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State practices in providing health and long-term care to dually eligible persons

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State Practices In Providing Health and Long-Term Care To Dually Eligible Persons

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This report is also available with an appendix that details state practices. To receive a copy of the detailed report contact Scripps Gerontology Center at (513) 529-2914.

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Abstract

The dual-eligible population consists of low-income Medicare beneficiaries who are in most cases also aged, blind, and/or disabled, and therefore eligible for Medicaid. Congress, concerned with the high cost of health care for this population, enacted provisions that cumulatively mandate state Medicaid programs to assist different categories of low-income Medicare beneficiaries with their Medicare Part A and/or Part B premiums.

The two programs that pay for this population's care, however, have conflicting rules and objectives. The Medicare program's emphasis "on freedom of choice" prevents states from requiring their dually eligible populations to enroll in Medicare managed care plans. At the same time, the state Medicaid programs' wish to control costs and prevent cost shifting, but this goal is achievable only if they can manage their clients' Medicare activities to some extent.

This study examines how various states verify the enrollment of dually eligible clients in Medicare managed care plans, and how their Medicaid programs have adopted procedures to deal with the impact of dual-eligible clients' enrollment in these plans. The study also examines the provision of care for the dual-eligible population in the selected states, investigating the initiatives in place in these states. Finally, the study outlines steps necessary if the State of Ohio plans to establish a coordinated care delivery system so that the dual-eligible persons could receive their care from a unified set of providers.

We found that with the exception of three states in the study, which offer Medicaid managed care to all populations, either the states did not permit dual-eligible persons to enroll in Medicaid managed care or, if they did so, these clients were required to disenroll from the Medicaid managed care program when they enrolled in a Medicare managed care plan. At present, only one-third of the states in the study track dual-eligible persons' enrollment in Medicare managed care, and these are the only states capable of verifying payments to Medicare managed care plans. Two-thirds of the states reported that they are participating in the outreach efforts to find, verify, and assist the low-income Medicare beneficiaries (if eligible) with their premiums and possibly with their co-pays and deductibles.

A few states had experimented with providing integrated care to their dual-eligible population either statewide or in a demonstration project. They all mentioned the lengthy waiver approval process; most were still in the early stages and were working out or modifying the design of their integrated care delivery system. Finally, based on the experiences of other states and Ohio's own experience with Medicare managed care a series of procedural steps for establishing a coordinated care delivery system for the dual-eligible persons is proposed.

Background

The dual-eligible population consists of low income Medicare beneficiaries who are in most cases also aged, blind and/or disabled, and therefore eligible for Medicaid. Congress, concerned with the high cost of health care for this population, enacted provisions in 1988, 1989, 1990, 1992, 1994, and 1997 that cumulatively mandate state Medicaid programs to assist different categories of low-income Medicare beneficiaries with their Medicare Part A and/or Part B premiums. In certain categories of dual eligibility these provisions also require assistance with deductibles, co-pays, and (at the state's option) Medicare managed care (Part C) premiums.

This population's[1] frailty and poor health, and mental condition have led to high costs for care. Therefore states that administer, and partially fund the Medicaid program, and the federal government through the Health Care Financing Administration, are interested in ways to improve the service delivery systems for these clients. Of course, both parties hope to control costs in the process. Nationally, in 1997, the dual-eligible population was estimated to account for 17% of the Medicare population and 19% of the Medicaid population. In the same year, health and long-term care utilization by this population was estimated to account for about 28% of the total Medicare budget and 35% of the Medicaid budget (Murray & Shatto, 1998).

However, the two programs that pay for this population's care have conflicting rules and objectives. The Medicare program's emphasis "on freedom of choice" prevents states from requiring their dually eligible populations to enroll in Medicare managed care plans. At the same time, the state Medicaid programs wish to control costs and prevent cost shifting, but this goal is achievable only if they can manage, to some extent, their clients' Medicare activities. Managed care programs potentially could improve access to coordinated care, but they lack experience with the older disabled population. Meanwhile, older people eligible for both Medicare and Medicaid must follow confusing and sometimes conflicting rules.

