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Issues

*Information and ideas for those
 serving seniors.*

on Aging

Managed Care: A New Challenge for Seniors

Health care cost containment, often called “managed care,” is impacting senior citizens in new and often challenging ways. With the world’s highest per capita health care costs, the Medicare Trust Fund faces insolvency while the senior population continues to grow in age, infirmity and number. Medicare has implemented various cost containment strategies since its inception. The Medicare Peer Review Organizations (PROs) continue to evaluate the appropriateness of Medicare hospital admissions and lengths of stay. In 1983, the Health Care Financing Administration (HCFA) implemented Diagnostic Related Groups (DRGs) in an effort to limit incentives for lengthy hospitalizations. The most recent innovation is the shift of Medicare recipients to managed care plans.

THE GROWTH OF MANAGED CARE PLANS

Nationally, more than four million seniors now receive their health care through Health Maintenance Organizations (HMOs), while ten years ago this was a rare event. In the Twin Cities, approximately 70% of seniors are now enrolled in HMOs while the other 30% rely on traditional Medicare, usually with a Medicare supplemental policy (MedSup). HMOs are continuing to expand in greater Minnesota as well, with formerly independent clinics and hospitals being purchased by corporate entities.

The drive to contain costs has caused nationwide discussion and impending legislation regarding the financial incentives used by HMOs to control physician behavior in discussing all care

options with patients, and in ordering diagnostic tests and treatment for HMO enrollees. In addition, health advocates continue to raise concern about the quality of care for seniors and particularly for senior HMO participants.

THE IMPACT OF MANAGED CARE

Two phenomenon have resulted from the significant and rapid changes in the health care delivery system. Patients—especially older adults—often feel that they are being sent home from the hospital too quickly. Hospital lengths-of-stay continue to decrease, and many procedures which formerly required inpatient care are now being provided on an outpatient basis. Thus, patients are being discharged from hospitals more quickly than ever before, often feeling—correctly—that they are being sent home before they have recovered sufficiently. Though there are home care services and skilled nursing facilities available to assist these patients, inadequate discharge planning by the hospital or HMO frequently results in unmet needs.

In this new paradigm, patients more often question whether they received a correct diagnosis and adequate treatment of their health problems. The HMO trend, along with physician retirement, means that most elderly patients are under the care of a younger doctor who is new to them. Doctors are challenged by the patient—physician age and experience disparity, their lack of knowledge about their patients’ health and social backgrounds, and family and support systems. In addition, production standards required by some HMOs and clinics keep office appointments too brief for doctors to really get to know

their patients. Thus, patients often have not had time to develop trusting relationships with their new doctors. In the case of quick discharge, this can cause them to believe that they have received inadequate medical care.

OBTAINING QUALITY MANAGED CARE

Addressing these concerns requires health consumers to understand three important issues regarding their health care services and payment. First, consumers need to understand the different types of health plans, how to make an informed enrollment decision, and how to utilize their health plan for maximum benefit. Second, consumers need to take responsibility for communicating their needs, desires and concerns to their physicians and health plans. And last, they need to know how to appeal a decision made by their health plan in a timely and effective manner.

These are all difficult issues which require a large body of knowledge about current health care delivery practices, health insurance concepts and one’s own health care needs. Those working with and advocating for seniors with health care or insurance concerns can benefit from a working knowledge of these issues, but will often need to work with a care manager to integrate an individual patient’s needs with the health plan’s services. This is particularly true when the issue is really the patient’s lack of trust in the physician and his plan of care. Many “premature” discharge problems are related more to inadequate communication between the patient and doctor as well as a lack of discharge planning. Care managers can be highly effective in resolving these situations.

TYPES OF MEDICARE MANAGED-CARE HEALTH PLANS

■ Risk Contracts

In these plans, Medicare pays the HMO a set amount to provide all health services for participants. Services must include all those provided by traditional Medicare coverage, and some plans include extra services. All care must be obtained from the HMO network except in emergencies. A few plans now allow participants to obtain some services out of network for an additional fee. About 65% of enrollees do not pay a monthly premium for their basic “Risk Contract” health plan, while 25% pay between \$20 and \$60 per month. Almost 4 million seniors nationwide are enrolled in this type of plan. Minnesota Risk Plans include:

MEDICA HEALTH PLANS

- SeniorCare Basic
- SeniorCare Plus
- SeniorCare Complete
- SeniorCare Options

BLUE PLUS

- Preferred Seniors Standard Option
- Preferred Seniors High Option

HEALTH PARTNERS

- Partners for Seniors Standard Option
- Partners for Seniors High Option

■ Health Care Prepayment Plans (HCPP)

