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Medicare Managed Care: Has Its Time Come?

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I. Introduction

Although the U.S. Department of Health and Human Services (HHS), through its Health Care Financing Administration (HCFA), authorized Medicare beneficiaries to enroll in risk-based managed care plans /1/ in 1982, only recently has enrollment begun to accelerate. In 1985, only 300,000 Medicare beneficiaries were enrolled in managed care plans; however, by 1995, the number had swelled to 3.1 million. /2/ This increased enrollment was due, in part, to proliferating marketing schemes by plans themselves and to promotion of the use of managed care as a Medicare option by the federal government.

Medicare meets a broad array of acute care needs but covers relatively few long-term care services either in the home or in a nursing facility. /3/ Yet Medicare beneficiaries, whether their eligibility is based on age or disability, are among those most at risk for needing long-term care. /4/ Medicaid is the primary source of public funding for long-term care, /5/ with "Medicare, the Social Services Block Grant, the Older Americans Act programs, the Department of Veterans Affairs, other state programs, and [consumer] out-of-pocket spending" helping to pay for these services. /6/ This fractured funding stream leads to fragmentation of services between acute and long-term care, as well as between home and community-based and nursing facility care. It also leads to fragmentation of administration. /7/ Moreover, care often lacks coordination between and among the various acute and long-term care components. /8/ These shortcomings will become increasingly apparent as the population ages and Medicare beneficiaries are encouraged to enroll in managed care plans to meet their acute care needs.

II. Issues in Medicare Managed Care

Medicare /9/ managed care plans can be either federally qualified health maintenance organizations (HMOs) /10/ or competitive medical plans (CMPs). /11/ In either case, plans must provide the services generally covered under Medicare Parts A and B and make services, including emergency care, available and accessible when needed. /12/ Moreover, plans "must provide meaningful procedures for hearing and resolving grievances between" the plan and enrollees. /13/ Regulations provide for written notice to an enrollee within 60 days of an adverse determination, reviews by both the plan and HCFA, administrative hearings, and judicial review. /14/ Despite statutory and regulatory protections, the shift in emphasis in Medicare from traditional fee-for-service to

managed care raises issues for low-income Medicare beneficiaries concerning coverage, due process rights, and quality assurance.

A. Demonstration Projects

HCFA recently initiated two demonstration projects. One is designed to broaden the managed care choices available to Medicare beneficiaries, thus increasing the number of Medicare enrollees. A second will explore methods to improve Medicare managed care payment methodologies. /15/

1. Medicare Choices Demonstration Project

HCFA announced in April 1996 that it had chosen 25 managed care plans to participate in its Medicare Choices Demonstration Project. The project is designed to test the use of different managed care delivery system options, including provider-sponsored networks, provider-owned HMOs, and preferred provider organizations, in order to increase participation in areas where Medicare HMOs are either unavailable or underutilized. HCFA chose nine cities with high enrollment in commercial managed care plans but low enrollment in Medicare HMOs, along with several rural locations, as demonstration sites /16/ and expects plans to be certified and ready to enroll beneficiaries in 1997. /17/

2. Competitive Pricing Demonstration Project

The Competitive Pricing Demonstration Project focuses on altering the payment methodology for Medicare managed care plans. Most Medicare HMOs are paid on a risk basis, /18/ that is, they receive a set payment per HMO enrollee for a defined set of services to be provided to the enrollee when medically necessary. This "capitated" payment is set at 95 percent of the "adjusted average per capita cost" (AAPCC) for non-HMO beneficiaries and varies by county and with enrollee demographics such as age, sex, and disability. /19/ If the projected AAPCC payment to an HMO is greater than the cost of providing care to Medicare enrollees, then the HMO must either accept a lower payment from HCFA or pass the savings on to its enrollees. /20/

Under the Competitive Pricing Demonstration Project, HCFA will develop, rather than using the AAPCC, a new payment rate for each project site following bids submitted by the plans on a "community standard" benefit package. The community standard benefit package represents the most common plan offered in the area. HCFA wants to assure access to more than one plan at the current premium level and, ideally, to restructure its payment mechanism without reducing current services. Thus, in areas where most or all plans offer a zero premium option, HCFA will set a payment rate that enables more than one plan to offer that alternative. /21/

