Managed Care for Medicare-Medicaid Dual Eligibles: Appropriateness, Availability, Payment, and Policy

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The bifurcation of responsibility for caring for dual eligibles has helped create a fragmented service delivery system, fraught with administrative inefficiencies, barriers to more effective care, and incentives to shift costs. To better serve this population, the federal government and several states have developed a number of pilot initiatives that promote integration by relying on capitated managed care. However, evidence suggests that this approach may be plagued by certain problems, including lack of experience with persons who are chronically ill, incentives to under provide care, favorable selection, limited plan availability, and mixed outcome and satisfaction performance. Although case-managed approaches pursue integration without capitation, they must typically rely on voluntary provider cooperation to be successful, something that is difficult to achieve. Given the recent nature of most integration initiatives, it is recommended that policymakers continue to promote innovation in each of the following areas: care coordination, administration, provider payment, plan participation, and evaluation.

Keywords: Medicare; Medicaid; managed care; elderly; dual eligibles; case management; capitation; integration; demonstrations

Federal and state initiatives to integrate acute and long-term care usually focus on Medicare beneficiaries who also qualify for Medicaid (i.e., the dual eligibles). Compared to other beneficiaries, the nation's approximately 6.3

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million duals are especially vulnerable and have high medical care costs (Centers for Medicare and Medicaid Services [CMS], 2003). They also face additional problems that arise from their being served by two separate programs (Medicare and Medicaid), administered under two different authorities (the federal and state governments), that, for the most part, cover two different types services (acute and long-term care). This bifurcation of responsibility in caring for duals has resulted in a fragmented delivery system, fraught with inefficiencies and incentives to shift cost. The primary vehicle suggested for reform are managed care organizations that (a) directly provide, or arrange to provide for health and long-term care services through affiliated providers, and (b) receive a prepaid, fixed monthly payment or capitation in exchange for assuming full responsibility for all covered benefits.

In short, this article characterizes the dually eligible population and describes the problems associated with meeting their health and social service needs in an uncoordinated system. It reviews managed care as a vehicle for integrating those services and discusses important issues, including doubts about managed care's appropriateness for vulnerable groups, lack of plan availability, evidence of risk selection and inadequate risk adjustment, and problems in obtaining voluntary provider participation in programs relying on care management without capitation. It concludes that policy makers must continue to learn from what has come before, while pursing more effective solutions to the Medicare-Medicaid integration problem.

**Dual Eligibles Defined**

Dual eligibles qualify for Medicare and Medicaid. Most qualify for Medicare because they are either age 65 years or older, or younger than age 65 but disabled and receiving Social Security benefits. Most qualify for Medicaid because they are either aged, blind, or disabled and meet the income and asset requirements for Supplemental Security Income assistance, or because they are medically needy, having spent down their income and assets to pay for their medical or long-term care costs to state-determined levels. The majority who qualify for Medicaid are eligible for full Medicaid benefits. Others, however, are only eligible for Medicaid coverage of some portion of their Medicare premiums and cost sharing.

