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# Managed Care and Dually Eligible Beneficiaries: Challenges in Coordination

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*This article describes administrative issues and beneficiary perspectives on the delivery of medical services under Medicare+Choice (M+C) and/or Medicaid managed care organizations (MCOs) for dually eligible beneficiaries. We interviewed staff at nine health plans in four market areas in 2000 and 2001, and conducted beneficiary focus groups in 2001. The study reveals beneficiary confusion about the relationship between their dual coverage and managed care enrollment, and problems with care and benefit coordination across these arrangements, based on regulatory and administrative obstacles to effective benefit and care coordination for beneficiaries enrolled in these varied managed care arrangements.*

## INTRODUCTION

While CMS and individual States consider managed care an important vehicle for improving health care delivery and controlling expenditures, health plans contracting with Medicare or with individual State Medicaid Programs face many challenges. These challenges are particularly complex when health plans enroll beneficiaries who are covered by both Medicare and Medicaid, known as dually eligible beneficiaries. The central goals of this article are to: (1) describe the existing varia-

tion in Medicare and Medicaid managed care combinations in which dually eligible beneficiaries are enrolled; (2) identify problems that health plans, beneficiaries, and providers encounter when dually eligible beneficiaries are enrolled in health plans; and (3) discuss the implications of these findings. Prior to addressing these goals we provide background information on Medicare/Medicaid dual eligibility and managed care options available for these beneficiaries.

## Characteristics

About 17 percent of Medicare beneficiaries in 1999 were also enrolled in Medicaid, representing about 6.2 million dually eligible beneficiaries (CMS analysis of Medicare Current Beneficiary Survey data). These dually eligible beneficiaries accounted for about \$50 billion in Medicare expenditures (24 percent of the total for all Medicare beneficiaries) and \$63 billion in Medicaid expenditures (35 percent of the Medicaid total). These beneficiaries receive assistance from their State Medicaid Programs with Medicare premium payments and their Medicare copays and deductibles. If their income and assets are low enough, dually eligible beneficiaries may also receive Medicaid benefits from their States, such as community and facility long-term care (LTC), acute care, behavioral health, pharmacy benefits and medical transportation. This group is sometimes referred to as “full benefit” dually eligible beneficiaries. The categories of dual

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eligibility and their respective benefits can be found at [www.hcfa.gov/medicaid/dualelig/](http://www.hcfa.gov/medicaid/dualelig/).

Despite the additional resources available to dually eligible beneficiaries, serving these beneficiaries can be particularly challenging for both health plans and medical care providers. In comparison to other Medicare beneficiaries, dually eligible beneficiaries are known to have poorer health status, higher health care costs, less education, be more culturally diverse, and have an increased likelihood of using LTC. In 2000, 55 percent of dually eligible beneficiaries reported fair or poor health status compared with 26 percent among the non-dually eligible Medicare population. Sixty-three percent of dually eligible beneficiaries had less than a high school education in comparison to 29 percent of non-dually eligible beneficiaries. Twenty two percent of dually eligible beneficiaries lived in LTC facilities compared with only 3 percent of non-dually eligible beneficiaries. Higher percentages of dually eligible beneficiaries have diabetes, pulmonary disease, stroke, and Alzheimer's disease than non-dually eligible Medicare beneficiaries. Dually eligible beneficiaries also are disproportionately older, female, and from minority populations (Shatto, 2002).

Indeed, because Medicaid status (also known as welfare status) serves as a proxy for poor health in the demographic risk-adjustment models that are the basis of M+C capitation payments, M+C organizations receive substantially higher capitation payments for each dually eligible enrollee. As a result of their poor health status and increased likelihood of using a range of services, dually eligible beneficiaries are a group for which care and benefit coordination are simultaneously important and complex.

## **Managed Care: History and Objectives**

Policymakers have long promoted managed care as holding promise for care delivery through a model that could offer a high degree of coordination and integration across the spectrum of covered acute, chronic, and LTC services. The combination of risk-based capitation, comprehensive benefit packages, and broad flexibility in the allocation of services offered by health plans has been considered an arrangement that could lead to the efficient and cost-effective provision of high quality services and care (Schlesinger and Mechanic, 1993; Walsh, French, and Bentley, 2000).

Neither Medicare nor Medicaid was designed to enable managed care options. However, both programs have been amended since enactment in 1965 to develop managed care options. Title XVIII has been amended several times to enable risk-based financing for Medicare, with the M+C Program per the Balanced Budget Act of 1997, the current foundation for Medicare managed care (MMC). Medicaid Programs have enabled managed care through voluntary health plans per the provisions of Title XIX section 1915(a), and through section 1115 waivers. Amendments to Medicaid in the early 1980s enabled States to develop primary care case management and MCOs that are capitated and may include mandatory enrollment options (section 1915(b)). For many Americans dually eligible for both Medicare and Medicaid, all these provisions guide the delivery and payment for the health care benefits available to them under the Social Security Act, and interface with other entitlements such as Social Security itself and benefits from the Department of Veterans Affairs. Their totality represents an enormous

and complex set of rules and regulations under which consumers, caregivers, providers, and government labor.

### **Managed Care Initiatives**

Managed care programs such as the Program of All-Inclusive Care for the Elderly and demonstrations such as the Social/Health Maintenance Organization, the Minnesota Senior/Disability Health Options, and the Wisconsin Partnership Program have been designed and implemented with an orientation to enroll and serve dually eligible and frail or chronically ill populations. These have been examined in some detail (e.g., Greenberg, Leutz, and Altman, 1989; Harrington and Newcomer, 1991; Branch, 1998; Kane, Flood, Keckhafer, et al., 2001; Kane, Weiner, Homyak, et al., 2001). However, the vast majority of dually eligible MMC enrollees nationwide (approximately 300,000) are in traditional M+C organizations. Very little information is known about how these beneficiaries arrange to obtain for themselves the services to which they may be entitled under Medicaid, but for which, their Medicare health plan has little or no obligation to provide assistance. Similarly, dually eligible Medicaid recipients also are enrolling voluntarily, or are subject to mandatory Medicaid MCO enrollment, in some States. Little is known about how individuals in these plans obtain their Medicare services or how the two are coordinated.

