

BEHAVIORAL HEALTH ISSUE BRIEF SERIES

Issue Brief #10

Medicare, Managed Care, and Behavioral Health Care

Sara Rosenbaum, J.D.

Barbara Markham Smith, J.D.

Center for Health Services Research and Policy

The George Washington University School of Public Health and Health Services

November 2000

Introduction

This issue brief examines Medicare and managed care for Medicare beneficiaries with behavioral health needs. Medicare's performance for persons with mental illness and addiction disorders is of major significance to Medicare cost and quality matters, and thus, to managed care performance. In 1996, psychosis ranked 6th among all Medicare DRG hospital discharge rankings, and psychotherapy represented one of the program's leading Medicare Part B procedure codes.¹ These figures may underestimate the financial impact of behavioral disorders in Medicare program costs since the tendency to under-detect and inadequately treat both mental illness and addiction disorders among the older population is well documented.²

Behavioral disorders play a major role among the nation's 40 million Medicare beneficiaries, 34.4 million of whom qualify on the basis of age and 5.6 million of whom qualify on the basis of disability. Behavioral disorders that transcend the normal aging process are common among older Americans, and Medicare plays a significant role in the Social Security Disability Insurance (SSDI) program.³

Although only a relatively small proportion of Medicare beneficiaries are enrolled in managed care arrangements at the present time, proposals to expand the use of Medicare managed care can be expected to receive a good deal of attention in the coming years as part of a larger debate over Medicare's long term future. Thus, this issue brief examines the Medicare+Choice (M+C) program from the perspective of Medicare beneficiaries with mental illness and addiction disorders.

¹ Health Care Financing Administration, *Data Book* (1998).

² Id.

³ Mental Health: A Report of the Surgeon General (DHHS/OS/1999) Ch. 5, p. 336. Available at: <http://sgreports.nlm.nih.gov/NN/>.

Following a brief overview of Medicare's basic behavioral health coverage provisions and the M+C program, this issue brief reviews federal M+C performance specifications from a behavioral health perspective.

An Overview of Medicare

Basic Structure

Medicare is a social insurance program that entitles recipients of Social Security Old Age Survivors and Disability Insurance to coverage for a defined set of benefits. Medicare consists of Parts A, B and C. Part A confers coverage for medically necessary hospital, skilled nursing facility, and home health care and is financed through payroll taxes paid jointly by employers and employees. The payroll tax is a non-discretionary deduction for both employers and employees and benefits vest upon attainment of age 65 or the onset of a qualifying disability.⁴

Part B is a voluntary program that is open to enrollment by persons entitled to Medicare Part A. Part B covers physician services, services of other clinical providers,⁵ and a range of outpatient, diagnostic, home health care and durable medical equipment services. Largely subsidized by general revenues, Part B is also supported by enrollee premiums, with premium contributions capped at 25 percent of program costs.⁶

Medicare Part C, created by the Balanced Budget Act of 1997 (BBA), establishes the M+C program. M+C expands the use of managed care and other insurance products under the program. Part C establishes minimum qualification specifications for participating managed care organizations and revises the managed care payment methodology. The law also provides certain beneficiary safeguards and program performance standards.

Medicare's achievements have been extensively documented. The program has improved longevity and the quality of life and has been widely hailed for its role in reducing the level of economic and racial disparities.⁷ Medicare financing undergirds the modern health system and has made possible the dissemination to the broader population of technological advances in medical care, particularly care in hospital inpatient settings.

Medicare Limitations Relevant to Mental Illness and Addiction Disorders

As with many social programs, Medicare suffers from certain limitations which have received significant attention in recent years. Most of these limitations, some of which reflect the general nature of insurance and others of which underscore Medicare's need for modernization in a

⁴ 42 U.S.C. §1395 et seq.

⁵ Freestanding clinical providers whose services are covered under Medicare are federally qualified health centers and rural health clinics. Federally qualified health center and rural health clinic services include the services of clinical psychologists and clinical social workers. §1861aa of the Social Security Act.

⁶ In 2000, the Medicare Part B beneficiary premium payment amounted to \$45.50 per month.

⁷ Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Brookings Press, Washington D.C., 1977); Marilyn Moon, *Medicare, Now and in the Future* (Urban Institute Press, Washington D.C., 1993); Barbara Smith and Sara Rosenbaum, "Potential Effects of the 'Premium Support' Proposal on the Security of Medicare" *The Journal of the American Medical Association*, November 10, 1999.

dramatically altered health care environment, take on more significance in the case of persons with chronic illnesses and disabilities such as mental illness and addiction disorders. Furthermore, Medicare contains certain coverage limitations specific to mental illness that may result in the under-financing of necessary behavioral health services in a managed care setting, particularly in an era of tightened premium payment levels.

Medicare's limitations with respect to both services and eligibility have been extensively documented over the years. First, Medicare fails to cover non-hospital, institutional care services other than services furnished by skilled nursing facilities during recovery from a spell of illness that requires prior hospitalization.⁸ Long term institutional care of the type found in the Medicaid program is not covered.

Second, Medicare fails to cover virtually all outpatient prescription drugs. Because the lack of prescription drug coverage among retirees and persons with disabilities is associated with lower family income, lower-income Medicare beneficiaries (who are also at heightened risk for both physical and mental illness) are most at risk for non-coverage. This gap in Medicare coverage is particularly serious for persons with mental illness and addiction disorders; data indicate that prescription drug spending may be the single fastest growing component of total national mental illness/addiction disorder (MI/AD)-related health expenditures.⁹

Third, cost-sharing for covered benefits is relatively high and is particularly so for services related to the treatment of mental illness.¹⁰ Medicare covers a range of MI/AD-related services, including the services of both independent and clinic-based psychiatrists, psychologists, counselors, and mental health and addiction treatment facilities. However, among all procedures for the treatment of illness, mental illness is singled out for additional limitations. In contrast to normal cost-sharing rules, the basic Medicare program pays only 62.5% of allowable charges for MI/AD services compared to 80% for services related to the diagnosis and treatment of physical disorders.¹¹ Furthermore, psychiatric inpatient coverage is limited to 190 lifetime days rather than the normal spell-of-illness standard applicable to hospitalization for physical health problems.¹² High cost-sharing particularly affects beneficiaries whose incomes are too low to enable them to buy supplemental coverage to augment Medicare's limited coverage but not low enough to qualify for Medicaid. An estimated one-third of all Medicare beneficiaries rely on Medicare alone for virtually all medical care and thus potentially face significant out-of-pocket medical expenses.¹³

Fourth, the medical necessity standard used by Medicare reflects the standards found in conventional insurance products; this limitation is consistent with the fact that Medicare was enacted to provide for older Americans the same type of coverage that employers furnish to working age persons and their family members.¹⁴ Under Medicare's coverage rules, otherwise covered services

⁸ §1861(i) of the Social Security Act.

