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Survey Issues Regarding Dual Eligible Populations: Design of a Medicare Fee-For-Service CAHPS Survey

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The research consortium for the Consumer Assessment of Health Plans Study (CAHPS), a project sponsored by the Agency for Health Care Policy and Research, is working with the Health Care Financing Administration (HCFA) in the development of a CAHPS survey questionnaire for the Medicare fee-for-service (FFS) population. About 16 percent of Medicare beneficiaries also are "dually eligible" for health insurance coverage under state Medicaid programs, which offers a form of supplemental health insurance provided by Medicaid rather than private Medigap insurers. The dual eligibles encompass a wide range of health conditions, functional status, and health care needs. They tend to stay in the Medicare fee-for-service (FFS) sector, joining Medicare risk contracting health plans at lower rates than other beneficiaries. Thus, they are an important target population for a Medicare FFS CAHPS consumer rating survey. Yet they pose a unique challenge for designing a CAHPS questionnaire that is responsive to the diversity of their health service needs, living and personal care arrangements, forms of Medicaid coverage, and health care preferences and expectations, while balancing these issues within the context of the overall Medicare FFS population.

This memorandum describes a number of the issues regarding dual eligibles that should be examined as a Medicare CAHPS FFS survey instrument is developed. First, the types of Medicaid eligibility categories are defined, and the types of Medicare beneficiaries who qualify for Medicaid under those categories are described. Next, survey issues are discussed regarding the variety of benefit designs established by the Medicaid programs, all which all have some form of effect on access to care, service utilization, and choice of providers for the dual eligibles. Finally, some issues are examined related to Medicare FFS dual eligibles who are enrolled in Medicaid managed care.

Medicaid Eligibility Categories

Although the details of the states' Medicaid eligibility categories vary, there are three basic forms of eligibility, all of which qualify individuals based on low income along with other factors. "Mandatory categorically needy" is the first category. States must qualify groups of individuals receiving cash assistance under specified public programs, as well as other related individuals. Included in this category are old age, blind, or disabled individuals who are determined by the Social Security Administration (SSA) to qualify for Supplemental Security Income (SSI), for which their income must be below the Federal poverty level. Most of the SSI recipients are dual eligibles who also have Medicare coverage. The second eligibility category is "optional categorically needy," for which states may choose to offer Medicaid eligibility. Dual eligibles in this category include institutionalized individuals with income and resources below specified limits, persons receiving care under home and community-based services waivers, and recipients of state supplementary payments. Finally, individuals may qualify as "medically needy" if they do not meet the income and resource standards for categorically needy, but they have such large medical care expenses that their net incomes (after medical expenses) are low enough to meet the poverty standards. For example, elderly Medicare beneficiaries residing in nursing homes who spend down their assets can qualify for Medicaid coverage as medically needy.

The Medicare Catastrophic Coverage Act established two other special categories under which limited Medicaid coverage is provided for low income Medicare beneficiaries who are

not eligible for SSI. Those with incomes below 100 percent of the Federal poverty level are qualified Medicare beneficiaries (QMBs), for whom Medicaid programs must pay their Part B premiums and Parts A and B deductibles and coinsurance. Those with incomes between 100 percent and 120 percent of the Federal poverty level qualify as specified low-income Medicare beneficiaries (SLMBs). Medicaid programs only have to pay the Part B premiums for the SLMBs. Some members of these groups also may have full Medicaid benefits if they qualify as either categorically or medically needy.

A distinction must be made between eligibility for QMB or SLMB status and actual enrollment in the program. Low rates of participation have been found for QMB and SLMB eligibles. One study found that only 63 percent of eligible QMBs and 10 percent of eligible SLMBs were actually enrolled (Moon et al., 1996). Another study estimated that only 41 percent of QMB eligibles were enrolled, and found that participation was higher for poor and less educated beneficiaries, those in poorer health, rural residents, African-Americans, and Hispanics (Neumann et al., 1995). A study of Medicaid buy-in arrangements found extensive interstate variation in enrollment rates, ranging from 7 percent to more than 20 percent of Medicare beneficiaries being covered by state Medicaid programs. The variations were concluded to reflect differences in states' policies and the composition of states' populations (Merrell et al., 1997).