### **METHODS**

To gain an understanding of the types of managed care combinations available and the number of dually eligible beneficiaries participating in various arrangements, we reviewed CMS data (analysis of the 1998 Medicare Denominator File and the

Enrollment Database; analysis of Group Health Program Data) and State data (Kaye et al., 1999); and enrollment and eligibility data from selected States' Web sites in 1999. We also used these data to select four market areas for site visits and extensive case studies. The market areas were selected because they each have a substantial M+C presence, enroll at least some of their dually eligible beneficiaries in Medicaid managed care, and reflect varied Medicaid managed care policies regarding enrolling dually eligible beneficiaries.<sup>1</sup> State administrators provided guidance in selecting plans, and entrée to Medicaid managed care plans in the target market areas. We approached M+C plans directly. In each market area, we met with administrators and staff of at least two health plans. Across the four market areas, we met with M+C-only (two plans), Medicaid-only (two plans), and health plans offering both (five plans), including a mixture of for-profit and not-for-profit organizations. We held a series of meetings at each plan, interviewing government relations administrators responsible for compliance with Federal and State regulations, enrollment, member services, provider relations (for issues affecting physicians and other providers), utilization review, case management and quality improvement staff (including the medical directors), and claims processing departments.

We conducted site visits to managed care plans in Los Angeles County, California; Portland, Oregon; Miami, Florida; and Philadelphia, Pennsylvania. In Philadelphia and Los Angeles County, we conducted beneficiary focus groups (11 groups in total). This effort was supported by assistance from the health plans. The focus group participants were all dually eligible beneficiaries (or their caregivers), age 65

<sup>1</sup>Further information about site selection is available on request from the authors. Information about the plans, however, is not available as we offered them anonymity.

or over, who had been enrolled in health plans for either their Medicare or Medicaid benefits, or for both for at least 6 months. The focus group protocols included questions designed to assess beneficiary understanding of their coverage, sources of information used by beneficiaries to understand their joint coverage, and to learn about beneficiaries' experience receiving medical services and accessing payment for that care. We further supplemented our case study activities with numerous Web-based searches of CMS and State information for beneficiaries and with follow-up discussions with managed care administrators and State informants.

## **FINDINGS**

### **Overview**

To understand benefit coordination, we first identified the combinations of managed care arrangements in each of our market areas, examined coordination of benefit rules under Medicare and Medicaid for dually eligible beneficiaries under these arrangements, and identified particular problems in coordination of benefit (COB) rules associated with the various combinations of managed care and fee-for-service (FFS) benefits. For dually eligible beneficiaries to access the services to which they are entitled, the beneficiaries, the plans, and providers each have to be knowledgeable in these areas, information systems have to support COB, and the details of payment arrangements have to be known and operationalized. Our findings cover six areas related to benefit and care coordination: (1) the managed care arrangements in each of the four market areas and coordination of benefit issues by plan type or combination; (2) beneficiary knowledge and information needs; (3) health plan information needs; (4) specific issues

regarding copayments across programs; (5) the loss of zero premium M+C products in many market areas, and how one State has addressed this issue; and (6) aspects of case management and clinical care coordination activities within the health plans.

### **Managed Care Arrangements**

Dually eligible beneficiaries can be found enrolled in M+C plans, Medicaid plans, or both based on a combination of market factors and State regulations. M+C enrollment is open, on a voluntary basis, to all categories of dually eligible beneficiaries, in market areas with M+C organizations. However, enrollment in Medicaid MCOs is limited to full benefit dually eligible beneficiaries, and depends on individual State regulations as well as managed care markets. State policies dictate whether dually eligible beneficiaries have the option to enroll in Medicaid MCOs at all, and whether enrollment is voluntary or mandatory. States with Medicaid MCO enrollment for dually eligible beneficiaries establish policies on the combinations of Medicaid MCO and Medicare coverage permitted, i.e., whether those enrolled in M+C plans are encouraged, allowed, or forbidden to enroll in Medicaid managed care simultaneously. Where such simultaneous enrollment is permitted, States further determine whether beneficiaries may receive both benefits within the same health plan, or from two unrelated health plans. These varying combinations can differ not only from State to State, but within market areas of individual States, depending on managed care penetration or State regulations. Thus, dually eligible beneficiaries may be enrolled in varying combinations of managed care and FFS for each of these two benefits.

The number and percent of dually eligible beneficiaries who are enrolled in Medicaid managed care varies across

**Table 1**  
**Enrollment of Dually Eligible Beneficiaries in M+C and Medicaid Managed Care in Four States**

State	Total Beneficiaries		Dually Eligible Beneficiaries		
	Medicare	Dually Eligible	Medicare Managed Care	Percent In Medicare Managed Care	Medicaid Managed Care
California	4,139,502	856,974	89,694	10.5	93,000
Florida	2,994,687	367,546	51,946	14.1	18,267
Oregon	522,499	65,413	18,018	27.5	21,143
Pennsylvania	2,195,187	218,656	18,469	8.4	54,300

NOTES: M+C is Medicare+Choice. A number of these States have limited the enrollment of dually eligible beneficiaries enrolled in Medicaid MCOs.

SOURCES: Walsh, E.G., and Clark, W.D.; California enrollment data, February 2000; Florida enrollment reports, February 2000; Oregon enrollment reports, March 2002; Pennsylvania Department of Public Welfare, December 1999.

States and across market areas within States due to a combination of factors. The presence of M+C is primarily determined by individual health plans in response to county level payment rates leading to areas with sizable M+C penetration and others with no M+C presentation at all. The presence of Medicaid managed care is determined by State regulations (later described), as well as business decisions of individual health plans. Table 1 presents information about dually eligible beneficiaries and managed care enrollment in our four case study States. Of these States, California has the highest number of Medicare beneficiaries (4.1 million), almost 1 million of whom are dually eligible. About 11 percent of these dually eligible beneficiaries in California were enrolled in a M+C plan in 2001. California's requirements regarding enrollment in Medicaid managed care for dually eligible beneficiaries vary by county of residence, with about 93,000 enrolled in Medicaid MCOs in February 2000. (We do not present the percent of dually eligible beneficiaries enrolled in Medicaid managed care by State because the appropriate denominator is not clear: State and Federal figures differ on total dually eligible beneficiaries in each State, and are from different time periods. In addition to discrepant time periods, the differences may relate to which categories of dually eligible beneficiaries States and CMS track,

or lags in State reporting of dually eligible beneficiaries enrolled or other factors.)

