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Implementing State Demonstrations for Dual Eligibles Has Proven Challenging

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Contents

Letter

	3
Results in Brief	4
Background	6
Voluntary State Programs Have Limited Operational Experience and Scope	10
Developing and Implementing Dual-Eligible Initiatives Has Been a Lengthy Process	16
Conclusions	26
Agency Comments and Our Evaluation	27

Appendixes

Appendix I:	Examples of Advantages States See in Integrated Care for Dual Eligibles	32
Appendix II:	Descriptions of PACE, S/HMO I and II, and EverCare Programs	33
Appendix III:	Concepts Being Tested by States' Integrated Care Demonstrations for Dual Eligibles	37
Appendix IV:	Description of Medicaid Integrated Care Programs in Texas, Florida, and Colorado	39
Appendix V:	BBA Changes to Medicare HMO Payment Methodology	42
Appendix VI:	GAO Methodology for Combining Part A and Part B Risk Adjusters	44
Appendix VII:	Comparison of Medicare Payments Under M+C, PACE, and State Demonstration Programs	46
Appendix VIII:	Comments From the Health Care Financing Administration	47

Tables

Table 1:	Comparison of Key Characteristics of State Integrated Care Programs	12
Table 2:	Time (in Months) for Planning, Federal Review, and Preparing for Implementation of Four State Waiver Requests	18
Table 3:	GAO Analysis of Risk Adjusters for Programs Serving Dual Eligibles	23
Table 4:	Comparison of PACE, S/HMO, and EverCare	35
Table 5:	1999 Risk Adjusters for Programs Serving Dual Eligibles	44

Table 6: Payments Under M+C, PACE, and State Demonstrations That Serve Frail Dual Eligibles Living in the Community, for a 75-Year-Old Female Residing in Each Location in Calendar Year 1999 46

Abbreviations

BBA	Balanced Budget Act of 1997
CCN	Continuing Care Networks
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
M+C	Medicare+Choice
MedPAC	Medicare Payment Advisory Commission
MOU	memorandum of understanding
MSHO	Minnesota Senior Health Options
OMB	Office of Management and Budget
PACE	Program for All-Inclusive Care for the Elderly
SCO	Senior Care Options
S/HMO	Social Health Maintenance Organization

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Health, Education, and
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The Honorable Charles E. Grassley
Chairman
The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Ron Wyden
United States Senate

Hoping to expand the scope of earlier provider-initiated demonstrations, states have been seeking federal waivers since the early 1990s to use managed care approaches to integrate the delivery of acute and long-term-care services for certain "dual eligibles"—low-income Medicare beneficiaries who also qualify for *full* Medicaid benefits.[1] Dual eligibles often receive their Medicare and Medicaid benefits from two different sets of providers. In part, this situation stems from the different rules under which the two programs operate and the fact that Medicaid pays for services not covered by Medicare, reducing the incentive for dual eligibles to enroll in a Medicare managed care plan. While some states require or allow dual eligibles and other Medicaid beneficiaries to enroll in a managed care plan to receive Medicaid benefits, Medicare beneficiaries (including dual eligibles) cannot be required to do so in order to receive Medicare benefits. In fact, an estimated 97 percent of dual eligibles receive their Medicare benefits under Medicare's fee-for-service option. To foster the delivery of benefits in a more integrated fashion, some states are exploring the pooling of separate Medicaid and Medicare payments and making one managed care plan responsible for the delivery of all covered services. The theory is that the managed care plan will have an incentive—a per-beneficiary payment—to provide the most appropriate care in the most

[1]The term "dual eligible" is sometimes applied to other low-income Medicare beneficiaries who do not qualify for full Medicaid coverage under state income standards but who receive Medicaid coverage of Medicare cost-sharing requirements.

cost-effective setting.[2] However, states have often raised concerns about the length of the federal review process for these complex initiatives—initiatives that raise important financing issues.

Concerned about the apparent limited experience to date with states' integrated care initiatives, you asked us to determine (1) the status and key features of state initiatives to integrate care for dual-eligible beneficiaries and (2) factors that have contributed to the length of the waiver negotiation process and implementation time frames. To address these issues, we interviewed program officials in seven states that sought federal approval for integrated care demonstrations: Colorado, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin. We obtained a federal perspective on these initiatives from officials at the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services (HHS) responsible for their review and approval, and from officials at the Office of Management and Budget (OMB) who establish rules for federal financial participation. We also interviewed providers either participating in integration initiatives or planning to enroll dual eligibles, and advocates for dual-eligible beneficiaries. In addition, we reviewed (1) pertinent documents related to integrated care initiatives, such as state waiver proposals and the terms and conditions that accompanied federal approval, and (2) the available research on dual eligibles, including information on the Program for All-Inclusive Care for the Elderly (PACE) and other provider-initiated demonstrations that served as a point of departure for state integrated care programs. We performed our work between May 1999 and April 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Currently, two states are enrolling a small number of dual eligibles in limited geographic areas into integrated care programs, and two additional states plan to implement programs by 2001. Officials in these four states view their initial efforts as stepping stones and plan to make their programs more widely available. Since the 1995 approval of an integrated care program in Minnesota, the states of Wisconsin and New York also have received federal approval to integrate Medicaid and Medicare services for dual eligibles. HCFA and Massachusetts are working toward final approval

[2]App. I describes some of the advantages states see in integrated care programs for dual-eligible beneficiaries.

of that state's program.[3] The Minnesota and Wisconsin demonstrations have operated for over 3-1/2 years and 1-1/2 years, respectively, and currently serve about 4,200 dual eligibles in 12 counties. New York expects to begin implementation in May 2001 in the Rochester area. Massachusetts has a goal of statewide enrollment with an implementation target date of early 2001. States are emphasizing service delivery in beneficiaries' homes and targeting different segments of the dual-eligible population compared with PACE, which enrolls only frail individuals—that is, people who are at risk of nursing home placement. The demonstrations in Minnesota and New York are open to all dual eligibles over the age of 65—both community residents and those in nursing homes. In contrast, Wisconsin's program focuses on the noninstitutionalized—individuals who are at risk of nursing home placement and are either elderly or younger and physically disabled. Two states are contracting or plan to contract with health plans that had no prior experience in bearing financial risk, such as hospital-based plans and community-based long-term-care organizations; Wisconsin is also contracting with PACE sites. All plans in states with approved programs are nonprofit, including the three participating health maintenance organizations (HMO) in Minnesota.

Important factors associated with states' decisions about pursuing integrated care programs for dual eligibles are the complexity of planning and implementing a demonstration and the extended time frames needed to do so. At present, states need to undertake considerable planning before waiver submission and then again after approval to bring health plans on board and to prepare for actual enrollment. Finding the overall challenges too great, Florida and Texas dropped the idea of integrating Medicare and Medicaid services and instead are developing projects integrating Medicaid acute- and long-term-care services only. Colorado is now pursuing a program that avoids the use of waivers altogether. States have criticized the length of the process required to gain federal approval for their initiatives. In states with approved programs, the federal waiver review process ranged from over 1 year to over 3 years. Though some delays were associated with HCFA's 1997 reorganization and the heavy new demands on the agency as a result of 1997 legislation, HCFA has taken action to try to speed up the review process.

[3]In April 2000, HCFA and Massachusetts signed a memorandum of understanding (MOU) that establishes terms and conditions and defines the federal and state roles and responsibilities in implementing an integrated care program. The MOU reflects the commitment of both parties to implementing a demonstration program. A number of steps need to be taken prior to final approval and implementation.

Difficulty in reaching agreement on an appropriate Medicare payment methodology for integrated care programs was an important factor that delayed the approval of state waiver applications. The challenge has been to agree on payment rates that adequately compensate health plans for differences in frailty among dual eligibles while meeting OMB's requirement that Medicare demonstrations not increase federal Medicare expenditures from what they would have been without the demonstration. In contrast to Medicare, which pays managed care plans a rate based on the average cost of dual eligibles, adjusted for demographic differences, HCFA and OMB's approach to demonstrations has generally been to establish a separate, higher rate for frail dual eligibles and a lower rate for healthier dual eligibles. On the basis of the PACE precedent, single, higher payment rates for frail dual eligibles were approved for Minnesota, Wisconsin, and Massachusetts. Only New York's demonstration is exploring the variability in costs among frail dual eligibles by establishing several rates rather than a single payment rate. For now, Wisconsin and Massachusetts have agreed to rates that they believe may not be adequate to cover the costs of serving disabled and frail dual eligibles, respectively, but are continuing to work toward establishing higher rates. Medicare's move toward a new diagnosis-based risk-adjustment methodology raises concerns for state demonstrations because research has shown that the methodology tends to underestimate the costs of frail beneficiaries. This situation underscores the importance of learning from these four state demonstrations so that their experience may inform similar initiatives that other states may be considering.

Background

While Medicare and Medicaid generally cover different populations, an estimated 2.5 million low-income individuals are dually eligible for full

Medicaid coverage and services covered by Medicare.[4] For such dual eligibles, Medicaid also covers Medicare part B premiums. Medicare, the federal health insurance program for elderly and disabled Americans, covered an estimated 39 million beneficiaries at a projected cost of $233.4 billion in fiscal year 1999.[5] Medicare is financed by a combination of payroll taxes, beneficiary premiums, general revenue, and interest on trust fund assets. On the other hand, Medicaid serves certain low-income beneficiaries and is jointly funded by state and federal revenues. In fiscal year 1998, the federal government paid 57 percent of Medicaid's $177.1 billion cost to cover about 40.5 million beneficiaries. Subject to certain federal statutory requirements as well as HHS guidance and review, each state designs and administers its own Medicaid program by (1) setting income and asset eligibility requirements, (2) selecting which optional beneficiary groups and services to cover, and (3) determining the scope of and payments for mandatory and optional services.

Medicaid fills in Medicare coverage gaps for its low-income elderly and some of its younger physically disabled beneficiaries.[6] Medicare covers their acute-care needs, such as hospitalizations and physician services, but generally does not pay for long-term care, except when it is accompanied

[4]The total number of dual eligibles was about 6.5 million in 1996 and included Medicare beneficiaries who do not qualify for full Medicaid coverage. The Congress established three programs to assist Medicare beneficiaries with incomes above the qualifying level for full Medicaid coverage. Under the Qualified Medicare Beneficiary program, Medicaid pays Medicare premiums, deductibles, and coinsurance for individuals with incomes at or below 100 percent of the federal poverty level. Under the Specified Low-Income Medicare Beneficiary program, Medicaid pays the Medicare part B premium for individuals with incomes above 100 percent but less than 120 percent of the federal poverty level. Finally, the Qualifying Individuals program, which operates with fixed funding for a 5-year period beginning in 1998, assists individuals on a first-come, first-served basis; Medicaid is required to pay the Medicare part B premium for beneficiaries with incomes at least 120 percent but less than 135 percent of the poverty level and to provide a small rebate of Medicare premiums for beneficiaries with incomes at least 135 percent but less than 175 percent of the federal poverty level. See *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS-99-61, Apr. 9, 1999), p. 4.

