaid, and by the reforms to Medicare's managed care program, which are intended to give all Medicare beneficiaries a range of new coverage choices. Health plans focused on serving the Medicaid population today are likely to feel the impact of these reforms whether or not they currently serve dual eligible beneficiaries.

This paper assesses the business opportunities and challenges for Medicaid-focused plans created by the MMA. Specific questions we will address include:

- How will reform change states' decisions and incentives regarding Medicaid managed care, specifically for dual eligibles?
- How will reform affect dual eligible beneficiaries currently enrolled in Medicaid managed care?
- Should Medicaid-focused plans consider entering Medicare Advantage?
- What advantages will there be to participating in Medicare as a Special Needs Plan?

This paper is organized in two parts. Part I provides a broad overview of the Act's key provisions. Part II summarizes what is known about the characteristics of dual eligible beneficiaries, and discusses the experience to date of dual eligible beneficiaries in Medicaid and Medicare managed care. It concludes with a discussion of how state Medicaid agencies may respond to Medicare reform.

Part III considers business and policy implications of Medicare reform for ACAP members. It begins with a discussion of the impact of the drug benefit on dual eligible beneficiaries, the key concerns of state Medicaid officials in the wake of reform and the ways in which future decisions about Medicaid managed care might be affected. Subsequent sections evaluate each of three strategies health center-affiliated plans may take with regard to serving dual eligible beneficiaries. These are:

- **Option 1. Medicaid-only**: Continue to focus exclusively on the Medicaid population, which, depending on state policies, may include dual eligible beneficiaries in some states.
- **Option 2. Local Medicare Plan:** Participate both in Medicaid and as a "local plan" in Medicare Advantage. In this option, the plan would offer coverage for all Medicare covered services, including the drug benefit, to any Medicare beneficiary. Some plan

members would be enrolled in a Medicaid product, some in a Medicare product, and some potentially in both.

- **Option 3. Special Needs Plan (SNP)**: Participate in Medicaid and as a Special Needs Plan in Medicare Advantage. Coverage of Medicare services would be offered only to Medicare beneficiaries eligible for full Medicaid benefits.
- **Option 4**. **Long-term Care**: Regardless of participation status in Medicare, incorporate long-term care services in managed Medicaid contracts.

The paper concludes that health plans currently serving dual eligibles are likely to face added administrative challenges following implementation of the Medicare drug benefit. If plans are currently administering drug coverage for dual eligible beneficiaries, they may also experience a dramatic reduction in their Medicaid capitation rates. If states do not include management of long-term care services in managed care contracts, plans may find that they do not have an opportunity to achieve significant savings for states with these members. These concerns could be sufficient for plans to consider advocating that their states no longer enroll dual eligibles in Medicaid managed care.

Whether entering Medicare Advantage (Option 2) is attractive for ACAP plans will depend critically on a range of factors specific to the health plan and local market, including whether the plan currently serves dual eligibles, the plan's existing membership and provider network, local Medicare managed care payment rates, and whether there are existing players in Medicare managed care. For a plan with existing dual eligible members and a sufficient provider network, entering Medicare Advantage may represent a significant boost in revenue, with little start-up cost. In contrast, a plan that does not serve dual eligibles today, has a limited network, and faces well established existing commercial players could find launching a Medicare product both expensive and risky.

In general, plans are likely to face substantial start-up costs associated with necessary system changes, expansion of provider networks, and marketing functions. Yet whether future payment rates will continue to be attractive once competitive bidding is in full swing after 2006 is unclear. Future competition with regional PPOs, which may be able to take advantage of subsidies to offer richer benefits, further complicates the decision about whether to enter this market.

Special Needs Plans appear to offer a much-needed opportunity to provide an integrated plan that coordinates Medicaid and Medicare coverage for dual eligible beneficiaries. For health plans already serving dual eligible beneficiaries, Option 3 offers revenue growth without substantial investment. Plans with the infrastructure and systems capability to coordinate coverage effectively may find that this is a sufficient incentive for beneficiaries to join and simplifies life for participating network providers. But achieving seamless coordination may be quite difficult. CMS is likely to treat Special Needs Plans much like regular Medicare plans, just with more limited enrollment. Health plans will also need to determine whether Medicare capitation rates will be able to sustain a "zero premium" product over time, or work with state Medicaid agencies to ensure that states pay the required beneficiary premium. There is also some risk that Medicare payment rates would not fully reflect costs incurred if plans attract a

very frail population. Finally, start-up and fixed administrative costs must be amortized over a relatively small membership.

Finally, a fourth option for ACAP plans is to consider expansion into the managed long-term care arena. In this option, rather than taking on a new population, health plans expand the range of services which they coordinate and for which they bear risk. This opportunity existed prior to Medicare reform, and the risks and advantages are not fundamentally changed by reform. However, plans that are at risk for long-term care services may find reform further complicates their ability to coordinate care for dual eligibles (which may already be compromised by lack of ability to coordinate Medicare acute care services). Now those health plans will also lack control over prescription drug coverage, for which they will need to rely on each Medicare beneficiary's chosen private drug plan. We suggest that managing long-term care services is likely to be more attractive for the Medicaid SSI population than for dual eligibles. The exception to this may be Special Needs Plans, to the extent that they already coordinate the full range of Medicaid and Medicare benefits (including drug coverage).

I. OVERVIEW OF MEDICARE MODERNIZATION ACT

Medicare reform has important implications for all health plans, regardless of whether they currently participate in Medicare. The most important provisions affecting ACAP plans are the creation of the new prescription drug benefit (Medicare Part D) and reform of the current Medicare managed care program, now called Medicare+Choice but renamed "Medicare Advantage" by the MMA. In addition, a provision in Medicare Advantage that allows for the creation of specialized plans to serve chronically ill, institutionalized, or dual eligible beneficiaries is of special interest to health plans serving the Medicaid market today. These provisions are described below, beginning with the short-term changes that take place in 2004 and 2005.

Table 1. Medicare Reform Implementation

Summer 2004	Medicare Advantage regulations issued
January 1, 2005	CMS announces regions for Part D Rx plans and Medicare Advantage PPOs
First Monday in June 2005	Health plans submit premium bids for Medicare Advantage and Part D Rx plans
September 2005	Employers and Medigap carriers notify beneficiaries of drug benefit and supplemental coverage options
November 15, 2005 – May 15, 2006	Open enrollment begins for Medicare Advantage and Rx plans
January 1, 2006	Medicare Advantage and Rx plans effective date

A. Phase I: Changes to Take Place in 2004 and 2005

From the perspective of health center-affiliated health plans, there are two key aspects of reform worthy of note in 2004 and 2005. First, as a transitional measure, the MMA establishes a Medicare-endorsed prescription drug discount card program beginning in June 2004. Second, payment rates for Medicare managed care plans have been increased, effective March 2004.

Drug Discount Cards

All Medicare beneficiaries, with the exception of beneficiaries eligible for full Medicaid benefits, are eligible to enroll in a drug discount card starting in May 2004. The discount card program is not likely to have a major impact on plans exclusively serving Medicaid beneficiaries as currently enrolled plan members are, by definition, excluded from the program.

CMS has approved 28 Medicare discount drug cards, which beneficiaries will be able to purchase beginning in May and will be effective June 1. In addition, may Medicare managed care plans will be offering cards exclusively to their enrolled members. CMS has estimated that the cards will offer beneficiaries discounts of up to 25 percent on selected drugs. Medicare beneficiaries with incomes below 135 percent of the federal poverty level (currently $12,124 single/$16,363 married) who sign up for a drug discount card are eligible for transitional assistance of $600 per year to purchase prescription drugs. The cards will be offered free to this group, while higher income beneficiaries may be charged an enrollment fee of up to $30 per year.