Survey issues regarding Medicaid eligibility:

1. Because the states vary in the criteria they use for determining Medicaid eligibility, samples of dual eligibles residing in different states may represent different populations. The most consistently defined groups are the SSI population and the QMB/SLMBs (both of which use Federal rules). This issue has implications regarding whether the survey sample should be stratified for dual eligible subgroups, e.g., by SSI eligibility, others with full Medicaid benefits, and QMB/SLMBs.
2. The low enrollment rates in the QMB/SLMB program also have implications for the survey sampling frame. Those who are identified on Medicare records as Medicaid buy-ins are a subset of the Medicaid eligible. A sample drawn from this group, therefore, may not be representative of the full Medicaid-eligible population. A choice could be justified for using either group for the sampling frame--actual or actual plus potential dual eligibles--but it will be important to interpret survey results carefully so results are not generalized inappropriately to the other group.

Characteristics of Dual Eligibles

Differences among certain subgroups of dual eligibles in their access to care and health care utilization have been documented in research studies. Such differences are not surprising, given the diversity of health conditions and levels of functional status represented among the dual eligibles. Two basic categories of dual eligibles are the elderly (age 65 years or older) and those below age 65 with chronic disability. An often overlooked point is that the age 65-and-older Medicare population includes some disabled individuals who first were Medicare-eligible due to disability. When disabled beneficiaries "age" into eligibility based on old age, HCFA reclassifies them as old-age beneficiaries. Within each of these categories, dual eligibles vary widely in their health and functional status, as shown by the examples in Table 1.

Table 1

Examples of Dual Eligible Groups

Disability	Old Age
Blindness	Generally healthy but low income
Developmental disability	Frail elderly
Mental retardation	Nursing home residents
Paralysis	Assisted living facility residents
End stage renal disease	Catastrophic illnesses
Chronic mental illness	

The characteristics of the dual eligible population have been changing in recent years. As a result of growth in the disabled population, the disabled now outnumber the elderly dual eligibles. The disabled population also is becoming younger, and the mix of disabilities is shifting toward more persons with mental than physical impairments (Davis and O'Brien, 1996). Disabled beneficiaries have more functional limitations, poorer health status, lower incomes, and experience more barriers to health care than do elderly beneficiaries.

Two special groups within the disabled population merit attention: disabled children and persons with chronic mental illness. Disabled children represent about 5 percent of the Medicaid population, and they tend to be high users of health care (Crown et al., 1995). Their health care needs, including the roles of parents or other guardians, differ from those of adult Medicare beneficiaries. In addition, although most Medicaid programs currently exempt dual eligibles from Medicaid managed care, there are movements in some states to enroll dual-eligible children in primary care case management plans or other managed care plans (Bernadin and Backman, 1995).

The chronically mentally often face barriers to care. Those with a mental disability who responded to the Medicare Current Beneficiary Survey were less likely to have a primary physician, and they were less satisfied with the overall quality of care, availability of after-hours care, follow-up care, and coordination of care. They also were more likely to report unmet need (Rosenbach, 1995). On the Medicaid side, states are beginning to implement carveout mental health plans, through which dual eligibles with mental illnesses will receive Medicaid-covered services (Callahan et al., 1995). These plans may coordinate mental health care and reduce costs, including coordination of care with Medicare-covered benefits, but it is uncertain how they might affect care for dual eligibles with chronic mental illnesses.

The diversity of living arrangements for the elderly dual eligibles poses another challenge for survey design. Although the healthier poor elderly live independently, 24 percent of dual eligibles reside in nursing homes, assisted living facilities, or other institutions. Over half of the oldest old (85+ years) dual eligibles reside in an institution (HCFA, 1996). Dual eligibles are a subgroup of the Medicare beneficiaries residing in institutions. One study found that 44 percent of elderly nursing home residents start and end their nursing home stays covered by private payers, 27 percent start and end as Medicaid recipients, and 14 percent spend down to become Medicaid eligible (Spillman and Kemper 1995). Not only do institutionalized persons have poorer health status and cognitive and physical functional status than other elderly dual eligibles, but the service delivery structures in which they

receive health care also are quite distinct. The families of institutionalized dual eligibles also are more heavily involved in their care and support.