[5]This estimate is based on Congressional Budget Office projections. After subtracting beneficiary premiums, the fiscal year 1999 Medicare net cost to the government was projected to be $210 billion. Disabled Americans qualify for Medicare after they receive cash disability benefits under title II of the Social Security Act for 24 months.

[6]In 1995, the cost-sharing liability for Medicare-covered services averaged about $760 per beneficiary. For those living at the poverty level, this cost represented about 10 percent of income ($7,470) for a single person and 15 percent of income ($10,030) for a couple. (See GAO/HEHS-99-61, p. 1.)

by a need for skilled care, either in an institution or in a beneficiary's home. Medicaid covers long-term-care services delivered either in a nursing home or, at state option, in the community and provides benefits generally not covered by fee-for-service Medicare, such as prescription drugs. The extent of Medicaid coverage for dual eligibles, however, differs across states. Drug coverage and community-based care may be limited or unavailable in some states for certain populations but more comprehensive in others. Some services are covered by both programs. For example, dual eligibles can obtain services under the Medicare home health and skilled nursing facility benefits that are similar to long-term-care services paid for by Medicaid. When a benefit is covered by both programs, such as post-acute skilled nursing facility care or home health services, Medicare is the primary payer. Because of pressures in both programs to control costs, the overlap in benefits has, at times, resulted in tension between state and federal officials as to which program should cover certain services.

Most Medicare beneficiaries may choose between two different delivery systems—a fee-for-service model, in which individuals receive services from the providers of their choice who are paid separately for each service, and an HMO option, in which all covered services must be obtained from a participating health plan that is paid a fixed per-person, per-month fee (capitation). The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice Program (M+C) to reflect steps taken to encourage the wider availability of HMOs and the participation of other types of coordinated care plans. As of June 1, 1999, about 18 percent of Medicare beneficiaries were enrolled in a Medicare HMO, while the remaining 82 percent were in the program's fee-for-service option. About 97 percent of dual eligibles receive their Medicare benefits on a fee-for-service basis. States also use both fee-for-service and managed care for Medicaid beneficiaries. About 54 percent of Medicaid beneficiaries, primarily low-income families, are enrolled in managed care either on a voluntary basis, like Medicare, or through mandatory state programs. Some states have mandatory programs that require dual eligibles to receive Medicaid services from a managed care plan.

Dual eligibles, both those with full Medicaid coverage and those for whom Medicaid only provides assistance regarding Medicare cost-sharing, are among the most vulnerable Medicare beneficiaries. Although some dual eligibles are relatively healthy, many have substantially greater health care needs and fewer resources to meet those needs than the average Medicare beneficiary. By definition, dual eligibles are poor: most had annual incomes below $10,000, and one-fifth had annual incomes under $5,000 in 1997.

Almost 40 percent of dual eligibles are minorities. Compared with Medicare-only beneficiaries, dual eligibles are more likely to

- be female;
- live in a nursing home;
- have a serious disease or chronic condition such as stroke, diabetes, mental disorder, or incontinence;
- suffer from serious functional limitations, both physical and cognitive; and
- have less access to a regular source of care or preventive services and make greater use of emergency room services.

Dual eligibles were estimated to represent 17 percent of Medicare beneficiaries in 1997, but they accounted for about 28 percent of Medicare expenditures that year. Similarly, they accounted for 19 percent of the Medicaid population but 35 percent of Medicaid expenditures, primarily because of their higher use of nursing home care.[7] Medicare and Medicaid expenditures for dual eligibles were an estimated $113 billion in 1997. The nonelderly disabled and persons aged 85 and older—who are more likely to be dually eligible—are the fastest growing segments of the Medicare population.

Since the early 1990s, states have expressed interest in experimenting with managed care approaches that integrate services for Medicare beneficiaries who are eligible for full Medicaid benefits. In addition to cost savings, states are attempting to (1) address the fragmentation in delivery systems, (2) ensure access to primary and preventive care, (3) improve accountability for health outcomes, (4) provide incentives for the appropriate use of medical services, and (5) reduce administrative differences between Medicare and Medicaid. To integrate Medicare and Medicaid services, states have generally sought federal waivers of certain Medicare and Medicaid requirements. Currently, there are two relevant federal waiver authorities. Section 222(b) of the Social Security Act Amendments of 1972 provides authority for demonstrations that experiment with the Medicare payment methodology. Section 1115 of the Social Security Act authorizes demonstrations that test Medicaid

[7]William D. Clark and Melissa M. Hulbert, "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities," *Health Care Financing Review* (Winter 1998).

program innovations.[8] A long-standing federal policy for the approval of such demonstrations is that they be budget neutral—that expenditures under the waiver be no higher than they would be without a waiver.

Experimentation with approaches to coordinate the delivery of acute- and long-term care under a capitation arrangement dates back to the 1970s. The Congress has authorized four demonstration programs since then: (1) PACE, (2) two generations of the Social Health Maintenance Organization program (S/HMO I and S/HMO II), and (3) EverCare. These demonstrations vary in the extent to which they serve dual eligibles: while 96 percent of PACE enrollees were dual eligible in 1997, S/HMO and EverCare enrollment of dual eligibles represented 5 to 6 percent and 70 to 75 percent of enrollees, respectively. PACE targets frail individuals and attempts to keep them out of nursing homes, while EverCare focuses on improving outpatient services for beneficiaries who already reside in nursing homes.[9] S/HMO expands the traditional Medicare benefit package by adding some long-term-care benefits. Compared with PACE, S/HMOs provide more limited long-term-care benefits. (App. II compares and contrasts these demonstration programs.)[10]

Voluntary State Programs Have Limited Operational Experience and Scope

Four states have obtained or soon expect to obtain approval to establish Medicaid/Medicare integrated care demonstrations for dual eligibles. Only the demonstrations in Minnesota and Wisconsin are operational—for 3-1/2 years and 1-1/2 years, respectively. These two programs are currently small, operating in a total of 12 counties, with enrollment of about 4,200. In addition to frail, elderly dual eligibles, healthier dual eligibles are often eligible to enroll in these voluntary programs. Several states also plan to enroll non-dual Medicaid- or Medicare-only beneficiaries. Developing plan capability to integrate care is a challenge because participating plans have

[8]Currently, section 222(b) is codified at 42 U.S.C. 1395b-1(a)(1)(A). Despite its new codification, most health care professionals—including HCFA—continue to refer to the authority as a 222 waiver. The 1115 waiver is codified at 42 U.S.C. 1315(a).

[9]Individuals who are determined to be at risk of nursing home placement, that is, "nursing-home-certifiable," are considered frail. Generally, frail individuals require assistance with daily activities such as bathing or dressing. States are responsible for making these eligibility assessments using state standards.

[10]For a more detailed discussion of these demonstrations, see Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Selected Medicare Issues,* ch. 5 (Washington, D.C.: MedPAC, June 1999).

limited experience in providing the broad range of services covered under the demonstrations. Because of program complexities and the lengthy waiver-approval process, several other states that considered pursuing similar demonstration initiatives decided instead to focus on integrating Medicaid acute- and long-term-care services.

Few State Programs Are Operational; Scope and Enrollment Are Currently Small

The first state integrated care program—Minnesota Senior Health Options (MSHO)—was approved in 1995 after almost 4 years of development and negotiation with HCFA and OMB over federal waivers. Implemented in 1997, MSHO became an important model for other state initiatives. Since MSHO, HCFA also has approved the Wisconsin Partnership Program, which was fully implemented in January 1999, and the Monroe County, New York, Continuing Care Networks (CCN), which plans to begin enrolling beneficiaries in May 2001. A fourth program, Massachusetts' MassHealth Senior Care Options (SCO), is expected to receive final approval and begin implementation by early 2001.

Program officials in Minnesota, Wisconsin, and New York told us that the modest size of their voluntary programs—operating or scheduled to operate in 13 counties with an overall enrollment goal of about 16,400 beneficiaries—is only a starting point.[11] They consider these demonstrations to be the basis for larger projects that may eventually expand to other locations or cover additional populations. MSHO, the largest operational program, has an enrollment goal of 4,000. As of April 2000, the program had enrolled 3,435 beneficiaries in seven counties in the metropolitan Minneapolis-St. Paul area.[12] Minnesota has requested HCFA's approval to expand eligibility to include younger, disabled dual eligibles under age 65. With enrollment of 782 as of March 2000, Wisconsin officials received federal approval to raise the Partnership enrollment cap from 1,200 to 2,400 in the five counties that enroll beneficiaries. New York's goal is to enroll 10,000 participants in Monroe County, the area adjacent to Rochester. Massachusetts is the only demonstration with an initial goal of statewide enrollment. State officials hope to enroll up to 42,400 dual

[11]HCFA has granted some states waivers that allow mandatory enrollment in Medicaid managed care programs. Medicare beneficiaries' enrollment in managed care plans is entirely voluntary.

[12]Minnesota has permission to operate MSHO in seven metropolitan area counties. It currently lacks a provider network in one county (Carver), but dual eligibles in that county are eligible to enroll in MSHO using a network in an adjacent county.

eligibles during the first 5 years of the program. The scope of the SCO program will ultimately depend on the willingness of plans across the state to participate. Table 1 compares key characteristics of these four states' integrated care programs.