The drug discount card and the transitional assistance program will be replaced by the Medicare Prescription Drug Benefit beginning in January 1, 2006.

Increase in Medicare+Choice Payment Rates for 2004 and 2005

Medicare managed care plans will receive higher payment rates than were authorized under previous law, starting in March 2004 and continuing in 2005. The purpose of the increase is to stabilize the Medicare+Choice program, which has suffered from the sharp enrollment drops and the withdrawal of multiple plans in recent years. The increase is the result of a number of changes to the payment formula, the most significant of which is the establishment of a new minimum payment equal to 100 percent of the estimated cost of Traditional Medicare. The net effect of the payment changes is to provide an average increase for 2004 over 2003 of 10.9%[1].

The Medicare managed care payment formula is quite complex. Essentially, however, county payment rates for 2004 are equal to the highest of:

- **"Floor" payments**. For rural areas, this is $555.42 PMPM and for qualifying urban areas, $613.89 PMPM.

[1] Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act, Lori Achman and Marsha Gold, Mathematica Policy Research, Feb 17, 2004. The figure differs from the CMS estimate of 10.6 percent, as that is an average across all counties, while 10.9 percent figure is a weighted average that reflects managed care enrollment.

- **A minimum update over the previous year's rate** of 2 percent or the national growth rate percentage, whichever is higher. The national growth rate percentage is 6.3% for 2004 and 6.6% for 2005.

- **A "blended" payment rate**. This rate is based on a 50-50 average of local and national fee-for-service spending. (In past years, blended rates were almost never paid, as a budget neutrality provision in the formula required that total payment not exceed what it would have been otherwise. However, the budget neutrality provision was eliminated in MMA.)

- **100 percent of average estimated fee-for-service costs in the county (new provision)**. This payment rate reflects an estimate of costs for demographically similar beneficiaries enrolled in traditional Medicare (adjusted to exclude a portion of Medicare costs related to graduate medical education).

On average, Medicare managed care payment rates in March 2004 will be equal to 107 percent of estimated fee-for-service costs. However, actual rates vary substantially by county and by the plan's risk profile. As a result, payment rates for many rural counties are over 120 percent of estimated fee-for-service costs, while rates for many urban counties are much closer to estimated fee-for-service spending.

Final Medicare plan payment rates for 2005 will be announced on May 10, 2004. Last week, however, CMS announced that it anticipates the minimum increase will be 6.6 percent over 2004 rates.

CMS is phasing in a new risk-adjustment system designed to better reflect differences in the health status of plan members. In 2003 and previous years, rates were based 90 percent on demographic factors (including dual eligibility status) and 10 percent on plan risk-adjusted rates. The previous risk adjustment system was based only on the principal inpatient diagnoses of members admitted to the hospital. In 2004, CMS is shifting to a new methodology based on both inpatient and outpatient data. Thirty percent of 2004 payments will be based on the risk-adjusted rate, and 70 percent on demographics. The law's phase-in schedule calls for payment to be wholly based on the risk-adjusted rates by 2007.

Risk adjustment is of particular interest to plans that serve a disproportionate number of frail beneficiaries. In the past, risk adjustment has significantly under-predicted costs for the frailest beneficiaries. As a result, CMS has developed a "frailty adjuster "aimed at appropriately adjusting payment for this population. This payment adjustment is not currently being applied to payment for any plans other than those in PACE and other selected demonstration projects. CMS does not anticipate applying the adjustment to other Medicare Advantage plans at this time.

B. Phase II: Changes to Take Place in 2006: Medicare Advantage and the Prescription Drug Benefit

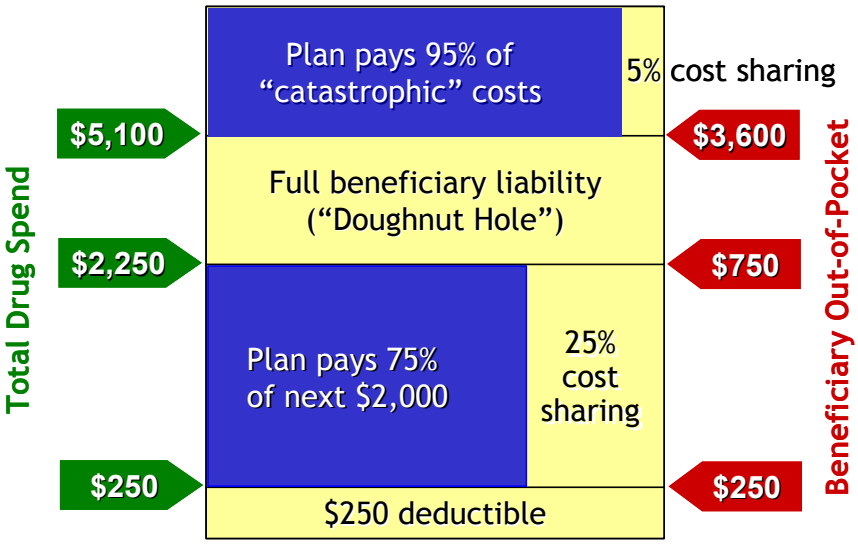
Medicare Prescription Drug Benefit: Part D

The new drug benefit, "Part D" of Medicare, is effective January 1, 2006 for all Medicare beneficiaries. Enrollment in Part D is voluntary. For beneficiaries enrolling in Part D, there are two options for receiving drug coverage:

- Beneficiaries choosing to remain in traditional FFS can receive drug coverage through competing, at-risk stand-alone prescription drug plans.
- Beneficiaries may enroll in a local or regional managed care plan, all of which must offer at least one option that includes the standard drug benefit. Beneficiaries who enroll in Part D and in a Medicare Advantage managed care plan must receive their drug coverage through the managed care plan (they can not enroll in a separate Part D drug plan.)

The bill includes premium subsidies and reinsurance payments to the drug plans designed to provide a 74.5 percent subsidy to the beneficiary, on average, for the total cost of the standard benefit. Taking this subsidy into account, the Congressional Budget Office estimates that beneficiaries not eligible for low income assistance will pay an average monthly premium of $35 for the standard benefit.

Figure 1. Standard Medicare Drug Benefit



Government payments for the prescription drug benefit will be the same for stand-alone drug plans and for managed care plans offering the benefit. In both cases, payment will be based on national average spending, adjusted to reflect geographic variation and the health status of beneficiaries enrolled in the plans. Specific beneficiary premiums will be related to the price of

the plan when compared to others in its region, so that beneficiaries will pay more if they choose more expensive plans. Underwriting gains and losses for the drug benefit will be shared with the government based on statutorily defined risk corridors, and the law intends that plans bear a greater share of risk over time.

Beneficiaries with low incomes will pay no premium if their income falls under 135 percent of the federal poverty level and will receive much more generous benefits. Full dual eligibles will have comprehensive coverage (there will be no gap or "donut hole"). They will pay a $1 copay per generic prescription, and a $3 copay per brand name prescription.

Table 2. Low-Income Beneficiary Subsidies

	135%-150% FPL Asset Test: Less than $10,000 single/ $20,000 married	100%-135% FPL with Asset Test: Less than $6,000 single/ $9,000 married	Less than 100% FPL and Eligible for full Medicaid Benefits
Premium	Sliding scale	$0	$0
Deductible	15% cost sharing to out-of-pocket threshold	$0	$0
Copay	Greater of 5% or $2 generic/$5 brand	$2 generic/$5 brand	$1 generic/$3 brand

Medicare Drug Benefit for Dual Eligible Beneficiaries

Currently, beneficiaries eligible for Medicare and Medicaid receive their prescription drug benefit through the Medicaid program. Starting January 1, 2006, full dual eligibles will be automatically disenrolled from Medicaid drug coverage and must enroll in Medicare Part D in order to receive the new drug benefit.