⁹ Coffey, *supra*.

¹⁰ Medicare Payment Advisory Commission. Report to the Congress: Selected Medicare Issues (June 1999). Available at: http://www.medpac.gov/publications/generic_report_display.cfm?report_type_id=1.

¹¹ But note that the 62% rule does not apply in the case of FQHC and RHC services.

¹² Social Security Act S. 1812(b)(3), 1833.

¹³ The Henry J. Kaiser Family Foundation. Medicare Quick Facts. Available at: <http://www.kff.org/docs/sections/medicare/quickfacts.html>.

¹⁴ Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY, 1997; 2000-01 supplement). Ch. 4

are excluded unless they are “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹⁵ Services that are not considered necessary and reasonable to treat an illness or injury, such as maintenance services for persons with chronic and disabling conditions, would not be covered. However, the “judicial gloss” that has been placed on the program as a result of more than 35 years of Medicare coverage appeals has clarified that in order to be considered “treatment,” under the Act, a procedure does not have to restore full “normal functioning” and need only improve a patient’s condition in accordance with reasonable medical evidence, with strong emphasis placed by courts on the opinion of treating physicians.¹⁶ Thus, as a practical matter, Medicare finances a substantial amount of care related to chronic illness.

Fifth, Medicare imposes a two-year waiting period on coverage for SSDI recipients following a finding of disability. Given the distribution of diagnostic conditions under the SSDI programs (discussed below), the two-year exclusionary provision has particular significance for persons with mental illness. Finally, since 1996, the SSDI program has excluded individuals whose disability is primarily based on alcohol abuse or addiction disorder.

The Impact of Mental Illness and Addiction Disorders on the Medicare Beneficiary Population and on Medicare Expenditures

Mental illness and addiction disorders have a significant influence over Medicare costs and quality because of the prevalence of both conditions among Medicare populations. Based on 1994 data from the U.S. Public Health Service, an estimated 12.7 percent of Medicare claimants have a primary diagnosis of MI/AD.¹⁷ Another 4.9 percent present MI/AD as a secondary diagnosis.¹⁸

Older Beneficiaries:

It is difficult to accurately assess the true extent of the impact of MI/AD disorders on Medicare because it is difficult to measure and identify the prevalence of mental illness and addiction disorders among the elderly.¹⁹ Indeed, there are relatively limited data on MI/AD in the Medicare population. Approximately 20 percent of persons ages 55 and older experience specific mental disorders that are not a normal part of the aging process, including late onset schizophrenia, post-traumatic stress disorder (the prevalence of which is expected to increase as Vietnam veterans enter Medicare), various anxiety disorders, and the psycho-social sequelae to Alzheimer’s disease. Anxiety disorders occur in 11.4% of older adults in any given year. Suicide rates are highest among older adults compared to all other age-groups.²⁰

Mental illness among older Americans is not well understood, in part because the normal aging process is associated with the loss of mental functioning and in part because mental disorders among older persons are likely to occur as part of an overall accumulation of physical and mental health problems. Similarly, addiction disorders and other substance abuse among older persons are

¹⁵ §1862(a) of the Social Security Act.

¹⁶ *Law and the American Health Care System*, Ch. 2(G).

¹⁷ Mental Health, United States, 1998, Ch.12.

¹⁸ *Ibid.*

¹⁹ United States Public Health Service, “Mental Health, A Report of the Surgeon General”. *op cit.*

²⁰ *Ibid.*

less well understood. The clinical definitions for these disorders have been developed from experience with younger populations; thus, their presence may be missed if practice guidelines developed for the non-elderly populations are used. Older people have lower tolerance abilities for chemical substances and appear to experience their effects at much lower “dosages” than are associated with addiction disorders among non-elderly persons.

Among older beneficiaries, identified addiction disorders present primarily as alcoholism and misuse of prescription drugs rather than use of illicit drugs.²¹ However, the prevalence of addiction disorders involving illicit drugs is expected to increase with the entry of the baby boomers into Medicare because of their greater tendency to use illicit drugs.²²

Beneficiaries with Disabilities:

Mental illness plays a singularly important role in the SSDI program and thus, mental illness can be expected to be quite prevalent among beneficiaries whose eligibility is based on the receipt of disability benefits. In 1995, 22 percent of all SSDI recipients were estimated to be disabled as a result of mental, psychoneurotic and personality disorders. This group of disorders represented the single largest medical basis for disability that year. Moreover, federal statistics indicate that between 1970 and 1995, mental disorders doubled as a proportion of all disabling conditions under the SSDI program.²³ In Medicare, 31.6 percent of those with MI/AD have SSI/SSDI status. Nearly one-third of those beneficiaries identified with MI/AD originally came into Medicare because of their disability status.²⁴

With respect to alcoholism and addiction, changes in Medicare coverage enacted in 1996 prohibit coverage for individuals whose disability is primarily the result of addiction or alcoholism. However, these changes may have had little impact on the overall proportion of disabled beneficiaries for whom addiction or alcoholism is a co-occurring condition. Furthermore, these changes would not alter eligibility for persons whose disability at one time might have been associated with alcoholism or addiction but whose other health problems have now assumed primary importance in the finding of disability.