These plans are similar to Cost Contracts, but usually cover only Part B expenses (doctors and outpatient services), while participants rely on traditional Medicare for Part A (hospital and other) expenses. About 447,000 nationwide seniors are enrolled in this type of plan. The Minnesota HCPPs include:

HEALTH PARTNERS

- SeniorChoice
- SeniorChoice Advantage

MEDICA HEALTH PLANS

- PHP + Medicare

■ Medicare Select Plans

These plans are essentially MedSup plans which require participants to choose their health providers from an approved list to obtain full benefits. If participants use out-of-network providers, Medicare pays traditional coverage. Minnesota Medicare Select Plans include:

BLUE CROSS BLUE SHIELD OF MINNESOTA

- Senior Gold

HEALTH PARTNERS

- MedCenters Seniors Choice II

MEDICA HEALTH PLANS

- SeniorCare Secure

■ Cost Contracts

This type of HMO allows participants to use out-of-network services by paying Medicare’s usual coinsurance, deductibles and charges. About 200,000 seniors nationwide are enrolled in this type of plan.

TYPES OF TRADITIONAL MEDICARE SUPPLEMENT PLANS

The National Association of Insurance Commissioners (NAIC) has approved nine levels of MedSup plans which may be sold to seniors enrolled in Medicare. Every insurer selling MedSup insurance must design their plans to meet the standards set by the NAIC, so consumers need only evaluate the stability of the insurance company and the cost of comparable policies. The Minnesota Commerce Commissioner has licensed 24 commercial insurers to sell only two levels of MedSup plans to Minnesotans.

TYPES OF MEDICARE SUPPLEMENTS FOR LOW INCOME SENIORS

There are three options available nationwide for seniors who cannot afford the premiums required by HMOs or by MedSup insurers. (All fees listed are for 1996.) These include:

■ Service Limited Medicare Beneficiary (SLMB)

This program which is accessed through the county social service office waives the Medicare Part B premium of \$42.50 per month, which increases the annual income of a single person by \$552 per year. However, the participant is still responsible for Medicare copays and deductibles. Single participants are limited to \$774 of gross income per month and assets of \$4000, while couples may have monthly gross income of \$1035 and assets of \$6000.

■ Qualified Medicare Beneficiary (QMB)

This program which is also accessed through the county social service office, also waives the Medicare Part B premium of \$42.50 per month, which increases the annual income of a single person by \$552 per year. In addition, the Medicare Part A and B premiums, deductibles and copayments are waived. To qualify for the QMB program, single participants can have \$645 of gross income per month and assets of \$4000, while couples may have monthly gross income of \$863 and assets of \$6000. All physicians who participate in the federal Medicare program also accept QMB patients, which includes nearly all U.S. physicians.

■ Medical Assistance (MA)

Single persons with net monthly income of \$420 and \$3000 in assets, and couples with net monthly income of \$525 and \$6000 in assets are eligible for MA, which is accessed through the county social service office. Medicare plus MA covers nearly all medical services, including prescription drugs, dental care, and eyewear.

■ Minnesota Senior Federation Sponsorship

Minnesota seniors with gross monthly income of \$1290 for singles and \$1726.67 for couples, as well as \$21,000 to \$31,000 in assets plus a homestead, qualify for the Senior Partners Care program sponsored by the Minnesota Senior Federation (MSF). Participating Providers waive Medicare copayments and deductibles for members of Senior Partners Care. There is a \$17 annual administrative fee, and membership in the MSF at \$15 per year (\$20 couple) is encouraged. In addition, the MSF administers programs for chiropractic, dental, medical equipment, optometric and podiatric care. The MSF Health Plan Information Center can be reached at 642-1398 from 10:00 a.m. to noon and from 1:00 p.m. to 3:00 p.m., Mondays through Fridays.

HOW TO APPEAL A HOSPITAL DISCHARGE ORDER

It is important that seniors and their advocates know how to appeal a hospital discharge order—and why they are appealing—if they believe their health is at risk due to the discharge. The appeal process requires specific actions with strict time limits, which when followed correctly will allow the patient to remain in the hospital during the initial appeal process.

■ Hospitalized Medicare-HMO Patients:

- ▶ When a health plan provides written notification to a Medicare-HMO patient that his/her continued hospital stay will not be covered, it must include instructions to appeal the decision. The patient/advocate must request, either in writing or by telephone, an immediate review by NOON of the first working day after receipt of the denial notice. This request must be made to the PRO whose name and address are shown in the denial notice.

In Minnesota, the PRO is Stratis Health (formerly called Foundation

for Health Care Evaluation), and can be reached at 612/854-3306.