Table 1: Comparison of Key Characteristics of State Integrated Care Programs

	State initiatives			
	Operational		Approved but not operational	Pending
Program name	Minnesota Senior Health Options (MSHO)	Wisconsin Partnership Program	Continuing Care Networks (CCN)	MassHealth: Senior Care Options (SCO)[a]
Location	7 metropolitan counties around Minneapolis/St. Paul (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington)[b]	5 counties—2 urban (Dane, Milwaukee) and 3 rural (Chippewa, Dunn, Eau Claire)	Monroe County, New York (Rochester area)	Statewide (dependent on qualified bidders/provider network participation)
Approval date/operational status				
Date approved	April 1995	October 1998	September 1999	Pending
Date operational	February 1997	January 1999	May 2001 (projected)	Early 2001 (projected)
Eligible population	1. Dual eligibles aged 65 or older. 2. As of fall 2000, planned expansion to individuals under age 65 with physical disabilities.[c]	1. Frail elderly aged 55 or older at risk of nursing home placement who are Medicaid-only or dual eligibles. 2. People ages 18 to 65 with physical disabilities at risk of nursing home placement who are Medicaid-only or dual eligibles.	1. Dual eligibles aged 65 or older. 2. Medicare beneficiaries.	1. Dual eligibles aged 65 or older. 2. Medicaid beneficiaries aged 65 or older who are not Medicare-eligible.
Enrollment				
Cap/goal	4,000 goal	2,400 cap (increased from 1,200 as of Mar. 2000)	10,000 goal	42,400 goal in first 5 years (40 percent of 106,000 MassHealth seniors)
Current enrollment	3,435 average monthly enrollment as of April 2000[d]	782 enrolled as of March 2000	Enrollment expected to begin in May 2001	Enrollment expected to begin in early 2001

	State initiatives			
	Operational		Approved but not operational	Pending
Health plan characteristics				
Number of plans/type of organization	Three participating nonprofit HMOs. Most plans are contracting with newly formed geriatric care systems to provide all or part of the MSHO benefit package.	Four Partnership providers who are all nonprofit community-based organizations	One local nonprofit provider-based health system, which includes hospitals, nursing homes, and a PACE program (a second health system withdrew from the demonstration in Feb. 2000)	32 organizations (including hospital networks, PACE providers, and Medicare HMOs) have expressed interest in becoming SCOs[e]
Unique features[f]	1. 76 percent of enrollees live in nursing homes. 2. Plans are responsible for the first 180 days of nursing home care for community enrollees.	1. Model is similar to PACE, but without restrictions on primary physician or use of day care. 2. Two providers are PACE sites. 3. Includes the younger, physically disabled. 4. Operates in some rural areas	1. Is testing a capitation payment model that is risk-adjusted for functional status of enrollees. 2. Will use a local provider-based health system. 3. Will enroll dual eligibles and Medicare beneficiaries in the same plan.	1. HCFA has an MOU with state to jointly select and contract with SCOs. 2. Enrollment broker will enroll and disenroll beneficiaries. 3. Has a goal of being a statewide program.
Waivers				
Medicaid[g]	Section 1115 approved in 1995 but recently switched to 1915(a) and 1915(c) combination	Section 1115	Section 1915(a) and 1915(c) combination	Section 1915(a)
Medicare	Section 222	Section 222	Section 222	Section 222

[a]In April 2000, HCFA and Massachusetts signed an MOU that established terms and conditions and defined the federal and state roles and responsibilities in implementing an integrated care program. The MOU reflects the commitment of both parties to implementing a demonstration program. A number of steps need to be taken before final approval and implementation.

[b]MSHO is authorized to operate in 7 counties, but currently there are no networks in Carver County.

[c]The fall 2000 expansion is for Medicaid contracts only. Before expansion is allowed for Medicare, Minnesota needs to complete the transition from its section 1115 waiver and request an amendment to the current Medicare 222 waiver.

[d]Since the inception of MSHO, Minnesota has served over 6,000 enrollees. Because of their overall frailty, many enrollees died while in the program.

[e]These 32 organizations attended a series of technical assistance sessions on the Massachusetts program held between February and October 1999.

[f]Appendix III summarizes the concepts HCFA is testing with these demonstration programs.

[g]Although Wisconsin has a section 1115 Medicaid waiver for its Partnership Program, New York and Massachusetts eventually opted to use a different, nonwaiver authority—section 1915(a), which allows voluntary programs for dual eligibles and is not subject to OMB's budget-neutrality policy. Because of continuing negotiations with OMB over Medicaid budget neutrality, Minnesota has received approval to

switch from its 1115 waiver to a combination of 1915(a) authority and a 1915(c) waiver. The 1915(c) waiver allows states to provide home and community-based services to individuals at risk of nursing home placement and permits Minnesota to access some special eligibility provisions such as protection against spousal impoverishment.

State Programs Also Enrolling Healthier Dual Eligibles

Initiatives in Minnesota, Wisconsin, New York, and Massachusetts are attempting to expand on earlier, provider-initiated demonstrations, particularly the PACE model. State initiatives differ from PACE in that not all enrollees are frail and that service delivery occurs outside of the adult day care center. Generally, states are designing their voluntary programs to appeal to a broader population, including healthier dual eligibles and even Medicare-only beneficiaries. The programs in Minnesota, New York, and Massachusetts offer the option of enrollment to any dual eligible over age 65, both those in the community (the healthy as well as the frail) and those in nursing homes. In contrast to the other state initiatives, Wisconsin's Partnership Program enrolls frail, elderly dual eligibles aged 55 or older and dual eligibles with physical disabilities under age 65. Frail dual eligibles are those whom the state has assessed as at risk of nursing home placement. Three states also include some non-dual eligibles in their programs. In New York's CCN program, all Medicare beneficiaries are eligible to enroll. A state official told us that since the program is voluntary, having a larger enrollment base makes it easier to attract health plans. In Massachusetts, a small number of Medicaid-only beneficiaries over age 65, primarily immigrants who do not qualify for Medicare, will also be eligible for the program.[13] In Wisconsin, Medicaid recipients who meet the program's other eligibility criteria may enroll.

Most Participating Health Plans Have Limited Experience in Providing a Range of Covered Services

Developing plan capability to integrate care for dual eligibles is a challenge for implementing demonstrations. The eight health plans involved in the approved demonstrations in Minnesota, Wisconsin, and New York include hospital-based plans, community-based long-term-care organizations, PACE sites, and HMOs. All eight participating plans we reviewed are nonprofit entities, including three HMOs located in Minnesota, a state that

[13]Most Americans aged 65 or older are entitled to participate in Medicare. These individuals (or their spouses) established their entitlement during their working careers by paying the Hospital Insurance payroll tax on earnings covered by either the Social Security or railroad retirement systems for at least 40 quarters.

requires such plans to be nonprofit.[14] At the outset of the demonstration programs, few of the participating plans had the ability to offer both acute- and long-term-care services. As a result, most plans had to either acquire the needed capability or subcontract with other providers to fill gaps in their networks. Some are small, nontraditional providers and did not participate previously in the Medicare program. Plans are at significant financial risk because they are responsible for the entire range of services. In general, these programs include few "carve outs," and plans are expected to show flexibility in providing any services that keep enrollees out of nursing homes and hospitals.[15]

Three States Ultimately Focused on Integrating Medicaid Services

Three of the seven states we reviewed—Colorado, Florida, and Texas—modified their original plans and focused only on integrating Medicaid acute- and long-term-care services. Each of these states considered establishing a program to integrate Medicare and Medicaid services for dual eligibles modeled on Minnesota's approach. Although Colorado's dual-eligible demonstration for Mesa County was approved in July 1997, the state dropped the Medicare portion over a year later because of concern that the plan would lose money if it accepted HCFA's proposed Medicare payment rate rather than the cost-based payment it was receiving.[16] Texas and Florida narrowed their programs, in part to avoid the time associated with obtaining section 1115 and section 222 waivers. In addition, Texas preferred a program with mandatory enrollment. While this is possible in Medicaid, HCFA cannot waive the requirement that dual-eligible Medicare beneficiaries have the freedom to choose whether to join a health plan to obtain their Medicare benefits. Texas is currently implementing an initiative in Harris County that requires mandatory enrollment of Medicaid beneficiaries and offers an inducement for dual eligibles to enroll voluntarily in the same HMO for their Medicare services. Florida is focusing on capitating home and community-based services and, when

[14]HMOs participating in MSHO typically subcontract with care systems that tend to be owned by provider groups—clinics, hospitals, and long-term-care providers. Most of these care systems are organized as for-profit enterprises, even though many of the hospitals and long-term-care providers that sponsor them have nonprofit status. These care systems are locally based and not owned by out-of-state companies.

[15]Benefits not the responsibility of the managed care plan are referred to as "carved out."

[16]Under a cost contract, Medicare pays the reasonable cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing).

necessary, nursing home care for dual eligibles aged 65 or older in two counties. (See app. IV for more information on these state initiatives.)

Developing and Implementing Dual-Eligible Initiatives Has Been a Lengthy Process

States have criticized the length of the process required to gain federal approval for integrated care demonstrations, which ranged from 16 months to over 3 years. In part, the length of the negotiation process was due to (1) temporary delays that occurred around the time of HCFA's 1997 reorganization, (2) the BBA's imposition of a heavy new workload on the agency, and (3) BBA Medicare payment changes. HCFA has since undertaken initiatives intended to speed up the review process. But focusing on negotiations with HCFA and OMB overlooks other factors that contributed to the time required to launch these complex initiatives—the actual development of the proposal and the need to contract with health plans. These two tasks added considerable time to the overall process.

Ensuring that demonstrations did not increase federal Medicare expenditures also tended to prolong negotiations. At issue is the appropriate payment factor for frail dual eligibles. Though HCFA and OMB believe that federal financial interests are best protected by using risk adjusters that reflect variability in the costs of frail dual eligibles who may enroll, this approach is reflected in only one of four state demonstration programs—New York's. On the basis of precedents established by earlier provider-initiated demonstrations, Minnesota, Wisconsin, and Massachusetts each negotiated a single risk adjuster for frail dual eligibles.[17] The debate over risk adjusters for Wisconsin and Massachusetts is not over, since both states view the payment rates as inadequate. Furthermore, HCFA has reserved the right to substitute a more appropriate risk adjuster in the waiver agreements negotiated to date.

[17]In Massachusetts, the risk adjuster for frail dual eligibles varies by gender.