In 2000, the Medicare program covered 40.7 million beneficiaries, including 35.2 million individuals age 65 years and older (86.5%) and 5.5 million disabled individuals younger than age 65 (13.5%) (CMS, 2003). Of the 6.3 million (15.5%) Medicare beneficiaries who were also eligible for full Medicaid benefits and/or for Medicaid payment of Medicare cost-sharing
requirements, 4.1 million (64.2%) were older than age 65. Data from the 2000 Medicare Current Beneficiary Survey indicate that dually eligible Medicare beneficiaries are particularly vulnerable compared to persons who qualify for Medicare only (see Table 1). Not only are they disproportionately poor, by definition, but also are more likely than non–dually eligible Medicare beneficiaries to be frail elders age 85 and older and disabled individuals younger than age 65. They are also more likely to be non-White, female, unmarried, institutionalized, alone, less educated, report fair or poor health, and suffer from functional and cognitive impairments such as limitations in instrumental activities of daily living and basic activities of daily living.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Duals</th>
<th>Nonduals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total beneficiaries</td>
<td>U.S. $6.313 million</td>
<td>U.S. $34.315 million</td>
</tr>
<tr>
<td>Income less than $10,000</td>
<td>80.46</td>
<td>14.55</td>
</tr>
<tr>
<td>Age 85 and older</td>
<td>15.12</td>
<td>10.69</td>
</tr>
<tr>
<td>Under age 65 but disabled</td>
<td>35.78</td>
<td>9.47</td>
</tr>
<tr>
<td>Non-White (Hispanic, Black, Other)</td>
<td>42.33</td>
<td>15.92</td>
</tr>
<tr>
<td>Female</td>
<td>63.15</td>
<td>55.09</td>
</tr>
<tr>
<td>Unmarried</td>
<td>80.40</td>
<td>42.89</td>
</tr>
<tr>
<td>Institutionalized</td>
<td>21.60</td>
<td>2.66</td>
</tr>
<tr>
<td>Living alone if in community</td>
<td>31.77</td>
<td>28.26</td>
</tr>
<tr>
<td>Less than 12 years of education</td>
<td>62.95</td>
<td>28.90</td>
</tr>
<tr>
<td>Fair/poor self-reported health</td>
<td>55.35</td>
<td>26.22</td>
</tr>
<tr>
<td>1+IADL or ADL limitation</td>
<td>76.59</td>
<td>44.06</td>
</tr>
<tr>
<td>Upper extremity limitation</td>
<td>61.39</td>
<td>40.76</td>
</tr>
<tr>
<td>Mobility limitation</td>
<td>71.14</td>
<td>46.81</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>36.90</td>
<td>24.68</td>
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<td>Multiple chronic conditions</td>
<td>74.87</td>
<td>70.46</td>
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<tr>
<td>Hypertension</td>
<td>55.70</td>
<td>55.25</td>
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<tr>
<td>Diabetes</td>
<td>23.91</td>
<td>16.93</td>
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<tr>
<td>Arthritis</td>
<td>52.89</td>
<td>55.97</td>
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<tr>
<td>Osteoporosis/broken hip</td>
<td>17.09</td>
<td>16.22</td>
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<tr>
<td>Pulmonary disease</td>
<td>19.74</td>
<td>13.86</td>
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<tr>
<td>Stroke</td>
<td>14.49</td>
<td>10.94</td>
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<tr>
<td>Alzheimer’s disease</td>
<td>12.09</td>
<td>3.28</td>
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<tr>
<td>Parkinson’s disease</td>
<td>2.28</td>
<td>1.32</td>
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<tr>
<td>Skin cancer</td>
<td>6.14</td>
<td>17.14</td>
</tr>
<tr>
<td>Other type of cancer</td>
<td>11.98</td>
<td>17.63</td>
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NOTE: IADL = Instrumental activity of daily living; ADL = Activity of daily living.
Except for arthritis and cancer, dually eligible beneficiaries are also more likely to suffer from most chronic ailments and diseases.

It is not surprising that dual eligibles use a disproportionate share of resources relative to their numbers. In 1999, total per capita health spending for dually eligible Medicare beneficiaries ($16,278) was more than 2 times higher than for non-dually eligible beneficiaries ($7,396) (CMS, 2002). Dual eligibles, although 17% of Medicare beneficiaries that year, accounted for 24% of total spending (U.S. $50 billion) (Kaiser Commission on Medicaid and the Uninsured, 2003). Similarly, although only 19% of Medicaid recipients, dual eligibles accounted for 35% of Medicaid expenditures ($63 billion) (Kaiser Commission, 2003), a percentage that exceeds 50% in some states (New England States Consortium, 2001).

Divided Responsibility:
Implications

The basic problem is that neither Medicare nor Medicaid has responsibility for the entire system (Miller & Weissert, 2003). Multiple financing and delivery systems typically require that duals try to obtain care from a confusing assortment of badly coordinated providers and care settings that have no incentive to interact given separate sources of funding. Inconsistent practices and poor communication along with separate medical record systems pose significant barriers to meeting the total care needs of individual patients. Despite their greater need for continuity, dual eligibles are, in fact, less likely than Medicare beneficiaries with other supplemental coverage to report having a usual source of care (CMS, 2003). They are also less likely to receive certain preventive care, follow-up, and testing, and though they use more health services, they are less likely to receive timely, appropriate care (Merrell, Colby, & Hogan, 1997).

