MAKING MEDICARE AND MEDICAID WORK BETTER TOGETHER

STOPPING COVERAGE LOSS AND DISRUPTION

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 integrated 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 while successfully integrated coverage may improve access for some beneficiaries, systemic issues remain that put the gains—for both enrollees and plans—at risk.

One such issue is churn—a term that refers to the cyclical loss and regaining of coverage. Churn can occur within a program, as when Medicare beneficiaries switch between different Medicare Advantage Plans due to dissatisfaction, involuntary disenrollment, after experiencing predatory marketing practices, or after simply being confused by advertising.

Churn can also occur with regard to the benefit as a whole, as when individuals who have Medicaid or a Medicare Savings Program lose access to that coverage, which can happen as a result of failure to recertify, temporary changes in income or other status, interstate moves, or administrative error. For individuals enrolled in integrated care, churn can interrupt access to necessary care or provider access. Churn also impacts plans' ability to effectively manage care for enrollees. Integration is a valuable benefit for dually eligible individuals. It can ensure that duals are bolstered, not burdened, by their eligibility for both programs. Without changes across the entire system to reduce churn, people in integrated care plans will remain vulnerable to this disruption.

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. They also need support and protections to make it easier to stay enrolled in plans that are working well for them—to avoid disenrollment due to loss of Medicaid status or mistake. 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" or into less integrated D-SNPs.

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.

Mrs. E Loses Her Aligned Dual-eligible Special Needs Plan (D-SNP) Due to a Recertification Error

Mrs. E is a 66-year-old dually eligible beneficiary who called the Medicare Rights Center's National Helpline for assistance after receiving notice that she had lost her Medicaid after failing to return her recertification packet. Mrs. E explained that she never received a recertification packet or any other related paperwork.

A Medicare Rights counselor contacted Mrs. E's local Medicaid office to confirm that her Medicaid was ending. After receiving confirmation, the counselor explained to Mrs. E that she would need to reapply for Medicaid. Mrs. E would also need to reapply for a Medicare Savings Program (MSP), as her Medicaid enrollment had led to automatic enrollment into an MSP, and without Medicaid she also lost her MSP. Mrs. E could have appealed her Medicaid disenrollment, but the deadline to appeal, as listed on the termination notice, had passed. Having to reapply and wait for Medicaid and MSP approval meant that Mrs. E might go months without access to her Medicaid and MSP benefits. This meant potentially needing to forgo care or pay out of pocket and needing to pay for her Medicare Part B monthly premiums, which are covered by MSP enrollment.

Unfortunately, these were not the only issues Mrs. E faced as a result of not renewing her Medicaid benefit.

Mrs. E was enrolled in a Dual-eligible Special Needs Plan (D-SNP) with an aligned Medicaid plan. The plan offered a care coordinator who helped her manage her various specialist appointments, and Mrs. E liked knowing that all her care was covered and her providers could easily communicate with each other about her complicated medical situation. To be enrolled in this plan, Mrs. E had to have Medicaid. Her disenrollment from Medicaid—though she remained eligible—meant that she was also disenrolled from her D-SNP.

As indicated above, Mrs. E's aligned D-SNP was a type of integrated plan where her D-SNP and Medicaid Managed Care Organization (MCO) plan were offered by the same company. The goal of alignment is to ensure that beneficiaries have a more seamless experience accessing health care. Mrs. E had come to rely on her integrated coverage and provider networks. Losing this coverage would interrupt her care. Suddenly, Mrs. E faced two challenges: she had to reapply for benefits and attempt to maintain access to needed care.