In Table 2, we summarize Medicaid MCO enrollment policies for full benefit dually eligible beneficiaries by market area.<sup>2</sup> Each of these market areas is subject to a different set of State policies based on Medicare enrollment status (FFS or M+C), LTC use, and Medicaid MCO enrollment for dually eligible beneficiaries. For example, although there are liberal exemptions on an individual basis and those with Medigap policies or other third party resources are excluded from Medicaid MCO enrollment in Oregon, in general, dually eligible beneficiaries who receive their Medicare benefits on a FFS basis are required to enroll in a Medicaid MCO. Medicaid MCO enrollment for individuals choosing M+C plans in Portland, Oregon is more complicated: dually eligible beneficiaries who are in M+C plans that have a companion Medicaid product are mandated to enroll in that companion product, while those in a M+C plan without a companion Medicaid product are prohibited from enrolling in another Medicaid MCO (Mitchell and Saucier, 1999). In contrast, in Los Angeles County, California, dually eligible beneficiaries could choose to enroll in either an M+C plan or a Medicaid MCO,

<sup>2</sup> Medically needy, qualified Medicare beneficiaries (QMB)-only and specified low-income Medicare beneficiaries (SLMB) are free to enroll in M+C plans, but are not enrolled in Medicaid MCOs.

**Table 2**  
**Medicaid Managed Care Organization (MCO) Enrollment Policies, by Market Area**

Area <sup>1</sup>	Mandatory MCO Enrollment for Dually Eligible Beneficiaries in Medicare FFS	M+C Enrollees	Home and Community-Based Waiver Clients	Nursing Facility Residents
Portland, Oregon	X	Only in a related plan.	X	X
Los Angeles County, California	NA	NA	NA	NA
Miami, Florida	NA	Only in an unrelated plan.	NA	NA
Philadelphia, Pennsylvania	X	In either related or unrelated plans.	X	NA

<sup>1</sup> Each of these market areas is subject to a different set of State policies based on Medicare enrollment status (FFS or M+C), long-term care use, and Medicaid managed care organization enrollment for dually eligible beneficiaries.

NOTES: FFS is fee-for-service. M+C is Medicare+Choice. NA is not applicable.

SOURCES: Kaye, N.: Medicaid Managed Care: A Guide for States and Health Economics Research interviews with State officials.

but not both, regardless of whether or not companion plans exist—even if enrolling in a staff model health maintenance organization. In Miami, Florida, the State allowed simultaneous enrollment in both M+C and a Medicaid MCO, but only in two unrelated plans, while in Philadelphia, Pennsylvania, dually eligible beneficiaries enrolled in an M+C plan, could choose to remain in Medicaid FFS or enroll in a related or an unrelated Medicaid MCO.

States also categorize their Medicaid beneficiaries according to services they utilize, such as those who live in institutions (LTC, psychiatric facilities, or others), or whether they receive services through Section 1915(c) 2176 home and community-based services (HCBS) waivers. Medicaid managed care enrollment may be required, optional, or unavailable by these categories. As seen in Table 2, only Oregon enrolls nursing facility residents in Medicaid MCOs, both Oregon and Philadelphia enroll HCBS waiver clients in Medicaid MCOs, while both categories of LTC users are excluded from Medicaid MCOs in Los Angeles and Miami. Even when LTC users are enrolled in Medicaid MCOs, their LTC services (both HCBS and facility-based care) are carved out and delivered on a FFS basis.

## Coordinating Benefits

While some elements of care coordination pertain to all types of managed care plans operating under either the Medicare and Medicaid Programs, and any combination of managed care enrollment and FFS benefits, other aspects relate to whether a managed care plan is responsible for M+C, Medicaid managed care or both. Regardless of the specific combination of managed care and FFS, coordinating benefits for Medicare beneficiaries starts by identifying what additional coverage, if any, a beneficiary has. For those with more than one coverage there are several components of COB, including:

- Determining what services each coverage includes.
- Determining which coverage is primary (i.e., which is billed first) for any services covered by more than one insurer.
- Identifying what cost sharing (i.e., copays and deductibles) there may be and whether the beneficiary or the secondary insurer is liable.
- Collecting any cost sharing from the responsible other party, be it the beneficiary, Medicaid, or another insurer.

In coordinating Medicare and Medicaid, unique rules apply in COB that differ from the COB rules between Medicare and any

other insurer. Medicare is the primary payer for services that are covered by both Medicare and Medicaid, as it is with private Medigap policies (also called Medicare supplemental insurance policies), while Medicare is the secondary payer in most other combinations (e.g., employer-sponsored coverage). Most categories of dually eligible beneficiaries (Supplemental Security Income, other full benefit dually eligible beneficiaries, and QMBs) are not liable for Medicare copays and deductibles, although States are not required to pay the full Medicare cost sharing on behalf of their dually eligible beneficiaries (Mitchell and Haber, 2002). In addition, although Medicaid coverage varies by State, it generally includes many services that are not covered by traditional Medicare at all, such as outpatient prescription drugs, LTC services, some preventive services, podiatry, and dental services. Finally, Medicaid does pay Medicare Part B premiums for almost all categories of dually eligible beneficiaries, which all other beneficiaries pay for themselves or receive as a retiree benefit.

In summary, there are multiple enrollment combinations and inconsistent and complex policies for coordinating Medicare and Medicaid benefits for dually eligible beneficiaries. Our goals in conducting case study activities were to learn how this complexity plays out in the day-to-day operations of MCOs contracting with CMS or with State Medicaid Programs, and for the beneficiaries seeking to access medical services utilizing their combined benefits.

### **Beneficiary Knowledge and Information Needs**

To access the full range of benefits, dually eligible beneficiaries need to understand which services are covered by each plan or

FFS coverage that they have, and how multiple coverages work together. They need basic information about their liability for copayments or deductibles under either Medicare or Medicaid and how to ensure they are not charged inappropriately for these. When enrolled in an M+C plan, they need to understand that they must seek all of their Medicare-covered services from that plan. When enrolled in a Medicaid MCO, they need to understand that many, though not all, of their Medicaid services must be delivered through that plan.

