Helpline Case Study

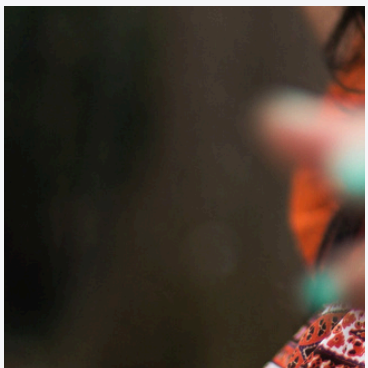
Challenges Faced by Dual Eligibles

Medicare-Medicaid Integration

This case study series was supported in part by Arnold Ventures. Medicare Rights Center maintains full editorial control over all of its policy analysis and communications activities.





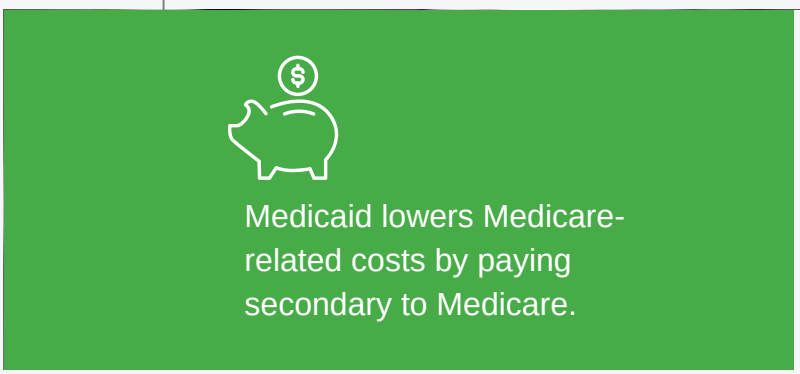

Aims of the Case Study Series

This case study series aims to help policymakers, advocates, and beneficiaries better understand the challenges faced by people with Medicare. Each case tells the story of a client who called the Medicare Rights Center's National Helpline for assistance. Cases highlight common obstacles and provide possible solutions.

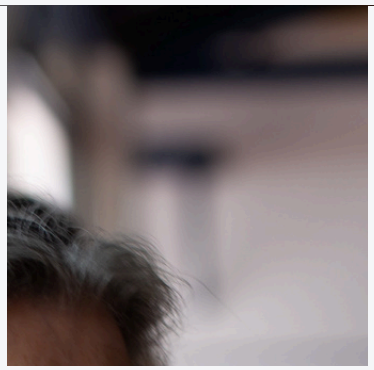
The two-part case study below explores common issues with unintegrated care for individuals dually eligible for Medicare and Medicaid. The challenge of making two types of coverage work together too often falls to the beneficiary and their family/caregivers, providers, and community organizations. However, payers can eliminate some of these challenges through program and plan designs that aim to coordinate and combine Medicare and Medicaid services and payments. Integrated care refers to the coordination of Medicare and Medicaid benefits for dually eligible beneficiaries. Such coordination is most often accomplished through managed care plans and programs that pay for and deliver a person's Medicare and Medicaid services.

Medicare-Medicaid Integration

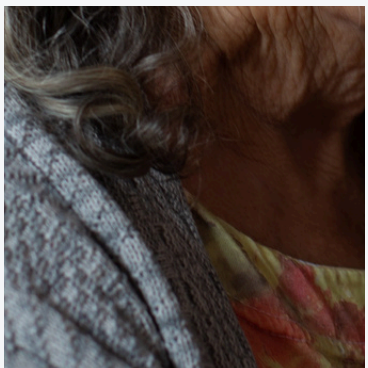
Integrated care aims to improve the beneficiary experience, given that navigating separate Medicare and Medicaid benefits can feel fractured. But integration is still a work in progress, and results are varied. For instance, major differences exist from plan to plan, with some plans offering integrated networks, benefit structures, and appeals and others appearing to provide no substantial benefits to their enrollees. At both the state and federal levels, beneficiaries need tools and education to distinguish between integrated and nonintegrated plans, as they are often marketed similarly despite disparities in value. States can require greater integration through plan contracts and should also work toward improving upon federal standards for integrated care so that all plans provide a meaningful minimum benefit.