Waiver Development and Contracting Remain Time-Consuming, but HCFA Has Taken Steps to Address Negotiation Time Frames

Federal review and approval account for only a portion of the total time involved in crafting and implementing an integrated care demonstration. For example, MSHO was under review for about 16 months, but it was in the planning stage for more than 2 years before Minnesota formally submitted its request for a demonstration waiver (see table 2). In addition, after receiving approval in early 1995, the state spent about 2 years negotiating contracts with health plans and taking the other steps necessary to implement the program. As with Minnesota, several years elapsed between Massachusetts' preparation of a concept paper and its submission of a waiver application. New York officials pointed out that state and provider issues can also add time to the development of a waiver proposal. The CCN program was formally approved in September 1999, but officials anticipate enrollment will not begin until 19 months later to allow time to develop a contract with a local health system and to build the necessary enrollment, payment, and data-reporting systems. During the 32 months that Wisconsin's waiver application was under review, the state worked with community-based organizations that had expressed interest in participating in the program. These organizations initially operated under partial capitation to help them transition to accepting full financial risk.[18] Because this transition period coincided with waiver negotiations, about 2 months elapsed between HCFA approval and the phase-in of plan responsibility for Medicare-covered services. In commenting on a draft of this report, HCFA noted that operational differences between Medicaid and Medicare add an additional element of complexity to demonstrations. Considerable effort has been made to understand and then try to streamline various administrative systems that must be in place for these demonstrations to begin.[19]

[18]These organizations actually enrolled dual eligibles in 1996, operating under an existing home and community-based services waiver as prepaid health plans with hospital, laboratory, and X-ray services carved out and paid on a fee-for-service basis. Medicare services for enrollees were also paid on a fee-for-service basis.

[19]Enrollment, marketing, evidence of coverage contracts, provider contracts, grievance and appeals systems and rights, benefit definition and coordination, and other key systems and policies must be worked through between each state and HCFA.

Table 2: Time (in Months) for Planning, Federal Review, and Preparing for Implementation of Four State Waiver Requests

	State planning prior to waiver submission	Federal review	Implementation (time between approval and enrollment)
Minnesota (MSHO)	26	16	21
Wisconsin (Partnership Program)	12	32	2
New York (CCN)	29	40	19 (based on estimated enrollment date)
Massachusetts (SCO)	30	36[a]	Awaiting final approval and implementation

[a]As of June 2000.

Source: Interviews with program officials.

According to state and federal officials, HCFA's July 1997 reorganization and new BBA workload demands unintentionally lengthened the review process. Initially, the reorganization, combined with turnover among experienced staff, resulted in delays while new responsibilities and chains of command were being worked out. The timing of the reorganization also coincided with enactment of the BBA, which placed additional demands on HCFA management because of the significant number of Medicare and Medicaid initiatives that the agency was directed to develop and implement. Moreover, because of changes in Medicare's HMO program and the initiation of new payment methodologies for some Medicare benefits, state officials had to evaluate the BBA's effect on the financing and operation of their demonstration programs. Appendix V describes the BBA changes to the Medicare HMO payment methodology.

Subsequent to these events, HCFA and OMB took several steps to speed up the review and approval process and to improve overall communications with state officials. For example, HCFA determined that an existing nonwaiver authority, section 1915(a), can be used instead of 1115 waivers to integrate the financing of acute- and long-term-care demonstration projects. Section 1915(a) allows voluntary Medicaid programs that only require HCFA approval of health plan contracts and are not subject to the budget neutrality policy.[20] In commenting on a draft of this report, officials in Minnesota, New York, and Massachusetts said that the use of the 1915(a) authority had not resolved their concern about OMB's budget neutrality policy on the Medicaid side and that the 1915(a) option limits their ability to expand eligibility to, for example, higher-income individuals at risk of entering a nursing home. Minnesota stressed that, given predicted financing problems with the Medicare program and the projected increase in the elderly population, experimentation with building comprehensive chronic care delivery systems should be a higher priority for the federal government. HCFA is also testing a new approach to working with the states. HCFA and Massachusetts have signed an MOU that establishes a partnership in developing an integrated care demonstration. Under this agreement, HCFA and Massachusetts will jointly select and contract with the participating health plans, which should facilitate program implementation.

Developing a Medicare Payment Methodology for Frail Dual Eligibles Has Been Difficult for Some States

Securing federal and state agreement on how much Medicare will pay health plans has taken considerable time and effort. HCFA and OMB have attempted to ensure that Medicare pays no more for dual eligibles who voluntarily enroll in an integrated care demonstration than it would have paid had these beneficiaries remained in the fee-for-service program. Most state integrated care demonstrations are open to all dual eligibles, which raises the issue of how to adjust payments for the anticipated costs of dual eligibles who actually join the demonstration. Medicare's payment methodology normally pays health plans on the basis of the average cost of all dual eligibles, adjusted for certain demographic factors that affect health costs. This process of adjusting the average rate up or down for different enrollee characteristics is known as risk adjustment. State and federal officials have to reach agreement about the health status

[20]HCFA must approve health plan capitation rates, which may not exceed the upper payment limit—that is, what would have been paid for an equivalent population in fee-for-service.

characteristics and associated service costs of those who might be attracted to the demonstrations.

The approach taken by HCFA and OMB recognizes that frail dual eligibles are more expensive than their healthier counterparts. Wisconsin and Minnesota use the PACE risk adjuster for frail enrollees, while Massachusetts plans to use a variation of the S/HMO I adjuster. Only the payment methodology in the New York demonstration attempts to reflect the variability in the cost of frail dual eligibles by establishing three different payment categories. To compensate for higher payments for frail dual eligibles, two of the three states using a single risk adjuster are required to use a lower payment rate than the M+C rate for nonfrail dual eligibles. HCFA said that because of an oversight, Minnesota was not required to use a lower payment for nonfrail dual eligibles.

Wisconsin and Massachusetts are concerned about the adequacy of their payment rates. Wisconsin is enrolling younger, physically disabled dual eligibles who, it believes, are considerably more expensive than frail PACE enrollees. Massachusetts analyzed Medicare and Medicaid claims data to support its request for a higher risk adjuster for frail dual eligibles than was ultimately approved, but OMB was skeptical about this analysis. Medicare's move toward a new diagnosis-based risk-adjustment methodology, as mandated by the BBA, has raised concerns that it might be applied to specialized programs such as PACE and state demonstrations. Research has shown that the new methodology tends to underestimate the costs of frail beneficiaries, who are a disproportionate share of these programs' enrollees.

Dual Eligibles Are More Costly Than the Average Beneficiary

Medicare policy for persons enrolling in HMOs is to pay the plans no more than what the program would have paid had that person received services in the traditional fee-for-service program.[21] To accomplish this, rates paid to HMOs have been based on the average program costs for fee-for-service beneficiaries. However, costs vary dramatically across individuals. To protect HMOs that serve many individuals with above-average costs and to protect the Medicare program from situations in which many individuals

[21]In fact, the Medicare payment rate for plans was initially set at 95 percent of the average fee-for-service cost so that the program would benefit from savings that health plans could generate. However, Medicare HMOs have generally been overpaid, because beneficiaries who enrolled have been healthier than the average beneficiary. See *Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments* (GAO/HEHS-99-144, June 18, 1999).

with below-average costs join HMOs, these average rates are adjusted to reflect the expected cost of actual enrollees. This risk adjustment is achieved by multiplying the average rate by a factor that adjusts the rate paid either up or down. For example, because older persons are expected to have higher costs, a plan is paid 1.26 times the average for an 85-year-old male beneficiary who joins the plan. Dual eligibles have also been demonstrated to have higher costs, so plans are paid even more—2.22 times the average—if the 85-year-old male enrollee is a dual eligible. The Medicare HMO payment for dual eligibles is based on the estimated average cost of this population—including both healthier and sicker dual eligibles. While dual eligibles are, on average, more costly to serve than other Medicare beneficiaries, there is considerable variability. Some dual eligibles are relatively healthy and seek few medical services during the course of a year, while others' medical expenditures more closely resemble costs for the Medicare program as a whole. Finally, a segment of the dual-eligible population is much more expensive than the average dual-eligible beneficiary. Even among frail dual eligibles, costs vary considerably.

HCFA and OMB Have Approved a Variety of Frailty Risk Adjusters

Relying on the precedent set by PACE, HCFA and OMB recognize that frail dual eligibles are more expensive than their healthier counterparts. In granting states a higher risk adjuster for frail dual eligibles, HCFA and OMB have generally lowered the payment for healthier dual eligibles. However, HCFA officials told us that, because of an oversight, what they characterized as a "long-standing approach" was not applied to Minnesota.[22] As a result, health plan payments for healthier dual eligibles in Minnesota equal what is paid for all dual eligibles under M+C. While Minnesota, Wisconsin, and Massachusetts use a single risk adjuster for frail dual eligibles, New York's CCN program uses several risk adjusters that attempt to reflect differences in impairment among frail dual eligibles.

Recognizing the differential costs to serve individuals with greater needs, PACE established a precedent for higher Medicare payments for frail dual eligibles. Because PACE enrolls only frail individuals, rather than a cross section that includes healthier dual eligibles, it was necessary to develop a special risk-adjustment factor for its enrollees. The PACE factor of 2.39 represents a "best estimate" based on 1983 negotiations and available data. After about 15 years of implementation experience and a number of HCFA-sponsored research projects, the extent to which the PACE risk adjuster

[22]S/HMO I was the first demonstration to implement lower payment rates for community-dwelling, nonfrail plan members in 1985.

accurately pays for the frail dual eligibles enrolled in the program remains unclear.[23]

Table 3 presents our analysis of risk adjusters used for dual eligibles enrolling in M+C HMOs, PACE, and the demonstrations in Minnesota, Wisconsin, New York, and Massachusetts. Appendix VI describes the methodology used in this analysis. Minnesota and Wisconsin use the PACE risk adjuster for frail dual eligibles, which applies the same factor regardless of age or gender. The risk adjusters negotiated by Massachusetts for frail dual eligibles are those used by the S/HMO I demonstration and vary only by enrollee gender.[24] Finally, New York's system adjusts for the level of impairment (using three categories) and the gender of the enrollee. Enrollees must be nursing-home-certifiable to be considered frail. In MSHO, only about 170 of the approximately 3,400 enrolled dual eligibles are classified as frail elderly living in the community. All of the 782 individuals enrolled in Wisconsin's Partnership Program as of March 2000 are frail elderly or younger disabled individuals at risk of nursing home placement. To illustrate how these different risk adjusters affect payments under different demonstrations, appendix VII compares the Medicare payments for nursing-home-certifiable enrollees in PACE and state demonstration programs with the payment under M+C for a hypothetical dual-eligible beneficiary.