### **Available Sources of Information**

We reviewed numerous CMS and State Web sites for information about coordinating Medicare and Medicaid benefits in general and for managed care enrollees. The majority of beneficiaries do not use the Web, but the CMS Web site includes the consumer-oriented information guides that many beneficiaries access in print format, such as *Medicare and You*. These documents offer little information to help beneficiaries understand dual eligibility, as found by previous researchers (Harris-Kojetin et al., 2001) and none about how managed care enrollment in either M+C or Medicaid plans affects dually eligible beneficiaries. These guides and other components of the Web site are missing important information about the special rules applicable only to dually eligible beneficiaries. The only information for beneficiaries about dual eligibility is to alert Medicare beneficiaries that if they are low income they may qualify for Medicaid or for enrollment in the Medicare Savings Programs (e.g., QMB or SLMB). State Web sites are similarly lacking in information relevant to coordination of Medicare and Medicaid benefits in general, and for those in managed care in particular.

Member handbooks are another potential source of information to assist enrollees to access care and to understand the plan benefits. However, the focus group participants we interviewed varied in their ability to use managed care member handbooks as an information source, and many criticized the complexity of the information available. In addition, the member handbooks we reviewed were written primarily as if all members had only one coverage—even in health plans that simultaneously enrolled dually eligible beneficiaries in M+C and Medicaid managed care products. We found that even dually eligible beneficiaries enrolled in both M+C and Medicaid managed care within the same health plan receive two separate sets of materials.

Member service staff are another source of information for managed care members. Many of the focus group participants had called member services about problems with referrals, bills, copayments, and prescriptions, while others had not thought to call the plan for assistance. Beneficiaries who did call member services generally described these experiences as positive; member service staff were courteous and generally took care of their problems satisfactorily. The plans we visited invest substantial resources in these services, including large telephone banks, information systems for staff to draw on, and training and supervision. Plans serving dually eligible beneficiaries include those with M+C only, Medicaid only, and those with both, and the possible combinations can vary by county even for members of the same plan. Customer service for dually eligible beneficiaries is complex. Staff need to have information about all combinations possible for their members, what the combined benefits are in each combination, what the plan's responsibility is according to the member's enroll-

ment status, and current information about each member's eligibility (e.g., M+C organizations must have up-to-date information about Medicaid status). Some of these needs are dependent on access to information from the State or from CMS, others are based on a plan's own practices, e.g., what information is available about additional coverages on the screens available to customer service staff. Plans with both M+C and Medicaid products were investing in cross training member service staff for both. Other effective practices included electronic files available to member service staff indicating dual eligibility, and intensive training and supervision.

### **Regulatory Impediments to Effective Consumer Information**

Not only is it difficult for beneficiaries to understand “medical-bureaucratize” as one focus group participant described the available materials, but current Federal and State regulations and practices also impede the dissemination of information that is important for dually eligible beneficiaries. These requirements include restrictions on information in marketing materials, mailings to beneficiaries, and member handbooks. For example, M+C organizations are not allowed to include information explaining that dually eligible beneficiaries are not liable for any copays or deductibles in the M+C explanation of benefits. This restriction derives from Federal regulations and requirements regarding standardizing information from all M+C organizations to facilitate comparisons between plans. Unfortunately, these Federal requirements do not take dual eligibility into account. At the time of our site visits, CMS regional office staff had recently denied permission to a plan seeking to mail out dual-specific information to its dually eligible members. The plan had wanted to



inform these beneficiaries that they are not liable for M+C copays or deductibles, and to be sure to show their Medicaid card at the point-of-service in order to have their M+C copays waived. While the plan and the regional office continued to negotiate this issue, an opportunity was lost to include the information in a routine mailing to plan members.

Health plans providing both M+C and Medicaid managed care are also subject to two sets of approval processes regarding beneficiary education materials, including separate approvals from Medicare and Medicaid for their marketing materials and member handbooks. In addition to the added burden to health plans inherent in having to acquire separate approvals, the State and Federal requirements may differ, for example, regarding the acceptable reading level for member education materials.

### **Problems Resulting from Lack of Understanding**

Health plan staff described many situations that result from the lack of beneficiary understanding of their coverages and of how managed care functions, and the focus group discussions brought these issues home. According to the health plans, beneficiaries had difficulty understanding each coverage separate and apart from the other, as well as the relationship between Medicare and M+C, and between Medicare and Medicaid generally and in each combination previously described. Medicaid MCOs reported that their members often seek care from a Medicare provider who is not in the Medicaid MCO network. While this is the beneficiary's right, it creates a number of problems for the beneficiaries, for providers, and for the Medicaid MCO. The resultant problems include:

- The Medicaid MCO does not have an opportunity to provide case management, as the non-participating physicians are not subject to the MCO plan's policies. As a result, the MCO plan incurs liability for prescription drugs, and potentially for deductibles and copayments for other hospitalizations and other services (e.g., radiology services including magnetic resonance imaging) that the plan did not authorize.
- In some States, if the Medicaid MCO did not authorize the service, the plan can refuse to pay copays and deductibles for services provided. In other States, the plan is expected to pay these as historic cost-sharing expenditures are part of the capitation rate development.
- Out-of-network physicians could be affiliated with out-of-network hospitals, skilled nursing facilities, and home health agencies. As a result, the plan may receive bills from these providers and lose the opportunity to manage post-acute care transitions. If the beneficiary then requires LTC, the beneficiary may be placed in a facility that is not served by PCPs or other providers who have contracts with the Medicaid MCO, disrupting continuity of care.

M+C plans and Medicaid MCOs also described problems related to use of the Medicaid FFS card and the lack of information at the provider level of current health plan enrollments. In Florida, we learned that beneficiaries often use their Medicaid eligibility card to purchase prescription drugs, for which the beneficiary should be using a managed care member card. In such instances, the State pays the provider and then bills the Medicaid MCO. The beneficiary has timely access to a needed service, but the health plans report the process is burdensome. The plan absorbs the costs of processing the claims

submitted by the State. The plan also has to reimburse the State based on the rates paid out, not the plan's negotiated rate established with the provider. In contrast, in California, at the time of our site visits, the State put a block on the Medicaid card of any dually eligible beneficiary enrolled in an M+C plan (i.e., providers verifying eligibility or submitting a claim are denied). This was done to ensure the M+C plan was billed for any Medicare services or additional services such as pharmacy benefits offered by the plan. While reducing billing errors, there can be a negative effect on access to Medicaid services that are not covered by the M+C benefit package. Plan informants explained they had to inform the State by fax to "turn the card back on" for each specific service needed by the beneficiary and outside the M+C benefit, and that there had been substantial delays in State processing of some of these requests.