The introduction of Medicare managed care, which was designed to make the system more efficient, created an opportunity to provide a unified system of care for the dually eligible

[1] The dual-eligible population is characterized as mostly older, sicker, less educated, living alone, female, and unmarried. In addition, they are more likely to be nonwhite, cognitively impaired, and in need of long-term care (Lyons & Rowland, 1996; Murray & Shatto, 1998; Riley, 1998; Rowland et al., 1998).

population. Yet because Medicare guarantees freedom of choice for older people, the states are limited in their ability to design a coordinated care delivery system where cost effective and appropriate care can be guaranteed. Currently, because of limited coordination between HCFA and the state Medicaid agencies, the state Medicaid programs must follow a process that is slow and cumbersome at best in order to verify whether and when a dually eligible client has enrolled in a Medicare managed care plan.

In this study we examine how various states verify the enrollment of dually eligible clients in Medicare managed care plans, and how their Medicaid programs have adopted procedures to deal with the impact of dual-eligible clients' enrollment in these plans. A few states have attempted innovative ways to provide comprehensive coordinated care to their dually eligible residents without infringing on their freedom of choice. Other states have requested special waivers from HCFA. We will review the states' experience with their dually eligible populations, and investigate the initiatives in place in other states. Finally, we will explore ways for Ohio to provide coordinated care in some form of managed care, so that dually eligible clients can receive care from a unified set of providers.

Methods

The data for this study come from several sources. We obtained information on the following areas from interviews with one or more officials associated with the state Medicaid agency in selected states: (1) characteristics of the state's Medicaid managed care plans; (2) the state's process for identifying dual-eligible clients enrolled in Medicare managed care and their procedures for reimbursing Medicare managed care plans; (3) the state's participation in outreach efforts to identify potential Medicare beneficiaries qualified for the buy-in program and the outreach methods employed; and (4) whether the state currently has created or is planning to create an integrated care delivery system. We selected for the survey all states in which more than 10% of the Medicare beneficiaries were enrolled in Medicare managed care plans as of August 1998. Of those 23 states, (Arizona, California, Colorado, Connecticut, Florida, Hawaii, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nevada, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, and Washington)

the following 15 agreed to participate: Arizona, Colorado, Florida, Hawaii, Illinois, Massachusetts, Minnesota, Nevada, New Jersey, New York, Ohio, Pennsylvania, Texas, Utah, and Washington.

We conducted semi-structured interviews with an official or officials (selected by the state's Medicaid director) in the state Medicaid agency between November 1999 and mid-January 2000. The interviews ranged from 20 to 45 minutes. Because states' practices vary considerably, we left many of the questions open-ended to allow for elaboration of specific programs and practices. Hawaii asked to respond to a written survey; therefore its responses are limited because there was no opportunity for any follow-up questions.

To supplement what we learned from state Medicaid agencies we interviewed one Medicare managed care medical director whose plan had faced many of the same challenges (e.g. plan pullback, and limiting benefit package) that plans in other states were faced with during the last two years. In addition, we spoke with a geriatrician who had treated many of the dual-eligible clients as fee-for-service Medicare beneficiaries and as Medicare managed care enrollees; we asked him to reflect on any noticeable characteristics of clients, reasons for enrolling in Medicare managed care, and whether all persons in his practice who could be dually eligible knew about Medicaid buy-in programs. We also requested and received a brief profile of the dual-eligible population from Ohio's Medicaid recipient file from the Ohio Department of Job and Family Services.

Other information in this report comes from published description of projects, state health plans, and HCFA and state agencies' web sites. These results are supplemented by information from the Census of Population, to reflect the relative size of the states surveyed, and by information obtained from HCFA's web site on the size of the populations eligible for Medicaid and Medicare.

A detailed description of dual eligibility categories is presented here, for reference, as we refer to each group throughout this report.