[23]In 1983, HCFA and On Lok, the precursor of the PACE program, agreed on a rate that is between the expenditures of an expensive comparison population enrolled in fee-for-service—who were assumed to be nursing-home-certifiable on the basis of their pattern of service use—and the average spending for less costly beneficiaries living in nursing homes. Post-1983 research studies have examined the appropriateness of the PACE rate. The conclusions have been mixed. Studies using older data tend to confirm the PACE rate but show considerable variation in spending for frail persons—ranging from 1.66 for the least costly nursing-home-certifiable beneficiary up to 4.0 for individuals with severe disabilities or recent hospitalizations. On the other hand, studies using more recent data suggest that the comparison population is more expensive and that therefore the PACE rate may be too low. A 1997 study noted that more recent data reflect the sharp increase in Medicare home health payments since a court decision in 1988 struck down HCFA's interpretation of the home health benefit as inconsistent with the Medicare statute. (See Gruenberg and others, *An Examination of the Impact of the Proposed New Medicare Capitation Methods on Programs for the Frail Elderly* (Cambridge, Mass.: Long Term Care Data Institute, Jan. 1999), pp. 42-3, and *An Examination of the Cost-Effectiveness of PACE in Relation to Medicare* (Cambridge, Mass.: DataChron Health Systems, Inc., Jan. 1997).

[24]While the M+C payment includes a 5-percent discount off the base rate to reflect the anticipated savings from HMOs, the Congress authorized an exception to this methodology for the S/HMO I demonstration. Massachusetts will use the S/HMO I risk adjuster, but it will be multiplied by the discounted M+C base rate.

Table 3: GAO Analysis of Risk Adjusters for Programs Serving Dual Eligibles

	Male	Female
M+C HMOs[a]		
Frail and nonfrail dual eligibles 65-69 years old	1.13	0.91
Frail and nonfrail dual eligibles 85+ years old	2.22	1.74
PACE		
All enrollees (only frail persons living in the community may enroll)	2.39	2.39
Minnesota (MSHO)		
Frail dual eligibles (all ages)	2.39	2.39
Nonfrail dual eligibles 65-69 years old	1.13	0.91
Nonfrail dual eligibles 85+ years old	2.22	1.74
Wisconsin (Partnership Program)		
All enrollees (only frail persons may enroll)[b]	2.39	2.39
Massachusetts (SCO)		
Frail dual eligibles (all ages)	2.71	2.42
Nonfrail dual eligibles 65-69 years old	1.01	0.83
Nonfrail dual eligibles 85+ years old	2.11	1.51
New York (CCN)		
Frail (all ages)		
With mild impairment	1.66	1.66
With moderate impairment	2.81	2.50
With severe impairment	3.57	3.04
Nonfrail dual eligibles 65-69 years old	1.01	0.83
Nonfrail dual eligibles 85+ years old	2.11	1.51

Note: To simplify comparisons, we combined the Medicare part A (hospital services) and part B (physician and outpatient services) risk adjusters into one number. These risk adjusters apply to either healthier dual eligibles or those determined to be at risk of nursing home placement but still living in the community. A different risk adjuster is used for dual eligibles who reside in nursing homes.

[a]The M+C risk adjuster for dual eligibles is based on the estimated *average* cost of this population, and therefore makes no separate adjustment for frailty. However, M+C payments for dual eligibles do vary according to the age and gender of the enrollee.

[b]Frail includes both elderly and younger disabled individuals who are at risk of nursing home placement.

Source: GAO calculations, based on approved risk adjusters for each program.

Wisconsin and Massachusetts Are Concerned About Adequacy of Frailty Adjuster for Their Demonstration Programs

Wisconsin and Massachusetts program officials told us that they are concerned about the adequacy of the Medicare payments approved for certain dual eligibles.[25] Both states view the agreements reached with HCFA and OMB on Medicare payments as temporary. In the meantime, Massachusetts plans to subsidize health plan payments to make up for what they perceive as a Medicare shortfall.

Wisconsin. Wisconsin's Partnership Program is unique in that two of the four sites are enrolling younger, physically disabled dual eligibles. A Partnership official believes that this group is much more expensive to serve than frail, elderly dual eligibles. However, the state lacked supporting data to justify a risk adjuster higher than the 2.39 PACE rate.[26] Using data based on sites' experience with enrolling this population, the state hopes to demonstrate to HCFA and OMB that Medicare's cost of serving younger, disabled dual eligibles requires a risk adjuster closer to 4.0. A state official acknowledged the complexity of the task and indicated that the state plans to collect data over the next 18 months to make its case.

Massachusetts. On the basis of the state's analysis of merged Medicaid and Medicare data, Massachusetts concluded that the cost of serving frail dual eligibles requires a risk adjuster of 4.03. OMB officials told us that they had serious reservations about the state's analysis. In particular, they were skeptical about the high proportion of total expenditures for frail dual eligibles that the state attributed to Medicare—about 78 percent. In contrast, national data show that Medicaid and Medicare expenditures for dual eligibles are about evenly divided between the two programs. Moreover, Massachusetts analyzed data for the period from July 1, 1994, to June 30, 1995. Changes mandated by the BBA in 1997 have lowered Medicare expenditures on home health and thus altered the relative contribution of Medicare. These changes were not reflected in the older data analyzed by the state. Massachusetts acknowledged this shortcoming but noted that post-BBA data were not available.

Another federal concern involved Massachusetts' inability to account for variability in the costs of the frail dual eligibles who actually enrolled in the

[25]Massachusetts accepted the HCFA/OMB offer to use the S/HMO I risk adjuster on an interim basis.

[26]PACE enrollees must be 55 years or older, but on average they are 80 years old. Medicare beneficiaries under age 65 have not been allowed to enroll in S/HMO I but are enrolled in S/HMO II.

program. Massachusetts proposed applying the same high-frailty adjuster to all nursing-home-certifiable dual eligibles, even though research has shown considerable variation in the costs of such beneficiaries. Massachusetts officials argued, however, that their program would appeal primarily to sicker dual eligibles who have the most to gain from better-coordinated care. The state lacked assessment data on dual eligibles that would allow differentiation of the relative frailty of those deemed to be nursing-home-certifiable.

Massachusetts agreed to HCFA and OMB's proposal to use, on an interim basis, the S/HMO I risk-adjustment methodology that pays a higher rate than PACE for the frail elderly.[27] However, the state believes that the S/HMO I risk adjuster still underpays for nursing-home-certifiable dual eligibles. The state has a strategy for augmenting the Medicare portion of the capitation payment to health plans that enroll the frail elderly. In contrast to its original plan to focus enrollment on persons living in the community, Massachusetts now plans to make a concerted effort to enroll beneficiaries who are already in nursing homes because research related to the PACE program has shown that nursing home beneficiaries have lower Medicare expenditures. Having more nursing home beneficiaries enrolled will provide funds to subsidize the Medicare cost of nursing-home-certifiable beneficiaries.[28]

Research Suggests That New Diagnosis-Based Risk Adjuster for Medicare Would Underpay for Frail Dual Eligibles Enrolled in Specialized Programs

In 1999, the Secretary of Health and Human Services deferred application of a new diagnosis-based risk adjuster to specialized programs such as PACE and the Minnesota integrated care demonstration. The new BBA-authorized risk-adjustment system for M+C HMOs, for which phase-in began in January 2000, initially will use diagnoses from hospital encounter data to adjust payments (see app. V for details on the implementation schedule). States have been concerned about the applicability of this approach to demonstration programs because research has shown that while the new diagnosis-based risk adjusters improve the overall accuracy of Medicare payments to health plans, they tend to underestimate the cost

[27]Massachusetts declined HCFA's suggestion that the state become a test site for the new diagnosis-based risk adjusters that are under development for Medicare HMOs.

[28]As of fiscal year 1999, there were 37,397 dual eligibles in nursing homes in Massachusetts.

for plans concentrating on frail beneficiaries.[29] Moreover, the underestimation of the cost increases when the population served is more functionally limited and thus tends to cost more. MedPAC concurred with the deferral and further recommended that HHS undertake research to identify factors influencing the costs of care for frail beneficiaries and other beneficiaries to determine what changes are needed to improve M+C claims-based risk adjustment for frail beneficiaries, including an assessment of data needed to support improvements in M+C risk-adjustment systems. Risk adjusters for such special populations need to account for the potentially greater severity of individual conditions and the multiplicity of conditions these persons may have. While state concerns have been temporarily addressed, uncertainty remains, because in approving the demonstration programs HCFA has explicitly reserved the right to substitute a "more appropriate" Medicare payment methodology for the MSHO, Partnership Program, and CCN demonstrations if one is developed.

Conclusions

Despite broader interest, only three states have received approval to implement integrated care demonstrations for dual eligibles. Currently, state programs are small in both geographic coverage and enrollment. Undertaking such demonstration programs requires a strong commitment on the part of states, given the considerable front-end planning needed prior to submitting a waiver proposal and the lengthy postapproval efforts to bring on-line health plans capable of integrating the delivery of acute- and long-term-care services. Some states have expressed concern about the length of the federal review process, which was prolonged by negotiations between federal and state officials over the Medicare payment methodology. Several states are using the PACE risk adjuster, which, after 15 years, still has not been validated, and which does not reflect differences in the costs of frail beneficiaries. Only one approved state demonstration is designed to test multiple payment categories that attempt to take into account the variations in costs of frail dual eligibles. Medicare's move toward a new diagnosis-based risk-adjustment methodology raises concerns for state demonstrations because research has shown that the methodology tends to underestimate the costs of frail beneficiaries. This

[29]Gregory C. Pope and others, "Evaluating Alternative Risk Adjusters for Medicare," *Health Care Financing Review*, Vol. 20, No. 2 (Winter 1998), and Leonard Gurenberg and others, *An Examination of the Impact of the Proposed New Medicare Capitation Methods on Programs for the Frail Elderly* (Cambridge, Mass.: Long Term Care Data Institute, Jan. 1999).

situation underscores the importance of learning from these four state demonstrations so that their experience may inform similar initiatives that other states may be considering.

Agency Comments and Our Evaluation

Comments on a draft of our report were provided by the Administrator of HCFA; the Branch Chief, Health Financing Branch, Health Division, OMB; the Director of Program Development, Massachusetts State Department of Health; the Director of Minnesota Senior Health Options, Minnesota Department of Human Services; the Director of the Division of Program Development and Initiatives, New York State Department of Health; the Project Manager, Wisconsin Partnership Program; and two academic experts.

