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REPORT TO THE CONGRESS

New Approaches in Medicare

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MEDPAC Medicare Payment Advisory Commission

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patients needing long-term care are discharged to a SNF because the SNF care is covered by Medicare. Eventually, the 100 days of Medicare coverage expire or the patients' needs shift from skilled care to a lower level of care, and Medicaid becomes the primary payer. However, if Medicaid had been the primary payer from the beginning, the patients might have been advised about noninstitutional options at the outset of the stay, potentially leading to a better outcome for the patient and lower costs to Medicaid (Ryan and Super 2003).

Access to care

Payment and coverage rules can affect access to care for dual eligibles in different ways. First, although Medicaid provides many services not available through Medicare, variation in Medicaid benefits across states means that not every dual eligible has access to the same benefits. For example, some states may cover dual eligibles for dental and hearing services; other states may not. Lack of coverage reduces access, particularly for low-income populations.

Second, Medicaid's role as a supplemental insurer in promoting access to care for dual eligibles may be diminished as a result of the BBA clarification that allows Medicaid to pay providers less than the full Medicare cost sharing amount. Because of this, total payments to providers for dual eligibles may be considerably below that for other beneficiaries.

As a supplemental insurer, Medicaid provides financial assistance to dual eligibles by paying beneficiaries' Part B premiums and limiting providers' ability to bill beneficiaries for cost sharing. In addition, Medicaid coverage—on top of Medicare coverage—may improve access to care for dual eligibles by generally paying providers more than they would have received if the beneficiaries had been covered by Medicare or Medicaid alone. Research indicates that physicians segment their potential patient pool based on insurer type and prefer to treat higher-paying patients first. Higher payments, therefore, encourage physicians to treat more dual eligible patients and, conversely, lower payments may discourage providers from caring for dual eligibles (Thompson 2003).

A study of nine states by the Department of Health and Human Services found that lowering the Medicare cost sharing paid by Medicaid decreased the likelihood that a dual eligible would have an outpatient physician visit and reduced the total number of visits the person would have. A 10 percent reduction in cost sharing decreased the probability of having an outpatient visit by 3 percent. This effect was more significant for outpatient mental health treatment than for other outpatient care. Indeed, the probability of an outpatient mental health visit decreased by 21.3 percent in the study state with the highest payment reduction (Thompson 2003).

Third, conflicting payment and coverage rules may cause complications for providers. For example, a dual eligible who is receiving nursing home care (not SNF care) is eligible for Medicare coverage of durable medical equipment. However, if a nursing home has all of its beds certified for Medicare (which is increasingly the case), the DMERC will assume the patient is covered under the Medicare SNF benefit (which includes full payment for durable medical equipment) and will, therefore, deny the claim. The problem is that the DMERC does not now receive information about the patient's source of coverage, so the only information it has is the certification of the bed.

Another example of the coordination problem stems from state Medicare maximization programs that require home health providers to submit proof of Medicare denial before they can submit a claim to Medicaid for payment. Providers complain that this step delays receipt of payment.

Paying MA plans

In general, MA plans are paid a capitated rate per enrollee based on the rate for the beneficiary's county of residence multiplied by a risk-adjustment factor that is intended to reflect the relative health status of the enrolled beneficiary. CMS has recently implemented a new risk-adjustment method—called the CMS hierarchical condition category model—that pays more accurately for patients' clinical needs. The method of payment for dual eligibles is not different than for other beneficiaries. However, because dual eligibles often have more health problems than nondual eligibles, the payments generated for dual eligibles by the new risk-adjustment formula would likely be higher than for nondual eligibles.

The risk-adjustment method includes an additional adjustment for beneficiaries enrolled in a PACE or demonstration plan—such as Minnesota Senior Health Options and Disability Health Options, Massachusetts Senior Care Options, or the Wisconsin Partnership Program (WPP)—which tend to have more frail dually eligible enrollees. This frailty adjuster, phased-in beginning in 2004, is intended to capture predictable