Survey issues regarding characteristics of dual eligibles:

1. The diversity of characteristics and health care utilization patterns for subgroups of dual eligibles should be considered in designing the survey sample, selecting items for the questionnaire, and establishing variables that identify the different groups for use in analysis of survey results.
2. Questions regarding chronic conditions, including chronic mental illness, should be included in the survey to capture information on the health and functional status of dual eligibles.
3. Proxy interviews will be needed for dual eligibles who have impairments that prevent them from completing a survey questionnaire.
4. The parents will need to be involved as survey respondents for dual eligibles who are children.
5. Access to care and responsiveness of providers to special health and personal care needs are important health care issues for dual eligibles.
6. Given the large percentage of elderly dual eligibles who reside in institutions and differences in the service delivery processes for these individuals, it would be informative to perform special analyses (in future studies that include the institutionalized) of the health care experiences they report on the survey. Stratification of the sampling frame on institutional (nursing home) status would be one approach to ensuring adequate sample for such analyses.
7. The dual eligibles might be used as a category of heavy users for calculating summary information in the consumer rating report on the Medicare CAHPS FFS survey.

Structures of Medicaid Benefits

Many of the Medicaid-covered services available to dual eligibles are similar to those covered by private Medigap insurers, whereas others are more focused on the unique needs of the dual eligibles. In addition, some individuals qualify both for Medicaid benefits and as QMBs and SLMBs, while others only qualify as QMBs and SLMBs, and therefore have Medicaid coverage only for their Medicare premiums and cost sharing.

Traditional supplemental services covered by Medicaid include prescription drugs, dental care, and vision and hearing care. Although Medicaid also covers many of the Medicare-covered services, Medicare pays for all these services for dual eligibles as their primary payer, with Medicaid serving as secondary payer. The additional services covered by Medicaid include nursing home care, home health services that complement those covered by Medicare, home and community-based services for persons who otherwise would be in a nursing home, personal care services, and targeted case management services for specified population groups (e.g., chronically mentally ill). Many of the supplemental services are optional benefits, and others are provided through special Medicaid waivers under a variety of organizational arrangements. The states vary in whether they cover the optional services and what limits they place on coverage.

Survey issues regarding structure of Medicaid benefits:

1. As a result of the substantial differences in the scope and types of Medicaid benefits covered, dual eligibles may have differing perceptions of their access to care and the responsiveness of service providers, depending on their type of eligibility and the state Medicaid program in which they are enrolled.
2. When addressing service issues for dual eligibles, the survey design may treat some aspects of Medicaid-covered supplemental services in the same way as Medigap benefits. The same is not true, however, for many other Medicaid benefits (nursing home, personal care) that are unique to the dual eligibles and that are an important aspect of both their total care and their perceptions of the quality of the care they receive.
3. It will be important to ask questions regarding coordination of care and benefits, which can be used to assess coordination of Medicare and Medicaid benefits for the dual eligibles. This issue is similar to coordination of benefits with Medigap policies, but many policymakers have expressed concerns regarding fragmentation of care and conflicting Medicare and Medicaid policies that indicate these issues may be severe for at least some of the dually eligible groups.

Effects of Medicaid Managed Care on Dual Eligibles

Because the Medicare CAHPS FFS survey is intended to develop information on beneficiaries' experiences with FFS health care, it is not clear what to do about the fraction of Medicare FFS dual eligibles who are enrolled in some form of managed care on the Medicaid side of their dual eligibility. Historically, states have exempted dual eligibles from mandatory enrollment in Medicaid managed care plans, but some dual eligibles have enrolled under voluntary options. States are beginning to change these policies to require managed care enrollment. For example, New Jersey currently offers voluntary health plan enrollment for SSI recipients, and it is preparing to make health plan enrollment mandatory for this group in the near future. In addition, a number of states are implementing demonstrations to test integrated delivery and payment systems for dual eligibles.

Primary care case management is another form of managed care being used by many states, some of which require participation by dual eligibles. Under this model, Medicaid recipients choose a primary care provider who is responsible for managing their care and approving referrals to specialists, hospitalizations, and other services. These policies, designed to direct care actively, conflict with a long-standing Medicare policy of allowing FFS beneficiaries freedom of choice of providers and health care services (Parker, 1997).

Survey issues regarding dual eligibles in Medicaid managed care plans:

1. A decision is needed on whether to include in the sampling frame the dual eligibles enrolled in Medicaid health plans or primary care case management plans. If they are excluded, they probably would have to be dropped in a screening step during survey administration because the Medicare administrative data does not provide information on Medicaid health plan enrollment. In addition, the sample size for this subgroup likely would be small because many Medicaid programs do not require health plan enrollment for dual eligibles.

2. The survey might include questions about beneficiaries' ability to choose providers, thus allowing examination of perceptions of dual eligibles regarding their freedom of choice. If the sampling frame excluded dual eligibles enrolled in Medicaid managed care, however, such questions would yield information only regarding access to providers who serve Medicaid recipients, rather than effects of managed care on provider choice.

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