Geriatric Services Capacity Assessment

Domain 6 – Benefits and Resources

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INTRODUCTION

Purpose

The Geriatric Services Capacity Assessment was developed to help health plans and health systems, including community providers, hospitals, and other health care delivery organizations, evaluate their current ability to meet the needs of geriatric adults and to identify strategic opportunities for improvement.

Geriatric-competent care focuses on providing care and support for maximum function and prevents or eliminates barriers to integrated, accessible care.

Serving Senior Medicare-Medicaid Enrollees

Medicaid provides health coverage to more than 4.6 million low-income seniors, nearly all of whom are also enrolled in Medicare. Medicaid also provides coverage to 3.7 million people with disabilities who are enrolled in Medicare. In total, 8.3 million people are enrolled in both Medicaid and Medicare, which accounts for more than 17 percent of all Medicaid enrollees. Many of these beneficiaries have complex care needs; they have a significant impairment in physical functioning (some difficulty with two or more activities of daily living) and/or severe impairment in cognitive functioning. Health organizations must adapt to adequately meet the needs of this growing vulnerable population.

Medicare-Medicaid Enrollee Population

- *59 percent are elderly*
- *Compared to other Medicare beneficiaries, Medicare-Medicaid enrollees have:*
  - *More chronic conditions*
  - *More cognitive and other functional limitations*
  - *Lower income*

How to Use This Tool

Inherent in geriatric-competent care is the need to engage the individual in defining their care goals and needs. Establishing geriatric-competent care within a health plan or health system affects all functional areas of the plan or system, from direct care delivery to contract and payment modifications to management systems to the inclusion of a full range of home- and community-based care options and supports. As such, all key functional areas in the organization should be represented in the completion of the Tool.

6 BENEFITS AND RESOURCES

Having both Medicare and Medicaid does not always meet all the needs of the older individual because of the different categories or levels of coverage for which a person is eligible. Medicare covers different types of services and goods depending on the plan(s) for which the person is eligible or elects—Part A, B, C, D, and a Hospice benefit. A person with Medicare coverage may have Part A (acute care) and D (medications) but not Part B (supplementary which covers outpatient care and durable medical equipment) or Part C (managed care). Medicare does not cover long term support and services in the community so Medicaid programs provide these services when the individual is eligible through his or her Medicaid program. Medicaid benefit determination identifies whether an individual is eligible for "full" Medicaid or "partial" Medicaid benefits. Each state determines for their constituents what services Medicaid will cover and how much of the Medicare co-payment will be financed by the state. The dual status of having both Medicare and Medicaid is an amalgamation of each program of health and LTSS insurance rather than separate benefit coverage. Consumers that are entitled to benefits under Medicare as well as Medicaid are referred to as "Medicare-Medicaid enrollees".

Added to the complexity of coverage between Medicare and Medicaid is the bifurcation of reimbursement sources for providers. Although a person has dual coverage, payment for services and goods comes from the two separate coffers—federal and state. Additionally, each system manages and coordinates what services and goods are authorized independently of each other. Recent innovations and demonstrations are striving to correct inefficiencies and resolve any confusion by better synergizing or articulating these funding streams into a seamless system. Specific CMS departments have been created to coordinate financial alignment initiatives and coordinate communication. In addition, demonstration models of care, such as the Financial Alignment Initiative, have been instituted in which states, managed care plans and the Medicare system cooperate to coordinate care

for Medicare-Medicaid individuals and funnel Medicare and Medicaid reimbursement through one stream to be managed by the state.[1]

Practitioners and other providers will want to understand, at least at a high level, just how complex these issues are for the geriatric Medicare-Medicaid consumer and his or her family. Providers will want to know to whom and where to refer older consumers for assistance with understanding their benefits and obtaining needed services or goods, both covered and not covered by their insurance. They may also need to provide clinical consultation or written justification to assist an older Medicare-Medicaid enrollee to become eligible for needed services.

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1 CMS Innovation Center http://innovation.cms.gov/

6.1 Insurance Coverage

Geriatric consumers may have Medicare coverage, Medicaid coverage, both, and may also have private insurance. Within Medicare, there are several coverage types – Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage) and Part D (outpatient pharmacy). Not all beneficiaries have all types. Some individuals elect to receive all benefits through managed care under Medicare Advantage.