This project also seeks to improve beneficiaries' ability to make informed choices about their Medicare options. HCFA will contract with an independent third party to prepare and distribute information to beneficiaries explaining Medicare fee-for-service and managed care programs and to

conduct enrollment and counseling. HCFA chose to use a neutral third party to provide information and counseling, rather than allowing plans to perform this function, to ensure objectivity and to deter plans from discouraging enrollment of sicker beneficiaries. /22/

HCFA was criticized for its selection of Baltimore, Maryland, as the first site for the Competitive Pricing Demonstration Project. State officials fear that the higher cost of offering services in Baltimore city, as opposed to the surrounding Baltimore county, will discourage plans from serving city residents. In addition, the project's implementation date coincides with the start of a Maryland initiative to enroll all Medicaid recipients in managed care plans. Finally, state officials question whether Baltimore is a good site to test competitive pricing, given Maryland's unique hospital rate-setting structure. /23/

B. Regulation of Physician Incentive Payments

On March 17, 1996, HCFA published final rules with a comment period to implement a 1990 law restricting incentives that Medicare and Medicaid managed care plans can offer physicians to reduce referrals to specialists and for specialized equipment. /24/ In these "physician incentive plans," physicians may receive bonuses for low referral rates or reductions in fees for high referral rates. In addition, some plans shift the risk for higher costs of referrals to physicians. While the plans consider physician incentives as cost containment, advocates worry that the incentives create a conflict of interest for providers by discouraging them from recommending necessary medical care.

Under the statute and regulations, plans that contract to serve Medicare and Medicaid beneficiaries may not directly or indirectly pay physicians or physician groups to induce them to limit medically necessary services to a specific patient. Plans must provide information to HCFA about physician compensation arrangements, including information on types of incentives and stop-loss protection. They must also disclose to beneficiaries the types of incentives used, whether they provide stop-loss protection, and the results of any patient-satisfaction surveys. /25/ Plans imposing a "substantial financial risk" on a physician or physician groups must also conduct enrollee-satisfaction surveys and must provide physicians with stop-loss protection for 90 percent of the cost of referral services exceeding 25 percent of potential payment. A plan in which a physician could lose more than 25 percent of potential reimbursement from the plan because of referrals for medical services is considered to impose a "substantial fi
nancial risk." /26/

Advocates could use the information disclosed to HCFA to develop consumer education materials that compare locally available plans. This information could also be helpful in discussions with physicians about whether a beneficiary has received necessary services or as part of an appeal of the denial of services deemed not medically necessary.

The final rules published in the Federal Register were effective on April 26, 1996; HCFA announced that it would consider comments received by May 28, 1996. However, on May 28, 1996, HCFA sent letters to state Medicaid agencies and managed care plans delaying the effective date of the regulations until 1997 and promising that no enforcement actions would be taken.

Although the letters indicated that HCFA's Office of Managed Care was preparing a Federal Register notice to establish new compliance dates, no notice was published as of July 22, 1996. Thus, HCFA has given no notice to the general public of its decision to revise the final rules published on March 27, 1996. /27/

C. Due Process Concerns

Medicare beneficiaries have experienced numerous problems in obtaining prescribed services through HMOs, especially when services are costly and ongoing. /28/ Often they must reach the administrative law judge review level before favorable action is taken. In addition, beneficiaries are not always given adequate notice explaining that a requested item, service, or procedure has been denied, reduced, or terminated. Nor are they uniformly informed about how to obtain a review of an HMO decision. As the number of beneficiaries in Medicare managed care plans increases, so do the consequences of some HMOs' failure to provide covered services and to comply with notice and appeal rights. Thus, developing appropriate checks and balances to Medicare HMO coverage decisions becomes more critical. /29/

The Medicare statute and regulations include due process protections for beneficiaries enrolled in HMOs. Medicare HMOs must provide beneficiaries with "meaningful procedures for hearing and resolving grievances," including the opportunity for an administrative hearing and judicial review, /30/ and must send written notice to beneficiaries of an adverse decision within 60 days of a request for services. /31/ Unfortunately, beneficiaries have had to resort to litigation to enforce their due process rights. /32/

D. Quality Assurance and Consumer Satisfaction

For the fifth time in less than a decade, the General Accounting Office (GAO) criticized HCFA's enforcement of quality assurance standards for Medicare HMOs. /33/ Based on its analysis of HCFA's previous attempts to implement quality assurance programs, /34/ GAO expressed concern about whether HCFA will implement its new Health Care Quality Improvement Program and take action against providers who are not improving their performance adequately. "[W]e have found that HCFA has often failed to act firmly even when the provider was not making good faith efforts or acceptable progress." /35/