HCFA

HCFA agreed with the report's overall findings and conclusions but commented on our description of its efforts to identify an appropriate payment methodology for frail dual eligibles. HCFA stated that it has engaged in a large body of research in an attempt to find an appropriate payment methodology. Because recent research has uncovered numerous problems with the use of "frailty" measures for payment purposes, HCFA believes that defining a payment methodology for integrated care demonstrations may require moving beyond the common notion of using survey-based functional status, or "frailty," as a risk adjuster. Therefore, it is seeking to refine the frailty approach or find an alternative risk-adjustment methodology for plans that enroll special populations. We agree that a narrow conceptualization of frailty is unlikely to be sufficient and that clinical assessments are preferable to survey-based information. In fact, many states determine frailty by conducting a face-to-face assessment of an individual's need for assistance with daily living, not by relying on surveys or questionnaires. Risk adjusters for such special populations need to account for the potentially greater severity of individual conditions and the multiplicity of conditions frail individuals may have. We have revised the report to more fully portray HCFA's research efforts and have clarified the refinements of risk-adjustment methods needed for these populations.

HCFA also acknowledged that difficulties in defining an appropriate payment methodology significantly contributed to the amount of time taken for states to obtain program approval. However, HCFA stressed the importance of the BBA payment changes and noted that they further complicate negotiations with states. We agree and have highlighted the BBA changes in the report. At HCFA's suggestion, we have also expanded

the discussion on the effect of operational differences between Medicare and Medicaid programs on the length of the approval process. (HCFA's comments are included in app. VIII.)

States and Expert Reviewers

Minnesota provided extensive comments on the draft report, some of which were echoed by officials from New York and Massachusetts and our expert reviewers. Most reviewers believed that the report should have (1) described in more detail the budget neutrality issues raised by integrated care demonstrations, (2) placed less emphasis on PACE, (3) discussed more fully state program objectives, and (4) discussed additional issues that add to the complexity of implementing these demonstrations. We have modified the report where appropriate to reflect these comments, and we further discuss the first two areas in the following paragraphs.

Budget Neutrality Policy

Although the states generally recognized that HCFA and OMB contend with legitimate issues in establishing reimbursement rates for integrated care demonstrations, they suggested either that the flexibility around these issues is insufficient or that OMB's policy needs to be reconsidered. Massachusetts and Minnesota officials criticized HCFA and OMB's policy on Medicare budget neutrality, which requires the use of M+C rates rather than historical fee-for-service costs as the basis for comparison. States expressed concerns with both the base rate used to determine reimbursement rates for the demonstrations and the risk adjusters applied to those rates.

While acknowledging the link between M+C payment rates and fee-for-service spending prior to the BBA, officials from Massachusetts and Minnesota nonetheless took issue with the decision to base payments on M+C rates and argued that historical fee-for-service spending would be a more appropriate basis for measuring budget neutrality. They noted that dual-eligible beneficiaries are not typically enrolled in M+C plans because Medicaid pays their Medicare cost-sharing and gives them access to medications and other services not covered by Medicare. Similarly, M+C plans have little incentive to encourage enrollment among frail dual eligibles because of this population's relatively high costs, which may not be fully reflected in current M+C payment policy. OMB, however, used the M+C base rates and focused the negotiations on what it considered to be the most important issue—developing appropriate risk adjustors for a voluntary program designed to appeal to frail beneficiaries.

Massachusetts officials stated that the methodology used to compute M+C rates makes the rates too low for determining budget neutrality. First, they said that M+C rates are automatically discounted by 5 percent below estimated fee-for-service costs, in part to adjust for favorable selection in M+C plans. However, the 5-percent reduction in payments was not designed to offset favorable selection but rather to capture some of the projected cost savings from the more efficient provision of care in managed care plans. OMB officials said that the process of developing risk adjustors for the Massachusetts demonstration took into consideration the fact that M+C base rates were discounted to reflect the anticipated efficiencies of managed care delivery systems. Moreover, favorable selection may be the result not only of plans' marketing practices but also of enrollee self-selection, which may still occur in the integrated care setting. Second, Massachusetts officials stated that a BBA provision (known as blending) would slow the rate of growth of payments in high-cost areas (such as Massachusetts) and reduce variation in payments across counties. However, a slowdown in fee-for-service spending growth has postponed the implementation of this provision. Thus, only minor blending occurred in 2000, and no blending will occur in 2001 or as long as fee-for-service spending growth remains low.

PACE

The states and the expert reviewers said that the draft report overemphasized PACE and overstated its importance as a starting point for their demonstrations. They concluded that we were suggesting that PACE should be viewed as an alternative to states' demonstrations. The report presents information on PACE to provide important context with respect to states' demonstrations—both differences and similarities. States, we noted, are going beyond the PACE model because it serves only the frail elderly who meet state criteria for nursing home placement and it relies on adult day care centers, which some elderly find too restrictive. We stressed that state demonstrations, unlike PACE, also are serving (1) healthier dual eligibles and (2) nursing home residents. States believe that the former may become frail and thus benefit from preventive health care and screening, while the latter could benefit now from better management of primary care and acute-care services. Finally, the report points out a similarity between state and provider-initiated demonstrations—the use of the PACE and S/HMO precedent to negotiate similar risk adjusters for frail enrollees.

All those commenting on the report also provided technical comments, which we incorporated when appropriate.

As agreed with your staffs, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We will then send copies to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate congressional committees; and others upon request.

If you or your staffs have any questions, please call me at (202) 512-7118 or Walter Ochinko, Assistant Director, at (202) 512-7157. Other major contributors to this report include Sally Kaplan, Carmen Rivera-Lowitt, Susanne Seagrave, and Shari Sitron.

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Associate Director, Health Financing and
Public Health Issues

Examples of Advantages States See in Integrated Care for Dual Eligibles

Advantage	Example
Continuity of care	In order for Mary to live in her own home, her daughter arranged for support services covered by Medicaid. Mary fell and broke her hip and was in the hospital for 4 days. When she came home, she needed additional services. For the new services, Medicare paid instead of Medicaid, so her health care workers also changed. In an integrated care program, Mary would have had a care coordinator to help arrange for her care before, during, and after her hospital stay. Thus, Mary would have been able to keep the same workers.
Nontraditional benefits	Alice, who is 81 and lives in her own home, has severe arthritis of the spine. The integrated care program coordinator found that Alice has been sleeping in a recliner for over a year because she had been unable to lie flat in a bed. Alice was very uncomfortable in the recliner and was not sleeping well. The care coordinator ordered a hospital bed, which made a big difference in Alice's comfort. She is sleeping better because she can change her position during the night and her pain has been lessened.
Interdisciplinary team	The interdisciplinary team approach ensures care coordination across systems that currently operate independently. The team coordinates all aspects of care and targets points of intersection, where the health care system traditionally breaks down, to coordinate transitions between service providers. The interdisciplinary team knows all aspects of a participant's care plan, preventing situations where two or more different systems prescribe duplicative or contradictory treatments. Participants' involvement in decision-making ensures a high degree of satisfaction.

Sources: Minnesota Senior Health Options and the Wisconsin Partnership Program.

Descriptions of PACE, S/HMO I and II, and EverCare Programs

This appendix describes four provider-initiated demonstration programs. Table 4 compares and contrasts these programs.

PACE

In 1983, the Congress directed HHS to approve the necessary waivers for On Lok Senior Health Services in San Francisco. On Lok originated as an adult day care center in 1971, but over time it added capacity to integrate health and social services. The Congress authorized PACE as a demonstration in 1986 to replicate the delivery system pioneered by On Lok. An expansion from 10 to 15 PACE sites was approved 4 years later. The BBA transformed PACE from a demonstration with a fixed number of sites to a permanent program under Medicare, granting states the option of offering PACE to their Medicaid enrollees.[1] As of April 2000, there were 25 PACE sites serving about 6,000 enrollees, with additional locations, known as "pre-PACE" sites, participating under Medicaid capitation only.

PACE seeks to maintain the frail elderly in the community. Enrollment is open to all individuals aged 55 years or older who meet states' standards for being at risk of nursing home placement and reside in the area served by the PACE sites.[2] Such individuals are commonly referred to as "frail" because they have difficulty performing daily activities such as bathing or dressing and are thus at risk of nursing home placement. In fact, PACE enrollees require human assistance with an average of three activities

[1]HCFA is in the process of issuing implementing regulations to reflect the BBA changes. The PACE interim final rule, published November 24, 1999, in the *Federal Register*, does not specify the frailty factors to be used in determining Medicare and Medicaid payment rates for PACE sites. The frailty factor used to calculate the Medicare payment rate must be specified in the PACE agreement. The monthly Medicaid capitation payment amount must also be specified in the PACE program agreement and take "into account the comparative frailty of PACE participants."

[2]Though 96 percent of PACE enrollees are dual eligibles, eligibility for both Medicaid and Medicare is not a participation requirement. States' assessments of individuals vary considerably in terms of (1) their nursing home eligibility criteria; (2) whether state standards require a specific number and types of impairment or rely on the judgment of the individual responsible for the assessment; and (3) their sophistication, including whether they document degrees of impairment.

of daily living.[3] On average, enrollees are 80 years old. Health and long-term-care services are paid for on a capitated basis and provided primarily in adult day health centers, participants' homes, or inpatient facilities as needed. A multidisciplinary team of physicians, nurses, social workers, physical and occupational therapists, and others manage enrollee care. In structure, PACE resembles a small, staff-model HMO, in which doctors are employees of the health plan. Most of the PACE sites are quite small. While enrollment ranges from 39 to almost 900, more than one-half of the sites serve under 200 enrollees and only two serve more than 500.

S/HMO I and II

S/HMO I, which has been in operation since 1985, tests a model intended to integrate acute, chronic and long-term care, and social services provided through capitated HMOs. All enrollees are entitled to basic Medicare benefits and expanded benefits (such as prescription drugs and eyeglasses). In addition, enrollees determined to be at risk of institutionalization—commonly referred to as nursing-home-certifiable—under state Medicaid standards are entitled to a long-term-care benefit. The Congress mandated the second-generation S/HMO II demonstration in 1990. It is similar to the S/HMO I in many ways, but it refines the targeting of at-risk beneficiaries, financing methods, and benefit design of the S/HMO model. HCFA chose six organizations to participate, but only one is currently active. S/HMO II incorporates practices developed by geriatricians into the operations of the plans, such as comprehensive geriatric assessments for certain patients, treatment of functional problems, and an interdisciplinary team approach. Both S/HMO I and S/HMO II include a case management component that emphasizes community-based services and coordination of nursing home and non-nursing home care. Enrollment in S/HMO I and S/HMO II as of April 2000 was 81,718.