(1) those Medicare beneficiaries (Part A only) who qualify for full Medicaid benefits based on their eligibility for Supplemental Security Income (SSI) or meeting the SSI assets test[2]

[2] Assets are bank accounts and other liquid assets, as well as real estate, automobiles, and other personal property.

and having an income between SSI and 100% of poverty level, or those who have met state spend-down requirements. Members of this group are also called Qualified Medicare Beneficiaries with Full Medicaid benefits (QMBs Plus);

(2) those Medicare beneficiaries (Part A only) referred to as Qualified Medicaid Beneficiaries (QMBs), who have income up to 100% of the federal poverty level, although their assets may be as much as 200% of the allowable SSI resource limits;

(3) those Medicare beneficiaries (Part A only) designated as Specified Low-income Medicaid Beneficiaries (SLMBs), who have incomes between 100% and 120% of federal poverty level and meet the same assets test as the QMBs;

(4) those defined as Qualified Disabled and Working Individuals (QDWI), who were formerly eligible for Medicare Part A and lost that eligibility due to returning to work. Their income level could be as much as 200% of the federal poverty level, and they meet the same assets test as the QMBs. These individuals can retain Medicare benefits by paying Part A premiums. Medicaid must pay this premium;

(5) qualifying Individuals (QIs), who qualify for Medicare Part A, have an income between 120 and 135% of the federal poverty level, and meet the same assets test as the QMB population. An annual cap is placed on the amount of money available for this buy-in program, which currently is scheduled to expire at the end of 2002 (Health Care Financing Administration, 2000).

The extent of benefits received from Medicaid by a dual-eligible person depends on his or her eligibility designation. The Medicaid program is responsible for all deductibles, coinsurance, Part B premiums, and Part A premiums if needed for QMBs, only Part B premiums for SLMBs, and Part A premiums for QDWIs. The Medicaid program will pay all or part of the Part B premiums, based on the individual's income level, for the QI population. The Medicaid program is most generous to QMBs Plus, those with full Medicaid eligibility. For these clients, the program is responsible for all deductibles, coinsurance, Part A (if necessary) and Part B premiums, prescription drugs, medical transportation, and long-term care services.

Findings

Unlike Medicare eligibility, Medicaid eligibility is not a permanent status. Therefore snapshots of dual-eligible clients at any given point during a year will differ from a look at any other given time. In April 1999 there were about 148,000 dual-eligible persons in Ohio. The great majority were female (69%), while 44% were under 65. About one-half (49%) of the PASSPORT, Ohio's Home- and Community-Based Care Services (HCBS), population were dual eligible, and about one-third of 148,000 dual eligible persons resided in nursing homes.

Examining Ohio's continuously dual eligible population with full Medicaid benefits results in a much smaller population with different characteristics. Among individuals who were continuously dual eligible over a 18 month period (January 1997-June 1998), we found that a much smaller population (31,300) were qualified for full Medicaid benefits such as prescription medicine, medical transportation, and long-term care services. A much smaller proportion (32%) of the continuously dual-eligible population was under 65 years old; a larger proportion was female (72.3%); and about the same proportion was in an institution (Ohio's Medicaid recipient file, 1999). The short periods of Medicaid eligibility and the varying degrees of dual eligibility are complicating factors in attempts to enroll these clients in Medicaid managed care or in an integrated care program, if such a program existed. Other states expressed similar differences between those who were Medicaid eligible for a short period of time versus those who were eligible for an extended period of time. In fact several states in our study had a different policy governing those who were Medicaid eligible for less than three months.

As previously mentioned, we surveyed states that had a greater than 10% Medicare managed care penetration rate. Table 1 presents population figures as well as the size of their Medicare and Medicaid populations for these selected states.

Except for California, which elected not to participate, all of the states in the United States which are more populated than Ohio participated in this study. The proportion of 65+ population in the selected states ranged from 8.7% in Utah to 18.5% in Florida; Ohio's 65+ population is 13.3% of the state's total. The Medicaid managed care enrollment, which is not age

based and is a function of the type of waiver that state holds (whether enrollment is mandatory or voluntary and which populations are excluded) ranged from 13.4% in Illinois to 99% in Colorado.

Although Medicare managed care enrollment has been increasing steadily since its inception, during the last two to three years it has suffered a series of setbacks involving plan withdrawals, pullbacks, limiting of participation, service reduction, and premium charges, which have had a negative impact on enrollment. Ohio's Medicare managed care enrollment has remained steady at around 17% (Health Care Financing Administration, 1999). Fewer plans in Ohio now cover rural areas, however; more of the urban Medicare beneficiaries in Ohio are enrolled in Medicare managed care plans today than a year or two ago.