Some Medicare beneficiaries may also be eligible for Medicaid benefits based on limited income and resources or disability. Depending on the state in which the person resides and whether he or she has full or partial benefit eligibility, Medicaid may provide assistance with paying for Medicare premiums and additional out-of-pocket medical expenses. These individuals may also be eligible for other services not provided under Medicare such as long term support services.

Some consumers may also purchase Medicare Supplement Insurance (Medigap) policy, retiree insurance, or other private plans. Some consumers also have Veterans benefits.

6.1.1 Does the IDT understand what is meant by dual eligible coverage and the demographics of this population, and in particular the older consumer within this distinct group?

Medicare-Medicaid enrollees as a group are among the sickest and poorest individuals in the country. Over half of Medicare-Medicaid Enrollees are low-income geriatric consumers. These individuals rely on their providers to help them navigate complex insurance programs and health and service systems to obtain services and coverage that they are entitled to as a Medicare-Medicaid consumer.

6.1.2 Is staff knowledgeable generally of the different types of Medicare eligibility and the various eligibility categories for Medicaid?

Providers and involved individuals in an older consumer's care can enhance care coordination activities with a foundational knowledge of Medicare and Medicaid eligibility requirements. In addition to the parts of Medicare coverage, there are Medicare categories designed for specific occupation such as Railroaders Medicare and Black Lung Medicare. Individuals with full Medicaid coverage and those with partial Medicaid benefits are further categorized within each of those classifications, affecting what services and benefits are covered. [2] Providers need not be experts in this knowledge base but rather have enough understanding to facilitate care and direct the older consumer to expert advice and .

[2] Centers for Medicare and Medicaid Services. Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance. Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf

6.1.3 Is staff knowledgeable of whom and where to refer Medicare-Medicaid enrollees for explanations and understanding of their Medicare coverage as well as their Medicaid policy?

Providers and others involved in the individual's care will want to provide information to each consumer about the resources that can help him or her obtain needed information about Medicaid, Medicare and community resources. Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging, and State Health Insurance Assistance Programs (SHIP), as well as Certified Professional Geriatric Care Managers and Geriatric Social Workers are experts in identifying these resources.

6.1.4 Is staff knowledgeable at a general level about how supplemental insurance options help provide coverage for older consumers?

Consumers who are enrolled in Medicare Part A and Part B may also choose to enroll in Medicare supplemental insurance, also known as Medigap. Medigap policies are sold by private companies and help to pay some health care costs that Medicare does not cover. This type of service may be especially beneficial for Medicare-Medicaid enrollees who receive limited or no state Medicaid funding for particular goods or services because of the category of Medicaid eligibility they hold or the state's particular coverage limitations.

6.2 Benefits, Services, and Programs Available to Medicare-Medicaid Beneficiaries

Medicare-Medicaid enrollees are entitled to programs and services available under both Medicare and Medicaid. Benefits under Medicaid vary greatly by state because of the authority and funding state governments apply to their Medicaid programs. State Medicaid agencies can also apply to CMS for waivers that allow them to use federal funding to contribute to their management of Medicaid programs in order to enhance the services that are available to specific populations.

6.2.1 Is staff generally knowledgeable about Medicaid benefits, regardless of what state administers the program?

Medicare-Medicaid beneficiaries may qualify for additional services and programs beyond what is available under Medicare. The federal government does mandate that states provide the following minimum benefits to Medicaid enrollees:

- Inpatient and outpatient hospital services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Transportation to medical care

If any of these services are also covered by a consumer's Medicare plan, Medicare will be the first payer for all or a portion of the expense; Medicaid then covers the balance or possibly any additional consumer out-of-pocket expenses.

6.2.2 Is staff able to refer older consumers to resources to assist them in understanding Medicaid benefits specific to your state?

The federal government allows states to elect to provide certain "optional" benefits to Medicaid enrollees. Additional potential benefits that may be provided through state Medicaid benefits:

- Prescription drug coverage
- Clinic services
- Rehabilitation therapies: physical therapy, occupation therapy, speech, hearing and language disorder services.
- Respiratory care services
- Additional diagnostic, screening, preventative and rehabilitative services
- Podiatry
- Chiropractic services
- Dental services and/or dentures
- Optometry services, including eyeglasses
- Prosthetics
- Private duty nursing services
- Hospice
- Case management
- Services for geriatric consumers in an institution for mental disease
- Services for the intellectual/developmentally disabled
- Home and community based services such as home-delivered meals, adult day health, chore service, personal care or self-directed personal assistance services
- Tuberculosis-related services

It is important for the IDT to be aware of all services that an older consumer may utilize and to discuss which services are critical to the care of the individual. The Kaiser Family Foundation provides information about which benefits are available in which states: http://kff.org/data-collection/medicaid-benefits as does the Aging and Disability Resource Center, see for example http://dcoa.dc.gov/service/additional-resources-adrc.