### **Health Plan Information Needs and Gaps**

In order to coordinate benefits and care for dually eligible beneficiaries, health plans need to know that a member is dually eligible, they need up-to-date information about enrollment in any other plans, and, for beneficiaries enrolling in both M+C and Medicaid MCOs, the plans need to coordinate enrollments. As basic and reasonable as these needs may be, all of them are problematic for plan operations. Benefit coordination is affected by enrollment procedures and related data requirements for new managed care enrollees, for enrollees who disenroll from a managed care plan, and for plans serving beneficiaries whose status may change. M+C plans are subject to CMS regulations, and have access to CMS data to verify Medicare eligibility and to learn about dual eligibility of

their enrollees (as reported by each State to CMS). Medicaid MCOs are subject to a separate set of enrollment requirements set by each State, and access to State information systems regarding Medicaid eligibility. In this section, we will describe how these different enrollment processes play out for plans and the dually eligible beneficiaries that they serve, and issues related to access to and the timeliness of the eligibility data these plans need.

Dual eligibility status is changeable. M+C plans may have members who were not dually eligible at initial enrollment, but become so, or who lose their dual status because their circumstances change, they neglect to apply for recertification, or experience problems with the State recertification process. Some M+C plans conduct or outsource activities to identify members who may be eligible for Medicaid, QMB, or SLMB status and assist them with the application process. However, the changeability in Medicaid status creates an additional set of problems for M+C plans, providers, and beneficiaries.

### **Enrollment and Eligibility Data Issues**

Because the two programs are administered separately, M+C and Medicaid MCOs access separate sources of data about eligibility. The lack of coordination of eligibility and enrollment information, combined with time lags that occur within each data system, are problematic for plans, providers, and beneficiaries.

M+C organizations do not have access to accurate and timely information about Medicaid status or about enrollment in Medicaid MCOs. Even in health plans that have both M+C and Medicaid managed care plans (and hence have access to State enrollment and eligibility data), this is problematic. Beneficiaries may be approved for Medicaid, QMB, or SLMB status several months

before the data are entered into the CMS system and available to the M+C plans. This lack of information has implications for plans, beneficiaries, and individual providers:

- M+C plans do not receive the appropriate capitation payment from CMS until the dual status of their members is established. While retroactive adjustments correct these differences, they are a source of substantial administrative burden to the M+C plans.
- Until the M+C plan receives the information from CMS that the beneficiary is also covered by Medicaid, the beneficiary will get charged for copays and deductibles for which the beneficiary should not be responsible. There is no mechanism by which to identify copayments made by beneficiaries directly to the providers nor to require that providers return any copays or deductibles that they have collected.
- Without knowing that enrollees have additional coverage, M+C case management staff and primary care doctors miss the opportunity to coordinate with Medicaid-covered services unavailable to Medicare-only beneficiaries.
- Some M+C plans pay their primary care providers in proportion to the individual capitation payments received from CMS. In these plans, primary care providers receive a lower-than-indicated capitation payment for members who have not yet been identified as dually eligible beneficiaries. This may lead providers to more strictly limit the services they provide to these members than they would otherwise.

Medicaid MCOs do not have access to accurate and timely information about enrollment and disenrollment from M+C plans. This is particularly salient in States where certain combinations of plan enrollment are prohibited—e.g., if a plan is not allowed to simultaneously enroll a dually eligible beneficiary in both products (e.g.,

Florida, California). Without timely information about M+C enrollments, the Medicaid MCOs face several challenges that affect the plan, providers, and beneficiaries:

- Medicaid MCOs face an administrative burden to inform members of their unacceptable dual enrollment and, where applicable, offer the beneficiary choices about what enrollment to keep and which to drop.
  - Medicaid MCOs have to retroactively disenroll beneficiaries, resulting in cash-flow problems for the plans, and ill will generated with beneficiaries and providers.
- M+C and Medicaid MCOs that jointly enroll individual beneficiaries confront problems coordinating accretion dates (the dates new enrollments become effective). For example, under Oregon's Medicaid managed care rules, new enrollments are effective within 1 week of signing the enrollment forms, whereas M+C enrollments for the same individuals are only effective at the beginning of the next month. As a result, an individual may be in the Medicaid plan before his or her enrollment in the M+C plan becomes effective, creating special challenges regarding benefit coordination. This is very confusing for beneficiaries, and burdensome for the health plans and providers.

## Cost Sharing

Medicare FFS coverage includes substantial beneficiary cost-sharing obligations. For example, the deductible for each hospital episode in 2002 is \$812, and there are additional daily copays for stays beyond 60 days. In addition, outpatient services carry a 20-percent copay for each visit. While M+C copays and deductibles have been substantially lower than those in FFS, on the order of \$5 or \$10 per physician visit, these aspects of cost sharing

have been rising dramatically in some M+C plans. The average M+C enrollee paid \$219 for copays and deductibles in 2001, and those in poor health paid \$614 (Achman and Gold, 2002c), almost the entire monthly income of an individual eligible for QMB status (\$759 in 2002). Even nominal copays are burdensome for low-income beneficiaries or those with chronic conditions and may serve as a barrier to needed care. Indeed, legislation was introduced in 2001 to eliminate Medicare cost-sharing requirements to improve access to preventive services for Medicare beneficiaries with chronic conditions (Medicare Chronic Care Improvement Act of 2001).

Under Federal policy, full-benefit dually eligible beneficiaries and QMBs are not liable for these FFS cost-sharing requirements as Medicare copays and deductibles are covered under their Medicaid benefit—although State practices vary regarding the level of payment, as permitted under the Balanced Budget Act of 1997 (Mitchell and Haber, 2001). However, we learned in the course of our meetings with plan administrators and from the beneficiary focus groups that beneficiaries are sometimes charged inappropriately for copays and deductibles. Plan staff also report that providers and plans have difficulty getting payment from Medicaid for the copays and deductibles either because the State does not cover the copays, the State cannot determine what the copayment amount should be, or the individual payments are too small to warrant billing costs. The obstacles are especially problematic for small providers. While provider claims to Medicare under FFS generate crossover claims to Medicaid, this does not occur in M+C. While some plans would be happy to submit bills on behalf of their providers, only plans that are licensed as providers themselves are eligible to submit bills to the State.