The Impact of Mental Illness and Addiction Disorders on Medicare Spending:

Notwithstanding the clinical under-identification of the scope of the problem, the effects of coverage limits in general, and the additional limits that apply to Medicare coverage of mental illness and addiction disorders, Medicare financing of mental health and addiction services is substantial. Among all persons with severe mental illness, more than 21% are insured by Medicare.²⁵ Medicare spending for mental health and addiction services is growing at a faster rate than spending by any other payer.²⁶ In 1996, Medicare accounted for 13.4 percent of all mental health and addiction

²¹ Surgeon General's Report, *supra*.

²² *Ibid*.

²³ United States House of Representatives, Committee on Ways and Means, *Green Book* (1995), Table 1-28.

²⁴ Mental Health 1998, *supra*.

²⁵ D.D. McAlpine and D. Mechanic, “Utilization of Specialty Mental Health Care Among Persons with Severe Mental Illness: the Roles of Demographics, Need, Insurance and Risk,” *Health Services Research*, 35:1, Part II (April 2, 2000).

²⁶ T. Mark, D. McKusick, E.King, et al., “National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996,” Department of Health and Human Services, Addiction and Mental Health Services Administration.

services spending, amounting to \$10.55 billion. Of this amount, \$9.6 billion was spent on mental health services while \$608 million and \$441 million were spent on alcohol and other addiction disorders for older beneficiaries and beneficiaries with disabilities, respectively. Medicare spending on MI/AD-related services has increased at an average annual rate of 9.2% since 1986. Significantly, Medicare spending for services related to non-alcohol forms of addiction has grown at an average annual rate of 13.7 percent, reflecting the relative growth of diagnosed addiction as a medical problem among older persons and persons with disabilities.²⁷

Managed Care and the M+C Program

In General

The M+C amendments of 1997 represent a Congressional effort to modernize Medicare's fundamentally important role in the health care system by broadening the program's reliance on private managed care products in the hope of containing costs while expanding beneficiary choices of types of insurance products. Whether the M+C program ultimately will be successful in bringing about Medicare's large-scale conversion to managed care is not clear at this point because statutory changes in the managed care payment methodology appear to have reduced companies' willingness to participate in the program. Thus questions have emerged about the efficacy of using managed care to generate cost-savings for Medicare.²⁸ Notwithstanding these questions, federal policymakers' ongoing interest in the use of managed care services and techniques for the Medicare population may be expected to increase as the size of the older population grows, as the current generation of older workers accustomed to managed care systems reaches retirement age, and as Medicare's cost pressures continue to mount. For these reasons, understanding the potential implications for persons with mental illness and addiction disorders of Medicare's existing managed care program structure is important in a period of changing public policy and widespread general interest in the performance of managed care for persons with mental illness and addiction disorders.

Managed care has the potential to result in care integration and greater investment in primary and preventive services that is more difficult to achieve in a fragmented fee-for-service system. Furthermore, in the case of older Americans, managed care may be able to avoid one of the greatest impediments to its smooth operation in the Medicaid context: shifting eligibility patterns that interrupt care and reduce preventive investment incentives. In other words, Medicare's universal entitlement structure promotes the type of continuity of coverage that is essential to the creation of stable insured service delivery arrangements.

At the same time, other factors may cause Medicare managed care to grow more slowly than originally anticipated. First, enrollment in Medicare managed care currently is voluntary and may not be particularly appealing for the millions of beneficiaries who basically are unfamiliar with managed care and unaccustomed to its operational structure. Second, a significant proportion of Medicare beneficiaries require an intensity of health services that extends far beyond the management and treatment norms of most managed care companies. With sufficient time, financial support, and market expansion incentives (such as compulsory enrollment to boost volume),

²⁷ Ibid.

²⁸ Health Care Financing Administration: Medicare Program--Medicare Choice Program. OGC-00-43 July 25, 2000. Available at <http://www.gao.gov>.

companies might be expected to fill this market. However, as long as basic market incentives of payment and volume are missing, companies may be unwilling to structure their products to enable more intensive service delivery over a broader range of services. As with Medicaid, creating publicly sponsored managed care products for beneficiaries with a significant level of disability raises a unique set of issues. For beneficiaries with serious disabilities, health care costs are higher and utilization assumptions vary. Special considerations need to be given to the formation of networks, access protections, the development of practice standards and guidelines, and the deployment of quality measurement tools.

It is probably fair to say that under the current climate, the managed care industry on its own might not aggressively pursue Medicare beneficiaries with significant mental illness and addiction disorders. Research suggests (not surprisingly) that MCOs that participate in M+C do not offer products designed to attract beneficiaries with significant mental illness and addiction disorders. For example, in exchange for payment levels that exceed projected costs, Medicare MCOs have the option to offer their enrollees additional services and benefits and/or lower cost-sharing.²⁹ Given Medicare's more limited coverage for MI/AD services, companies might have used the generous payment levels they received prior to the 1997 M+C amendments to offer managed care products with enriched mental health benefits. Studies of pre-1997 Medicare managed care products do not suggest that companies specifically selected behavioral health for enriched coverage (although the additional prescription drug coverage that previously was relatively common under Medicare managed care certainly would have been attractive to any person with a serious health problem).

Nor does it appear that the Health Care Financing Administration (HCFA) has the ability to actively grow a specialty market for managed behavioral health care. As a matter of federal statutory law, M+C contractors must cover and furnish all services covered by Medicare. This statutory requirement effectively prevents HCFA from directly contracting with companies that furnish only a subset of Medicare-covered benefits and services. While HCFA might be able to contract with "disease management" companies that specialize in the comprehensive care of beneficiaries with specific health conditions (e.g., companies that enroll and comprehensively serve persons with MI/AD disorders),³⁰ the potential for such a market to develop under current conditions is probably non-existent, since the voluntary nature of Medicare managed care would produce too few covered lives to make such products viable, at least on a financial risk basis.

To be sure, there is no reason why disease management companies that specialize in managing Medicare beneficiaries with behavioral disorders could not sub-contract with general

²⁹ This incentive to furnish enriched coverage as a means of boosting enrollment was easier for companies to achieve when Medicare managed care payment rates were more generous. Payment limits enacted under the Balanced Budget Act of 1997 appears to have significantly limited companies' willingness to supplement what traditional Medicare offers. "Implementation of Medicare+Choice & Implications for Beneficiary Choice and Enrollment Lock-in: A Research Agenda," Brian Biles and Barbara Markham Smith, Center for Health Services Research and Policy, GWU School of Public Health and Health Services, the Commonwealth Fund (unpublished draft).