States do *not* have the ability to automatically enroll Medicaid beneficiaries in the Medicare Part D drug benefit. As a result, it is possible that despite extensive outreach efforts, some Medicaid beneficiaries could arrive at the pharmacy in January 2006 only to find themselves without drug coverage. If a beneficiary enrolls in Part D but does not select a drug plan, CMS will have the authority to randomly assign the beneficiary to one of the private, stand-alone drug plans.

Medicare Advantage: Local and Regional Plans

Beginning in 2006, the Medicare managed care program (Medicare+Choice) will be renamed Medicare Advantage, and health plans will have two options for participation. They may offer a "local" plan in a group of local counties that they determine, or they may participate as a regional plan.

Both local and regional plans must offer at least one product option that includes the standard Medicare drug benefit, although they may also offer options that do not include drugs. Local plans in Medicare Advantage can be designed in multiple ways – as HMOs, PPOs, Point of Service (POS) plans, private fee-for-service, or as Medicare Savings Account options. However,

no new local PPO applications (to cover a smaller service area) will be accepted during 2006 and 2007.

Regional plans will be introduced for the first time in 2006. These plans must be offered to beneficiaries throughout the regional service area (to be determined by CMS). The law requires that the regions be announced by CMS by January 1, 2005, and CMS is charged with designing the regions to be as consistent as possible with those for the free-standing Part D benefit. While many health plans are advocating that CMS allow 50 separate state-based regions, it is highly likely that regions will include multi-state service areas. Regional plans can be structured as either a PPO or POS option; beneficiaries must be able to see an out-of-network provider. There is no limit on the number of regional plans allowed.

Regional plans will face different financial incentives and requirements from locally-based plans. PPOs will be eligible for shared risk financing in 2006 and 2007 as well as bonus payments, such as for entering a region previously not served by any Medicare managed care plans. Regional PPOs also will have different benefit requirements; for example, they must offer a cap on catastrophic out-of-pocket expenses.

Medicare Advantage Payment Rates: Competitive Bidding

Beginning in 2006, payment rates for both local and regional plans - and beneficiary premiums - will be determined through a competitive bidding process. Plans will submit bids that will be compared against a "benchmark price." Benchmark prices will be determined in the same way that county payment rates are determined in 2004 and 2005 (essentially, for most areas that will be last years' rate inflated by a national growth factor). The government will pay no more than the benchmark price; beneficiaries will pay the full value of the difference if they choose a plan more expensive than the benchmark. If a beneficiary chooses a plan with a bid below the benchmark, the beneficiary will receive enhanced benefits or a reduced premium – and 25 percent of the savings will flow to the government. These funds will be deposited into a "stabilization fund" used to reduce premium increases in the future – for regional plans only.

Competitive bidding will have the impact of reducing plan payment levels. Today, if a plan can deliver core Medicare benefits at a cost below the government's payment rate, they may use 100 percent of the "savings" to fund supplemental benefits. After 2006, plans will be able to use only 75 percent of these savings. The net result will probably be to raise beneficiary premiums for plans that include generous supplemental benefits.

Finally, MMA includes a controversial provision for a demonstration program to begin in 2010, in which in some markets with a high share of beneficiaries enrolled in Medicare managed care, the competitive bidding process would be changed so that health plans compete directly with traditional Medicare. In these markets beneficiaries choosing to remain in the fee-for-service program may pay more to do so if private plans have lower costs. The law includes a number of provisions to limit the degree of premium increase beneficiaries could be forced to pay in this case.

Establishment of Special Needs Plans (SNPs)

MMA includes a brief provision that allows health plans to apply to be designated as a Medicare Advantage Special Needs Plan. As a Special Needs Plan (SNP), the health plan may restrict enrollment to Medicare beneficiaries within one or more of the following classes: institutionalized beneficiaries, Medicaid recipients, or beneficiaries determined by the Secretary who would benefit from this type of plan, such as persons with severe or disabling chronic conditions.

The law does not specify any additional requirements or ways (other than limited enrollment) in which SNPs might vary from other Medicare Advantage plans. Staff at CMS currently drafting the Medicare Advantage regulation told Lewin that while no final decisions have been made, they do not anticipate that there will be a separate regulation outlining a different set of requirements – or exemptions - for Special Needs Plans. Plans should assume until CMS indicates otherwise that SNPs will be treated exactly like other Medicare Advantage plans.

While there is recognition at CMS that there is a significant policy need for a coordinated approach to managing Medicaid and Medicare benefits for dual eligibles, it appears that CMS is likely to interpret this provision narrowly – at least at first – given the number of other sweeping reforms to the Medicare program that must be addressed in the next year. CMS staff suggested that one option they could pursue would be to seek comment from health plans and other stakeholders on the regulation of Special Needs Plans at the time that the proposed Medicare Advantage rule is issued. In addition, several of the demonstrations focused on dual eligible beneficiaries that were approved last year are likely to become a laboratory for fine-tuning regulatory requirements for Special Needs Plans.

C. Other Provisions

There are a number of other important provisions in MMA related to other forms of Medicare supplemental coverage, changes in drug pricing, and provider payment. While these provisions are not the focus of this paper, they are briefly described below as they may affect market dynamics and long-term strategic positioning for Medicaid-focused health plans, as well as for commercial health plans.

Reform of Medigap. Currently, over a quarter of Medicare beneficiaries purchase private supplemental insurance called Medigap. For many health plans, Medigap has been a stable and profitable line of business. Starting in 2006, MMA prohibits sale or renewal of existing Medigap policies that include prescription drug coverage (to beneficiaries that enroll in Part D) and calls for the addition of two new plan options, designed to be less expensive. As a result, there is likely to be significant flux in the Medigap market once the new drug benefit is effective; some beneficiaries will shift into managed care if that is more cost-effective, and others may shift to less expensive Medigap policies. If free-standing private drug plans become hard to afford, Medigap business may erode further if policyholders move into managed care instead.

Retiree Coverage. MMA provides a subsidy to employers of up to $5,000 per retiree per year to offer prescription drug coverage. Health plans and employers may restructure their benefit offerings to maximize the available subsidy.

Disease Management in Traditional Medicare. MMA establishes a program to begin introduction of disease management into the traditional fee-for-service Medicare program. Starting in 2005, CMS will select 10 sites to provide disease management for beneficiaries with diabetes and congestive heart failure (possibly along with other conditions). Vendors may include health plans, disease management firms, providers, or other entities. The pilot program is intended to be large-scale and to include randomized selection of beneficiaries and control groups; control and treatment groups at each site could total 30,000 to 40,000 beneficiaries.

Electronic Prescribing. MMA charges CMS with developing standardized data and transaction sets to promote electronic drug prescribing, establishes a federal grant program to providers to purchase equipment to implement these processes, and allows hospitals and health plans to subsidize the purchase of this equipment by physicians (as an exception to the anti-kickback laws). Initial data standards are to be developed during 2005, but will not be implemented until 2009. Many industry observers believe that these provisions could spur rapid adoption of electronic prescribing and that this may lead to closer adherence to formularies and increased generic substitution rates.

Health Savings Accounts (HSAs). HSAs are a new tax-preferred savings measure for people *not* eligible for Medicare. They must be paired with a high-deductible insurance policy. Unlike the Flexible Spending Accounts available in many employer plans today, the new HSAs will allow accumulated balances to roll over from year to year and employees will be able to take the accounts with them if they leave a firm. HSAs may be offered as an individual or group product. While few health plans expect strong growth in these products in the short term, particularly among employer groups, many are developing products to test the concept.

Generic Drug Availability. The bill includes a number of reforms to patent law intended to speed introduction of generic drugs. For example, brand-name drug manufacturers may now file only one 30-month stay per product, vs. multiple successive stays.