Some focus group participants described their successful use of their various medical cards to receive services without inappropriate copayment charges (*“If there is something that [the M+C plan] does not cover, then [the Medicaid MCO] picks it up”*), or had their problems resolved after calling member services (*“I get bills sometimes, and I show both cards, but I’ll get a bill, and I’ll have to call them and tell them I have a second insurance and that’s the last I hear of it”*). However, the following are just a few examples showing that dually eligible beneficiaries are indeed being charged copayments inappropriately, and many did not know they were not liable for these charges:

*“When I went to the doctor, I showed them both and he said then we accept this one and I won’t need the health card anymore. So I threw the other one away and I pay a co-pay of \$5.”*

*“My card states that I shouldn’t be paying for medication, but yet when I show it to them they make me pay either \$5 or \$10.”*

*“I do (pay a co-pay) and I only show the (M+C Plan) card.”*

*“They told me to give them both cards, but my doctor only uses (the Medicaid plan card) for her patients.”*

*“They just take (the M+C plan) card and I pay the \$10 copay.”*

Beneficiary confusion about cost sharing has come up in several CMS studies that we have conducted including the evaluation of Oregon’s section 1115 Medicaid waiver (Walsh, French, and Bentley, 2000), and the evaluation of the QMB and SLMB programs (Walsh, Hoover, Haber, et al., 2001) with dually eligible beneficiaries enrolled in M+C organizations reporting that they have been paying copays routinely,

often over the course of many years. Copayment charges are not only burdensome for these beneficiaries, they can also become a barrier to needed services, as explained by one focus group participant: *“As far as my medications, I haven’t taken any of them. I’ve dropped them because of the copayment. Because I can’t afford the copayment.”*

It is clear that beneficiaries lack key information about their joint coverages, and M+C plans repeatedly indicated frustration with the lack of information from CMS about dual eligibility and barriers to conducting effective member education such as mailings targeted to their dually eligible members. In addition, the plans pointed out that other factors contribute to inappropriate copayment charges. Individual medical practices and other providers need to understand the regulations, and the need to ask beneficiaries to show all their health insurance cards at every encounter. In addition, the lack of timely eligibility information available to plans means that those M+C members who become dually eligible after enrollment are not identified as such for several months—so the plan treats them as M+C only.

## **M+C Premiums**

The loss of zero premium plans (plans for which the beneficiary does not have to pay a monthly premium to the M+C plan) in many market areas since 2000 (Achman and Gold, 2002b), has created a new problem for dually eligible beneficiaries, M+C plans, and for States. Dually eligible beneficiaries cannot afford to pay M+C premiums, Federal regulation prohibits segmenting the Medicare market by classes of beneficiaries, and States stand to lose the benefits associated with M+C enrollment of their dually eligible beneficiaries. In this

section, we describe the issue and the development of a solution in California.

Individual M+C organizations may provide a variety of products, each with a different benefit package. Basic plans offer the same benefits as traditional Medicare, while other plans incorporate additional services like prescription drug coverage. M+C plans may charge monthly premiums for any or all of their products, and historically competed with each other, with Medicare FFS, and with Medigap policies based on the combination of added benefits and related premium charges. In market areas with high capitation payments, M+C plans offered enriched packages without charging monthly premiums. Prior to 2001, many M+C organizations had at least one zero premium M+C plan, either basic packages or products with additional benefits such as pharmacy. However, the number of zero premium M+C plans has decreased substantially since 2000, even for basic M+C coverage (Achman and Gold, 2002c).

The loss of zero premium M+C plans has created a new problem for dually eligible beneficiaries, States, and the M+C plans because dually eligible beneficiaries cannot afford to pay these premiums. At the same time, States are not required to pay M+C premiums on behalf of their dually eligible beneficiaries. Without M+C, QMB-only and SLMB-only beneficiaries may receive fewer preventive services and their services are not subject to utilization management, potentially increasing costs. To the extent M+C plans cover additional benefits beyond traditional Medicare, a loss of M+C enrollment for full benefit dually eligible beneficiaries translates to increased Medicaid costs for States. There are also administrative burdens and costs to M+C plans when members fall behind in premium payments, partly a function of

Medicare regulation requiring 3 continuous months of non-payment before a plan can disenroll a beneficiary.

Our first site visits occurred in fall 2000, when many plans were preparing to charge premiums for the first time, and were concerned about the potential impact on their dually eligible members. At least one plan wished to inform dually eligible beneficiaries that they would be exempted from the M+C premium payments (taking into consideration the higher capitation payments received for dually eligible beneficiaries), but this request was denied by CMS as discriminatory against other beneficiaries. Another plan was concerned with accessing premium payments from the States to replace beneficiary payment. Some plans contacted CMS to determine whether they would need to attempt to collect private premium payments from dually eligible enrollees, as they knew this would lead to disenrollment. CMS determined that these M+C plans would need to attempt to collect the private premiums, however, the plans were advised that failure to pay did not mean that plans would need to disenroll these beneficiaries from their plans. This arrangement, although only addressing part of the issue, was necessary because M+C regulations forbid discrimination in marketing among different classes of beneficiary enrollees.

At the same time, several M+C plans and the State of California initiated discussions on whether and how the State might pay private M+C premiums. States are not required to pay private premiums; however, they may negotiate with M+C plans to arrange payment of M+C premiums. The State of California entered into arrangements with some M+C plans that took effect in 2001. The State agreed to pay the private M+C premium on behalf of the QMB Plus (full benefit) dually eligible enrollees as it anticipated the premium

support would be lower than the increased pharmacy expenses the State would incur if these beneficiaries disenrolled from M+C plans. The agreement did not include any State funding for M+C copayments such as those charged at physicians' offices on a per visit basis.