HCFA's new strategy is based on quality assurance programs used by commercial managed care organizations, emphasizing "cooperation with providers, continuous quality improvement, development of performance measures, and improved information about beneficiaries' satisfaction with the care they receive in fee-for-service arrangements and HMOs." /36/ If HCFA finds a deficiency after a site visit, the HMO must submit a plan and timetable for taking corrective action. According to GAO, the use of self-corrective action instead of government penalties to improve quality results in repeated violations of the same quality standards, to the detriment of beneficiaries. /37/

GAO cited several reasons why HCFA's quality assurance program is inadequate. First, instead of determining the effectiveness of the monitoring program, HCFA checks only whether HMOs have procedures and staff to perform quality-assurance monitoring. Second, an HCFA review does not incorporate reports of state peer review organizations and other Medicare monitoring entities. Third, HCFA does not collect routine utilization data, such as hospitalization rates, the use of home health care, or the number of people receiving preventive services, upon which to base determination of over- or underutilization of services. /38/ Fourth, HCFA has failed to publish regulations concerning physician incentive plans. /39/ Finally, HCFA has not followed the lead of private employers and released its site visit reports to the public. /40/ As a result, Medicare beneficiaries are not given information about quality of care that might affect the decision to enroll or remain in a particular HMO.

Quality of care information is sometimes published as a "report card" measuring plan performance against selected indicators, which may include the results of member-satisfaction surveys. /41/ However, the Office of Inspector General (OIG) recently concluded that beneficiary surveys as currently performed by HMOs had limited use for Medicare beneficiaries since they did not target Medicare enrollees or ask questions specific to Medicare enrollees on their general survey. /42/ OIG also found that the surveys lacked uniformity and had technical problems that might cause enrollee dissatisfaction to be underreported. /43/ Finally, OIG noted that HMO disenrollment rates were important performance indicators since those who disenrolled were more likely to have had problems than those who remained in the plan. /44/

II. Special Issues in Integration

Generally, there are two paths to integrating Medicare acute care services with long-term care: integrating financing structures and integrating delivery systems. Financial integration consists of "pooling of financial resources for both acute and long-term care services into one funding stream." /45/ This is most easily accomplished in a capitated system where "providers receive a fixed payment in advance to provide a range of services." /46/ However, merging funding sources is fraught with political and practical difficulties.

Delivery system integration can entail simple improvement of the process of transfers and referrals but may involve expanding home and community-based services. As choices increase, coordination of care becomes pivotal. Full-scale implementation is often described as altering the entire system to employ "multidisciplinary teams trained in geriatrics at the center" of the system. /47/ Managed care concepts are being explored to administer long-term care itself, as well as to achieve the integration of acute care with long-term care services. /48/

A. Federal Demonstration Projects

Two federal demonstration projects /49/ represent the spectrum of integration models.

1. Social Health Maintenance Organizations

Social Health Maintenance Organizations (SHMOs) achieve integration by adding some long-term care benefits not offered in traditional Medicare managed care plans. /50/ SHMOs typically share five features. First, plans bear the financial risk of providing a full range of acute and long-term care services to enrollees. /51/ Second, costs of the range of long-term care services offered by SHMOs are capped to control them. /52/ Third, case management is provided to beneficiaries to coordinate delivery of long-term care services. /53/ Fourth, SHMOs serve beneficiaries with a wide range of disabilities, whether short-term or chronic. /54/ And, fifth, SHMOs utilize prepaid capitation systems, pooling funds from several payment sources. /55/

2. On Lock and Program of All-Inclusive Care for the Elderly

On Lock and the Program of All-Inclusive Care for the Elderly (PACE) programs are examples of the multidisciplinary approach to integration of acute and long-term care. These community-based programs target frail elderly persons and serve them in adult day care settings. /56/ These demonstrations, too, share five features. First, only beneficiaries meeting criteria for nursing facility services may be enrolled. /57/ Second, each PACE site offers the same comprehensive package of acute and long-term care services, either directly or through contracts with other providers. The range of long-term care services is much broader than that offered by SHMOs. /58/ Third, through capitated rates, each demonstration pools Medicare and Medicaid payments and funds more services than either program does separately through capitated rates. /59/ Fourth, PACE sites use staff-model HMOs with interdisciplinary case management teams to coordinate and direct care. /60/ And, fifth, these programs rely heavily on adult day care cent
ers to monitor and provide basic services to beneficiaries. /61/

B. Advocacy in Integration

The use of managed care financing and delivery theories to integrate long-term care for Medicare beneficiaries emphasizes concerns about quality assurance, due process protections, and consumer satisfaction raised in the acute care setting. Integrated services are typically needed by the most vulnerable Medicare beneficiaries, heightening the pressure for advocates to understand the opportunities in state-based integration endeavors.