³⁰ The use of specialty providers would not appear to constitute the type of discrimination that is specifically prohibited under federal law. Section 1852(b) of the Social Security Act. The anti-discrimination provisions of the law are designed to prevent Medicare MCOs from taking actions that keep out classes of persons based on health status. The use of specialty management companies for persons with serious health conditions that make their care in systems that lack specialized capabilities medically inappropriate is a different issue from activities aimed at promoting greater use of managed care by persons with behavioral disorders and encouraging the development of products that have special capabilities in this area.

service M+C plans for specialty management services. But as with prime contracts, the problem of small numbers may inhibit growth of such a specialty product. Furthermore, behavioral health coverage limitations in Medicare make the development of a specialty managed care industry much more difficult; Medicare simply covers too small a portion of the costs to make a specialty product viable.

If support for a more aggressive conversion to managed Medicare does grow in the coming years, then addressing both the general and MI/AD-specific structural limitations in the basic Medicare program takes on heightened importance because of the inability to ensure care of minimum quality in an environment in which the underlying financing mechanism simply fails to adequately fund critical health needs. Furthermore, even if managed care remains only a relatively modest aspect of Medicare, its performance for beneficiaries with mental illness and addiction disorders is a matter of great concern, given the prevalence of these conditions among the beneficiary population and the potential for managed care companies to make design choices that minimize the enrollment of these populations or either overtly or subtly invite their disenrollment.

In the absence of a more sweeping conversion to managed care, a central question for beneficiaries thus becomes the extent to which the design of the existing M+C program is consistent with the specific concerns that arise in the management of persons with serious and disabling health conditions. In the case of mental illness and addiction disorders, these concerns may be even more pressing since, compared to other chronic illnesses and disabilities, mental illness and addiction disorders suffer from inherent under-coverage problems as a result of the limitations in the basic Medicare program described above.

An Analysis of Current M+C Program Standards

Unlike Medicaid managed care, where much of the legal framework within which the industry operates can be found in the large contracts between state agencies and MCOs, M+C participation standards can be found in the federal statute itself as well as program regulations. A major question thus becomes how these federal standards address the natural and inevitable use of market-oriented product design and administration techniques to minimize enrollment by persons with higher health needs, particularly those with MI/AD whose care and treatment in a Medicare context are particularly under-financed.

Methods

For purposes of this analysis of M+C program standards in the context of mental illness and addiction disorders, we examine existing standards in several of the major domains that we have developed for our Medicaid managed care contract analyses.³¹ These domains relate to the key working elements of managed care: enrollment; disclosure of information; membership; benefits and coverage decision-making, provider network composition and capabilities; access, and quality measurement and improvement. Because the domains used for our Medicaid managed care studies have been developed with the assistance of experts in behavioral health care, we designed this

³¹ Sara Rosenbaum et. al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 3rd Edition. *Special Report: Mental Illness and Addiction Disorders and Medicaid Managed Care*. (Center for Health Services Research and Policy, The George Washington University School of Public Health and Health Services, Washington D.C., 2000).

analysis to use the same domains. Specifically, we analyzed the existing M+C standards against the analytic domains, taken from our earlier contract studies work, that are shown in Figure 1.

**Figure 1:
Analytic Domains Under Medicare+Choice**

1. *Disclosure and Enrollment*
 - Disclosure of information to prospective and current enrollees
 - Enrollment safeguards
 - Anti-discrimination in enrollment
 - The discretion given to managed care organizations to seek the disenrollment of certain members
2. *Coverage*
 - Benefits
 - Coverage for emergency and urgent care services
 - Coverage decision-making, including the standard of medical necessity and the use of evidence to guide treatment decisions
3. *Provider network composition and capabilities*
 - Basic provider network standards
 - Standards for the selection of network providers
 - Network oversight standards
4. *Access*
 - Geographic access
 - Access timelines
 - Access for persons with disabilities
 - Cultural competence
5. *Quality improvement and performance measurement*
 - Clinical studies
 - Member experiences with care
 - Oversight of utilization management activities

Findings

Disclosure and Enrollment

Disclosure of Information to Prospective Enrollees and Plan Members:

Because even loosely structured managed care products can have a significant impact on a member's choice of providers and access to care, policy makers in recent years have placed a major emphasis on disclosure. For persons with significant illnesses and disabilities, disclosure of network specifications and access rules take on particular importance. The statute requires that prospective members receive "information comparing plan options" including information on benefits, premiums, the plan's service area, quality performance and supplemental benefits. In the case of benefits, plans must furnish information on covered items and services beyond those provided under the "original" Medicare program, beneficiary cost-sharing, maximum limits on out-of-pocket expenses (if any), the extent to which beneficiaries can obtain services from out-of-network

providers, the extent to which enrollees may select among in-network providers; and the types of providers participating in the plan's network.³² HCFA regulations track these statutory standards.³³

Prospective enrollees thus would not be entitled to specific information regarding the extent to which specific treatments are offered (e.g., the nature of the plan's behavioral health program), nor are either prospective or actual members of a plan entitled to have access to the practice guidelines used by a company to make treatment decisions or structure its provider incentive systems for its network. Nor would prospective members be entitled to know if specific behavioral health providers are members of a particular network. While membership status for a particular provider could be gleaned from discussions with the provider prior to enrollment, a beneficiary probably would have no way of ascertaining the plan's overall behavioral health program.

Once enrolled, beneficiaries have the right to receive actual network information as well as information on general coverage and comparative plan information of the type available during the enrollment period. In addition, enrollees have the right to receive "upon request" certain "information on procedures used by the organization to control utilization of services and expenditures" as well as "an overall summary description as to the methods of compensation of participating physicians."³⁴ HCFA implementing regulations do not interpret these standards to include disclosure of information regarding practice guidelines, nor do the benefit disclosure regulations require disclosure upon request regarding specific practice guidelines.³⁵ Provider network disclosure regulations require plans to inform beneficiaries of the "number, mix and distribution" of health care providers in their networks, although the regulations do not require disclosure of the specialty status of particular providers.