Negotiations between M+C plans and States of this type are authorized in the M+C regulations (42 CFR 422.106). The regulation enables States to negotiate with M+C plans in the same ways as are available to employer group health plans with respect to establishing special benefit plans for dually eligible beneficiaries. States are able to negotiate premiums, cost sharing, and any Medicaid benefit under the State plan under a contract between the M+C plan and the State, so long as the basic Medicare benefits and coverage are maintained per the requirements of M+C. By 2002, California had entered into contracts with as many as eight M+C plans operating in various counties in the State. The California Premium Payment Program assisted 48,000 dually eligible beneficiaries to enroll in M+C plans through these contracts. The State contracts with the various M+C plans only in counties where the plans continue to offer pharmacy benefits. The 2002 contract expanded the pharmacy packages to include generic-only formularies as well as generic and brand name pharmacy benefit packages. The State continued to be willing to pay increased M+C premiums on behalf of dually eligible enrollees because it continued to believe that Medicaid pharmacy costs in FFS would exceed the cost to the State through the Premium Payment Program. The State and the participating M+C plans will re-evaluate these contracts and determine on a year-to-year basis whether it is in their interest to negotiate a contract. Neither the State nor M+C plans appear to have considered any potential value in negotiating

arrangements that would facilitate the coordination of care between Medicare and Medicaid Programs for those dual enrollees participating in both programs.

### **Case Management and Care Coordination**

Coordination of care is more extensive than dealing with copayment issues. Activities can include coordinating or facilitating in-plan services (e.g., referrals to specialists or for durable medical equipment), linking members to other resources outside the plan's benefit package, flexible service authorization on a case-by-case basis, reviewing risk screening assessments, and implementing disease management protocols. It is, however, an area where health plans and providers need accurate information about multiple coverages such as dual eligibility, and any simultaneous enrollment in managed care for those coverages. We asked the health plans how they identify individuals for case management services and about specific issues in care coordination for dually eligible beneficiaries. Focus group participants also shared some of their experiences.

### **Case Finding**

Each of the plans we interviewed described several approaches to identifying members in need of care coordination or medical case management, but none specifically targeted dually eligible beneficiaries. Federal regulations require [42 CFR 422.112 (b) (4) (i)] M+C plans to conduct health risk assessments, and some States, such as Oregon, have special care coordination requirements for their Medicaid MCOs. Beneficiaries access the Oregon exceptional needs care coordinator at their Medicaid MCO, by way of member services, referral by community

agency case workers, or the State ombudsman (Walsh et al., 2001). In response to the Federal requirements, M+C plans routinely send questionnaires to new enrollees, and some conduct outreach calls to new members. The information from these surveys or welcome calls are used to identify immediately anyone with an ongoing need for medications, oxygen, or other services that should be addressed without interruption, and to identify candidates for specific disease management programs. The most common approach to case finding from screening activities is identification of specific chronic conditions, for example identifying all new members with diabetes.

One M+C plan had a scoring algorithm associated with its screening tool, and referred all new members scoring in the top 5-8 percent for case management (as the system is proprietary, we received little information about the details). Once referred for case management, that plan conducted more extensive assessments and determined whether any particular assistance was needed for each case. Other routes to case management employed by plans include referrals from member services staff, and perhaps most commonly, hospital discharge planning activities. Focus group participants reported smooth transitions from hospital to home while not knowing who arranged the wheelchair, physical therapy, home health aide, or other services.

One large M+C plan we interviewed has a case management department comprised of experienced, bilingual social work staff who conduct outreach activities to identify potential dually eligible beneficiaries, particularly QMBs and SLMBs, and assist these members with the State application process. The plan benefits by accessing increased capitation rates, the members no longer have to pay Medicare Part B premiums, and, in the case of QMBs, may be

eligible for State coverage of copays and deductibles. Indeed, we have since learned of several private companies to which M+C plans outsource this activity.

## **Case Management Activities and Issues**

Regardless of how a dually eligible beneficiary comes into case management, coordinating services within the health plan and across systems is necessary to access the full range of health and social services that may be needed. As the primary payer for dually eligible beneficiaries, M+C plans need information about additional coverages in order to maximize the resources available to their members. For example, dually eligible beneficiaries in M+C plans are able to access additional durable medical equipment, home health, pharmacy and LTC benefits, but only if plan staff, providers or the beneficiaries are aware of the additional coverage. However, to the extent there are time lags between a beneficiary being approved for Medicaid and that information appearing in the CMS data, plans may not know of a beneficiary's dual status. In addition, the plans need to know whether a beneficiary is a "full benefit" dually eligible beneficiary, a QMB-only, or a SLMB-only. The CMS data does not provide this detail.

The challenges are greater, however, for Medicaid MCOs serving dually eligible beneficiaries. As the secondary payer, Medicaid MCOs are responsible for Medicare covered services such as hospital stays, skilled nursing facility care, and home health after the Medicare benefit is exhausted. However, the Medicaid MCO staff we interviewed expressed frustration that they have no way to learn of these services in advance of the beneficiary exhausting their Medicare benefits. As a result, the Medicaid MCO has no opportunity to man-

age such episodes or direct their members to in-network providers. In general, as the secondary payer, Medicaid MCOs do not know what is going on with the beneficiary, i.e., when the person is discharged from the hospital, or what therapies the person is receiving.

The problems associated with being the secondary payer are costly for Medicaid MCOs and for their contracted providers. Reluctant to review a claim more than once because of the resources involved, one plan automatically pays bills if they do not know who the primary payer is. If they pay mistakenly, they will go back to the provider and address the issue. Providers become frustrated when they are caught in the billing system for dually eligible beneficiaries, in both managed care and FFS. If they bill Medicare, they must wait for Medicare to deny the claim and then refile it along with the Medicare denial with the Medicaid plan. As a result of these provider-level reconciliations, participation in Medicaid MCOs can be seen as burdensome by providers as well as by the Medicaid plan.

## **Transitions to LTC**

As we previously described, the presence of managed care, and its associated provider networks create particular problems in continuity of care as dually eligible beneficiaries make transitions from acute to LTC or as they exhaust their Medicare benefits. M+C contracted providers may not accept Medicaid, and providers serving dually eligible beneficiaries under Medicare FFS may not participate in a Medicaid MCO's network.