6.2.3 Can providers help older consumers understand which services may not be covered under your state's Medicaid programs?

Just as it is important to understand which services are covered under your state's Medicaid program, it is equally important to understand which services are not covered. It is critical for consumers to have a solid understanding of the health care costs they need to include in their personal budgets. Geriatric providers, through referrals to experts or through their own in-house knowledge, can assist the older consumer in being actively informed consumers of health care and long term services and supports.

6.3 Managed Care, Incentives and Value-Adds

In recent years many states have opted to deliver their Medicaid services and programs through managed care organizations (MCOs). These organizations are under contract with the state for the state's Medicaid enrollees. A majority of Medicaid enrollees in any one state may receive their benefits through an MCO, either voluntarily or because their state has mandated this process. Medicare Advantage (also known as Medicare Part C) gives beneficiaries the option of receiving their Medicare benefits through private health plans. While the majority of Medicare beneficiaries are covered by Original Medicare, close to a third were enrolled in a Medicare Advantage plan in 2015.[3]

Under the Financial Alignment Demonstration, CMS is testing models with States to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. By aligning financing between the two programs, CMS aims to support improvements in the quality and cost of care for enrolled individuals.

6.3.1 Does the provider understand the role of managed care and how to work with the managed care organization to facilitate optimal care and services for the older consumer?

The role of an MCO in a consumer's health plan will depend largely on his or her state's Medicaid regulations. More information can be found at your state's Medicaid website. Despite a particular state's regulations, MCOs are required by federal law to meet certain standards for consumers. Each managed care plan must provide a quality program with right to appeal and grievance for consumers. Consumers must also have reasonable access to providers and the right to change managed care plans if they so choose. Providers serving geriatric patients will have a solid understanding of the policies in place in their state because states have autonomy over some ways in which managed care plans are executed. For example, states may choose to mandate managed care plans in some regions and not others. States also have the authority to provide different benefits to consumers enrolled in a MCO. In states where MCOs are not mandated, a consumer may choose to receive services directly from the state.

6.3.2 Is the provider knowledgeable about 'value-adds' available to his/her older consumer from the consumer's managed care companies?

Some Medicaid and Medicare managed care organizations will provide extra services, benefits, or goods to consumers as an incentive for signing up with their organization. These are known as 'value-adds' or 'value-added services'. The benefits are in addition to what is covered by their Medicaid package and/or their Medicare package and are marketed as an additional value above what they would get if they were not a member of a MCO. These extra services may include dental coverage, weight loss programs, smoking cessation programs, prescription drug coverage, transportation for medical and non-medical purposes, career developmental services, vision services, and services for developmental disabilities, among others. Geriatric consumers

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[3] Kaiser Family Foundation: Medicare Advantage 06.29.2015 http://kff.org/medicare/fact-sheet/medicare-advantage/

will benefit from a provider’s knowledge of the different managed care plans available in their state and the extra services offered by each plan.

6.3.3 Is the provider aware of incentives available from managed care companies for their members?

Incentives offered by a MCO can support geriatric providers as they encourage a healthy lifestyle for Medicare-Medicaid enrollees. MCOs may provide incentives to their members for activities and practices that promote a healthy lifestyle. They are aimed at promoting participation, engagement, and personal responsibility in one’s own health care. One example of incentives is free gift cards for following through with routine checkups and preventative screenings. (Note that incentive rules may vary by state.)

6.4 Pharmaceutical Assistance

Prescription drugs can represent a significant portion of a consumer's health care spending. Older consumers in particular are often prescribed as many as 10 or 15 different drugs. Medicare and Medicaid may cover a portion of the costs, but Medicare-Medicaid enrollees may still be left with significant financial obligations. When prescribing to Medicare-Medicaid consumers, it is prudent for geriatric providers to consider costs that will be associated with the medical treatment plan.