II. BACKGROUND: DUAL ELIGIBLE BENEFICIARIES IN MANAGED CARE

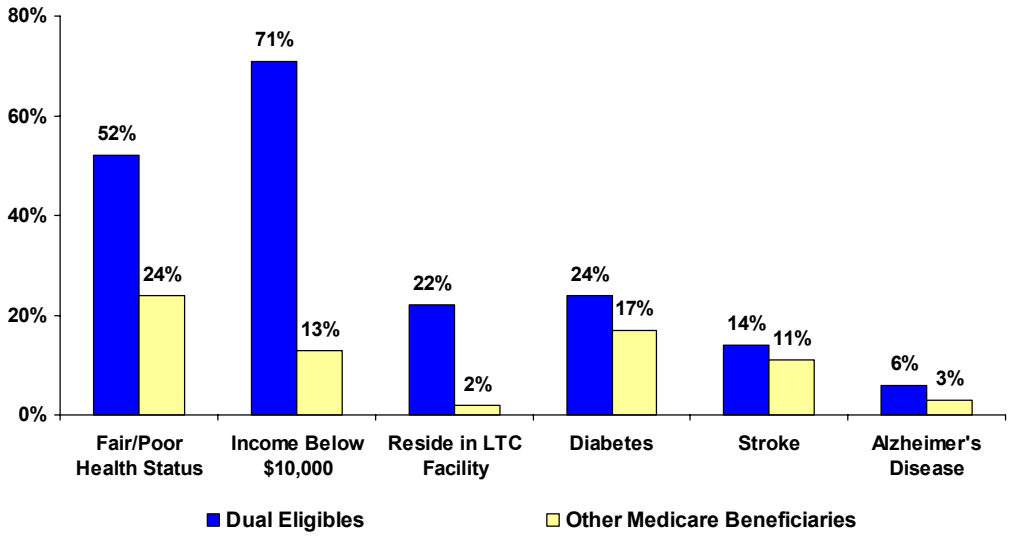
1. Characteristics of Dual Eligibles

In 2002, seven million Medicare beneficiaries received some form of assistance from Medicaid. Dual eligibles account for only a small share of beneficiaries (14 percent of Medicaid beneficiaries and 17 percent of Medicare beneficiaries), but they represent a much higher share of spending: more than 40 percent of Medicaid spending, and 24 percent of Medicare spending.[2]

Compared to the general Medicare population, dual eligibles have lower incomes, more chronic illnesses, and higher medical costs (see Figure 2). This group is also more likely to be in nursing home care. A third of dual eligibles are under 65.

[2] MedPAC, transcript of January 2004 meeting, accessed on March 5 at http://www.medpac.gov/public_meetings/transcripts/011504_dual_AM_transc.pdf, and Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government, Brian Bruen and John Holahan, Kaiser Commission on Medicaid and the Uninsured, November 2003.

Figure 2
Characteristics of Dual Eligibles Compared to Other Medicare Beneficiaries, 2000



Source: Kaiser Family Foundation estimates based on analysis of 2000 Medicare Current Beneficiary Survey.

The number of dual eligibles varies dramatically across states as a function of Medicaid eligibility levels and demographic differences. For example, dual eligibles represent 7 percent of all Medicaid beneficiaries in Alaska and Idaho, compared to 25 percent in Kentucky. [3]

There are several categories of dual eligibles. Most – 85 percent nationwide -- receive full assistance with Medicare premiums and cost sharing, along with coverage for all Medicaid benefits. This group, which we refer to as "full benefit dual eligibles," accounts for the vast majority of state spending. However, other dual eligibles receive assistance from Medicaid only in paying their Medicare premiums, and/or co-insurance and deductibles (this assistance is provided through a variety of programs, such as the Specified Low Income Medicare Beneficiary (SLMB) program, described in Table 3).

Many more Medicare beneficiaries may be eligible for some form of Medicaid assistance with Medicare premiums and cost-sharing than are currently enrolled in these programs. MedPAC reports that only 16 percent of those eligible for the SLMB program are enrolled, and estimates of the percent of beneficiaries qualified for the QMB program that are actually enrolled range from 55 to 78 percent[4]. Starting in 2006, the MMA requires states to screen Medicare beneficiaries for participation in the Medicare Savings Programs when they conduct eligibility screenings for subsidies related to the Medicare drug benefit.

[3] Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government, Brian Bruen and John Holahan, Kaiser Commission on Medicaid and the Uninsured, November 2003.

[4] MedPAC transcript of January 2004 meeting, accessed on March 5 at http://www.medpac.gov/public_meetings/transcripts/011504_dual_AM_transc.pdf

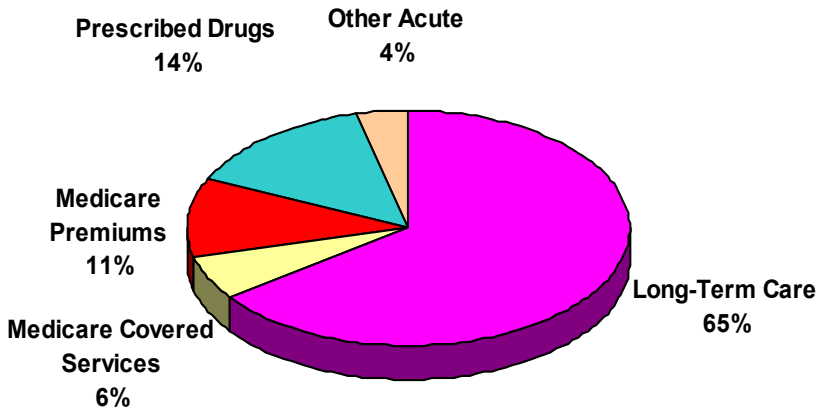
Table 3
Categories of Dual Eligibles

	Eligibility	Medicaid Benefits
Full Dual Eligibles	Varies. States must cover individuals receiving SSI cash assistance below certain income and asset limits.	Medicaid pays Medicare premiums and cost-sharing requirements; full Medicaid benefits
Qualified Medicare Beneficiaries (QMB)	Up to 100% of the FPL, assets limited to $4,000 per individual, $6,000 per couple	Medicaid pays Medicare premiums (A and B) and cost sharing.
Specified Low-Income Medicare Beneficiaries (SLMB)	Between 100% and 120% FPL, assets limited to $4,000 per individual, $6,000 per couple	Medicaid pays Medicare Part B premium.
Qualified Disabled and Working Individuals (QDWI)l	Working, disabled individuals up to 200% FPL, assets limited to $4,000 per individual, $6,000 per couple	Medicaid pays Medicare Part A premium.
Qualifying Individuals (QI)	Between 120% and 135% FPL, assets limited to $4,000 per individual, $6,000 per couple	Medicaid pays Medicare Part B premium.

2. State Spending on Dual Eligibles

State spending for dual eligibles totaled over $91 billion in FFY 2002. Spending by state varies widely, driven both by the number and type of dual eligibles in the population. Most of this spending – 65 percent - is for long-term care services.

Figure 3
State Spending on Dual Eligibles, 2002



Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.

The percent of dual eligibles in all 50 states is shown below in Table 4.