- ▶ The PRO will contact the patient/advocate to solicit their views, and immediately obtain medical records from the hospital. The PRO doctor may contact the patient's doctor to discuss the situation. This process takes one to two working days.
- ▶ If the PRO agrees with the patient, the patient will not be responsible for payment of the approved additional hospital days other than applicable copayments.
- ▶ If the PRO agrees with the health plan, the patient will not be responsible for payment until noon of the next day after receiving the PRO's notification. The patient/advocate can request a reconsideration by the PRO, but may end up paying for one or two days of hospitalization while the reconsideration is pending.
- ▶ Patients/advocates may also begin a Medicare Appeals Process. Instructions for this process are contained in the denial notice.
- ▶ In addition to following the appeal process outlined by the health plan, patients or advocates can contact the Minnesota Department of Health (MDH), Managed Care Systems Section at 612/282-5600 or 800-657-3916 for assistance. The MDH is the regulatory agency for HMOs in Minnesota, and have staff available to assist consumers with concerns or questions about their HMO care and services.

■ Hospitalized Medicare patients when hospital and doctor agree on discharge

- ▶ When the hospital and the patient's doctor agree that a Medicare patient should be discharged, the hospital provides a written Notice of Noncoverage stating that the patient's doctor agrees with the hospital's decision. The patient/advocate must request, either in writing or by telephone, an immediate review by NOON of the first working day after receipt of the Notice of Noncoverage. This request must be made to the PRO whose name and address are shown in the denial notice. In Minnesota, the PRO is Stratis Health (formerly called Foundation for Health Care Evaluation), and can be reached at 612/854-3306.
- ▶ The PRO will contact the patient/advocate to solicit their views, and immediately obtain medical records from the hospital. The PRO doctor may contact the patient's doctor to discuss the situation. This process takes one to two working days. If the PRO agrees with the patient, the patient will not be responsible for payment of the approved additional hospital days other than applicable copayments.
- ▶ If the PRO agrees with the hospital and doctor, the patient will not be responsible for payment until noon of the next day after receiving the PRO's notification. The patient/advocate can request a reconsideration by the PRO, but may end up paying for one or two days of hospitalization while the reconsideration is pending.
- ▶ Patients/advocates may also begin a Medicare Appeals Process.

Instructions for this process are contained in the denial notice.

■ Hospitalized Medicare Patients when hospital and doctor disagree on discharge

- ▶ When the hospital wants a Medicare patient discharged BUT the patient's doctor disagrees, the hospital must request a review from the PRO and notify the patient that the review has been requested.
- ▶ If the PRO disagrees with the hospital, it may not give the patient a written Notice of Noncoverage, and Medicare hospital benefits continue.
- ▶ If the PRO agrees with the hospital, it will give the patient a written Notice of Noncoverage. The patient/advocate can request a reconsideration by the PRO, but may end up paying for one or two days of hospitalization while the reconsideration is pending.
- ▶ Patients/advocates may also begin a Medicare Appeals Process. Instructions for this process are contained in the denial notice.

HOW TO APPEAL AN HMO DECISION

HMOs generally have a written "second opinion" and complaint process. Consumers must read their contract carefully and follow the steps listed in the contract exactly as outlined. In addition, many health plans have "Patient Representatives," social workers or others designated as liaisons between the health plan and enrollees. These intermediaries and their phone numbers are usually listed in health plan booklets or can be found by calling an HMO clinic. Medicare beneficiaries may also use the Medicare Appeals Process if they have a complaint regarding a denial or limitation of treatment.

How Matrix Can Help

Matrix AdvoCare Network has provided care management services to elderly and disabled clients since 1987. Our goal is to help clients solve health care and social problems, including those which arise from insurance-related issues. In addition, many hospitalized clients and their families are facing very significant decisions, such as a permanent move to a care facility, enrollment in a hospice program, or loss of physical function or mental ability.

Our registered nurse Care Managers are knowledgeable about the health needs and problems of the elderly as well as today's reimbursement systems for health care services. By identifying the source of each client's – and their family's – concern, Care Managers facilitate communication with the health care team and payors. And by "speaking the same language" as the physicians and other health care providers,

Care Managers ensure that the client's and family's concerns are expressed clearly to the doctors and health plan, and that the health providers focus on the client's needs in their treatment plan. In addition, the Care Managers are able to help clients and families with appropriate discharge planning options, so that care needs are met both during and after hospitalization.

Trustees, attorneys, clients and families have found that working with a Care Manager can result in a positive outcome when differences arise between clients and providers, or between family members. Matrix recognizes the urgency of these situations, especially during a hospitalization, and can usually arrange an immediate visit by a Care Manager. In the Metro area please call 612/560-1010 or in greater Minnesota call 800/560-0961 for more information.