EverCare

EverCare, a subsidiary of United Health Care, began operating in 1993 with the primary goal of providing better case management for permanent

[3]Activities of daily living include bathing, dressing, feeding, toileting, and transferring. On average, PACE beneficiaries suffer from 7 to 8 major medical diagnoses and exhibit some degree of cognitive impairment. Over half of enrollees receive human assistance with walking. Finally, nearly 90 percent require assistance in taking medications, and almost all enrollees are dependent on assistance for meal preparation, shopping, housework, and other such activities.

nursing home residents. As of April 2000, EverCare had enrolled 10,725 nursing home residents. Unlike PACE and S/HMO, EverCare does not expand the Medicare benefit package significantly. EverCare assigns a physician and geriatric nurse practitioner to nursing home residents to provide primary care in the nursing home. The program provides these services to reduce residents' use of hospital and emergency room care. The demonstration also is intended to improve the quality of care and health outcomes and to develop practice guidelines.

Table 4: Comparison of PACE, S/HMO, and EverCare

	PACE	S/HMO	EverCare
Number of sites	25 in 13 states[a]	3 S/HMO I[b]; 1 S/HMO II[c]	6
Approval/enrollment dates			
Approved	1983 On Lok; 1986 PACE replication;[d] and in 1997, the BBA made PACE a permanent Medicaid state plan option	1984 S/HMO I; 1990 S/HMO II	1992
Enrollment commenced	1983 On Lok; 1990 for PACE replication sites	1985 S/HMO I;1996 S/HMO II	1993
Eligible population	Frail, elderly persons aged 55 or older who meet states' standards for nursing home placement and reside in the area served by the PACE organization. PACE enrollees require human assistance with an average of 3 activities of daily living.	S/HMO I and II: Individuals over 65 years of age who are entitled to Medicare part A and part B. In addition, S/HMO II also enrolls disabled individuals under age 65.	Permanent nursing home residents. Enrollees require assistance with an average of 4 to 5 activities of daily living.
Enrollment			
Cap	Some states establish a maximum number of enrollees	Cap for all sites: 324,000	None
Current enrollment	6,000 enrolled (as of Dec. 1999)	S/HMO I: 46,458; S/HMO II: 35,260 (as of Apr. 2000)	10,725 (as of Apr. 2000)
Health plan characteristics	25 plans. One-third are freestanding, community-based provider entities. The balance are health systems, community health centers, or larger long-term-care providers. PACE resembles a small, staff-model HMO, in which interdisciplinary team members are employees of the health plan.	Total of 4 HMOs. S/HMO I has 3 plans. S/HMO II has 1 plan (Health Plan of Nevada).	1 HMO—United HealthCare

	PACE	S/HMO	EverCare
Unique features	Program generally requires that enrollees attend the adult day health center and use only the plan's providers. The BBA made PACE a permanent program under Medicare, giving states the option of offering PACE to their Medicaid enrollees by amending their state Medicaid plans and gradually expanding the authorized number of PACE sites.	S/HMO I offers basic Medicare, expanded benefits (such as prescription drugs and eyeglasses), and community-based long-term care. The latter is only available to nursing-home-certifiable enrollees. S/HMO II plans incorporate practices developed by geriatricians into the operations of the plans, such as comprehensive geriatric assessments for certain patients, treatment of functional problems, and an interdisciplinary team approach.	Physician and nurse practitioners assigned to provide primary care in nursing homes to reduce use of hospital and emergency room care. Providers supply geriatric services, coordinate care, communicate with families, and oversee hospital care. Program does not cover prescription drugs or long-term nursing home care, but uses capitation payment that is sometimes increased above Medicare amounts to encourage physician visits.
Waivers			
Medicaid	Section 1115	Section 222	Section 222
Medicare	Section 222		

[a]The 13 states are Mass. (5); Calif. (4); N.Y. (4); Ohio (2); Wisc. (2); and Colo., Md., Mich., Ore., S.C., Tenn., Tex., and Wash. with one site each.

[b]The three S/HMO I sites are Medicare Plus II in Portland, Ore.; Elderplan in Brooklyn, N.Y.; and SCAN Health Plan in Long Beach, Calif.

[c]HCFA initially selected 6 sites, but only 1 (in Nevada) is currently active.

[d]On Lok, the PACE precursor, was authorized in 1983 and came under full capitation that year. In 1986, the Congress authorized frail elderly demonstrations to replicate On Lok. These programs became known as PACE and in essence On Lok became the first PACE site. No additional sites became operational until 1990.

Sources: PACE, MedPAC, and HCFA officials.

Concepts Being Tested by States' Integrated Care Demonstrations for Dual Eligibles

HCFA summarized the key concepts being tested by state integrated care demonstrations as follows.

Minnesota: Minnesota Senior Health Options (MSHO), approved April 1995:

- How is care delivered to dual-eligible beneficiaries through the integration of Medicare and Medicaid administrative requirements and processes as administered by the state? How are managed care organizations, the state, HCFA, and beneficiaries affected?
- How well do complex network arrangements deliver integrated Medicare and Medicaid services and care coordination to dual-eligible beneficiaries, including frail elderly community-dwelling and institutionalized members?

Wisconsin: Wisconsin Partnership Program, approved October 1998:

- How does the independent practice model of Partnership compare with the PACE model with respect to utilization, costs, and outcomes of care?
- How successful is the Partnership model for serving people with physical disabilities?
- How successful is the Partnership model as a model for rural health care delivery for elderly and physically disabled people?

New York: Continuing Care Networks (CCN), approved September 1999:

- How well does a functionally based payment model predict the costs of services for beneficiaries?
- How effective is the CCN model in integrating services for frail elderly beneficiaries in the context of overall plan enrollment of both Medicare-only and dual-eligible members, who may or may not be frail?
- How effective are innovative service delivery care management strategies that involve a combination of private and public financing for community long-term-care benefits?
- How effective are provider-based networks at delivering integrated care for Medicare and dual-eligible beneficiaries?

Massachusetts: MassHealth Senior Care Options Demonstration (SCO), awaiting final approval as of June 2000:

- Can states and HCFA evolve a more efficient administrative capability for implementing a demonstration?

- In two phases of financing, how will risk-adjusted payment systems be implemented and will these systems lead to improvement in predicting the costs of frail elderly beneficiaries?
- Will these changes benefit plans by making their costs more predictable and help beneficiaries by reducing the temptation of plans to avoid enrolling sicker, higher-cost beneficiaries?
- Does a coordinated enrollment process through an enrollment broker enhance consumer choice and understanding of the program?
- How effective are SCO models that emphasize geriatric expertise in both care planning and service delivery? How effective is the use of social and community support services in avoiding inappropriate nursing home placement of beneficiaries? Do innovative coordinated-care models result in the delivery of better, more cost-effective care?
- What efficiencies in program administration were gained from the competitive selection of contractors and 3-way contracts between SCO and federal and state governments?

Description of Medicaid Integrated Care Programs in Texas, Florida, and Colorado

This appendix describes three state programs that integrate health care financing and delivery for Medicaid services only. These states originally attempted to integrate Medicare and Medicaid acute- and long-term-care services, but for various reasons changed their initial plans.

Texas' Star+Plus Program (Operational)

In 1995, the state legislature required the Texas Health and Human Services Commission to pilot a cost-neutral model for the integrated delivery of acute- and long-term-care services for aged and disabled Medicaid recipients. Program officials originally planned on a fully integrated, mandatory program but then learned that an integrated care program cannot be mandated on the Medicare side. In addition, officials began to understand how complicated and time-consuming the process would be. Eventually, a combination 1915(b) and 1915(c) waiver, which mandated participation and capitated acute- and long-term-care services on the Medicaid side, was approved in January 1998.[1]

The targeted population is almost 60,000 aged and disabled Medicaid recipients in Harris County, Texas (Houston area). Provision of services began when the federal government approved waivers in January 1998, and enrollment became mandatory for Medicaid recipients in April 1998. As of December 1999, there were 54,873 enrollees—about half of whom were dual eligibles. An enhanced prescription drug benefit is available to dual eligibles who choose the same HMO for both Medicare and Medicaid services. Otherwise, coverage is limited to three prescriptions per month. As a result of limited marketing, only 300 enrollees had opted for this incentive. All enrollees have a choice of three HMOs, one of which also enrolls Medicare beneficiaries.

Florida's Long-Term-Care Community Diversion Pilot Project (Operational)

Florida submitted a waiver application to HCFA in November 1996 for its Long-Term-Care Community Diversion Pilot Project. The state originally wanted both a section 1115 Medicaid waiver and a section 222 Medicare waiver, but after discussions with HCFA, Florida decided not to integrate Medicare with Medicaid services because of the time it had taken other states to negotiate and obtain such waivers. Instead, the state chose to use

[1]Under section 1915(b), a state can mandate enrollment in a managed care plan. The 1915(c) waiver was required to allow Texas to incorporate services provided under its 1994 home and community-based services waiver.

a 1915(c) waiver that allows HMOs to be paid a capitated rate for nursing home and community-based services. The waiver was approved in March 1997.

The project now operates in the Orlando area with one HMO and in the Palm Beach area with two HMOs. Participants must be 65 years or older, meet Medicaid financial eligibility requirements, be nursing home certifiable, meet special clinical eligibility criteria, and be eligible for Medicare benefits. As of June 2000, enrollment in the Orlando area was 375 and in the Palm Beach area 325. All of the enrollees are dual eligibles.

Colorado's Integrated Care and Financing Project (Not Operational)

Rocky Mountain HMO approached Colorado about integrating acute- and long-term-care services in 1994—at the same time the state also began considering a similar initiative. Unlike most HMOs that are paid a capitated rate prospectively, Rocky Mountain is a cost-based Medicare HMO whose payments are settled after the fact. Rocky Mountain had a prominent share of the Mesa County market, including enrollment of more than half of the dual-eligible residents. As of March 20, 1999, there were 2,090 dual eligibles in Mesa County, 1,111 of which were enrolled in Rocky Mountain HMO. The state and Rocky Mountain HMO had estimated enrolling 7,720 Medicaid-only and dual-eligible beneficiaries in Mesa County.

The Integrated Care and Financing Project anticipated using a section 1115 Medicaid waiver and a section 222 Medicare waiver. Although financing issues were still being worked out, the state received HCFA approval on July 1, 1997. After approval, negotiations continued on a Medicare reimbursement methodology. Ultimately, however, HCFA and Colorado were unable to reach agreement. As a result, the state dropped the Medicare aspect of its project and focused on the integration of Medicaid acute- and long-term-care services using a section 1115 waiver.

HCFA approved Colorado's 1115 waiver in October 1999.[2] About a month later, Rocky Mountain announced its withdrawal from the integrated care program because of disagreements with the state over its Medicaid

[2]A factor that delayed approval of the Colorado program in 1999 was the need to address new mandatory criteria for including children with special needs in its waiver.

contract. Colorado now plans to establish an integrated care program in Denver without the use of Medicare and Medicaid waivers/authorities.