Fragmentation increases system costs as well. Patient discharges from expensive acute care facilities are often delayed unnecessarily because appropriate care in a nursing facility or patient’s home could not be arranged. Incentives built into the current system may even encourage excess institutional care use, which is certainly the case with Medicaid, which provides much more extensive coverage for care in a nursing home than in the home or community. Because individuals who are frail and disabled must often access the continuum of acute and long-term care services, integrating the community and institutional components of the long-term care system is especially important when serving dual eligibles. Outside of a handful of
demonstration projects, however, few programs attempt to integrate care in this manner.

Federal and state rules for contracting, enrollment, marketing, reimbursement, oversight, data collection, and quality standards are also different for Medicare and Medicaid. The resulting inconsistencies and overlapping requirements complicate caring for dually eligible beneficiaries, as providers and payers must maintain parallel administrative systems for the two programs. As a consequence, providers often need to conduct multiple assessments, develop multiple protocols, and establish multiple records for a single patient during a single episode of care. Interviews and focus groups conducted with beneficiaries and staff from nine health plans highlight confusion and lack of beneficiary understanding about their benefits and problems with care and benefit coordination based on regulatory and administrative obstacles (Walsh & Clark, 2002). One study estimated that 45% of the difference in average beneficiary costs between dual and non-dually eligible beneficiaries resulted from inefficiencies such as these (Liu, Long, & Aragon, 1998).

Overlap in coverage between two programs serving the same population also creates opportunities for cost shifting as a way for each program to limit its financial liability. Opportunities for cost shifting are particularly strong for services covered by both Medicare and Medicaid (e.g., nursing facility and home care) and may have contributed to explosive growth in Medicare home health spending between 1987 and 1998, as states made sure that agencies first billed Medicare before turning to Medicaid. Furthermore, where two programs cover the same population and no single entity is accountable for all care, reimbursement incentives may play a disproportionate role in influencing treatment decisions at the expense of patients’ best interests.

**Managed Care**

Reform of the nation’s health care delivery system is required if Medicare-Medicaid dual eligibles are going to be served more cost-effectively. Common goals include

- eliminate fragmented service delivery, while promoting enhanced continuity of care and more simplified access to services;
- develop community-based options that promote beneficiary independence through the use of the most cost-effective, least restrictive care settings;
- make benefits more flexible and responsive to the diverse and changing needs of individuals;
• promote improvements in care quality and beneficiary outcomes; and
• control costs through greater emphasis on prevention and primary care, reduced incentives to use institutional care, fewer opportunities to cost shift, streamlined administration, and less reliance on cost-based reimbursement.

The most frequently proposed vehicle for achieving these goals and integrating acute and long-term care for dual eligibles has been managed care. Particular arrangements range from managed fee-for-service systems using case management and utilization review, to managed care organizations that combine such activities with a variety of risk-sharing arrangements. Although traditional unmanaged fee-for-service plans simply reimburse independent providers for services rendered, managed care organizations directly provide or arrange to provide for services through affiliated physicians, hospitals, and other providers. Managed care organizations also assume varying degrees of risk for the care that they provide. Those assuming full risk receive a prepaid, fixed monthly payment or capitation rate in exchange for which they are responsible for all member services. Managed care organizations typically rely on prospective reimbursement to create incentives for providers to minimize spending by, theoretically, controlling inappropriate utilization and promoting early intervention. Managed care plans may also negotiate discounted rates with their provider networks, select low-cost providers, or give participating providers a financial stake in the cost of the services that they order. In 2002, more than 60% of the U.S. population, or 181.8 million Americans, including 90% of individuals covered by commercial insurance plans, were enrolled in managed care (MCOL, 2003). Although not nearly as common, enrollment of Medicare and Medicaid recipients in managed care has also grown.