6.4.1 Do providers understand what pharmaceutical assistance is provided under Medicare and Medicaid?

Many Medicare beneficiaries opt for Medicare Part D, which provides outpatient prescription drug coverage. For Medicare-Medicaid Enrollees, Medicaid assists with coinsurance costs and may cover Medicare-excluded medications in certain circumstances. Some states have expanded their Medicaid coverage to provide additional assistance for paying for prescription drugs; others have not. Medical management practices may exclude certain medications from coverage or limit the reimbursement for certain brand names through their pharmaceutical protocols. More information about a state's particular prescription drug coverage can be found on your state's Medicaid website or the federal government's Medicaid website.[4]

6.4.2 Do providers consider Medicare Part D drug coverage when developing treatment plans?

Medicare Part D does not cover all prescription drugs. Non-generic drugs are rarely covered under Part D, although consumers can appeal for special coverage. A list of excluded drugs can be found online.[5]

6.4.3 Do providers optimize therapeutic strategies that do not rely on pharmaceuticals?

Geriatric-competent providers maximize all therapeutic strategies and recognize that both under-treatment and over-treatment are common issues in geriatric prescribing. Optimizing non-drug therapies may reduce the need or dosage requirement for some medications. Geriatric primary care and nursing texts offer expert guidance on therapeutic strategies for common geriatric conditions and syndromes. If pharmaceuticals are used, geriatric-competent providers reference unbiased publications that compare costs and clinical outcomes for medications in the same therapeutic class. Consultation with geriatricians and geriatric pharmacists provides additional expertise in optimizing or simplifying complex medication plans, reducing polypharmacy and/or weighing risks, benefits and trade-offs (clinical and financial) of various options.

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[4] Medicaid.gov. State Prescription Drug Resources. Retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/State-Prescription-Drug-Resources.html

[5] Centers for Medicare and Medicaid Services. Part D Drugs/Part D Excluded Drugs. Retrieved from http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PartDDrugsPartDExcludedDrugs.pdf.

6.4.4 Does the provider know of, and facilitate the knowledge by the older consumer of, additional financial assistance available from pharmaceutical companies?

Some pharmaceutical companies will offer additional financial assistance for consumers with limited incomes. Consumers must meet eligibility requirements and assistance may only be offered for certain products. For example, Pfizer has established Pfizer Rx Pathways that offers insurance counseling, co-pay help, and free or discounted medicines. The pharmaceutical operating companies of Johnson & Johnson offer special financial assistance to low-income enrollees in Medicare Part D. Geriatric providers with knowledge of these assistance programs are better equipped to help consumers get the medications they need for proper care.

APPENDIX A: REFERENCES AND RESOURCES

Included in this appendix are references that were utilized and consulted during the development of this Tool or augment the information contained in the assessment tool. References are links to government websites, resources provided by professional organizations, or publications in academic journals. The references are divided by domain for ease of use.

Introduction

- **Slow medicine:** http://www.nytimes.com/2008/02/26/health/views/26books.html?_r=1&
- **Geriatric Competencies:** http://www.pogoe.org/gwiz
- **Geriatrics Competent Care Webinar Series:** https://www.resourcesforintegratedcare.com/Geriatrics_Competent_Care_Webinar_series

6. Benefits and Resources

- **Medicare-Medicaid Enrollees**: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Medicare-Medicaid-Enrollees-Dual-Eligibles/Seniors-and-Medicare-and-Medicaid-Enrollees.html
- **ACA and Medicare-Medicaid Enrollees**: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8192.pdf
- **Medicare Supplements**: http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html
- **Medicaid Benefits**: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html
- **Managed Care Organizations**: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html
- **Incentives and Value Adds**: http://www.kancare.ks.gov/health_plan_info.htm
- **Prescription Drug Coverage**: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/State-Prescription-Drug-Resources.html
- **Prescription Drug Coverage**: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/PartDDrugsPartDExcludedDrugs.pdf
- **Medicare Coverage Determination:** http://www.cms.gov/Medicare/Coverage/DeterminationProcess/
- **U.S. Preventative Services Task Force**: http://www.uspreventiveservicestaskforce.org/

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This document represents one domain of an eight-part self-assessment tool. To access additional domains, or to see the tool as a whole, please visit: https://www.resourcesforintegratedcare.com/. We also welcome any feedback to RIC@Lewin.com.