MAKING MEDICARE AND MEDICAID WORK BETTER TOGETHER

IMPROVING CARE COORDINATION

MEDICARE RIGHTS CENTER
Getting Medicare right

This case study series aims to help policymakers, advocates, and beneficiaries better understand insurance navigation and access challenges faced by people with Medicare and Medicaid.

Each brief tells the story of a client who called the Medicare Rights Center's National Helpline for assistance. Briefs highlight common obstacles to coverage and care and provide possible solutions.

The two-part case study below explores common issues with unintegrated care for low-income individuals who are dually eligible for Medicare and Medicaid. In the context of this publication, integrated care refers to the coordination of Medicare and Medicaid benefits for dually eligible beneficiaries. Where integrated care exists, the task of coordination is most often assigned to private managed care plans and programs that pay for and deliver a person's Medicare and Medicaid services. But Medicare and Medicaid coverage is too often unintegrated or not successfully integrated, and the challenge of making two types of health insurance coverage work together falls to the beneficiary and their family/caregivers, providers, and community organizations. Thankfully, insurers can eliminate some of these challenges through program and plan designs that better coordinate and combine Medicare and Medicaid services and payments.

Integrated care is still a work in progress, results are varied, and there are significant lessons to be learned. For instance, major differences exist from plan to plan, with some plans offering integrated networks, benefit structures, and appeals, and others appearing to provide no substantially integrated benefits to their enrollees. At both the state and federal level, beneficiaries need tools and education to distinguish between integrated and nonintegrated plans and to understand why integrated plans are more likely to serve their needs. Protections must also be put in place to protect consumers from misleading marketing practices intended to entice duals into enrolling in minimally integrated plans, also known as "D-SNP lookalikes." These protections can include Special Enrollment Periods (SEPs) and heightened standards for integrated plans so there are fewer "less good" options. Strict limitations on marketing impropriety are especially important because disparities in benefit coordination and overall beneficiary experience in more integrated compared to less integrated products can be great even when the "perks" advertised are similar. States can require greater integration through plan contracts and should also work toward improving upon federal standards for integrated care so that all plans provide a meaningful minimum benefit.

Ms. T Loses Her Therapist After Her D-SNP Fails to Resolve a Billing Issue

Ms. T is a 68-year-old dually eligible beneficiary who called the Medicare Rights Center's National Helpline for assistance with an ongoing provider issue. Ms. T had been seeing an in-network therapist who was billing her for Medicare cost-sharing. Ms. T was confused because she lived on a limited income and did not pay for any of her other services. She did not want to stop seeing her therapist because she needed the care, and the therapist's office was in a convenient location. However, paying the Medicare cost-sharing for her care was burdensome, and Ms. T seemed aware that she shouldn't owe anything.

A Medicare Rights counselor confirmed that Ms. T was enrolled in a Medicare Savings Program (MSP) at the Qualified Medicare Beneficiary (QMB) level. Beneficiaries who have QMB should not be billed for any Medicare-covered services they receive. More specifically, individuals with Original Medicare and QMB should not be billed for cost-sharing so long as they see any provider who accepts Medicare, while Medicare Advantage enrollees should not be billed when seeing in-network providers.

Ms. T was enrolled in a coordination-only (CO) Dual-eligible Special Needs Plan (D-SNP). CO D-SNPs are a type of Medicare Advantage Plan with minimal integration requirements. Ms. T enrolled in the plan because a marketing representative promised that it would offer a more seamless experience. Ms. T has a very low income and has health coverage through Medicare, Medicaid, and QMB. Prior to changing to a D-SNP, she had received her coverage through Original Medicare and a Medicaid Managed Care (MMC) plan. Under this set-up, she knew that she must see in-network providers and that, if she did so, she would typically owe no cost-sharing. But it was hard to find providers who were in network for her Medicaid plan. She therefore enrolled in a D-SNP to alleviate those concerns by having a network of providers who, she presumed, accepted her Medicaid coverage and were aware of QMB cost-sharing protections.

Instead, after enrolling in the CO D-SNP Ms. T's experience with her therapist felt no different than having Original Medicare and separate Medicaid coverage.