Medicaid Managed Care

States generally rely on two types of Medicaid managed care, including risk-based programs in which health plans assume full or partial risk for at least some Medicaid services, and primary care case management (PCCM) programs, in which states pay individual providers a small monthly fee in return for managing health care services for a defined population. By 2000, 55.0% of all Medicaid recipients were enrolled in managed care, up from 23.0% in 1994 (Kaye, 2001). The number of states with risk-based and PCCM programs, moreover, grew from 27 to 42 and 19 to 29, respectively, between 1990 and 2000. In general, long-term care recipients and Medicare-Medicaid dual eligibles are much more likely than other groups to be prohib-
Medicare Managed Care

The Balanced Budget Act (BBA) of 1997 replaced the existing Medicare Health Maintenance Organization (HMO) program with a new program, Medicare+Choice, which expanded the array of service delivery options available for Medicare risk contracting. Although the percentage of Medicare beneficiaries enrolled in a capitated health plan reached 17.3% in 1999, up from 3.3% in 1990, it steadily declined to 12.0% by 2003 (Medicare Payment Advisory Commission [MedPAC], 2003). Unlike states, which may make Medicaid managed care enrollment mandatory for most populations, or acquire special waivers to do so for others (e.g., duals), the federal government cannot require Medicare beneficiary enrollment in managed care. Relative to other beneficiaries, moreover, dual eligible enrollment has especially lagged.

A Managed Care Prototype for Integration

Despite state reluctance to enroll dual eligibles, most initiatives to integrate acute and long-term care for dual eligibles build on existing managed care arrangements to meld together components of the Medicare and Medicaid programs. According to Booth, Fralich, Saucier, and Riley (1997), fully integrated systems are those that provide for integrated financing, broad and flexible benefits, far-reaching delivery systems, care integration, unified program administration, and overarching quality systems. Three broad policy goals are considered here: financial integration, service delivery integration, and administrative integration.

For financial integration to take place, the funds used to pay for care must be pooled together. In a fully integrated system serving duals, a single contractor would receive combined Medicare and Medicaid capitation payments in exchange for assuming complete responsibility for the full range of Medicare and Medicaid benefits. Unlike fee-for-service systems, which limit reimbursement to specified service categories, fully capitated entities would, in theory, have the flexibility to provide all needed acute and long-term care. Because managed care plans are at risk financially, they should also have an incentive to emphasize prevention, reduce hospitalization, and substitute low- for high-cost settings (Booth et al., 1997). Ideally, dual capitation would...
also eliminate incentives to shift costs because the particular service mix would not directly affect Medicare or Medicaid expenditures.

As a first step, service delivery integration involves the development of comprehensive delivery systems with access to the complete array of health and social services necessary to meet the complex needs of dual eligibles. These systems would include physicians, hospitals, and nursing homes, for example, in addition to community-based providers with experience serving individuals who are chronically ill. Supportive residential options such as assisted living might also be included. Simply forming an expanded provider network does not ensure that integration will take place, however. Coordination also requires one or more of the following: (a) case managers, primary caregivers, and interdisciplinary care teams that facilitate communication and promote smooth transitions across providers and settings; (b) centralized member records that ensure timely access to beneficiary information; and (c) more active consumer involvement.

Administrative integration requires the development of unified Medicare and Medicaid program requirements, including contract administration, beneficiary enrollment, data management, and quality assurance. A fully integrated program, for example, would require only a single contract for plans serving dually eligible beneficiaries. This would not only establish a single point of accountability for Medicare and Medicaid benefits but also reduce duplication and other inefficiencies. To further minimize paperwork and better track utilization, it would also collapse beneficiary enrollment into a single process and authorize the collection of a complete set of encounter-level data. Through more consistent standards, fewer redundant requirements, and better coordination among overlapping oversight authorities, Medicare and Medicaid quality management activities would also be rationalized.