BBA Changes to Medicare HMO Payment Methodology

Before the BBA changed the rate-setting process for fiscal year 1998, the monthly amount Medicare paid plans for each plan member was tied directly to local spending in the fee-for-service program. In general terms, the pre-BBA rate-setting methodology worked as follows. Every year, HCFA estimated how much it would spend in each county to serve the "average" fee-for-service beneficiary. It would then discount that amount by 5 percent under the assumption that HMOs provided care more efficiently than the unmanaged fee-for-service program. The resulting amount constituted a base county rate to be paid to the plans operating in that county. Because some beneficiaries were expected to require more health services than others, HCFA "risk-adjusted" the base rate up or down for each beneficiary, depending on certain beneficiary characteristics—specifically, age; sex; eligibility for Medicaid; employment status; disability status; and residence in an institution, such as a skilled nursing facility.[1]

The BBA substantially changed the method used to set the payment rates for Medicare HMOs. As of January 1, 1998, plan payment rates for each county are based on the highest rate resulting from three alternative methodologies: a minimum amount ($379.84 in 1999); a minimum increase over the previous year's payment rate (equal to 2 percent); or a blend of historical fee-for-service spending in a county and national average costs, adjusted for local price levels.[2] The changes were intended to address criticisms of the preceding payment system by loosening the link between local fee-for-service spending increases and plan payment rate increases in each county. The blending provision, in particular, will eventually move all rates closer to a national average by providing for larger payment increases in low-rate counties and smaller payment increases in high-rate counties. In addition, the establishment of a minimum payment rate was meant to encourage plans to offer services in areas that historically have had low payment rates and few participating plans—primarily rural counties.

[1]Separate rates are calculated for (1) beneficiaries who qualify for Medicare because of a disability (under age 65) and (2) the elderly. Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

[2]Because of low growth in Medicare spending, and BBA's limit on aggregate health plan payments and minimum payment requirements, no county received a blended rate in 1998 or 1999. According to HCFA actuaries, the blending provision could not be funded because the BBA's minimum payment requirements resulted in total plan spending that exceeded the BBA's required limit on total health plan payments by $95 million in 1998 and $80 million in 1999. Blending occurred for the first time in 2000.

The BBA also directed the Secretary of Health and Human Services to develop and implement a better risk-adjustment method to adjust plan payments, beginning January 1, 2000. The interim health-based risk-adjustment methodology, based on the Principal In-Patient-Diagnostic Cost Group model, uses only hospital inpatient data to gauge beneficiary health status. Under this system, payments are still adjusted as well for beneficiary age, sex, original reason for Medicare eligibility (such as disability), and Medicaid enrollment. The adjustment for beneficiary residence in an institution has been eliminated from the methodology. HCFA proposes to phase in the new interim risk adjustment system slowly. In 2000 and 2001, only 10 percent of health plans' payments will be based on the new system. This percentage is scheduled to increase to no more than 20 percent in 2002 and is unspecified after this year.[3] Eventually, HCFA intends to implement a more accurate risk adjuster that uses medical data from additional health care settings and providers, such as physician offices and hospital outpatient departments.

[3]This revised phase-in schedule is outlined in the Medicare, Medicaid, and State Children's Health Insurance Program Adjustment Act of 1999.

GAO Methodology for Combining Part A and Part B Risk Adjusters

To make it easier to compare risk adjusters across programs, we combined separate part A and part B factors where applicable. Only the risk adjuster for the PACE program uses a single factor. The following formula shows our methodology for computing the single factors. Table 5 contains the actual part A and part B factors.

$$\text{Single Number Risk Adjuster in Table 3} = \frac{(\text{Part A Factor} \times \text{Part A Rate}) + (\text{Part B Factor} \times \text{Part B Rate})}{(\text{Part A Rate} + \text{Part B Rate})}$$

For example, the 1999 part A rate for Hennepin, Minnesota, was $242.11 and the part B rate was $179.90. The risk adjuster reported in table 3 for nonfrail dual-eligible males 65 to 69 years old is given by the following:

$$\text{Risk Adjuster for Non-Frail Dual-Eligible Males Aged 65-69} = 1.13 = \frac{(1.15 \times \$242.11) + (1.1 \times \$179.90)}{(\$242.11 + \$179.90)}$$

Table 5: 1999 Risk Adjusters for Programs Serving Dual Eligibles

	Male		Female	
	Part A	Part B	Part A	Part B
M+C HMOs				
Frail and nonfrail dual eligibles 65-69 years old	1.15	1.1	0.8	1.05
Frail and nonfrail dual eligibles 85+ years old	2.6	1.7	2.1	1.25
PACE				
All enrollees (only frail persons living in the community may enroll)	2.39	2.39	2.39	2.39
Minnesota (MSHO)				
Frail dual eligibles (all ages)	2.39	2.39	2.39	2.39
Nonfrail dual eligibles 65-69 years old	1.15	1.1	0.8	1.05
Nonfrail dual eligibles 85+ years old	2.6	1.7	2.1	1.25
Wisconsin (Partnership Program)				
All enrollees (only frail persons may enroll)	2.39	2.39	2.39	2.39

	Male		Female	
	Part A	Part B	Part A	Part B
Massachusetts (SCO)				
Frail dual eligibles (all ages)	2.88	2.49	2.88	1.79
Nonfrail dual eligibles 65-69 years old	1.02	0.99	0.69	1.01
Nonfrail dual eligibles 85+ years old	2.54	1.54	1.84	1.07
New York (CCN)				
Frail (all ages)				
With mild impairment	1.75	1.53	1.75	1.55
With moderate impairment	2.98	2.57	2.98	1.86
With severe impairment	3.82	3.23	3.82	1.98
Nonfrail dual eligibles 65-69 years old	1.02	0.99	0.69	1.01
Nonfrail dual eligibles 85+ years old	2.54	1.54	1.84	1.07

Comparison of Medicare Payments Under M+C, PACE, and State Demonstration Programs

To illustrate how different risk adjusters affect payments under various demonstrations, table 6 compares the Medicare payments under M+C, PACE, and state demonstration programs for a hypothetical frail dual-eligible enrollee living in the community. M+C HMOs are paid based on the average cost of all dual eligibles—both healthier and frail. Thus, their payments for frail dual-eligible enrollees are lower than payments based on separate risk adjusters for frail-only dual eligibles. In addition, table 6 reflects differences in the base payment rates due to differences in local health care costs.

Table 6: Payments Under M+C, PACE, and State Demonstrations That Serve Frail Dual Eligibles Living in the Community, for a 75-Year-Old Female Residing in Each Location in Calendar Year 1999

Program	Monthly payment
Minnesota (Hennepin County)	
M+C HMOs	$575.93
PACE	1,008.60
MSHO	1,008.60
Wisconsin (Dane County)	
M+C HMOs	526.86
PACE	922.66
Partnership Program	922.66
New York (Monroe County)	
M+C HMOs	584.93
PACE	1,024.35
CCN	
Low impairment	713.51
Medium impairment	1,072.59
High impairment	1,301.07
Massachusetts (Suffolk County)	
M+C HMOs	904.88
PACE	1,584.67
S/HMO I	1,681.54
SCO	1,601.47

Source: GAO analysis, based on HCFA's M+C rate data and interviews with states' officials.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

DATE: JUN 30 2000

TO: Kathryn G. Allen
Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report: "Medicare and Medicaid: Integrating Services for Dual Eligible Beneficiaries Has Proven Challenging" (GAO/HEHS-00-94).

Thank you for the opportunity to review and comment on this draft report concerning the difficulties of integrating Medicare and Medicaid services for dual eligible beneficiaries. Older Americans who are eligible for both Medicaid and Medicare are among the most vulnerable persons we serve. The Health Care Financing Administration (HCFA) is concerned that more be done to serve the needs of this group and to avoid fragmentation of services that sometimes exist for them. We support state demonstrations to showcase ways to better integrate services for dual eligibles and will work with States to ease their concerns over the length of the Federal review process.

Our comments in part relate to two general points made in the report: (1) Little progress has apparently been made in the development of appropriate payment methods for plans that specialize in special populations, and; (2) Approval for State demonstration programs involving specialized plans seemingly require long periods of time.

On this first point, we note that HCFA is committed to defining an appropriate Medicare payment methodology for integrated care programs. HCFA is engaged in a large body of research, both intramural and extramural, that attempts to find an appropriate payment method for plans, particularly those that enroll special populations. However, defining this appropriate methodology may require that we go beyond the common notion of using survey-based functional status, or "frailty," as a risk adjuster. Our most recent research has uncovered a number of conceptual and operational problems with the possible use of survey-based "frailty" measures for payment purposes. Through this large research agenda we are seeking to identify either an alternative to "frailty", or the best way to refine "frailty" for use in payment.

Page 2 – Kathryn G. Allen

On this second point, we would stress that the length of time many States have experienced in gaining approval for their projects is primarily a function of the difficulties involved in defining, among other issues, this appropriate payment methodology. Many of the special plans discussed in the report specifically seek out a disproportionately sick, frail population, and it is a very complex problem to find capitated payment methodologies, which will fairly compensate them. Another complicating factor is the recent changes in the methodology HCFA uses in the development of Medicare's capitation rate book. As a result of the Balanced Budget Act, there is a partial de-linking of fee-for-service payments and resulting county capitation rates. This change alone has made agreement on appropriate capitated payments difficult to achieve with States.

Now on p. 16.

In addition to comments on risk adjustment and payment as described above, HCFA suggests that the topic of "Medicare/Medicaid program complexity" be introduced as an additional factor in the report perhaps in the section "Developing and Implementing Dual Eligible initiatives has been a lengthy process" on page 17. In order to comprehend fully the difficulties involved in developing and implementing dual eligible demonstrations, it is essential to understand that Medicare and Medicaid are very different at the operational level. Considerable effort has been made by HCFA and the States to understand and then try to streamline various administrative systems that must be put in place for these demonstrations to commence. Enrollment, marketing, evidence of coverage contracts, provider contracts, grievance and appeals systems and rights, benefit definition and coordination, and other key systems and policies must be worked through between each State and HCFA. Program complexity is a significant issue in describing the time and effort involved with developing dual eligible demonstration initiatives. It should not remain an unrecognized factor in the report.

We appreciate the effort that went into this report and look forward to working with GAO on this and other issues in the future.

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