State limitations on enrollment in Medicaid MCO by service use category can create an additional problem for dually eligible beneficiaries who develop a need for HCBS or nursing facility care. For example, Medicaid MCO enrollees in States that



prohibit Medicaid MCO enrollment for LTC users must disenroll from their health plans. This can have two deleterious effects. First, the opportunity for a plan to manage the medical component of care and the opportunities for plan case management or member services staff to assist beneficiaries is lost with disenrollment from the plan. Second, where the Medicaid MCO is a staff model plan, mandatory disenrollment causes the beneficiaries to cut their ties with their medical team, including PCPs, specialists, and ancillary service providers.

Under M+C, beneficiaries are not required to drop out of their plans with these LTC transitions. However, we identified different problems associated with coordination of care for dually eligible beneficiaries in M+C plans and using LTC services. The key issue raised by one M+C plan is the beneficiary's right to select his or her PCP even when that physician does not attend patients in a particular nursing home. The M+C plan reported that its members who move into nursing facilities often choose to maintain their community physician, whereas the M+C plan would prefer the member to select a physician who routinely cares for members in that facility to facilitate quality care and to deal with the special clinical and administrative requirements of caring for these members. To address the disconnects between standard managed care practices (e.g., having to use a contracted vendor for pharmacy, radiology, and other services) and the realities of nursing facilities (e.g., in which the pharmacy supplier may not be the plan's pharmacy vendor) this plan allows specialized LTC PCPs to order services from out-of-plan providers. In addition, that M+C plan pays these physicians a higher capitation to account for the monthly physician visits required for nursing facility residents.

## SUMMARY

While many dually eligible beneficiaries are getting their medical services under each of the existing managed care arrangements, and health plans are engaged in a variety of disease management and other case management activities, it is clear from this study that current systems do not facilitate coordination of Medicare and Medicaid benefits in managed care. Health plans seeking to address these issues often encounter bureaucratic barriers. Our key findings regarding benefit coordination can be summarized as follows:

- Beneficiaries need a better understanding of their benefits.
- Health plans need timely access to information about beneficiary enrollment and eligibility status.
- Federal and State policies and practices do not consistently provide the intended assistance with Medicare cost sharing for dually eligible beneficiaries.
- This combination of problems leads to administrative burdens for health plans and providers, lost opportunities to manage the care of their members, and inappropriate charges to beneficiaries.

## CONCLUSIONS

The “managed” in managed care is meant to reflect the management of medical care, by creating an administrative structure that can focus on providing cost-effective, well-coordinated services. After meeting with nine health plans, all committed to delivering quality health care to dually eligible beneficiaries, it appears that managing information about beneficiary eligibility and managing the consequences of incorrect information take up a substantial amount of health plan time and resources. These information gaps include: delays in the flow of information between

States, the Federal Government, and the health plans indicating dual eligibility; obstacles to accessing information about Medicaid status including Medicaid MCO enrollment, and information at the beneficiary and provider levels about beneficiary liability for copays and deductibles.

The findings regarding beneficiary confusion indicate a clear need for dual-specific information in Medicare and State consumer information sources. All dually eligible beneficiaries need to understand the importance of showing all their health insurance cards at every encounter. Beneficiaries also should have clear information on whether they are liable for any copayments. As M+C plans increase the size of the copayment and deductibles, this issue becomes of critical importance for these low-income beneficiaries. In addition, given the challenges inherent in improving health plan access to eligibility information, beneficiaries need to advocate for themselves. However, improving beneficiary knowledge is not an easy task, given the low educational level of many dually eligible beneficiaries and the complexities of cost sharing, and plans seeking to address this issue encounter bureaucratic barriers. To achieve increased understanding, CMS and States should consider revising the consumer information available on the State and Federal level, easing restrictions on health plan communication with beneficiaries to allow them to disseminate dually eligible-specific coverage information in their marketing materials, handbooks, and letters.

The lack of timely enrollment and eligibility information available to the health plans is both problematic and challenging to address. Findings in this area reveal, again, that the basic context in which managed care is being practiced for dually eligible beneficiaries has suffered from the lack of specific attention to the administra-

tive details that might make for an improved service delivery environment in which M+C plans and Medicaid MCOs conduct business. Some solutions might appear simple, such as enabling health plans to access Medicaid eligibility online or for Medicaid plans to have access to systems that verify beneficiary M+C enrollment in specific health plans. However, actually solving these problems may be complicated, some improvements might require changes in regulations, permission for routine use and access to data systems, or even statutory changes. Perhaps the findings in this area may be instructive to policymakers, health plans, and providers in prioritizing administrative system changes that should be addressed and triaged according to the level of effort needed to make necessary changes.

This research also raises questions about some of the existing managed care arrangements, and whether CMS and the States can develop approaches that better facilitate coordination across the Medicare and Medicaid Programs. California's decision to pay for M+C premiums for dually eligible beneficiaries allowed many to remain in M+C plans. Other States may wish to consider this innovative approach. In addition, California and other States may wish to examine further how to create Medicaid wrap-around coverage through the M+C plans that would encompass other aspects of cost sharing (i.e., copayments and deductibles) under current regulatory authority. If States took this approach, the billing requirements for providers could be streamlined as they might be able to submit a single bill to the M+C plan and receive the total payments for which they have negotiated. This makes more sense than enrolling dually eligible beneficiaries in two products within the same plan, and would perhaps alleviate some of the administrative burdens (for

plans) and confusion (for beneficiaries and providers) associated with separate M+C and Medicaid MCOs within the same organization.

Two of the managed care arrangements we studied seem particularly problematic. First, it is not clear that States or beneficiaries are well-served by enrolling dually eligible beneficiaries in Medicaid MCOs in combination with Medicare FFS. As we reported, this arrangement can only lead to care management if the beneficiary essentially ceases to use his or her Medicare FFS benefit independent of the Medicaid MCO. Beneficiaries cannot be required to do so, and may not understand the financial and care coordination implications of their decisions to go outside of the Medicaid MCO network. Second, it is not clear there is any advantage to allowing (or requiring) dually eligible beneficiaries to enroll in M+C and Medicaid MCOs through two separate and unrelated health plans. This arrangement does not promote coordination of care, but rather creates two unrelated administrative and billing structures to address COB issues. There may be additional disadvantages if the two unrelated organizations contract with different provider networks.

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