**Issues to Consider When Integrating Care for Duals**

Federal and state policy makers have implemented initiatives aimed at integrating acute and long-term care services for Medicare-Medicaid dual eligibles. These include federal initiatives such as the Program for All-Inclusive Care of the Elderly (PACE) and Social HMO demonstration, and state initiatives such as the Minnesota Senior Health Options (MSHO), the Wisconsin Partnership Program, and Arizona Long-Term Care System (ALTCS). Although the number of initiatives has grown, there are a variety
of factors that inhibit their effectiveness for dual eligibles. They include doubts about managed care’s appropriateness for vulnerable populations, lack of plan availability, evidence of risk selection, and inadequate risk adjustment.

**Managed Care’s Appropriateness for Vulnerable Populations**

Managed care organizations primarily serve a relatively young and employed population. Medicaid programs in most states have focused their managed care programs on children and adults who are nondisabled, while Medicare beneficiaries enrolled in managed care tend to be healthier than those not enrolled. Relatively few plans have had experience serving vulnerable groups such as the elderly who are dually eligible, who often have special needs associated with chronic conditions, multiple system failures, and lack of social resources. Some analysts doubt whether such plans have the expertise or willingness to take on the risks associated with providing the specialized care required by populations who are predominately chronically ill and disabled (Friedland & Feder, 1998). They also fear that financial incentives to do less may lead to the underprovision of appropriate services, resulting in access and quality problems. The following examines these concerns in the context of resource use and costs, quality of care, and satisfaction.

Findings from the PACE, ALTCS, and Medicare HMO evaluations indicate that managed care plans serving the elderly typically use fewer resources and operate more cheaply than traditional fee-for-service arrangements. While Medicaid capitation payments under PACE were higher, Medicare capitation payments were found to be much lower than what would had been spent had members not enrolled (Chatterji, 1998). This latter result is reflected in Arizona, where Medicaid payments were significantly less than what would have occurred in a typical Medicaid program (McCall et al., 1996). They are also consistent with the Medicare HMO evaluation, which found that Medicare HMOs spent 10.5% less than what would have been spent for the same enrollees in Medicare’s fee-for-service system (Brown, Clement, Hill, Retchin, & Bergeron, 1993).

Overall, quality of care findings have been mixed—often no different, but sometimes worse. Although evaluators concluded that Social HMOs performed well for individuals who were healthy and acutely ill, results showed that they did not perform well for those who were impaired or acutely ill with chronic impairments (Manton, Newcomer, Lowrimore, Vertrees, &
Harrington, 1993). Although no significant difference was found between Arizona’s managed care system and New Mexico’s traditional Medicaid program with respect to certain nursing home outcomes, Medicaid nursing home residents in Arizona were more likely to experience unfavorable results such as a decubitus ulcer, fever, and catheter insertion (McCall et al., 1996). Even the PACE evaluation, with its generally positive findings, revealed that the project’s impact on health outcomes tended to be more fleeting than its effect on utilization (Chatterji, 1998). Results from the Medicare HMO evaluation and other studies are also mixed (Brown et al., 1993; Kane, Homyak, Bershadsky, & Lum, 2002; Kane, Homyak, Bershadsky, Lum, & Siadaty, 2003).

In general, elderly HMO enrollees sometimes report being more satisfied with financial and coverage aspects than fee-for-service beneficiaries and less satisfied with other dimensions. Although unimpaired Social HMO enrollees reported higher satisfaction than fee-for-service beneficiaries in all areas except interpersonal relations, enrollees who were impaired reported lower satisfaction in all areas but finance and benefits (Newcomer, Harrington, & Preston, 1994). Compared to their counterparts in New Mexico, SSI recipients in Arizona’s Medicaid program reported being less satisfied with their overall medical care but slightly more satisfied with ease and convenience and costs paid out of pocket (McCall, Jay, & West, 1989). Similarly, a comparison of Medicare HMO and fee-for-service beneficiaries found the former to be less satisfied with most care dimensions but more satisfied with costs and service coverage (Brown et al., 1993). PACE enrollees, on the other hand, were more satisfied with their overall care arrangements compared to people who applied to PACE but later declined to enroll (Chatterji, 1998). Although there were few differences between Wisconsin Partnership beneficiaries and their families and comparable persons who were frail and older in the same area or in matched outside areas (Kane, Homyak, Bershadsky, & Lum, 2002), MSHO families reported lower caregiver burden (Kane et al., 2003).