In a survey of changes in Medicare managed care plans the United States General Accounting Office in 1999 cites a series of reasons for plan withdrawal, pullbacks, and service reductions mentioned by plan administrators (U.S. General Accounting Office, 2000). These reasons include inability to establish a providers' network, inability to compete effectively with other plans, dissatisfaction with payment levels, and the administrative cost of keeping up with new HCFA rules and regulations. The Medicare managed care plan's medical director in Ohio whom we interviewed for this study cited similar reasons. She also mentioned underestimation of costs of providing care in rural areas, where access to care has been limited either by lack of providers or by clients' lack of health care insurance before becoming Medicare eligible. The geriatrician in our study stated that the Medicare managed care enrollees who were not Medicaid eligible had a greater need for health care, especially for services that Medicare fee-for-service does not cover. The high rate of health care utilization in the first few months following Medicare managed care enrollment combined with frequent disenrollment has led some plans to limit services and others to pullback from some areas in the state.

Currently eight Medicare+Choice health plans are preparing to withdraw from 58 counties in Ohio as of December 2000 affecting almost 67,000 enrollees. Ten of those counties, all rural, would have no Medicare+Choice option after this withdrawal. A total of 2,680 current

enrollees and a larger number of Medicare beneficiaries with no Medicare+Choice option will be affected (Lankarge, 2000).

Table 1
Estimated Population, Medicaid and Medicare Beneficiaries for Selected States: 1998
(in thousands)

State	Estimated Total Population[a]	Estimate 65+ Population[a]		Medicare Total Beneficiaries[b]	Medicare Managed Care Enrollment[b]		Medicaid Eligible Total Population[c]	Medicaid Managed Care Enrollment[e]	
		Number	Percent		Number	Percent		Number	Percent
Texas	19,565	1,999.7	10.2	2,153	340.3	15.8	1,719.2	437.9	25.5
New York	18,140	2,423.8	13.4	2,657	509.8	19.2	2,140.1	634.2	29.6
Florida	14,812	2,734.1	18.5	2,703	767.0	28.4	1,417.9	915.6	64.6
Pennsylvania	12,158	1,904.3	15.7	2,079	529.2	25.4	1,325.2	904.7	68.3
Illinois	11,966	1,496.0	12.5	1,620	175.6	10.8	1,308.6	175.6	13.4
Ohio	11,260	1,500.9	13.3	1,679	273.6	16.3	1,032.4	292.8	28.4
New Jersey	8,091	1,105.8	13.7	1,181	143.5	12.1	643.1	376.8	58.6
Massachusetts	6,151	860.6	14.0	945	214.4	22.7	850.8	533.0	62.6
Washington	5,693	652.0	11.4	707	177.6	25.1	788.9	718.0	91.0
Minnesota	4,746	583.1	12.3	639	107.1	16.8	428.8	225.5	52.6
Arizona	4,575	617.5	13.5	632	249.6	39.5	432.8	368.3	85.1
Colorado	4,009	401.8	10.0	442	152.5	34.5	218.1	215.9	99.0
Utah	2,107	184.1	8.7	195	39.3	20.1	123.6	112.8	91.3
Nevada	1,744	200.0	11.5	212	76.7	36.2	90.6	35.1	38.7
Hawaii	1,228	158.3	12.9	156	52.5	33.6	163.7	131.8	80.5

[a] United States Bureau of Census (1999, June 15). Population estimates for the U.S., Regions, Divisions, and States by 5 years. Annual time series estimates, July 1, 1990 to July 1, 1998 (includes revised population counts)[Online]. Available: http://www.census.gov/population/estimates/state/5age9890.txt
Note: Census Bureau regularly revises its population estimates. The web site referenced here (states' population estimates in 1998) is no longer accessible. However, at the time this report was prepared for publication the population estimates for July 1999 was posted at http://www.census.gov/population/estimates/state/stats/st-99-10.txt which are similar to 1998 population estimates.