1. Federal Medicare and Medicaid Waivers

Integration of acute and long-term care services and financing generally requires states to obtain waivers of Medicare and Medicaid requirements from HCFA. /62/ Waiver applications are complex, highly technical, and often drafted with little public notice or chance to review or comment; the HCFA review and approval process affords little more opportunity for advocacy. /63/ However, waiver approval is not automatic, and HCFA can impose a variety of limitations and conditions on design, implementation, and funding.

Advocates can be particularly persuasive on behalf of individual clients whose care will be affected by proposed waivers. Quality assurance, accessibility of the appeal process, and consumer satisfaction are three areas where individual client needs can be used to demonstrate that strict consumer protections are essential. /64/

2. Dual Eligibility

Most elderly Medicaid beneficiaries are eligible for Medicare as well. This dual eligibility utilizes Medicaid funds to pay Medicare premiums, deductibles, and copayments, then covers services outside the usual Medicare benefits package. /65/ Dually eligible beneficiaries reap the benefits of low out-of-pocket costs, a wider array of both acute and long-term care services, and the availability of nonmedical services such as transportation and homemaker services.

But just as the combination of funding and benefits offers advantages, it can lead to greater difficulties for dually eligible beneficiaries. For example, while both Medicare and Medicaid may provide a particular home health service, each has its own criteria for reimbursement. Beneficiaries may be faced with recalcitrant claims administrators who do not understand the relationship between the two programs in an integrated setting, deny valid claims (or withhold necessary prior approval), and thus compel beneficiaries into the appeals process (for one or the other program, or both) in order to obtain services or payment. Providers also have an interest in manipulating the integrated system in order to maximize the higher reimbursement rates usually paid for Medicare services, resulting in cost shifting and lack of coordination in care delivery. /66/

States may obtain waivers of Medicaid's freedom-of-choice requirements in order to mandate that beneficiaries enroll in managed care plans. /67/ No such waiver authority exists permitting mandatory Medicare managed care. As a result, states wishing to integrate the systems must devise incentives for Medicare beneficiaries to enroll in Medicaid managed care plans. One common inducement is payment of all Medicare cost-sharing obligations upon enrollment in a Medicaid plan. While Medicare beneficiaries retain the freedom to enroll in other plans for Medicare services, they are responsible for their own Medicare cost-sharing obligations. /68/ In some instances, these inducements render Medicare's freedom of choice rather illusory.

III. Conclusion

Managed care is an idea whose time appears to have come -- for Medicare, Medicaid, and privately insured services. While new varieties seem to appear daily, they share common features as well as common problems. As the population of this country ages, the health care system will be challenged to provide both acute and long-term care in clinically appropriate, personally desirable, and cost-effective settings. Traditional consumer rights client advocacy /69/ forms a solid foundation for helping clients make wise choices in the managed care arena and vindicating their rights to adequate, accessible, high-quality care.

Footnotes

/1/ Risk contract managed care plans provide all Medicare benefits and have the option to provide services not offered, such as prescription drugs, hearing aids, and eyeglasses. Plans receive per-enrollee payments and then assume the risk of financial, all-covered services. Ruth Finkelstein et al., The Managed Care Consumer's Bill of Rights: A Health Policy Guide for Consumer Advocates 14 (1995).

/2/ Id. at 13.

/3/ Medicare offers limited coverage of skilled nursing facility care after a person has been hospitalized at least three days, 42 U.S.C. Sec. 1395d(a)(2)(B); 42 C.F.R. Secs. 409.30 et seq., and is certified as needing skilled or rehabilitation care, 42 U.S.C. Sec. 1395x(h). Medicare pays 100 percent of the cost for the first 20 days of care. The beneficiary is responsible for a daily coinsurance payment for days 21 through 100 ($92 per day for 1996) with Medicare paying the remainder. 42 U.S.C. Sec. 1395d(a)(2)(B). Medicare pays for some home health services including part-time or intermittent skilled nursing care and home health aide services; physical, occupational, or speech therapy; and certain medical equipment. Id. Sec. 1395x(m). Beneficiaries must be homebound, under a doctor's care, and in need of the services offered. 42 U.S.C. Id. 1395f(a)(2)(C), 1395f(a)(8), 1395n(a)(2)(F).