Table 4
Dual Eligibles by State, 2002[5]

State	Dual Eligibles as Percent of Total Medicaid Population	Medicaid Spending per Dual Eligible	Total Medicaid Spending on Dual Eligibles (in Millions)
Alabama	22%	$8,312	$1,349
Alaska	7%	$15,366	$144
Arizona	8%	$11,693	$765
Arkansas	21%	$8,316	$1,010
California	10%	$8,891	$8,290
Colorado	16%	$14,306	$1,014
Connecticut	17%	$27,000	$2,252
Delaware	10%	$16,061	$236
District of Columbia	11%	$15,276	$287
Florida	16%	$9,694	$3,933
Georgia	13%	$9,027	$1,622
Hawaii	11%	$9,340	$250
Idaho	7%	$13,318	$163
Illinois	11%	$13,466	$2,976
Indiana	14%	$14,671	$1,828
Iowa	19%	$13,615	$911
Kansas	15%	$17,271	$792
Kentucky	25%	$9,388	$1,961
Louisiana	15%	$9,176	$1,300
Maine	21%	$13,116	$645
Maryland	11%	$14,940	$1,368
Massachusetts	17%	$16,818	$3,638
Michigan	14%	$8,739	$1,891
Minnesota	15%	$21,236	$2,194
Mississippi	20%	$8,031	$1,092
Missouri	14%	$12,345	$1,983
Montana	14%	$12,880	$207
Nebraska	14%	$14,241	$533
Nevada	16%	$7,232	$208
New Hampshire	16%	$22,500	$455
New Jersey	18%	$15,703	$2,684
New Mexico	8%	$10,411	$405
New York	16%	$25,137	$15,217
North Carolina	19%	$10,366	$2,2824

[5] Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government, Brian Bruen and John Holahan, Kaiser Commission on Medicaid and the Uninsured, November 2003. Figures reflect total Medicaid spending, not State share.

State	Dual Eligibles as Percent of Total Medicaid Population	Medicaid Spending per Dual Eligible	Total Medicaid Spending on Dual Eligibles (in Millions)
North Dakota	21%	$18,136	$272
Ohio	13%	$20,111	$4,401
Oklahoma	14%	$9,250	$869
Oregon	10%	$11,227	$766
Pennsylvania	18%	$9,954	$3,339
Rhode Island	16%	$21,837	$715
South Carolina	13%	$9,998	$1,119
South Dakota	16%	$13,617	$240
Tennessee	14%	$8,310	$2,058
Texas	16%	$10,127	$4,956
Utah	8%	$13,882	$263
Vermont	17%	$8,782	$248
Virginia	19%	$9,757	$1,450

3. Current Dual Eligible Enrollment in Medicaid Managed Care

In recent years states have been pursuing policies to enroll more Medicaid beneficiaries in managed care programs as a measure to improve access and quality and contain costs. However, states have had less success bringing dual eligibles into managed care than other Medicaid populations. While 57 percent of all Medicaid beneficiaries were enrolled in managed care at the end of 2002,[6] only about 10 percent of dual eligibles are in Medicaid managed care.[7] States have faced a number of obstacles in implementing managed care programs for the dual eligible population, including inability to manage the Medicare portion of the benefit and limited incentives for beneficiaries to join a plan, and concerns about the ability to limit a Medicare beneficiary's freedom of choice of providers.

Twenty states enroll dual eligibles in 32 different Medicaid managed care programs.[8] Enrollment in these programs is heavily weighted in a few parts of the country, with ten states accounting for about 80 percent of dual eligible Medicaid managed care enrollment. Tennessee, California, Oregon, and Arizona are among the states with large numbers of dual eligible managed care enrollees. States have explored a variety of options in the design of Medicaid managed care programs for dual eligibles. Programs vary along a number of dimensions:

- voluntary vs. mandatory enrollment;
- service delivery through primary care case management (PCCM), or through a risk-based managed care plan;
- degree of integration of Medicare and Medicaid benefits, services, and financing; and

[6] Medicaid Managed Care Enrollment as of December 31, 2002, Centers for Medicare and Medicaid Services.

[7] Medicaid Managed Care for Dual Eligibles: State Profiles, Kaiser Commission on Medicaid and the Uninsured, October 2000.

[8] Medicaid Managed Care for Dual Eligibles: State Profiles, Kaiser Commission on Medicaid and the Uninsured, October 2000.

- exclusive enrollment of dual eligibles, or inclusion in a managed care program for other Medicaid populations.

Of the 32 Medicaid managed care programs that enroll dual eligibles, 22 have voluntary enrollment. However, nearly three-quarters of all dual eligibles in Medicaid managed care are in mandatory programs. Medicaid managed care enrollees are enrolled in capitated, full-risk managed care plans by an overwhelming margin, with only about 10 percent in PCCM options. Also, over 90 percent of Medicaid managed care dual eligibles are enrolled in programs that include other populations. There exist only a handful of Medicaid managed care programs that exclusively serve certain segments of the Medicaid population, such as beneficiaries eligible for nursing home care or SSI recipients.

4. Dual Eligible Enrollment in Medicare Managed Care

Enrollment in Medicare managed care is voluntary. In the mid 1990's most plans were available for "zero premium" above the regular Medicare premium. In recent years, however, most plans have begun charging a premium. For many Medicare beneficiaries, managed care is attractive as a way to fill in the coverage gaps created by Medicare's high cost-sharing requirements.

Less than 7 percent of dual eligibles nationwide are enrolled in Medicare managed care.[9] There is no incentive for full dual eligible beneficiaries to enroll in Medicare managed care, as they are entitled to full cost-sharing assistance from Medicaid. As a result, it seems reasonable to assume that the majority of Medicaid beneficiaries enrolled in Medicare managed care today are those only eligible for Medicaid assistance with Medicare cost-sharing or premiums, as they may stand to gain added coverage if the Medicare plan is more generous. It is worth noting, however, that Medicare payment rates (and enrollment data) do not distinguish among the types of dual eligibles, and many Medicare plans are not aware of these distinctions.

There are a handful of managed care programs specifically targeted to dual eligible beneficiaries, such as the PACE program, but these represent only a tiny percent of all Medicare beneficiaries. These programs attempt to manage all Medicaid and Medicare services, combining both capitation rates, and provide a single, coherent set of services for the beneficiary (and for providers).

For most dual eligibles, however, Medicaid and Medicare services are not coordinated, even if they are enrolled in a managed care plan. In fact, it is possible for beneficiaries to be enrolled in *both* a Medicaid managed care plan and a Medicare managed care plan. Some states, such as Oregon, require in this instance that the Medicaid beneficiary enroll in the MCO that offers the companion Medicare plan. But in other states there is no such requirement.

Simultaneous enrollment in Medicare and Medicaid plans probably occurs rarely today, as most dual eligible beneficiaries are enrolled in fee-for-service Medicaid and Medicare, but there is no mechanism to track this. Health plans themselves may not even be aware if this occurs. Lewin staff spoke to one large health plan that offers both lines of business yet makes no

[9] Case Studies of Managed Care Arrangements for Dually Eligible Beneficiaries, Edith Walsh et al, RTI International, September 26, 2003.

attempt to determine whether members might be enrolled in both, partly because their systems are not able to do so (they track Medicare members by social security number, and Medicaid members by Medicaid number).

States are not obligated to pay Medicare managed care premiums on behalf of Medicaid beneficiaries, and in most cases will not. An exception to this has occurred in a few instances where states have found it to their advantage to pay Medicare managed care plan premiums for beneficiaries who would otherwise incur Medicaid costs.

Medicare managed care plans currently have strong incentives to identify members who may be eligible for Medicaid assistance, as payment rates reflect a large increase for dual eligible beneficiaries. However, it seems clear that most Medicare plans are not well equipped to meet the needs of this population. Issues related to cost-sharing for this population are especially problematic. Providers treating dual eligible beneficiaries enrolled in fee-for-service generally can collect payment from both programs, although many states will not reimburse providers up to the full Medicare allowable rate. [10] The situation is more complicated for beneficiaries enrolled in Medicare managed care plans, as these plans have different premium and cost-sharing structures. Medicare+Choice providers may not be Medicaid providers, and so may have difficulty billing Medicaid for office visit copays or deductibles. In addition, state Medicaid programs may not be set up to handle these claims. The result is that beneficiaries enrolled in Medicare plans may be charged copays for which they should not be liable. [11] For health plans, this confusion over responsibility for beneficiary cost sharing can lead to beneficiary dissatisfaction as well as provider network and contracting problems.