Anti-discrimination in Enrollment:

The statute prohibits participating organizations from denying, limiting or conditioning the provision of coverage on the basis of factors that would be prohibited under provisions of the Public Health Service Act related to non-discrimination on the basis of health status or the anticipated need for health care.³⁶ Federal rules expand on this provision and prohibit discrimination on the basis of medical condition and specifically reference mental as well as physical conditions. The regulations also prohibit discrimination based on claims experience, receipt of health care, medical history, genetic information, and evidence of insurability. In addition, the rules specify that plans must be in compliance with the Americans with Disabilities Act and the Rehabilitation Act of 1973.³⁷

Disenrollment of Members:

Federal regulations give M+C organizations broad discretion to disenroll members who engage in "disruptive behaviors."³⁸ The level of plan discretion to disenroll "disruptive" members is

³² §1851(e)(4) of the Social Security Act

³³ 42 C.F.R. §422.64.

³⁴ §1852(c) of the Social Security Act.

³⁵ 42 C.F.R. §422.111(c).

³⁶ §1852(b) of the Social Security Act.

³⁷ 42 C.F.R. §422.110. For a discussion of the ADA in a managed care context see Double Issue Brief #5 & 6.

³⁸ 42 C.F.R. §422.74(b)(ii).

broader than that allowed by many state Medicaid programs, which typically permit plans to request disenrollment in similar situations but not to take unilateral action.³⁹ Furthermore, the standard against which disruption is measured under M+C tends to be circular, and the beneficiary protections accorded individuals who have been disenrolled on this basis are more limited than those that would be available under Medicaid. Federal regulations specify that the “disruptive” standard is met if the

*[...] individual’s behavior is disruptive [sic], unruly, abusive, or uncooperative to the extent that his or her continued enrollment in the plan seriously impairs the *** plan’s ability for furnish services to either the particular individual or other individuals enrolled in the plan.*

While plans must “establish that the individual’s behavior is not related to the use of medical services or diminished mental capacity,”⁴⁰ a disenrollment decision is not considered to be an “organization determination” under federal M+C rules. As a result, a member who is disenrolled for disruptive behavior has no right to an external review of a disenrollment decision based on disruption.

Minimum Enrollment Periods and Disenrollment for Cause:

Consistent with Congressional interest in the development of a Medicare managed care system that more closely approximates that found in the private sector, the statute provides that beginning in FY 2003, M+C plan enrollees may switch plans or revert to the “original” Medicare program only once during an “open-season” period which by law lasts for the first three months of the enrollment year.⁴¹ Beyond this point, the statute limits disenrollment to situations in which the member can demonstrate that among other matters, a plan “substantially violated” a “material provision” of its contract, including but not limited to a failure to provide timely medically necessary services or failure to provide services of adequate quality. HCFA regulations parallel the statute in this area and do not specify procedures to be followed in the case of beneficiaries with significant disabilities that limit their ability to seek a change in enrollment.

Benefits

Medicare managed care plans are required to offer the entire Medicare benefit package as a minimum floor for their Medicare products. As discussed above, this benefit package is very limited. Historically, however, the generous payment rates afforded to Medicare HMOs enabled them to augment the restrictive Medicare benefit package and thereby attract more beneficiaries to enroll. Indeed, enhanced benefits have been the major driver of HMO growth in Medicare. Typically this included coverage for most Medicare copayments and deductibles as well as prescription drug coverage and vision services.

Improved coverage for MI/AD services did not emerge as a significant supplemental benefit. However, with the increasing salience of drug therapies in the treatment of MI/AD, the

³⁹ *Negotiating the New Health System* (3rd edition). op. cit. Table 1.7.

⁴⁰ 42 C.F.R. §422.74(d)(2).

⁴¹ §1851(e) of the Social Security Act.

ability to enroll in these plans provided an important avenue for drug coverage for moderate and lower-income beneficiaries. For the under-65 disabled population not eligible for Medicaid, these plans may have been the only source of prescription drug coverage since these individuals have not had access to more traditional forms of Medicare supplemental insurance (Medigap).⁴²

As a result of the 1997 payment changes, Medicare managed care companies have significantly reduced prescription drug coverage, in some cases eliminating it altogether or charging much higher premiums. By 1999, 32 percent of M+C plans imposed \$500 limits on total prescription drug coverage.⁴³ Studies indicate that beneficiaries most likely to have health problems, particularly the under-65 disabled (a third of whom present significant MI/AD service needs) were most adversely affected by these changes.⁴⁴

Treatment and Coverage Decision-Making

As noted, the statute and implementing regulations provide that M+C products must offer the full benefit package offered under the Medicare program. As a result, the program's coverage standards and limitations and exclusions represent the minimum coverage standards for managed care entities. Furthermore, beyond coverage of a defined set of benefits, the statute and rules provide that HCFA's national coverage determinations (NCDs)⁴⁵ under the traditional program bind managed care companies, unless the agency determines that the national coverage determination meets the requirements for "significant costs" and thus does not have to be covered until the contract year in which the cost for the new coverage is included.⁴⁶ Finally, M+C organizations are bound by the decisions made by an external review entity under a Medicare coverage appeal as well.⁴⁷

In sum, the traditional Medicare program serves as the legal coverage baseline for the M+C program. Because the traditional Medicare program serves as the legal baseline for M+C coverage, as in Medicaid, Medicare beneficiaries remain entitled up to the full level of their statutory coverage. Unlike Medicaid, however, HCFA does not have the discretion to negotiate contracts with managed care companies that set contractual coverage standards at less than the full Medicare benefit level (Medicaid agencies can elect to place only a subset of all Medicaid coverage into their contracts with

⁴² It is unclear how many beneficiaries with MI/AD were in fact attracted to plans to obtain prescription drug coverage. The effects of concerns about losing access to traditional providers in restricted networks as a disincentive to enroll in plans and the resulting net effects on enrollment among this population have not been analyzed.

⁴³ Marilyn Moon, "Medicare+Choice: An Evaluation of the Program," Oversight Hearing: House Commerce Committee Subcommittee on Health and Environment, 1999.