The Medicare Rights counselor assisting Ms. T first explained that CO D-SNPs do not have to have a network that universally accepts Medicaid. This lack of federal network congruency requirements means that even in-network providers for a plan that specifically serves people with Medicaid do not need to accept Medicaid. That said, though it is often the case that Medicare providers can be unaware of QMB and its restrictions against improper billing, D-SNPs are expected to know the rules and help members resolve improper billing issues with their in-network providers. The therapist should not have been able to continue billing Ms. T for Medicare cost-sharing. Ms. T explained that she did speak to her plan-assigned care coordinator about this issue previously. While the plan set up a three-way call with the therapist, they did not offer assistance during the conversation and ultimately left her to resolve the issue.

Ms. T's Medicare Rights counselor helped her file a grievance with the CO D-SNP. The plan responded that the therapist should bill Medicaid but did not step in to coordinate directly with both and did not communicate with the therapist that cost-sharing billing is not allowed for QMB enrollees. Ms. T also had to work with Medicare Rights to get her therapist to reimburse her for past payments that she should not have had to pay.

In the end, Ms. T's therapist dropped her as a patient, citing continued billing errors as the reason. Ms. T fortunately found a new therapist, though it will require significantly more time and effort to travel to them for care.

Had her D-SNP taken an active role in educating the therapist and been more responsive to Ms. T's request for coordination and assistance, this issue may have been resolved without care interruptions and new barriers to continued care.

Integrated care promises to take the burden of managing different forms of insurance, provider networks, payment standards, appeals timelines, and more off beneficiary shoulders. In situations where Medicaid is responsible for secondary payment, the plan should help the provider bill Medicaid. In situations where Medicaid will not make payment, but the Medicare Advantage enrollee has Medicaid, QMB, or both, the law requires that the plan inform the provider about improper billing protections and that their in-network providers do not discriminate against low-income beneficiaries. Unfortunately, neither of these situations unfolded as they should have for Ms. T.

Mr. Y's Care Coordinator Saves His Needed Twenty-Four Hour Care

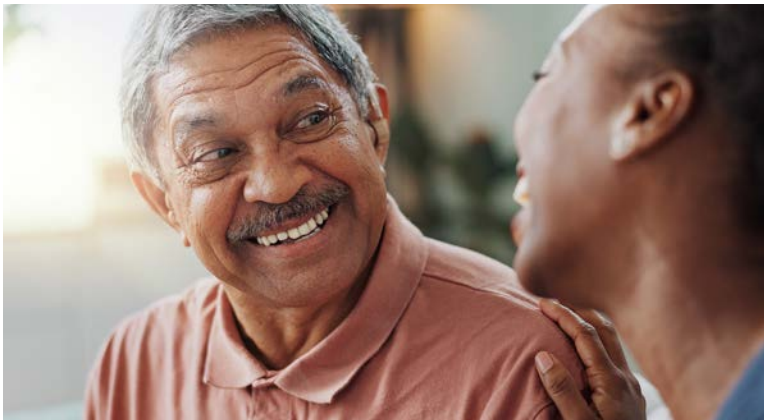
Mr. Y is a 76-year-old dually eligible beneficiary who called the Medicare Rights Center's National Helpline after unknowingly disenrolling himself from his Medicaid Advantage Plus (MAP) plan. A MAP plan is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), which is the most integrated D-SNP option available in Mr. Y's area. This plan combines an individual's Medicare and Medicaid coverage, creating the beneficiary experience of one plan that covers almost all of an individual's needed care, including Medicaid-covered home care. MAP plans are also required to provide care management services to ensure that enrollees can access all needed services.

Mr. Y receives 24-hour Medicaid home care services. Home care workers help Mr. Y with many activities of daily living, such as getting dressed, bathing, and using the bathroom. Because of his medical needs, he cannot independently live in his home without this care. When he spoke to one of his providers, she mentioned a different plan that many of her patients were enrolled in that would cover his needed care and provide additional benefits. The provider convinced him to switch his enrollment to this Medicare Advantage Plan, which was not a MAP plan, not realizing that his home care services would not be covered by the new plan.