III. BUSINESS IMPLICATIONS OF REFORM AND OPPORTUNITIES FOR COMMUNITY AFFILIATED HEALTH PLANS

This section of the paper addresses the implications of reform for dual eligible beneficiaries, state Medicaid agencies, and community affiliated health plans. We examine the ways in which serving dual eligibles will be affected, as well as the advantages and risks of participating in Medicare Advantage.

A. Implications of Medicare Reform for Dual Eligible Beneficiaries

Today, most dual eligibles have multiple insurance cards in their wallets. At a minimum, they have a Medicaid card and a Medicare card. Those in Medicaid managed care also have a health plan card. This situation is confusing already, and may become even more confusing for many dual eligible beneficiaries with implementation of the Medicare drug benefit.

Starting in November 2005, all Medicare beneficiaries – including all dual eligibles, even those in nursing facilities - will need to select and actively enroll in a prescription drug plan. As

[10] Case Studies of Managed Care Arrangements for Dually Eligible Beneficiaries, Edith Walsh et al, RTI International, September 26, 2003

[11] MedPac, transcript of January 2004 meeting, accessed on March 5 at http://www.medpac.gov/public_meetings/transcripts/011504_dual_AM_transc.pdf.

noted earlier, state Medicaid programs will not be able to automatically enroll these beneficiaries in the new Medicare Part D benefit. This may be a difficult process for many beneficiaries, and, particularly if they receive drug coverage from their Medicaid health plan now, they may turn to their Medicaid plan for assistance.

The table below illustrates sources of possible coverage for a full dual eligible beneficiary enrolling in Part D following Medicare reform.

Table 5
Options for Full Dual Eligible Coverage, January 2006

Medicaid	Medicare	Prescription Drugs
Fee-for-Service	Fee-for-Service	Stand Alone Drug Plan
Fee-for-Service	Managed Care	Provided by the Medicare health plan
Managed Care	Fee-for-Service	Stand Alone Plan D
Managed Care Health Plan A	Managed Care Health Plan A (same for both)	Provided by the Medicare health plan
Managed Care Health Plan A	Managed Care Health Plan B	Provided by the Medicare health plan

Once beneficiaries choose a Medicare drug plan, they may also face a number of changes in the delivery of the benefit compared to their experience in Medicaid. Today some beneficiaries do not have any copays, and for those that do, the beneficiary cannot be denied a drug for not paying the copay amount. Starting in January 2006, beneficiaries may be denied prescriptions if they cannot afford their copays ($1 per generic and $3 per brand for full dual eligibles). Medicare drug plan formularies also will differ from preferred drug lists in Medicaid – and there is no guarantee that the medications a beneficiary has been taking under Medicaid will be covered by the new Medicare formulary.

B. How Will States Respond to Reform?

Interviews with a number of CMS and state Medicaid officials indicate that few states have yet had a chance to consider the long-term implications of Medicare reform with regard to managed care options for their dual eligible population. In the short term, states will be focused on meeting multiple new administrative and financial challenges associated with the drug benefit, such as:

- Data reporting related to the Medicare discount card;
- Redesign of state pharmacy assistance programs;
- Assessing level of responsibility under the "clawback" provision (which requires state payments to the federal government for a share of the cost of the Medicare drug benefit);
- Implementation of new processes related to eligibility screening; and
- Recalculation of health plan capitation rates (where they currently include drugs).

One of the challenges states may face is a potential increase in the number of Medicare beneficiaries applying for Medicaid assistance. In a January 2002 focus group study by The Kaiser Commission on Medicaid and the Uninsured, lack of basic information about Medicaid was cited as the biggest enrollment barrier for seniors not enrolled in Medicaid. As part of Medicare reform, state eligibility offices will be required to process applications for Medicare Part D and to screen applicants for eligibility for other Medicare Savings Programs (such as the QMB, SLMB, and QI programs described above). This has the potential to help applicants identify other state programs for which they may qualify, including Medicaid.

The MMA allows states to provide wrap-around drug coverage to supplement the Medicare drug benefit, but at this point it seems unlikely that many states will pursue this option.

States that enroll dual eligibles in managed care – or have plans to do so - say they are not planning to scale these efforts back. For example New York plans to introduce managed care for dual eligibles in January 2005. However, only Medicaid plans also participating in Medicare will be able to enroll dual eligibles. Texas plans to expand its STAR+PLUS program into most urban areas of the state starting in 2005. Most dual eligibles in the areas served will be required to enroll in STAR+PLUS, which manages acute and long-term care services. Minnesota officials plan to continue and possibly expand existing demonstration programs, Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MDHO), which provide full Medicare and Medicaid coverage.[12]

Nevertheless, most states will have fewer incentives to enroll dual eligibles in managed care without responsibility for their prescription drug costs (after 2006). States will continue to have significant expenses for dual eligibles,[13] but these will be primarily for long-term care services, which are carved out of most managed care programs today. As shown in Figure 2 above (page 12), the largest remaining state expenditures for dual eligibles in 2006 (other than for long-term care) will be for premium assistance for Medicare beneficiaries, which cannot be reduced through managed care. In sum, there will be dramatically fewer opportunities to achieve savings unless programs can also achieve reductions in long-term care costs, perhaps by targeting beneficiaries eligible for nursing home care.

In the longer term, states have a compelling interest in managing the nursing facility costs for dual eligibles. Managed long-term care may offer states efficiencies from decreased cost-shifting between programs and better coordination of complex care.

[12] MDHO also serves disabled persons who only qualify for Medicaid.

[13] Eliminating state responsibility for drug costs is estimated to reduce total state Medicaid spending by only 6 percent, on average. See Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government, Brian Bruen and John Holahan, Kaiser Commission on Medicaid and the Uninsured, November 2003.

C. Option One: Participate only in Medicaid

Medicaid health plans that do not serve dual eligibles are likely to face little disruption in their operations from Medicare reform. There may be increased enrollment, if Medicaid enrollment increases overall, or if there are state incentives to enroll in managed care. In contrast, plans serving dual eligibles could face a significant impact.

Medicaid health plans currently administering drug coverage for dual eligibles may experience dramatic reductions in their capitation rates of close to 50 percent once drug benefits are removed. The table below shows the potential impact of carving out prescription drugs on Medicaid capitation rates, based on a recent Lewin study in Arizona.

Table 6
Capitation Rates With and Without Prescription Drugs

Plan	With Rx	w/o Rx
A	$300	$110
B	$260	$110
C	$330	$130
D	$320	$140
E	$240	$80
F	$250	$180
G	$210	$85

Whether or not plans face a financial impact, all plans that serve dual eligibles will face increased complexity. All dual eligible beneficiaries will select their own Medicare drug plan, which could result in a health plan needing to coordinate with multiple drug plans in order to serve their dual eligible members. Resulting challenges are likely to include:

- Obtaining access to drug utilization data from multiple sources if dual eligible members enroll in multiple private drug plans;
- Beneficiaries may turn to their Medicaid health plans with questions about their new drug coverage;
- Medicaid plans will have little or no ability to influence the drug plan formularies and approach to utilization management;
- Educating plan providers about the change in drug coverage, along with the impact of different formularies and cost sharing requirements;
- Educating pharmacies at community health centers (CHCs) about the need to participate in Medicare drug plan pharmacy networks or face the risk of having to turn patients who are accustomed to getting their drugs onsite away from the pharmacy;

- Renegotiating state capitation payment rates to exclude prescription drugs if they are not carved out already (or possibly arranging to provide coverage for drugs not covered by Medicare as a "wrap around" to the Medicare benefit);
- Assessing the risk of increased medical costs when the drug benefit is no longer managed in-house; and
- Loss of bargaining power and revenue from drug rebate collections under plan PBM contracts, resulting from transfer of drug coverage for dual eligibles.