[b] Managed Care Online. (1999). Managed care facts and figures. Medicare HMO enrollment by state. Available: //http:www.mcol.com/mcfact2.htm

[c] Health Care Financing Administration. (1999, April 8). Medicaid managed care penetration rates by state, June 30, 1998–National Summary Table [Online]. Available: http://www.hcfa.gov/medicaid/mcsten98.htm

Dual-Eligible Clients and Medicare Managed Care

Although nationally about 6.8 million (18%) of the Medicare beneficiaries are enrolled in Medicare managed care (Health Care Financing Administration, 2000), the proportion of dual-eligible persons in Medicare managed care is much smaller (Mollica and Riley, 1997). This low rate of participation may have multiple reasons, including:

(1) Some Medicare managed care enrollees are QMBs or SLMBs but are not aware that they may be qualified for Medicaid co-pays, deductibles, and premiums or even only for premiums. Both the physician and the Medicare managed care plan medical director whom we interviewed for this study indicated that some clients enrolled in Medicare managed care could be eligible for at least some Medicaid benefits.

(2) On the other hand, the composition of the Medicaid population is such (frail, disabled, in poor health, and poorly educated) that they may not know of the availability of Medicare managed care plans in their county, nor the benefits of joining a Medicare managed care plan.

(3) By joining a Medicare managed care plan, clients may benefit slightly in regard to coordination of Medicare health care services. That benefit, however, must be weighed against abandoning their regular health care providers, to whom they are accustomed. For some (with full Medicaid benefits) the benefits may be even less attractive since there will be no change in the total package of care that they receive when Medicaid and Medicare services are combined.

Our survey of the 15 states shows how dual-eligible clients are treated in the state Medicaid managed care health plans, how their enrollment in Medicare managed care plans is tracked, and what the states are doing to inform their population about Medicaid buy-in benefits (See Table 2).

Among the states that we surveyed, six (Hawaii, Illinois, New Jersey, New York, Pennsylvania, and Washington) offer Medicaid managed care with voluntary or mandatory enrollment for all populations, but did not allow a person enrolled in another managed care plan

to enroll in Medicaid managed care (in Hawaii this restriction is limited to those in Medicare managed care). Five states, (Massachusetts, Nevada, Ohio, Texas, and Florida), do not offer

Table 2
State Practices Regarding Dual Eligibles Enrolled in Medicare Managed Care
(n=15)

Dual Eligibles in Medicare Managed Care	
Not permitted to be in a Medicaid managed care (HI, IL, NJ, NY, PA, WA)	6
No Medicaid managed care for ABD/population (MA, NV, OH, TX, FL(aged population excluded))	5
Also in Medicaid managed care (AZ, CO, MN)	3
No Medicare managed care at the time of the survey (UT)	1
Do you actively verify Medicare managed care enrollment	
No enrollment tracking at this time (CO, IL, NV, PA, TX, WA)	6
Enrollment is verified actively (AZ, FL, HI, MN, NJ)	5
Attempting, but no satisfactory results (MA, NY, OH)	3
No Medicare managed care in state (UT)	1
Is there any concern for cost shifting?	
Not concerned (HI, IL, PA, TX, WA, NY, NV)	7
Third party liability unit verifies Medicaid co-pays (FL, MA, NJ)	3
Not sure whether there is cause for concern without verifying (CO)	1
Concerned (OH)	1
No improper activity is observed (MN)	1
Not an issue (UT)	1
No response (AZ)	1
Is the state participating in the Government Performance and Results Act's Outreach Efforts?	
Yes (MN, FL, HI, MA, NY, OH, TX, UT, WA, NJ)	10
No (NV, IL, PA)	3

Not decided (CO)	1
No response (AZ)	1

Source: Survey of state Medicaid officials. A detail state's summary is in the Appendix.

Medicaid managed care to the Aged, Blind, and Disabled (ABD) population (Florida includes blind and disabled but excludes aged population); therefore dual-eligible clients' enrollment in Medicare managed care in these states would not coincide with enrollment in Medicaid managed care.

Utah (since December 1998) no longer has any Medicare managed care providers in the state. In three states—Arizona and Colorado, where almost all of the Medicaid-eligible populations are in Medicaid managed care and in certain counties in Minnesota where Medicaid managed care is available—clients could be enrolled in two separate (Medicaid and Medicare) managed care plans.