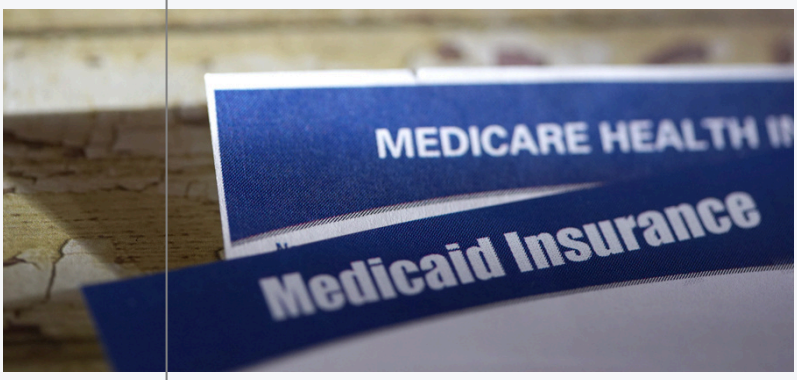
Medicaid lowers Medicare-related costs by paying secondary to Medicare.



Medicaid covers care after Medicare benefits have been exhausted.



Medicaid covers certain services that Medicare does not, like dental and long-term care.



Mr. G is Erroneously Denied Needed Equipment

Mr. G is a 79-year-old dually eligible New Yorker who called the Medicare Rights Center's National Helpline for assistance with an appeal. Mr. G was enrolled in a Medicare Advantage Plan and had a separate plan offered by a different company that was responsible for his Medicaid managed long-term services and supports (MLTSS). His Medicare Advantage Plan was responsible for paying for all Medicare-covered services, and the MLTSS plan was responsible for his Medicaid benefits, including his home health care services.

Mr. G was prescribed orthotic shoe inserts for the treatment of a stress fracture. He ordered them from a Medicare-approved Durable Medical Equipment (DME) supplier that is a Medicaid participating provider. He reached out to his Medicare Advantage Plan to confirm that they would cover the inserts but was told that orthotic shoe inserts were a Medicaid benefit, and the supplier should submit the claim to the MLTSS plan for payment.

After he had received the inserts, however, Mr. G's MLTSS plan sent him a denial notice. The notice said that Medicaid is the "payor of last resort" and that, because he is enrolled in Medicare, his Medicare Advantage Plan should have paid for the inserts.

Mr. G was caught between a Medicare plan saying Medicaid should pay and a Medicaid plan saying Medicare should pay, and he didn't know where to turn. Should he ask the supplier to send the claim to his Medicare Advantage Plan? If he waited for them to do that, and for an answer, he might run out of time to appeal the denial with the Medicaid plan. Was it worth filing that appeal if Medicare should have paid?

He was about to start the Medicaid appeals process when he contacted Medicare Rights' helpline. A counselor was able to explain that the Medicaid plan's denial was incorrect. Although Medicaid is the payer of last resort, Medicare coverage for orthopedic inserts is only available for people with diabetes-related foot disease. Because Mr. G does not have diabetes, Medicare would never pay for his orthotics, and the Medicaid plan is responsible.

Medicare Rights suggested that Mr. G send to his Medicaid plan the relevant pages from his Medicare Advantage Plan's evidence of coverage criteria, as well as the Medicare coverage guidelines and supporting medical documentation showing that he did not meet Medicare requirements for the inserts.

Mr. G's appeal was successful, and he received Medicaid coverage for his orthotic shoe inserts. His situation is not uncommon, and many dually eligible individuals suffer unfortunate health or affordability consequences because they are not able to navigate separate Medicare and Medicaid plans.