In addition to the added complexity, health plans opting to continue a focus on Medicaid-only services may potentially – over the longer run – face the risk of losing potential members to Special Needs Plans focused on the dual eligible population. This risk is much more likely to emerge as a concern in states where Medicare managed care is prevalent, where dual eligibles are enrolled in Medicaid managed care on a mandatory basis, and where a number of Medicaid-focused plans are competing head-to-head.

In summary, serving dual eligible beneficiaries is likely to be more difficult and less rewarding in the future for plans that administer only the beneficiaries' Medicaid benefits. In some instances, plans may wish to consider advocating that their state agencies exclude dual eligibles from Medicaid managed care.

D. Option Two: Participate in Medicare as a Local Plan

Given the uncertainties and difficulty surrounding regional plans, this paper focuses on the advantages of participating in Medicare Advantage as a local plan. As single-state Medicaid health plans, most ACAP member plans are not likely to have the option to enter Medicare Advantage as a regional plan. In theory, multiple plans will be permitted to band together to offer a regional PPO, but the operational challenges of doing so will be formidable. If CMS opts to draw a high number of regions that include only a single state, it may become attractive to consider this option. But consortia of plans that must cover a multi-state area will face a wide range of difficult issues, such as how to share underwriting gains and losses across the region and achieve joint development of provider networks, among others.

Whether entering Medicare Advantage is attractive will depend critically on a range of factors specific to the health plan and local market, including whether the plan currently serves dual eligibles, the plan's existing membership and provider network, local Medicare managed care payment rates, and whether there are existing players in Medicare managed care. For a plan with existing dual eligible members and a sufficient provider network, entering Medicare Advantage may represent a significant boost in revenue, with little start-up cost. In contrast, a plan that does not serve dual eligibles today, has a limited network, and faces well established existing commercial players could find launching a Medicare product both expensive and risky.

Why enter the Medicare Advantage market?

There are a number of reasons to consider entering Medicare Advantage.

- **Reform appears to signal a federal commitment to managed care.** The MMA's payment increases and subsidies for managed care reflect strong Congressional support for moving more of the Medicare population into managed care over the long-term.
- **Over time, managed care will be more affordable for beneficiaries.** In the future, beneficiaries seeking comprehensive coverage in fee-for-service Medicare will need to purchase both a private Medigap policy and a stand-alone drug plan. The combined premiums for these plans is likely to be higher than the premium for a managed care plan.
- **Huge market, with potential for profit.** Payment rate increases in MMA are substantial. In New York, for example, payment rates for plans serving Nassau County in Long Island will increase by 24.5 percent, while rates for next door Suffolk County will increase 19 percent. Together, these counties include more than 430,000 Medicare beneficiaries, of whom only 11 percent are currently in managed care.
- **Mission.** To the extent that the plan is committed to serving specific neighborhoods and offering coverage to all members of the family – for example, to serving grandparents who are caring for children in the family – entering Medicare Advantage takes the plan closer to that goal.

Risks

The risks of entering the Medicare managed care market are high. The MMA makes Medicare managed care more attractive by introducing a heavily subsidized drug benefit and increased payment rates. At the same time, however, it introduces new uncertainties. Risks to be assessed include:

- **Uncertain federal payment rates.** Although payment rates have increased significantly for 2004 and 2005, there is no guarantee that payment rates will remain at this level. In fact, it is safe to assume that if plans experience significant profits, Congress will act to adjust rates downward as part of what is likely to be an annual debate over cost containment in Medicare. Drug reimbursement, in particular, may pose a risk, if premium subsidies and government payments for prescription drug coverage lag rapidly rising actual costs of providing the benefit. The federal government also has no experience in determining appropriate payments for drugs in the Medicare program.
- **Competitive bidding will increase beneficiary premiums and drive price competition.** Most observers expect that plans will aim to set their bids just at the benchmark to maximize the federal contribution to premium. However, the competitive bidding system will reduce plans' ability to provide "free" supplemental benefits, resulting in increased beneficiary premiums – and enhanced price competition. Medicare beneficiaries in managed care have traditionally been very price sensitive, willing to shift products for small differences in monthly premium.

- **Constantly changing regulations.** Medicare reform will continue to be a moving target. Plans will find the regulation process more difficult – and that they have less influence to shape it – at the federal than at the state level.
- **Unknown impact of regional PPOs.** Regional plans may shift the historical market dynamics of Medicare managed care. Regional plans may be able to spread costs across a broad geographic region and, as a result, undercut prices based on the local market. This type of multi-state regional plan may disadvantage smaller players and BCBS plans.
- **Ability to build on existing provider network.** Non-Medicaid seniors are not accustomed to community health centers as their primary source of care, and will expect a wider range of other Medicare providers to participate. If many specialists have shunned Medicaid to date, will they be willing to join a FQHC-based health plan?

Operational Challenges

The operational challenges associated with launching a Medicare managed care product are substantial. Decisions to participate in Medicare must take full account of the following costs:

- Development of the capability to offer the prescription drug benefit (most likely through a pharmacy benefits manager);
- Provider contracting effort to address the needs of the elderly population which differ from pregnant women and children, including many beneficiaries using non-Medicaid providers;
- Development of systems to bill and collect beneficiary premiums (unless the plan is targeted at dual eligible beneficiaries);
- Shift in medical management priorities and approaches;
- Information system changes;
- Marketing costs: unlike in Medicaid, where many states limit plans' ability to approach beneficiaries directly, marketing is essential to succeed in the Medicare managed care. Plans without experience in marketing to individuals will need to develop this function;
- Ability to meet solvency and reserve requirements, which may differ from state requirements for Medicaid plans; and
- Considerably less ability to influence the regulatory environment, compared to Medicaid.

E. Option Three: Participate in Medicare as a Special Needs Plan (SNP)

Advantages

For plans interested primarily in serving dual eligibles, entering Medicare Advantage as a Special Needs Plan (SNP) may be the best option. Reasons to consider becoming a SNP include:

- **Revenue growth**. If a health plan is already serving dual eligible beneficiaries, entering Medicare may allow substantial growth in revenue – without any expansion of membership, or new marketing efforts. To the extent the plan is currently administering drug coverage for dual eligibles, this could offset reduction in Medicaid capitation payments for prescription drugs.
- **Maintain current organizational and strategic focus on Medicaid population**. This option allows a plan to exploit a market in which it has been successful.
- **Avoid potential erosion of dual eligible members**. To the extent that integrated plans are available, dual eligible members may gravitate toward them. If other competitors in the Medicaid market are able to offer a coordinated plan for dual eligibles, it may be necessary to match this capability to avoid loss of membership.

Risks

Many of the risks identified above for Medicare Advantage also apply to the SNPs. However, plans already serving the dual eligible population may find that start-up costs are substantially lower if they enter Medicare as a plan focused on dual eligibles (at least initially). In this instance plans may find that both provider contracting and marketing costs are less. For example, they may not need to contract with additional providers, and they may be able to rely on the existing network to assist in identifying and enrolling eligible beneficiaries.

Special Needs Plans will face unique challenges related to coordinating regulatory requirements for Medicaid and Medicare. Medicare's requirements may not adequately reflect this population's needs – and/or may conflict with Medicaid requirements, resulting in administrative complexity and high costs. For example, the enrollment process mimics the employer market, so that beneficiaries are only allowed to enroll once a year, or during special enrollment periods if their Medicaid status changes. This may make it difficult to identify and enroll dual eligible members, as plans will not have timely information about which Medicare beneficiaries are newly eligible for Medicaid. Those familiar with programs targeting dual eligibles suggest that it likely will be quite challenging to work within the framework of Medicare Advantage. Areas raising potential challenges:

- **Marketing materials**: standard material templates, such as the Evidence of Coverage, must be reworked to reference not only the Medicare benefit, but the beneficiary's entitlement to Medicaid cost sharing;
- **Enrollment requirements**: is an annual lock-in appropriate for dual-eligibles? How will plans identify potential members if their eligibility status changes? Must beneficiaries that cycle off Medicaid be disenrolled?