Most often the states do not know when their Medicaid clients are enrolled in Medicare managed care. Recently, the states and HCFA have begun working together to remedy this situation. To track Medicare managed care enrollments, five states (Arizona, Florida, Hawaii, Minnesota, and New Jersey) are using a variety of data sources: the Common Working File, the Group Health Plan State File, the Bendex (Beneficiary Data Exchange) file, the Medicare crossover file and enrollment lists from Medicare managed care plans in the state. Six states (Colorado, Illinois, Nevada, Pennsylvania, Texas, and Washington) do no tracking; three, (Massachusetts, New York and Ohio) are attempting to do so but are not satisfied with the quality of the matches that they have created. For Utah, tracking is not an issue.

In regard to cost shifting, seven states (Hawaii, Illinois, New York, Nevada, Pennsylvania, Texas, and Washington) reported that they are not concerned about this issue. Three (Florida, Massachusetts, and New Jersey) believe that there is cause for concern, and have their Third Party Liability Unit verify Medicare managed care charges. Colorado, which does not track enrollment, is unsure whether any cost shifting is occurring. Ohio is concerned; Utah, which has no Medicare managed care plan, has no reason for concern. All states that have a tracking system in place (Arizona, New Jersey, Florida, Minnesota, and Hawaii) stated that they process Medicare managed care charges electronically; all other states (including Ohio) handle these charges manually.

When the states were asked about Medicare managed care plan premiums, five (New Jersey, Minnesota, New York, Washington, and Massachusetts) replied that they would pay premiums, or higher premiums, if it was cost-effective to do so (Clients will be evaluated one by one, if the premiums were lower than the cost of Medicaid services which that client requires in the absence of Medicare managed care, then the premium for that client will be paid). Three, (Colorado, Ohio, and Texas), had discussed the issue and had not made a decision at the time of the survey; Florida reported that it would not pay; Pennsylvania would pay. For the remaining states, the premium was not an issue, because it was not raised by the Medicare managed care plans in their state.

We also questioned the states about their outreach efforts to find and assist QMBs, SLMBs, QIWDs, and QIs with their premiums, deductibles and co-pays as they apply to those individuals. The purpose of the buy-in programs is to help low-income Medicare beneficiaries with out-of-pocket expenses because of the high health care utilization in this population. A report by the Barents Group LLC (1999) estimates that in 1996 approximately 52.7 percent of Medicare beneficiaries eligible for QMB or SLMB did not participate in these buy-in programs. Some might be avoiding participation because of the stigma associated with receiving welfare.

When states were asked about their participation in the Government Performance and Results Act's measure to "Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Insurance" 10 states (Florida, Hawaii, Massachusetts, Minnesota, New Jersey, New York, Ohio, Texas, Utah, and Washington), said that they were participating; three (Illinois, Nevada, and Pennsylvania) were not participating; and Colorado has not decided whether it will participate.

The states are at different stages of their outreach efforts: some have only recently decided to participate, while others are well into their outreach campaigns. Most states received help for their outreach efforts from the Social Security Administration in identifying Medicare beneficiaries. Some states established an 800 number, so potential clients could call and learn more about the buy-in program. All states participating in the outreach effort have received

support and literature from HCFA. They have used senior centers, meals on wheels and other programs for the elderly population to distribute the literature.

We also examined whether any attempt has been made to create an integrated care delivery system, such that clients could receive all their acute and long-term care services from a single provider. Two states, Arizona, and Minnesota, have statewide programs in place and have had a few years of experience in coordinating care and time to improve the system. Texas is operating a large-scale demonstration project in the Houston area; Florida is conducting a demonstration project in the Orlando and Palm Beach areas; and New Jersey is embarking on a new effort to enroll the SSI population in Medicaid managed care. Some of the New Jersey managed Medicaid providers are also Medicare managed care providers. Therefore, even though not a designed integrated care delivery system, some coordination of care is expected to occur. Colorado had a plan for an integrated care system that did not materialize: some providers pulled out after a lengthy HCFA waiver approval process, and the state is revising the planned model. Washington, Massachusetts, Pennsylvania, and New York are in the planning stages of an integrated care system. The remaining states have no plans for such a system at this point.