/4/ Louise Starr et al., Managed Care Handbook for the Aging Network 2 (1996).

/5/ Barbara Coleman et al., New Directions for State Long-Term Care Systems Volume II: Addressing Institutional Bias and Fragmentation 2 (1996).

/6/ Joshua M. Weiner & Jason Skaggs, Current Approaches to Integrating Acute and Long-Term Care Financing and Services 2 (1995) (citing National Chronic Care Consortium, Health Care Reform: Barriers to Integration (1993)). The Older Americans Act offers social and nutritional services to older persons such as transportation, legal services, homemaker help, and Meals on Wheels. Coleman, supra note 5, at 2. Social services block grants provide money to states for services to low-income persons "to help them support themselves and avoid nursing home care." Barbara Coleman, New Directions for State Long-Term Care Systems Volume I: Overview 1 (1996).

/7/ Starr, supra note 4, at 61 -- 62.

/8/ Weiner & Skaggs, supra note 6, at 1 -- 3.

/9/ The traditional Medicare program follows a fee-for-service model in which beneficiaries choose their own doctors and are reimbursed for covered services at 80 percent of the Medicare-approved rate. 42 U.S.C. Secs. 1395 et seq. The requirements for Medicare managed care plans are found at 42 U.S.C. Sec. 1395mm.

/10/ 42 U.S.C. Sec. 300e-9(d).

/11/ Competitive medical plans (CMPs) are prepaid plans that do not meet the requirements for federally qualified health maintenance organizations (HMOs) but do provide, at a minimum, laboratory, X-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospitalization services. 42 C.F.R. Sec. 417.407(c).

/12/ 42 U.S.C. Secs. 1395mm(c)(2)(A), (4). As of January 1996, HMOs and CMPs may offer a "point of service" (POS) option that allows enrollees to receive specified medical services out of an HMO's or CMP's health care network. Plans that offer the POS benefit may impose higher cost-sharing requirements for the beneficiary. HCFA [Health Care Financing Administration] Guidelines, The Point of Service Benefit for Medicare Beneficiaries Enrolled in Risk Plans (Oct. 6, 1995), reprinted in [New Developments] Medicare and Medicaid Guide (CCH) Para. 44,179.

/13/ 42 U.S.C. Sec. 1395mm(c)(5).

/14/ 42 C.F.R. Secs. 417.258, 417.259.

/15/ Medicare Demonstration Projects: Hearing Before the Subcomm. on Health of the House Comm. on Ways and Means, 104th Cong., 2d Sess. (July 12, 1996) (statement of Bruce Vladeck, Administration, Health Care Financing Administration).

/16/ The nine cities are Hartford, Connecticut; Sacramento, California; Jacksonville Florida; Atlanta, Georgia; New Orleans, Louisiana; Columbus, Ohio; Philadelphia, Pennsylvania; Louisville, Kentucky; and Houston, Texas. The rural sites are located in Illinois, Montana, New York, North Carolina, and Virginia.

/17/ Medicare Demonstration Projects, supra note 15.

/18/ HCFA, Profiles of Medicare (1996) (chart MC-3).

/19/ 42 C.F.R. Secs. 417.588, 417.590.

/20/ Id. Sec. 417.592. E.g., 51 percent of HMOs in 1995 charged no monthly basic premium for Medicare Part B services (zero premium plans). HCFA, supra note 18, at chart MC-8. Forty-eight percent offered prescription drug benefits not routinely covered under Medicare. Id. at chart MC-9.

/21/ Medicare Demonstration Projects, supra note 15.

/22/ Id.

/23/ Medicare Pilot Project Now in Doubt, Baltimore Sun, June 18, 1996, at 1B.

/24/ 61 Fed. Reg. 13430 (Mar. 17, 1996) (to be incorporated in Medicare regulations at 42 C.F.R. Sec. 417.479) (implementing 42 U.S.C. Secs. 1395mm(i)(8)).

/25/ Id.

/26/ Id. at 13438.