Lack of Plan Availability

In 2000, 42% of Medicare beneficiaries lived in areas not served by Medicare+Choice coordinated care plans (MedPAC, 2003). Although 72% of beneficiaries living in urban areas had a choice of plans, 87% living in rural areas had no choice, casting doubt on managed care’s ability to serve sparsely populated areas. Eleven states also had virtually no coordinated care plan enrollment, while in many others enrollment was quite low. The number of
coordinated care plans participating in Medicare+Choice has also declined. Prior to the 1999 start of Medicare+Choice, for example, 66 contracts had been terminated (Committee on Ways and Means, 1999). Declining plan participation because of mergers and withdrawals has also taken place in Medicaid. Although the number of risk plans grew from 275 in 1994 to 375 in 1998, they declined to 320 in 2000 (Kaye, 2001). Plan withdrawal from Medicare and Medicaid may be related to two interrelated issues: risk selection and inadequate risk adjustment.

Risk Selection and
Inadequate Risk Adjustment

Evidence indicates that managed care plans serving people who are elderly experience favorable selection or the disproportionate enrollment of beneficiaries who are healthier, on average, than fee-for-service beneficiaries (Harrington, Newcomer, & Preston, 1993; Lichtenstein, Thomas, Adams-Watson, Lepowski, & Simone, 1991). Favorable selection may occur, in part, because individuals who are sicker are more likely to want to maintain long-standing relationships with non-plan-affiliated providers. It may also result from plan use of selective marketing techniques to promote enrollment among healthier beneficiaries. Given evidence of favorable selection, CMS believed that it has overpaid Medicare HMOs (MedPAC, 1998). Despite such perceived overpayment, however, health plans exhibit a continued reluctance to serve Medicare beneficiaries because of fears of unlimited liability, weak demand, and underpayment for frail beneficiaries. Dissatisfaction with the way rates are set is a factor underlying all these concerns.

To ensure that the federal government is not overpaying for beneficiaries who are healthier than average and that plans are receiving adequate payment for beneficiaries who are frailer than average, capitation rates can be adjusted for beneficiary risk. The mechanism for doing so is called risk adjustment, which is a process of setting capitation rates that reflect health status—paying plans more to care for beneficiaries who are ill and less to care for beneficiaries who are healthy. Prior to the BBA, CMS adjusted Medicare’s capitation rates using age, sex, disability, institutional, Medicaid, and working-age status. It is widely acknowledged, however, that such factors do an extremely poor job of adjusting for risk (MedPAC, 1998). As a consequence, the BBA mandated that CMS develop and implement a health status–based risk adjustment methodology, which the agency began to phase in January 2000. The new method adjusts capitation payments using enrollee’s inpatient hospital diagnoses in the previous year, if any, as well as traditional demographic
factors. Because of concerns that the new system underestimates the costs of caring for people with disabilities and overestimates the costs of caring for people without, CMS has excluded plans enrolling populations who are frail, including those participating in PACE and MSHO.

Another payment reform option is partial capitation, in which plans receive a percentage of the full capitation rate for each enrollee along with a percentage of the fee-for-service rate for each service delivered. By reducing financial risk, some believe that such an approach would encourage more plans to serve dual eligibles as well as blunt incentives to risk select or underprovide appropriate services (Newhouse, 1996). Because partial capitation still contains fee-for-service elements, however, it does not contain as strong an efficiency incentive as fully capitated systems. It also does not provide as large a prepaid pool with which to fund extra services.

Care Management in the Fee-for-Service System

Concerns about capitation have led some observers to focus on care management as a way to integrate care for dual eligibles. Care management coordinates the provision of acute and long-term care services across health and social service professionals and settings. It includes but is not limited to needs assessment, prior approval, care communication, and risk assessment. To varying degrees, it is used by most health care organizations, including existing managed care initiatives serving dual eligibles. PACE, Wisconsin Partnership, and the lone second-generation Social HMO site, for example, use interdisciplinary provider teams. The Oregon Health Plan, on the other hand, employs exceptional needs care coordinators to coordinate Medicaid acute and long-term care benefits, while most others, including MSHO and ALTCS, assign case managers.