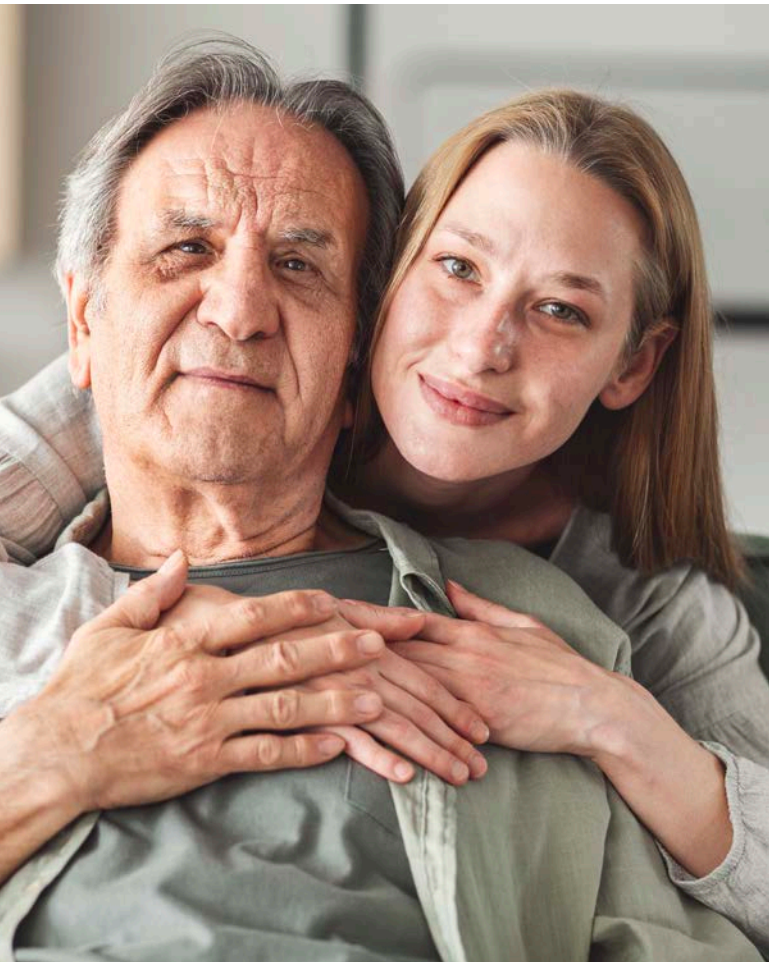
Unsurprisingly, the same state systems that had failed to send Mrs. E her recertification paperwork in a timely way were also slow to process her new application. Although Medicare Rights was able to help Mrs. E restore her Medicaid and MSP benefits, it took three months. During that time, Mrs. E was covered by Original Medicare with a stand-alone Part D plan for her prescriptions. She incurred higher out of pocket costs and, having been disenrolled from her D-SNP, missed medical appointments because her care was less coordinated and communicated to her. She also had been automatically enrolled into a Part D plan that she did not choose—previously, she received prescriptions from her D-SNP—and some of her prescriptions were denied at the pharmacy counter.

When Mrs. E's Medicaid application was finally processed, she re-enrolled in her D-SNP. She was able to access care coordination services again and was reassured that her provider network and Part D coverage would once again meet her needs. But the three months without her integrated coverage negatively affected Mrs. E's budget and health, and her plan and providers also incurred costs related to her experience of "churn."

Mrs. E was also left confused and disappointed by the experience. When she first became eligible for Medicare during the COVID-19 public health emergency, many renewal processes were automatic. There had been no changes to her income or assets. She didn't understand why, when simpler processes were available, her state would increase administrative obligations—and the related risk of error—to the detriment of older adults with complex health care needs.

Aggressive Marketing Tactics Push Mr. V into Disenrolling from His Integrated Plan

Mr. V is an 88-year-old dually eligible beneficiary with dementia whose granddaughter called the Medicare Rights Center's National Helpline after she discovered that he was no longer enrolled in 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. V's area. MAP plans combine an individual's Medicare and Medicaid coverage, creating the experience of one plan that covers all of an enrollee's needed care, including Medicaid-covered home care.