⁴⁴ MA Laschober and Patricia Newman, et al., "Medicare HMO Withdrawals: What Happened to Beneficiaries?" *Health Affairs*, Nov/Dec 1999.

⁴⁵ The NCD process is the formal process used by HCFA to decide when to add coverage under the law for an emerging treatment or procedure that previously was not recognized as qualified for coverage under basic program rules (e.g., a treatment, procedure or device that potentially falls into a coverage category but that was considered experimental or has just emerged in the market).

⁴⁶ §1852(a)(5) of the Social Security Act; 42 C.F.R. §422.109. The rules offer two alternative tests of significance for the term "significant cost." The first would be \$100,000 for a single service in FY 1999, adjusted by a national growth factor in subsequent years. The second alternative test is whether the estimated cost of all Medicare services furnished nationwide as a result of the NCD in question would amount to at least 0.1% of the national standardized annual capitation rate multiplied by the total number of enrollees nationwide for the applicable calendar year. 42 C.F.R. §422.109(c).

⁴⁷ See 42 C.F.R. §422.600 et seq. for external review standards.

MCOs). As a result, a M+C provider could not use practice guidelines that set coverage standards for MI/AD services at less than what the traditional program would require.

HCFA standards also speak to practice guidelines. As part of their overall relationship with providers, M+C organizations must use practice guidelines and utilization management guidelines that: 1) are based on reasonable medical evidence or a consensus of health professionals in the field; 2) “consider the needs” of the enrolled populations; 3) are developed in consultation with the network; and 4) are reviewed and updated periodically.⁴⁸

At the same time, however, neither the statute nor the regulations set an evidentiary standard for companies to follow in making initial treatment and coverage determinations. This standard, which has evolved over the 35 years of Medicare’s existence, essentially requires that coverage determinations be based on relevant and reliable evidence.⁴⁹ Nor, as noted, do the statute or regulations require companies to disclose the guidelines they use to make these determinations. Thus, while the traditional Medicare program would weigh evidence from the patient’s medical record, the opinion of the treating physician, and other relevant and reliable evidence concerning the patient’s condition or the known effects of certain treatments, the law does not expressly require companies to rely on the same range of evidence in making coverage determinations.

The absence of an evidentiary standard for initial determinations is important in light of evidence that managed care companies tend to use treatment guidelines that give at best limited consideration at the initial review stage to a patient’s specific condition or the treating physician’s own opinion.⁵⁰ Neither do the statute or regulations require a company to provide an enrollee with an explanation of the evidence that it considered in making its decision; a company’s only obligation under the law is to provide an “understandable” explanation of “the specific reasons for denial.”⁵¹

The lack of an evidentiary standard expressly tied to coverage and treatment decisions takes on greater importance in the case of Medicare beneficiaries with mental illness and addiction disorders, since their need for treatment for these conditions needs to be measured in light of their advanced age and disabilities and is more likely to co-exist with other physical health needs. Most mental illness treatment guidelines may be irrelevant to beneficiaries with co-occurring physical conditions and may be inappropriate and irrelevant when applied to patients of advanced age and frailer overall health status.

Provider Network Composition and Capabilities:

The statute sets certain standards for the physician members of provider networks. The law prohibits the use of physician incentive plans that either directly or indirectly induce a physician or physician group to reduce or limit medically necessary services for any specific individual enrolled in the organization.⁵² Federal law prohibits discrimination by M+C plans against classes of otherwise

⁴⁸ 42 C.F.R. §422.200(b).

⁴⁹ *Law and the American Health Care System*, op. cit. Ch. 2(g); Ch. 4.

⁵⁰ *U.S. Healthcare, Inc. v. Bauman; Moscovitch v. Danbury Hospital; McGraw v. Prudential Insurance; McGraw v. Prudential Insurance.*

⁵¹ 42 C.F.R. §422.568(d).

⁵² §1852(j)(4) of the Social Security Act.

qualified health providers,⁵³ but provides plans with broad authority to set network limits that are needed to maintain quality and control costs.⁵⁴

Network participation standards must be reasonable and must include notice of the rules on participation, as well as notice of adverse participation decisions and an opportunity for appeal such decisions. M+C organizations must also consult with participating physicians regarding medical policy, management and quality procedures.⁵⁵ Nor do the statute or regulations prohibit contractors from reimbursing different classes of specialty providers differently.⁵⁶ HCFA regulatory standards essentially parallel these statutory requirements.⁵⁷ Neither the statute nor the regulations require companies to be able to demonstrate that their networks include health professionals who specialize in the treatment or management of certain conditions, nor do the rules contain a broader requirement that providers at least be experienced in the identification, treatment and management of individuals within the Medicare population who have mental illness or addiction disorders.

While federal law does not specify the use of experienced networks, the standards do require plans to maintain networks that are “sufficient to provide adequate access” to covered services to meet the needs of the population served. This requirement, however, does not prohibit plans from including providers only to the extent necessary to meet the needs of the plan’s current enrollees, ensure quality and control costs. Therefore, historically low enrollment by those needing MI/AD services could justify formation of networks containing few MI/AD specialty providers. As a practical matter, a very limited number of such providers in a network could discourage enrollment by beneficiaries needing their services or make access to services more difficult once enrolled.⁵⁸

On the other hand, contractors must have procedures that insure access to specialty care by providing the care or arranging for out-of-network care if the plan is unable to provide it,⁵⁹ as well as procedures to identify beneficiaries with serious and complex conditions, monitor their progress, and develop and implement treatment plans.⁶⁰ Contractors must provide or arrange for “necessary specialty care.”⁶¹ The regulations do not require plan networks to be able to demonstrate certain basic capabilities in the identification, treatment and management of conditions that are prevalent among the beneficiary population, nor do the regulations set forth an evidentiary standard regarding how a plan must measure whether the use of a specialist is warranted.

Efforts to define serious and complex conditions and arrive at M+C treatment paradigms particularly pertinent to beneficiaries with MI/AD and other chronic conditions remain unresolved. The recommendations of the Institute of Medicine (IOM) in this regard have not been adopted, and

⁵³ §1852(b)(2) of the Social Security Act.

⁵⁴ *Id.*

⁵⁵ §1852(j)(1) of the Social Security Act.