States with either a demonstration or a statewide integrated care delivery system then were asked about the process of establishing such a system. Most states said that the procedure for acquiring a waiver from HCFA to receive broad exceptions to Medicaid law, in order to enroll the dually eligible persons in a dually capitated care system, was too lengthy. In Colorado the coalition of providers did not last through the years of waiver approval process. When the waiver was finally approved, the managed health care providers were no longer interested.

More recently, however, the State of Florida sought and received HCFA's advice in preparing for the waiver request. That step appeared to shorten the time for the waiver review. Under the Medicare Provision of the Balanced Budget Act of 1997, states are permitted to provide "coordinated" care to dually eligible persons under a Medicaid plan and a Medicare+Choice plan. No waiver request is necessary, although HCFA must be notified of such a plan. Under such a model, the care delivery is integrated while financing is not.

Several states in our survey mentioned that one or more Program for All-inclusive Care for the Elderly (PACE) sites are operating in their state. PACE is an integrated care delivery system modeled after On Lok Senior Health Services in San Francisco, which began providing capitated services in the 1980s. The program offers a full range of care such as primary, acute and long-term care services. The enrollees' health and long-term care needs are case-managed by a multidisciplinary team in day health centers. Participation in this program is voluntary and is open, in the communities where it is offered, to Medicare beneficiaries, age 55 or older with nursing home level of care. In almost all cases the clients are also Medicaid eligible.

The PACE program, as a replica of On Lok, started with its own federal statutory authority. However, the Balanced Budget Act of 1997 (BBA 97) establishes PACE as a permanent provider under Medicare program and a state option under the Medicaid program. The PACE Provider regulations were based on the BBA 97 published in November 1999, with a review and comment period that followed.

The number of clients served by these demonstration programs are limited. For example, in 1999, the enrollment in PACE sites ranged from 35 in Tri-Health SeniorLink in Ohio to 778 in On Lok Senior Health Services in California. In June 1999 a total of 6,265 clients were enrolled in PACE program sites across the country. As of January 2000, there were 25 organizations that were operating under Medicare and Medicaid capitations. Nine others were only Medicaid capitated, and about forty sites were examining the possibility of becoming a PACE provider (Van Reenen, 2000).

Some states were pleased with the PACE demonstration program operations in their state, while others were frustrated by slow enrollment and inability to attract additional clients. Although the PACE demonstration project has been a valuable experiment and had worked very successfully in some communities, it clearly has some limitations and is hard to replicate in other environments. With the total number of clients served between 1990 and 1999 summing to about 11,200 (National PACE Association, 1999) it is not the model for providing coordinated care to the 6.7 million dual eligibles nationally.

Although the demonstration and the statewide integrated care systems are operating on a capitated rate basis, not enough years have elapsed to permit examination of the benefits in terms of participants' improved health and quality of life. The issue of cost-effectiveness is inconclusive, because most of the initial capitated rates are established by negotiation (between the provider, HCFA, and the Medicaid program) rather than by studying dual eligibles' utilization patterns.

Discussion

In 1997, an estimated 6.7 million Medicare beneficiaries were dually eligible for at least part of the year at some level (Clark & Hulbert, 1998). They accounted for 17% of the Medicare beneficiaries. As the nation ages, the number of Medicare beneficiaries, and therefore the number of dually eligible persons, are expected to increase considerably. Given the degree of frailty and poor health in this population, their expected health care expenditures will be remarkably high. During 1997 the Medicare and Medicaid programs spent almost equal amounts ($56.7 billion and $56 billion respectively) to care for the dually eligible. Of this $112.7 billion total expenditure, about 36% was spent on long-term care expenditures (paid by Medicaid); 4% went to premium payments; and the remaining 60% covered acute care services in both programs. On average, the Medicare expenditures for a dually eligible client are 2.4 times greater than for other Medicare beneficiaries (Clark & Hulbert, 1998). Ohio is experiencing the same growth in its older population as the nation as a whole, therefore it will face an increased number of dual eligibles in the next 50 years.

Because of cost containment pressures as well as the desire to create a coordinated health delivery system for the vulnerable population, states may need to experiment with innovative ways to bring case-managed coordinated care to this frail population. A few lessons were learned from the Medicare managed care plans. Even though the health insurance providers who became Medicare managed care providers had previous experience in providing managed health care, few (if any) were experienced in serving a large-scale disabled population in poor health. As a

result they underestimated the cost of caring for this population, the needs of the population that they had proposed to serve, and the difficulties of complying with evolving regulations.