A Medicare Rights counselor confirmed that Mr. Y's MAP enrollment was ending and explained that he would still have the right to Medicaid-covered home care but would need to access it through a separate plan. There was no guarantee that he could continue to receive the same amount of home care or in-office care from his current providers due to varied networks among plans.

Thankfully, Mr. Y also had a care manager through his MAP plan. Under MAP, enrollees are assigned a care manager who works for their plan and whose critical role is to help make sure they get needed care. Beneficiaries can speak to their care manager for help accessing medical, behavioral, social, and educational services, and for other assistance. Mr. Y's care manager had also learned of his disenrollment from MAP and had actively reached out to him to discuss what the change meant for his care.

The care manager was able to arrange for Mr. Y to continue to receive his 24-hour home care services uninterrupted while Mr. Y worked with Medicare Rights to re-enroll in his MAP plan. The fact that his care manager was aware of the situation, proactively checked in with him, and communicated his needs to the plan helped Mr. Y feel safe and heard—and ultimately helped him keep his much-needed home care services.



Key Policy Recommendations

Fulfilling the promise of integrated Medicare and Medicaid coverage requires tracking a person's care across programs and providers. Communication between and among plans, providers, and the enrollee ensures that needed care is received—at the proper cost—while reducing redundant services and minimizing disruption.

As we've seen in Ms. T's case, many plans fail to meet basic requirements, let alone the higher standards of care coordination. However, more integrated and compliant plans, such as Mr. Y's, are aware of the many issues their members may face and ready to take steps to resolve them, minimizing disruptions in care and reducing the risk of negative health outcomes.

The Centers for Medicare & Medicaid Services (CMS) and state governments should consider the following recommendations for improving care coordination across integrated care offerings, which will lead to a better experience and better care for beneficiaries:

KEY RECOMMENDATION

Standardize Care Coordination

Care coordination varies across types of integrated care plans and even between plans with the same designation. D-SNPs should have standardized care coordination practices, which will improve beneficiary experiences across plans. Care coordination standards might include requiring plans to have specific care manager-to-member ratios, a direct line between members and their care manager or care team, and meaningful coordination of Medicare and Medicaid services to target aspects of the care system that remain disjointed. Care coordination standards should be publicly available and provided to members.

KEY RECOMMENDATION

Better Enforce Care Coordination

States should work together with CMS to enforce minimum care coordination standards for integrated plans. There should also be better enforcement of the general standards that are applicable to all plans; failing to uphold these standards can gravely affect dual-eligibles in particular. Language describing minimum standards should be included in State Medicaid Agency Contracts (SMAC) and be informed by various stakeholders, including dually eligible individuals in integrated plans and the advocates that serve them. SMAC standards should have teeth: Medicaid agencies and CMS should be empowered to investigate failures and act to ensure plan compliance.

KEY RECOMMENDATION

Enact Care Manager-to-Member Ratios

Plans should be required to adhere to specific care manager-to-member ratios, standardized based on member level of need. For example, a care manager who supports members with lower needs might have a larger caseload than a care manager who supports members with higher needs. Care manager-to-member ratios and a cap on care managers' caseloads should be developed based on current plan and member experiences with input from appropriate social work professionals.

KEY RECOMMENDATION

Offer a No Wrong Door Policy

Integrated care plans should have no wrong door policies when members contact either the D-SNP or Medicaid plan. This means that plan customer service staff should be trained to answer questions related to a member's whole plan, not only part of it.

KEY RECOMMENDATION

Expand Beneficiary and Provider Education

Dually eligible individuals and their providers need educational resources that explain Medicare and Medicaid, Medicare Advantage Plans, D-SNPs, and integrated options. Beneficiaries are otherwise more likely to make mistakes when choosing plans and trying to access benefits, and providers may struggle to accurately explain options to patients. States should work together with CMS to develop and promote new educational resources and/or improve existing ones.

KEY RECOMMENDATION

Provide Proper Training to Care Managers

Plans should be required to provide proper training to care managers so that they are educated about care coordination standards. Care managers should be well versed in their plan's standards and how to communicate standards clearly with members. Understanding standards will empower care managers to serve as effective advocates for their clients with plan representatives, providers, and others.

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