Mrs. H Faces a $9,000 Bill

Mrs. H is a 66-year-old dually eligible New Yorker who called the Medicare Rights Center's National Helpline after receiving a $9,000 bill for dental care. Mrs. H is enrolled in a Dual-eligible Special Needs Plan (D-SNP) and fee-for-service (FFS) Medicaid. D-SNPs are a type of Medicare Advantage Plan specifically designed for and marketed to people who also have Medicaid. Although Medicare does not generally cover dental services, Mrs. H chose a D-SNP that offers dental services as a supplemental benefit – this coverage was even highlighted on the Plan Finder website.

Mrs. H needed oral surgery, which she scheduled with a dentist in her D-SNP's provider network. While her D-SNP paid for some of the cost, she was left with a $9,000 bill. Mrs. H was confused and very worried. She tried to submit the bill to Medicaid for payment, knowing that Medicaid covers dental services and pays after Medicare does. However, Mrs. H received a denial from Medicaid because the dentist in her D-SNP's network does not accept Medicaid.

When Mrs. H called Medicare Rights, she told a counselor that she had dental coverage through her Medicare plan and that she also had Medicaid. The surgery was medically necessary, and she thought it should have been covered by Medicaid even if her Medicare plan denied it. How could she be facing such a large bill?

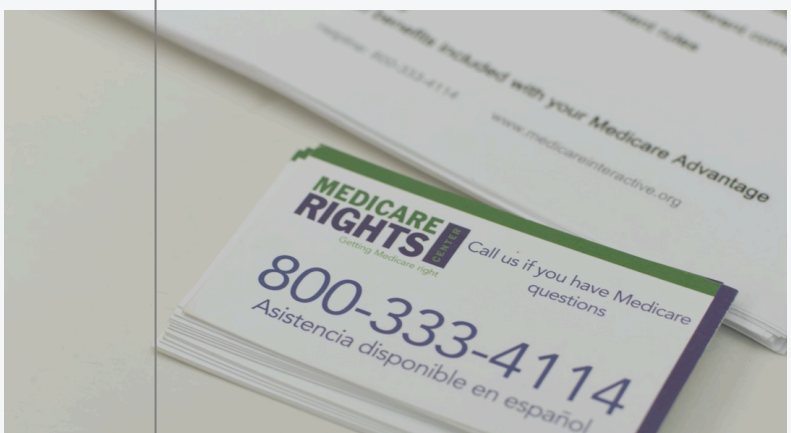
Mrs. H was surprised to learn that some in-network dentists from her D-SNP, a plan specifically designed for people with Medicaid, would not accept her Medicaid insurance. Furthermore, the supplemental dental benefit from her D-SNP was minimal, only covering routine care. Because Medicaid coverage for dental services is much more comprehensive, she would have been better protected had she seen a dentist who accepts Medicaid, even if they were outside of her D-SNP plan's network.

This news was surprising. Mrs. H knew that her D-SNP, a Medicare plan, paid first and that Medicaid was the payer of last resort; she thought that if she didn't follow the D-SNP rules, then

Medicaid wouldn't pay either. What she did not know was that the supplemental dental benefits advertised by the D-SNP and promoted on Plan Finder are not subject to the same rules and protections as regular Medicare benefits. For instance, if instead of dental surgery, Mrs. H needed sinus surgery—a regular Medicare benefit—the situation would have been entirely different. In that case, she would have had to see a provider who was in-network for the D-SNP, and Medicare rules would have prevented her from being billed for cost-sharing even if the provider didn't accept Medicaid.

The incongruency of Medicare and Medicaid provider networks, the lack of clear information from her D-SNP about her dental coverage and options, and the disparate treatment of supplemental Medicare benefits compared to regular Medicare benefits set Mrs. H up to make a costly mistake. Despite her having both Medicaid as secondary insurance and the Qualified Medicare Beneficiary (QMB) Medicare Savings Program, which prohibits providers from charging her Medicare cost-sharing, she was still unprotected because this was one of her plan's supplemental benefits.