⁵⁶ *Ibid.*

⁵⁷ 42 C.F.R. §§422.204 – 422.208

⁵⁸ The avoidance of plans with inadequate networks for treating MI/AD by beneficiaries needing those services would operate to continue to justify the practice of excluding MI/AD providers from those networks based on insufficient enrollee need. The end result could be a much smaller array of reasonable choices for such beneficiaries and reduced access to whatever supplemental benefits continue to be offered.

⁵⁹ 42 CFR 422.112 (a)(1).

⁶⁰ 42 C.F.R. §422.112(a)(4).

⁶¹ 42 C.F.R. §422.112(a)(3).

managed care organizations await further guidance in a forthcoming HCFA operational policy letter.⁶²

Access to Services

Beyond the general question of provider network size, composition and capabilities lie other questions of access, specifically measurements of time and geographic access as well as the fundamental question of cultural competence in the case of enrollees who are members of racial or ethnic minority groups. Federal regulations require access to covered care on a 24-hour-per-day, 7-day-per-week basis and provide that plans furnish care in a culturally competent fashion that meets the needs of persons with limited English proficiency.⁶³ Both emergency and urgent care must be furnished without regard to prior authorization or provider network affiliation.⁶⁴ At the same time, the statutory definition of an emergency condition triggering plan coverage is broad, covering conditions that would cause serious jeopardy to health of an individual or the health of a pregnant woman or her unborn child, serious impairment to bodily functions, or serious dysfunction to any bodily organ or part.⁶⁵ There is no specific direction regarding behavioral health emergencies.

Quality Management and Improvement:

HCFA regulations provide broad directives on quality improvement programs. Contractors must conduct performance improvement projects that achieve “through ongoing measurement and intervention” a “demonstrable and sustained improvement in significant aspects of clinical care and non-clinical areas that can be expected to have a favorable effect on health outcomes.” Plans must have clinical quality improvement projects that include clinical areas related to “the prevention and care of acute and chronic conditions” and “high risk services.”⁶⁶ Projects also must measure the adequacy of the complaint, grievance and appeal procedures. No regulation specifically requires quality improvement projects to reflect both physical and mental health conditions.

Conclusions and Implications

Policy development and program practice surrounding the use of managed care in Medicare can be expected to continue to develop in the coming years as a result of an aging population and accompanying cost containment pressures, an increasing level of experience with managed care among retired persons, and advances in health care quality management and improvement that support stronger emphasis on service integration. At the same time, and for many of the same reasons that have driven the Medicaid managed care experience, policy makers will find that developing and operating managed care systems for the Medicare population necessitates design and administration considerations not present in an employee benefit context.

⁶² The IOM defines a serious and complex condition as “one that is persistent and substantially disabling or life-threatening that requires treatments and services across a variety of domains of care to ensure the best possible outcomes for each unique patient or member.” *See* Summary and Explanation accompanying issuance of 42 CFR 112, June 16, 2000.

⁶³ 42 C.F.R. §422.112(a).

⁶⁴ 42 C.F.R. §422.112(c).

⁶⁵ Section of the Social Security Act. .

⁶⁶ 42 C.F.R. §422.152(d).

In an employee benefit context and under current law, employers are free to negotiate with health care companies for product designs that tailor covered treatments to industry-developed standards of practice and purchasers' cost expectations. This means that standards of treatment coverage can be fixed and irrebuttable and can be shielded from challenges by individual members for whom the standards are insufficient.⁶⁷

In the case of Medicare and Medicaid however, eligible persons are statutorily entitled not only to certain classes of benefits but also to a standard of coverage that measures the availability of covered benefits in accordance with the individual medical circumstances of a case. Conclusive presumptions regarding when otherwise covered treatments and services will or will not be made available to enrollees are not permitted; coverage must be based on a level of medical evidence that meets standards of due process.

The use of individualized standards to determine coverage may be the most fundamental legal distinction between publicly and privately sponsored managed care products since it creates significant limits on companies' ability to standardize their practice guidelines and treatment decisions. But beyond this legal limit on company discretion in the case of Medicare and Medicaid managed care products, there are other enormous differences that make the development of managed care products difficult.

The biggest difference relates to the nature of program enrollees themselves. Like Medicaid beneficiaries, Medicare beneficiaries are in significantly poorer health than the working population and their costs may be less predictable. Furthermore, there is a relative absence of practice guidelines for patients with multiple and serious health conditions that have been tested and found both reliable and relevant. As a result, cost containment is difficult to achieve, as is the standardization of practice and practice measurement. In the case of an industry as complex as managed care, this sea of "moving parts" makes designing products difficult especially for a member population that is for the most part still without managed care enrollment experience.

Companies can best navigate this complex situation if they confine their enrollment to the youngest and healthiest beneficiaries whose individual health needs are the least likely to press the limits of product design. At the same time, managed care products -- i.e., products that integrate coverage and care into single contractual arrangements that give contractors the discretion to allocate resources and manage resource consumption -- cannot be expected to grow (whether on a voluntary or mandatory basis) unless the products can demonstrate their appropriateness for populations that consume higher levels of care. Mental illness and addiction disorders, two highly prevalent and little understood conditions among older beneficiaries and those with disabilities, represent an important test of the managed care model.

The findings from this analysis suggest that in order to accommodate managed care for Medicare beneficiaries with mental illness and addiction disorders, several types of policy actions are needed. Some relate to program design while others relate to plan administration and oversight. Finally, some of the issues raised in this analysis go to the design of the underlying Medicare program itself.

⁶⁷ *Jones v. Kodak*.

Managed Care Design

In several respects, the design elements of the M+C program as set forth in the statute and implementing regulatory conditions of participation, work against persons with mental illness and addiction disorders. These design limitations could significantly and adversely affect the accessibility and quality of managed care for persons with mental illness and addiction disorders.