- **Competitive bidding and beneficiary premiums**: how would bidding work for SNPs? Would CMS allow plans to "waive" beneficiary premiums if plan bids exceed the adjusted benchmark?
- **Appeals provisions**: how will Medicaid and Medicare requirements be met?
- **Network access standards**: will CMS impose additional standards for institutionalized patients, home and community based providers, etc.

If You Build It, Will They Come?

There is significant risk that most dual eligible beneficiaries will choose to remain in fee-for-service Medicare. Dual eligibles have an extensive array of benefits available through Medicare and Medicaid and have little or no financial incentive to join a managed care plan – and even if some do choose managed care, they may not select SNPs. However, accessing the services and maximizing the use of benefits can be difficult for dual eligible members, who often have a complex array of providers. Some dual eligibles have also begun to encounter difficulty in obtaining cost-sharing assistance from Medicaid, and may be drawn to a coordinated plan. Better access to providers and "one-stop shopping" for their coverage might be an incentive that could draw members to a plan offering to coordinate not just the Medicaid and Medicare acute care benefit, but the drug coverage as well.

It is worth noting that for health plans not currently serving dual eligibles, expanding as a SNP will require more preparation and planning. Start-up costs will be higher – and must be spread over a small population. Furthermore, unlike other Medicare managed care plans, SNPs cannot expect to be able to charge a beneficiary premium (technically it may be allowed, but in practice would be a huge disincentive to enrollment). For all of these reasons, a particularly careful assessment of the likely costs and rewards will be necessary.

F. Option Four: Expand into Managing Medicaid Long-Term Care Benefits

In 2002, states spent $82 billion – or approximately one-third of Medicaid spending - on long-term care services. As states continue to seek the most cost-effective solutions for managing long-term care of Medicaid recipients, many are considering the benefits of managed care. At this time, seven states are operating some form of capitated managed care program for Medicaid long-term care services.

Table 7
States' Managed Long-Term Care Programs

States	Program Design
Wisconsin Family Care New York	• Medicaid nursing facility level of care (including, but not limited to, dual eligibles) • Voluntary enrollment on Medicaid side • No link to Medicare side • LTC only • Capitated on Medicaid side
Wisconsin Partnership	• Medicaid nursing facility level of care (including, but not limited to, dual eligibles) • Voluntary enrollment on Medicaid side • §222 waiver • All Medicaid services • Capitated on both sides
Arizona	• Medicaid nursing facility level of care (including, but not limited to, dual eligibles) • Mandatory enrollment on Medicaid side • No link to Medicare side • All Medicaid services • Capitated on Medicaid side
Delaware	• All dual eligibles, whether nursing facility level of care is met or not • Mandatory enrollment on Medicaid side • No link to Medicare side • All Medicaid services • Capitated on Medicaid side
Texas STAR+PLUS	• All dual eligibles, whether nursing facility level of care is met or not • Mandatory enrollment on Medicaid side • Create incentive to join same MCO in M+C program • All Medicaid services • Capitated on Medicaid side
Minnesota Massachusetts	• All dual eligibles, whether nursing facility level of care is met or not • Voluntary enrollment on Medicaid side • §222 waiver • All services • Capitated on Medicaid side

At least one state is moving forward with long-term care expansion. Texas is currently undergoing considerable effort to expand STAR+PLUS, a capitated managed care program which includes all Medicaid benefits, to all service areas in the state where Medicaid managed care is operating. At this time, the expansion includes both the Medicaid-only and full dual eligible population.

Medicare reform is not likely to lead states to adopt managed long-term care much more rapidly than in the past – at least in the next few years. Instead, states will be focused on meeting challenges related to managing eligibility processes for the Medicare drug benefit for low-income enrollees, re-calculating managed care and provider rates that include drugs, and re-organizing other benefits and programs to accommodate the new Medicare benefit.

Medicare reform is also unlikely to fundamentally change the business opportunities and risks associated with entering the managed long-term care market. It will, however, make serving dual eligibles even more complicated than it already is. The voluntary nature of the new Medicare drug program, as well as its delivery through multiple competing plans, will be a challenge. Plans must assure that beneficiaries are enrolled in Part D and coordinate with many new entities to make certain beneficiaries receive access to the drugs they need to maintain their health in the community. The net impact of reform will probably be to reduce the attractiveness of providing long-term care services to dual eligibles.

This option will likely continue to be most attractive in instances where the health plan controls the full range of benefits for the beneficiary – acute care, prescription drug, and long-term care. Plans already serving dual eligibles may find that they can also provide long-term care services efficiently (if they are also coordinating Medicare benefits). Plans not participating in Medicare may find it most advantageous to focus their efforts on the Medicaid-only disabled population.

Advantages

- **Opportunity to achieve significant state savings.** To the extent that plans can deliver substantial state savings, it may also create opportunity for higher plan margins.
- **Niche market.** The administrative challenges of serving Medicaid beneficiaries, combined with the financial risk of serving a high cost population, is likely to limit the number of plans in this market.
- **Does not require entry into Medicare.** States have significant costs associated with long-term care for the SSI population, as well as for dual eligibles. Plans may find that expansion into long-term care allows them to build on existing competencies and state agency relationships – allowing for growth without entering a completely new market.

Risks

- **Challenges in developing provider networks**. Provider credentialing and contracting is costly and can be politically complex.
- **Scarcity of providers/ non-traditional providers**. Plans may encounter areas where adequate networks are very difficult to maintain, due to a scarcity of paraprofessional providers (such as in personal care; respite; homemaker services; case management). Plans may also be unprepared to reimburse family and friend caregivers (which may be required if provider capacity is limited).
- **Multiple regulators/ state contacts**. Managed Medicaid long-term care intersects numerous non-Medicaid programs that often are administered outside the Medicaid agency.

Plans entering the market for managed long-term care should consider whether their strategy is dependent on state involvement in funding long-term care services for dual eligibles. The National Governor's Association Task Force on Medicaid has taken the position that dual eligibles should be the federal government's responsibility, and achieving this is now a primary goal of NGA's advocacy efforts in Washington. However, for plans that do not focus their efforts on dual eligibles, this may not be a concern.

IV. CONCLUSION

The Medicare legislation enacted last December will create fundamental shifts in the market for Medicare managed care. The inclusion of a heavily subsidized drug benefit, payment increases and a new competitive pricing system, and the establishment of regional or even multi-state PPOs will reshape the competitive dynamics for Medicare health plans – as well as for plans traditionally focused on the Medicaid population.

For health plans serving dual eligible beneficiaries today, providing care is already too often fraught with complexity and administrative challenges. Medicare reform has not simplified the situation. Dual eligible beneficiaries were not the focus of the legislators drafting the law, and are not the current focus of those at CMS charged with implementing it. The provision allowing for SNPs in the bill takes only a small step toward resolving the barriers associated with providing a truly coordinated care solution for dual eligible beneficiaries. Given that additional regulatory and legislative action in this area seems possible, even likely, over the next several years, a "wait and see" approach has some merits.

Nevertheless, Medicaid-focused plans should carefully consider the strategic as well as the financial issues related to participating in Medicare. How will your competitors respond to this opportunity? Could participation in Medicare improve bargaining power with local providers, or with the state? How would it affect your long-term ability to maintain an efficient cost structure? How would it support your plan's mission and long term growth plan? Over the long-term, what will Medicaid's role be in providing care for the dual eligible population?

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