This study began with examining the current health and long-term care delivery systems available to dual eligible persons in selected states hoping to find a model that would suit Ohio with its sizeable (about 150,000) population of dual eligible persons at any given time. We learned that there is not a simple, straightforward, successful model to follow. We found that most states, including Ohio, do not have mandatory Medicaid managed care enrollment for their ABD population. Therefore, the current Medicaid managed care providers have very little experience with providing even just health care to this segment of the population. The Medicare managed care providers that are supposed to be pioneering in the field of providing managed health care to older and/or disabled people did not do so well. Most, but not all, had to re-examine and re-define the product that they were offering, and the geographic area that they were covering. Yet, there is concern within the Medicare managed care plans that the capitation rate still underestimates the cost of caring for the enrollees (Health Care Financing Administration, 2000). The new capitation rates using inpatient hospital stays of Medicare+ Choice organization members are expected to improve these rates considerably. However, the General Accounting Office in two consecutive reports indicates that the Medicare managed care plans are overpaid (HCFA, 1999). Clearly there is a difference of opinion on what the health care utilization patterns of the older Medicare beneficiaries are and how much it costs to provide those services.

Any integrated care delivery system that plans to enroll a large number of dual-eligible clients will face the same fate. To begin with, the state must undergo a lengthy negotiation process with HCFA for waiver approval allowing the state to require the dual-eligible population to enroll in the integrated care delivery system. The managed care providers also need knowledge and experience with capitation rate setting, so that they will be compensated adequately and will achieve continuity and stability as a managed health care delivery system. HCFA and the states should forge partnerships, as they plan to oversee the management of these

integrated health delivery systems, by merging utilization data to study utilization patterns of this population and to experiment with capitation rate setting. Although these developments are necessary for starting a fully integrated health and long-term care delivery system, they will not occur quickly or simultaneously.

Ohio can benefit from a coordinated care delivery system, but the lessons learned from the state's experience with Medicare managed care should not be forgotten. Medicare managed care plans did not do well in rural areas and were forced to take drastic actions such as plan withdrawals, pullbacks, limiting participation, and service reduction. The medical director of the plan to whom we spoke pointed out two main reasons for difficulty in providing managed health care in rural areas. First, the beneficiaries in the rural areas had not previously had access to medical care. The package of benefits that the Medicare managed care plans were offering was attractive to the beneficiaries and expensive to the plans if clients attempted to take advantage of every service that was offered. The second problem was the inability to assemble a network of providers. About one third of Ohio's population lives in rural areas; therefore any coordinated care delivery system that attempts to operate in these areas will probably face the same problems as did the Medicare managed care plans, even though the beneficiaries in the rural areas could benefit most from such a system.

Ohio could begin considering a case-managed Medicaid long-term care plan in one or more urban areas, where there is an opportunity to create a network of providers. In assembling such a network, however, as Paul Saucier pointed out in a 1995 report, it must be remembered that dual-eligible persons are a diverse population with greater health care needs than the average Medicare or Medicaid beneficiary. The network should be prepared, in terms of capacity and expertise, to serve this population.

A good starting point for Ohio would be the development of a risk adjustment methodology for its dual-eligible populations. This will allow the state to set Medicaid capitation rates at a level which assures that providers can afford to remain part of the network and that allows the state Medicaid program to benefit from the savings, if there are any. Even so, the goal

of the coordinated care delivery system should not be Medicaid cost saving; rather, it should be a simpler and more effective way of delivering care to the state's most vulnerable population.

Ohio also should begin investigating the creation of a unified medical record system as it prepares to design a coordinated care delivery system. In this way, providers could review all other services that a client is receiving, regardless of the payer source.

Finally, the state must devise a way of monitoring the quality of the services rendered as well as evaluating improvement in the quality of the participants' lives.

Ohio, with about 1.5 million older persons and an estimated dually eligible population of about 150,000, could consider planning for a case-managed Medicaid long-term care plan in one of the metropolitan areas. The success of such a plan will depend on the strength of the network of providers that it can assemble. Such a plan could lay the groundwork for a fully integrated care delivery system in the future.

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