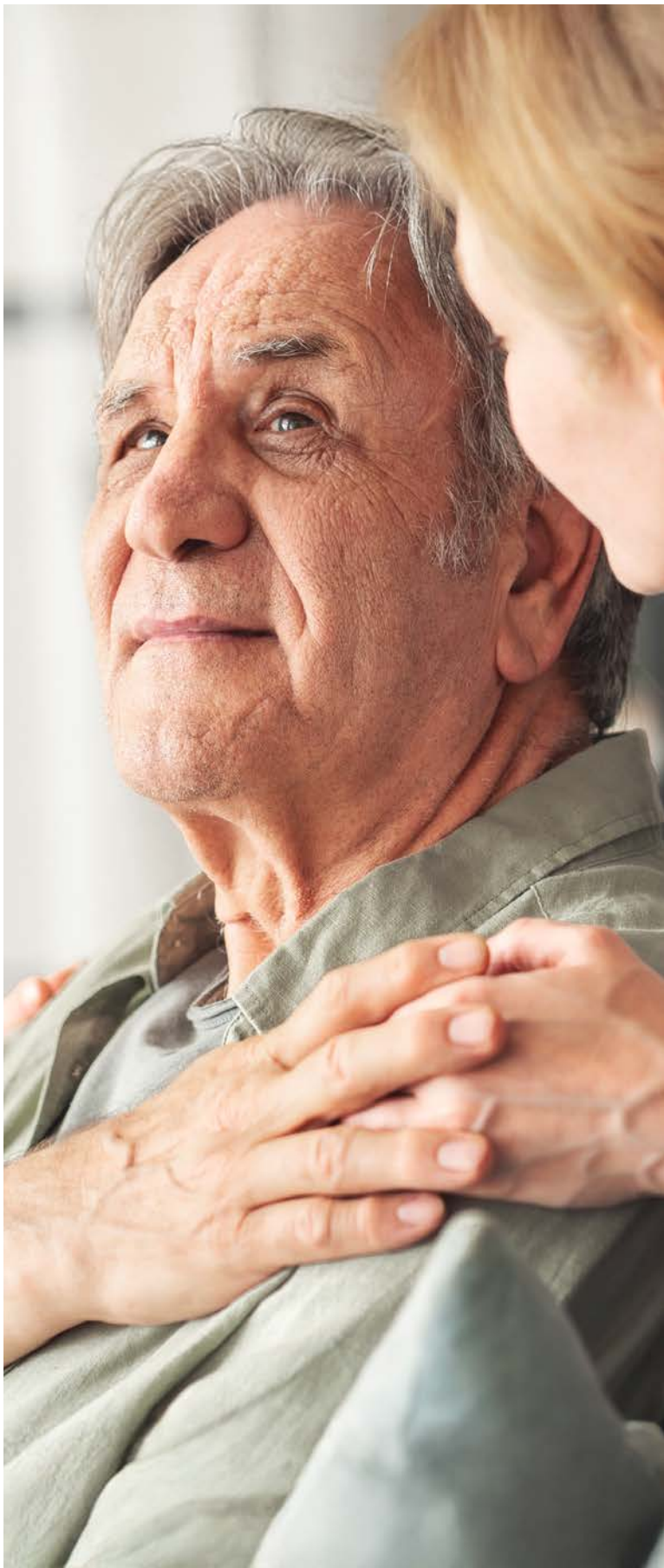


Mr. V's granddaughter learned of the change to his coverage after she took him to a routine visit with a specialist he had seen many times before, and they told her that they were no longer an in-network provider. Concerned, she investigated and discovered that her grandfather had received a marketing call from an insurance agent who convinced him to switch his enrollment to a different D-SNP, a coordination-only Dual-eligible Special Needs Plan (CO D-SNP). The agent had said that their D-SNP was designed for people like Mr. V, who had Medicare and Medicaid, and assured him that he would have the same benefits and could see the same providers.

Aside from the network assurances being untrue, Mr. V's granddaughter was particularly worried because the MAP plan, in addition to covering her grandfather's outpatient services, also administered his Medicaid live-in home care services. Switching to the CO D-SNP, which only paid for Medicare-covered services triggered a cascade of disenrollment that jeopardized his access to Medicaid home care, including the supervision and assistance with activities of daily living that made it possible for him to safely live in his home. While Mr. V's home health aide hadn't stopped coming yet, his granddaughter feared that it was only a matter of time before his services were disrupted. Neither Mr. V nor his granddaughter wished to change specialists.