First, existing standards give plans the discretion to unilaterally disenroll persons for “disruptive” conduct without any external appeal, with the burden of proof against disenrollment essentially placed on the member. Since persons with mental illness and addiction may be at greater risk for being labeled as disruptive, this autonomy could have a serious impact on their enrollment. It is a level of autonomy that is lacking in Medicaid managed care. Furthermore, this discretion appears to be inconsistent with Title III of the Americans with Disabilities Act, which identifies health care providers as places of public accommodation and therefore obligated to make reasonable accommodations for persons with disabilities.⁶⁸ Accordingly, the burden of demonstrating that an accommodation would require a fundamental alteration should fall to the company; a member with mental illness should not be obligated to demonstrate that accommodating mental illness is a reasonable matter.

A second limitation in design relates to defined enrollment periods and disenrollment for cause. By adopting a minimum enrollment requirement, 1997 amendments seek to move Medicare toward commercial practice of open enrollment followed by a mandatory enrollment period. This may make sense in the redesign of Medicare to favor a more managed care oriented environment. At the same time, the implementation of the minimum enrollment period standard flags the need for certain additional safeguards where the cause of the request is allegations of inadequate care or under-service in the case of an enrollee with disabilities. Performance measures that specifically identify such requests and ensure that managed care organizations undertake corrective reviews would be one way to address the issue. In addition, more basic protections may be required where the allegation concerns a level of under-service that could affect a patient’s health or safety. Finally, more detailed disenrollment request procedures may be necessary to ensure an expedited process when medically warranted and appropriate assistance for individuals whose disability limits their capacity to assemble the information needed to document their request.

A third limit in design is the absence of requirements related to the use of experienced networks. It is understandable perhaps that neither Congress nor HCFA is willing to identify the precise types of specialists who must be in a managed care network. But there is strong evidence from various health fields showing better outcomes among patients who are cared for by providers with specific areas of relevant experience. Given the evidence of difficulties in identifying, treating and managing mental illness and addiction disorders in older Americans, a sensible requirement might be for an experienced network, with definitions of what constitutes experience that are broad enough to permit the use of experienced providers on either a direct or consultative basis as the specific facts of a case and circumstances surrounding care dictate.

⁶⁸ Rosenbaum, S., Teitelbaum, J. and Silverstein, R. (1999). Double Issue Brief #5 & 6: “The Americans with Disabilities Act: Implications for Managed Care for Persons with Mental Illness and Addiction Disorders.” Available at: <http://www.gwhealthpolicy.org>.

A fourth limit is the absence of disclosure and medical evidence standards that ensure that the only guidelines that are used to guide treatment and coverage decisions are ones that are relevant to the population at hand and sufficiently reliable through research to be reasonable in their application. In view of the difficulties associated with diagnosing and treating mental illness and addiction in older persons and the unique circumstances that may surround the management of persons who are disabled by mental illness (as is the case with many SSDI beneficiaries), it would appear important that programs allow the use of treatment guidelines only to the extent that they are relevant and reliable for the covered population, and even then, only if disclosed. This is as true for guidelines related to physical health problems as for mental health treatment.

Administration of M+C

Many of the statutory and regulatory standards governing the M+C program appear to be sufficiently broad as a threshold matter to ensure basic legal protections. The major issue is the development of performance measurements that are designed to determine adherence to these standards in a mental illness and addiction disorder context. Because of the difficulties associated with diagnosing and treating MI/AD in older adults as well as the inherent under-financing problem where Medicare coverage of mental illness is concerned, the development of MI/AD-specific performance measurement standards would appear to be especially important in the case of quality improvement activities (e.g., MI/AD-specific clinical studies and analyses of the performance of other phases of company operations), network sufficiency and compliance with access standards, complaint and grievance evaluations, and performance in areas such as the management of emergency and urgent health problems.

In this context, collaboration around ADA measurements of managed care sufficiency in the context of members with disabilities would appear to be especially important. Currently there are no specific standards that identify the reasonable accommodations that M+C plans would be expected to make to demonstrate compliance with the ADA, even though compliance with the ADA is a basic condition of participation under the rules. Since it is very difficult for companies to know if they have achieved compliance with a broadly remedial statute that has no specific standards for measuring compliance in specific contexts, the development of compliance guidelines by HCFA, the HHS Office for Civil Rights, and SAMHSA would appear particularly warranted.

Fundamental Structural Reforms

Underlying the managed care-specific issues that arise in a Medicare analysis in the context of mental illness and addiction disorders are the fundamental limitations of the program itself. As long as coverage is more restrictive in the area of mental illness and addiction disorders, the resources to more adequately manage these conditions will also be lacking. In the pre-1997 period, when Medicare payments may have been overly generous in relation to the cost of care, these restrictions may not have posed quite as serious a problem as they do in the post-BBA environment, where significant limits on per capita payment levels now have been imposed.

As part of a Medicare modernization effort, consideration thus should be given not only to the addition of better coverage of services such as outpatient prescription drugs, but also to the achievement of parity within Medicare, an advance that has been brought to other forms of

coverage and a differential that should be eliminated. Whatever the original justification for cost-sharing differentials and amount, duration, and scope limitations, evidence from the modern health system suggests that with proper management, the cost of treating mental illness is no greater than that related to the cost of treating other illnesses and conditions. Parity in coverage should be as basic an element of a modernized Medicare program as it is now perceived to be in the case of employee benefits.

Further Study

In light of the emerging nature of knowledge regarding mental illness among older individuals and the relatively recent nature of the Medicare managed care experience, it is not surprising that there is very little literature on the managed care experiences of beneficiaries with mental illness and addiction disorders. At the same time, it is important for policy makers to gain a better understanding of how managed care companies that provide M+C address mental illness and addiction. Key questions that merit further research are:

- How do managed care companies design their networks to address mental health /substance abuse issues?
- What practice guidelines are in use, if any, and how have they been tailored to meet the needs and circumstances of the Medicare population?
- Is disruptive conduct a major issue and how do companies address issues of disruption and disruption-based disenrollment?
- How important do companies view mental illness and addiction disorders when they build managed care products for Medicare, and how are these concerns reflected in product design?
- What types of quality improvement activities in the areas of mental illness and addiction disorder treatment and prevention do companies that sell Medicare products undertake?
- How do cost-sharing and coverage differentials affect the mental illness components of the products that M+C companies offer?
- What has been companies' overall cost experience with the M+C market in the area of mental illness and addiction management?