A Medicare Advantage Plan with "duals" in the name that is marketed to people with Medicare and Medicaid should be an integrated option. And some D-SNPs do offer more integration and assistance. But coordination-only D-SNPs, like the plan that Mrs. H was enrolled in, have low integration requirements, and it is not easy to differentiate more and less integrated plans. Being enrolled in a less integrated D-SNP is often no different from having totally unintegrated care—and can even be worse because the illusion of integration can cause people like Mrs. H to make assumptions about coordination with devastating consequences.



Key Policy Recommendations

Although plan denials can be reversed via the appeals process, as in Mr. G's case, delays in care can lead to negative health outcomes. The appeals process is burdensome, and the administrative and logistical costs of improper denials should not be borne by those least well-positioned to manage them. Further, appeals are not always an option. As shown in Mrs. H's case, mistakes caused by incorrect coverage assumptions can have costly consequences. The goal of integrated care should be to eliminate—not add— obstacles caused by having to navigate multiple forms of insurance. The following recommendations would help states and the federal government achieve the promise of truly integrated care for dually eligible individuals:

1 Network Congruency

There are no federal network congruency requirements for integrated plans. States should work to implement 100% network congruency requirements for such plans to help ensure that enrollees have full access to care.

2 Integrated Appeals

A single appeals process for both Medicare and Medicaid eliminates barriers and harmful delays in receiving coverage for those who are dually eligible. Federally, only certain kinds of plans are required to integrate the first level of appeals. States may want to use New York's fully integrated appeals process as a model for further integration.

3 Product Clarity

Currently, it is difficult for consumers to determine if a plan is fully, partially, or not integrated at all. Plan names are generic, and the tools that exist to help consumers make decisions, like Medicare's Plan Finder, do not include actionable information about Medicaid benefits. CMS should ensure that D-SNP plan integration is easily communicable, whether through naming conventions or Plan Finder improvements. It should also be clear whether plans are only available to full or partial duals.

4 Insurer Staff Training

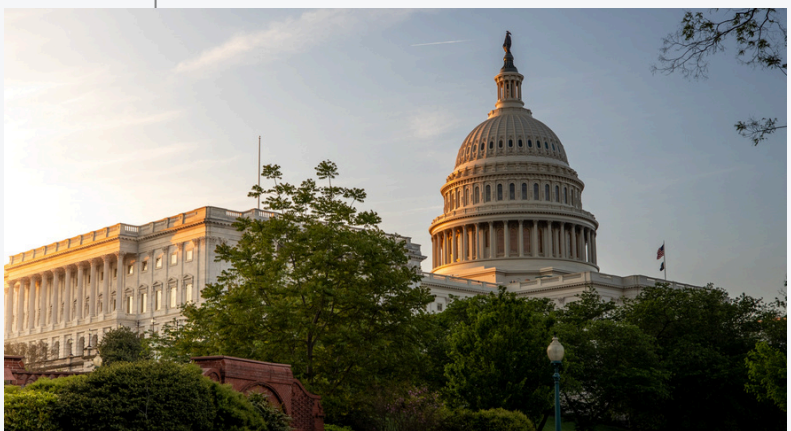
Plans should ensure that D-SNP staff are trained on how to support members with both Medicare and Medicaid. Members often reach out to their plans for support, and ensuring that staff can competently field Medicaid questions will reduce the likelihood of costly errors.

5 Beneficiary Education

Dually eligible individuals need educational resources that explain their integrated care options. Otherwise, they are at risk of joining a plan or program that does not meet their needs. States should work together with the Centers for Medicare & Medicaid Services (CMS) to develop and promote new educational tools or improve existing resources.

6 Ombudsman Programs

States should implement ombudsman programs through which beneficiaries can receive unbiased help and counseling. Problems with enrollment, coverage, and other issues for the dually eligible population are often complex, and even a well-informed person could easily make costly mistakes without professional guidance.



MEDICARE RIGHTS CENTER
Getting Medicare right

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives.

National Helpline: 800-333-4114

www.medicarerights.org | www.medicareinteractive.org

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