A Medicare Rights counselor confirmed that Mr. V would lose his MAP coverage at the end of the month. The counselor also explained that Mr. V 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 home care or in-office care from his current providers. Mr. V said that he would never have agreed to the change during his call with the insurance agent if he understood the consequences. He had felt pressured and confused during the conversation with the agent and had agreed only to get off the phone.

Medicare Rights and Mr. V's granddaughter were able to demonstrate to the Centers for Medicare & Medicaid Services (CMS) that Mr. V's enrollment in the CO D-SNP should be voided, and he was reinstated into his MAP plan. Mr. V's granddaughter also filed a misleading marketing complaint against the agent who enrolled Mr. V, as it seemed wrong to her that an agent could sell him a plan that would cause him to be worse off. In this case, the agent's plain lies meant that the enrollment could be undone. But even under more honest circumstances, the sheer number of mailings and calls from insurers—combined with the confusing array of products available—mean that many individuals every day make choices that may not be in their best health care interest.



Key Policy Recommendations

Medicare and Medicaid churn can negatively impact any beneficiary, but for dually eligible individuals enrolled in integrated care, the consequences can be particularly dire. As we have seen in Mrs. E's and Mr. V's cases, the loss—or even threatened loss—of integrated coverage can disrupt access to needed medical care and put a person's health at risk. And though administrative errors and misleading marketing triggered these disruptions, there are many causes of churn.

CMS and state governments should consider the following options for reducing integrated care costs and improving the experience and care of individuals enrolled in integrated coverage:

KEY RECOMMENDATION

Choice Counseling

For individuals not to lose critical coverage, plans should be required to have procedures in place that trigger choice counseling sessions for enrollees who are considering disenrollment. This may prevent enrollees from unintentionally interrupting their care.

KEY RECOMMENDATION

Expanded 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 explain options to patients. States should work together with CMS to develop and promote new educational resources and/or improve existing ones.

KEY RECOMMENDATION

Recertification Assistance

State Medicaid Agency Contracts (SMACs) should require that all D-SNPs provide enrollees with assistance with the Medicaid recertification process. This assistance should include but not be limited to tracking enrollees' Medicaid recertification cycles, helping with forms, and checking systems to ensure recertification materials were returned and processed.

KEY RECOMMENDATION

Simplified Recertification Processes

Many dually eligible individuals live on fixed incomes and have no income and asset changes from year to year. When possible, state Medicaid offices should automatically recertify Medicaid based on available data. States should also explore longer recertification timelines and alternative procedures for people who are likely to have unchanged eligibility.

KEY RECOMMENDATION

Medicaid Redetermination Prior to Any Default Enrollment Into an Integrated Plan

Default enrollment is a sometimes controversial mechanism that allows eligible insurers to move newly Medicare-eligible Medicaid Managed Care (MMC) enrollees into a qualifying D-SNP. However, beneficiaries who are automatically enrolled in a D-SNP via default enrollment are at risk of immediately losing that D-SNP if they are not promptly and properly evaluated for continued Medicaid eligibility (i.e. properly moved from younger adult Medicaid to older adult Medicaid). Automatic enrollment processes are not helpful when an individual may no longer even qualify for Medicaid, and when their changing care needs may require different kinds of coverage. States should ensure that newly Medicare-eligible individuals continue to qualify for Medicaid before allowing default enrollments to take place.

KEY RECOMMENDATION

Improvements to Integrated Coverage Marketing

Beneficiaries, especially dual-eligibles, often enroll in a plan because they are told it will cover additional benefits—but they are not always aware of benefits they might lose by switching coverage. Marketing messages, especially during over-the-phone or in-person marketing meetings with agents, need to be clear about what the plan offers, where networks overlap, and the comparative level of integration. Beneficiaries should be made aware whether the marketed plan is a less integrated product than their current coverage. Plans should be held more accountable for incidents when beneficiaries feel misled, even unintentionally.

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