Part of the advantage of combining care coordination with Medicare-Medicaid capitation is that it provides case managers with the necessary authority and flexibility to develop and implement care plans that effectively meet the medical and social service needs of individual clients. Some observers argue, however, that greater coordination need not involve capitation of all Medicaid and Medicare benefits, nor need it involve enrollment in managed care plans (Feder, 1997). Although it is only recently being considered in the context of fee-for-service Medicare, care management has long been applied to fee-for-service Medicaid. Consequently, some suggest taking advantage of state experience in managing Medicaid-covered benefits under
PCCM, 1915(c) home and community-based services waiver, and other programs (Feder, 1997; Hausner, Gaus, & Larkson, 1994). The biggest problem in achieving integration under the current system, however, is that Medicaid case managers have authority over Medicaid benefits only. They do not have the authority to authorize Medicare-covered services. One option would be to grant Medicaid case managers the authority to develop care plans involving Medicare services, to authorize Medicare as well as Medicaid services, and to substitute noncovered services for Medicare services if found to be cost-effective (Hausner et al., 1994).

Achieving integration through care management may be problematic, however. It is generally reported that case managers often find it difficult to establish meaningful working relationships with physicians. Because evaluators identified lack of coordination between physicians and case managers as one factor undermining the effectiveness of the original Social HMO demonstration (Harrington, Lynch, & Newcomer, 1993), the lone second-generation site has, during a period of several years, implemented extensive care coordination and communication processes to support physician practice (Newcomer, Harrington, & Kane, 2002). Financial incentives and management information systems along with the appropriate timing of management and physician involvement in the development and implementation of care management can play an important role in increasing physician participation in these activities (Waters et al., 2001).

Conclusion

Kingdon (1995) argued that among many other conditions necessary for policy adoption and legislative enactment, consensus among experts is an essential prerequisite. Clearly we do not have a consensus on the best way to proceed when integrating care for dual eligibles. On one hand, proponents strongly believe in the efficacy of using managed care to integrate acute and long-term care financing, service delivery, and administration under the two programs. In doing so, they hope to eliminate fragmentation, develop community service options, make benefits more flexible, promote quality of care improvements, and control costs. Implementation of dual eligible programs, however, requires CMS approval of waivers of certain Medicaid and Medicare program rules. States cite a number of statutory and regulatory barriers, including long review times and separate budget neutrality requirements for Medicare and Medicaid (U.S. General Accounting Office, 2000).

Extant studies, on the other hand, indicate that managed care may be plagued by certain problems where vulnerable populations are concerned.
However, given the recent nature of most state and federal initiatives, there is currently a dearth of research evidence with which to definitively evaluate current integration efforts. Policy makers, therefore, must continue to learn from what has come before, while pursuing more effective solutions to the Medicare-Medicaid integration problem. Federal action might include one or more of the following:

- promoting care coordination, including case management and centralized data systems;
- facilitating unified Medicare and Medicaid program administration;
- modifying budget neutrality requirements so that savings under one program can be applied against increased spending in the other and still show a net savings overall;
- using alternative payment mechanisms, such as partial capitation, which reduce plan risk, thereby promoting participation in programs targeted toward resource-intensive groups;
- spurring the development of better risk adjustment methodologies to guard against overpayment for healthy beneficiaries and underpayment for individuals who are frail and disabled;
- developing incentives that encourage health plans to participate in Medicare+ Choice and Medicaid managed care simultaneously;
- continuing existing federal initiatives until more research evidence becomes available;
- directing additional resources toward evaluation of existing programs; and
- supporting the development of Medicare- or Medicaid-based care management options independent of capitation, with incentives that encourage provider cooperation.

References


Chatterji, P. (1998, June). Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) demonstration: The impact of PACE on particular outcomes, final (Report prepared...


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