December 2012

MEDICARE AND MEDICAID

Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems, and States

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Highlights

Highlights of GAO-13-100, a report to congressional requesters

Why GAO Did This Study

Dual-eligible beneficiaries are low-income seniors and individuals with disabilities enrolled in Medicare and Medicaid. In 2010, there were about 9.9 million dual-eligible beneficiaries. Both programs have requirements to protect the rights of beneficiaries. These requirements are particularly important to dual-eligible beneficiaries, who must navigate the rules of both programs and generally have poorer health status.

To help inform efforts to better integrate the financing and care for dual-eligible beneficiaries, GAO (1) compared selected consumer protection requirements within Medicare FFS and Medicare Advantage, and Medicaid FFS and managed care, and (2) described related compliance and enforcement actions taken by CMS and selected states against managed care plans.

GAO identified consumer protections of particular importance to dual-eligible beneficiaries on the basis of expert interviews and literature, including protections related to enrollment, provider networks, and appeals. GAO reviewed relevant federal and state statutes, regulations, and policy statements, and interviewed officials from CMS and four states selected on the basis of their share of dual-eligible beneficiaries and use of managed care (Arizona, California, Minnesota, and North Carolina). GAO analyzed data on compliance and enforcement actions in Medicare Advantage and Medicaid managed care from January 1, 2010, through June 30, 2012.

View GAO-13-100. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

Medicare and Medicaid consumer protection requirements vary across programs, payment systems—either fee-for-service (FFS) or managed care—and states. Within Medicare, enrollment in managed care through the Medicare Advantage (MA) program must always be voluntary, whereas state Medicaid programs can require enrollment in managed care in certain situations. For example, Arizona requires nearly all beneficiaries, including dual-eligible beneficiaries, to enroll in managed care, but in North Carolina all beneficiaries are in FFS. In addition, Medicare and state Medicaid programs require managed care plans to meet certain provider network requirements to ensure beneficiaries have adequate access to covered services. For example, MA plans in rural counties must have at least one primary care provider per 1,000 beneficiaries. Subject to federal parameters, states establish network requirements for their Medicaid programs. For example, in California every plan must have at least one primary care provider per 2,000 beneficiaries. Finally, Medicare and Medicaid also have different appeals processes that do not align with each other. The Medicare appeals process has up to five levels of review for decisions to deny, reduce, or terminate services, with certain differences between FFS and MA. In Medicaid, states can structure appeals processes within federal parameters. States must establish a Medicaid appeals process that provides access to a state fair hearing and Medicaid managed care plans must provide beneficiaries with the right to appeal to the plan, though states can determine the sequence of these appeals. For example, Arizona requires beneficiaries to appeal to the managed care plan first, while a beneficiary in Minnesota may go directly to a state fair hearing without an initial appeal to the managed care plan.

Both the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program and oversees states' operation of Medicaid programs, and states took a range of compliance and enforcement actions to help ensure that MA and Medicaid managed care organizations complied with their consumer protection requirements. Between January 1, 2010, and June 30, 2012, CMS took 546 compliance actions against MA organizations on the issues GAO identified as generally related to consumer protections of particular importance to dual-eligible beneficiaries. Compliance actions included notices, warning letters, and requests for corrective action plans (CAP). During the same period, CMS took 22 enforcement actions against MA organizations, including the imposition of 17 civil money penalties—nearly all for late or inaccurate marketing materials. For five serious violations, CMS suspended enrollment into the MA plan and suspended the MA plan's ability to market to beneficiaries. Similarly, states used notices, letters, fines, and CAPs to improve Medicaid managed care plan compliance with Medicaid consumer protection requirements. During the same period, Arizona, California, and Minnesota required managed care plans to undertake 91 corrective action plans, 52 percent of which related to problems with plans' appeals and grievances processes.

In commenting on a draft of the report, the Department of Health and Human Services noted that the report was an accurate assessment of the programs we reviewed.