/27/ The final rules published on March 27, 1996, are available on the Internet at http://www.hcfa.gov/regs.

/28/ For a more detailed discussion of Medicare due process issues, see Alfred J. Chiplin, Jr. & Patricia B. Nemore, Due Process Considerations for Medicare and Medicaid Beneficiaries in Managed Care Systems, 29 Clearinghouse Rev. 629 (Oct. 1995).

/29/ In Daniels v. Wadley, 926 F. Supp. 1305 (M.D. Tenn. 1996), the court found that the appeal procedures in TennCare, Tennessee's Medicaid managed care waiver program, violated constitutional standards by failing to require predeprivation hearings and by failing to require that hearings be presided over by an impartial hearing officer. That standard is equally applicable to the Medicare managed care appeals processes.

/30/ 42 U.S.C. Sec. 1395mm(c)(5). Agency review is available when the amount in controversy exceeds $100; judicial review is available if the amount in controversy exceeds $1,000. Id. at Sec. 1395mm(c)(5)(B); 42 C.F.R. Sec. 417.259.

/31/ 42 C.F.R. Sec. 417.258.

/32/ See, e.g., Grijalva v. Shalala, 1995 WL 523609 (D. Ariz. 1995), a nationwide class action concerning the failure of Medicare HMOs to provide beneficiaries with covered services and with adequate procedural protection when services are denied.

/33/ Government Accounting Office (GAO), Medicare: Federal Efforts to Enhance Patient Quality of Care (1996) (GAO/HEHS-96-20); Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (1995) (GAO/HEHS-95-155); Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (1991) (GAO/HRD-92-11); Medicare: PRO Review Does Not Ensure Quality of Care Provided by Risk HMOs (1991) (GAO/HRD-91-48); Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (1988) (GAO/HRD-88-73).

/34/ Federally qualified HMOs with Medicare enrollees must implement ongoing quality assurance programs that include a quality assurance methodology, a peer review process, systematic data collection of performance and patient results, and remedial action procedures. 42 C.F.R. Sec. 417.107(h).

/35/ Federal Efforts, supra note 33.

/36/ Id. at 3.

/37/ Increased HMO Oversight, supra note 33.

/38/ Federal Efforts, supra note 33, at 18 -- 20.

/39/ As noted above, those regulations were published shortly after GAO completed its study, but HCFA has now delayed their implementation.

/40/ The National Committee for Quality Assurance (NCQA) has developed a quality-assurance tool, the Health Plan Employer Data and Information Set (HEDIS), to help corporations and their employees compare commercial health plans. Federal Efforts, supra note 33, at 18 -- 20. Analysis of managed care plans that have been reviewed by NCQA and information about the most recent version of HEDIS are available from NCQA's web site, http://www.ncqa.org.

/41/ General Accounting Office, Health Care: Employers and Individual Consumers Want Additional Information on Quality (1995) (GAO/HEHS-95-201).

/42/ Office of Inspector General (OIG), HMO Customer Satisfaction Surveys (1996) (OEI-92-9400360). Thirty-nine percent of the HMOs analyzed by OIG did not know the satisfaction rate of Medicare beneficiaries and 65 percent did not know their response rate. Id. at 5.

/43/ Id. at 7 -- 8. E.g., some survey instruments used an unbalanced rating scale with more options to rate the plan favorably than unfavorably. Fewer than half of the HMOs in the study had ever conducted a bilingual survey. Id.

/44/ Id. at 1.

/45/ Weiner & Skaggs, supra note 6, at 6.

/46/ Id.

/47/ Id. at 7.

/48/ Starr, supra note 4, at 62.

/49/ Medicaid-financed long-term care is straining state budgets, prompting state strategies using some type of managed care. Id. at 60 -- 63. This trend is exacerbated by the threat to reduce federal Medicaid appropriations through block grants or other mechanisms. Id. at 83. Many state studies are based on lessons learned from federal demonstrations, which are the focus of this discussion.

/50/ Weiner & Skaggs, supra note 6, at 11. To date, SHMOs have used two models: adding long-term care to existing HMOs or finding medical partners for existing long-term care organizations. Starr, supra note 4, at 64 -- 65

/51/ Weiner & Skaggs, supra note 6, at 11. Beneficiaries receive all Medicare acute, postacute, and ambulatory care services, as well as home health and nursing facility care, homemaker, personal care, and adult day care. Id.

/52/ Id. at 6 -- 7.

/53/ Id. at 12.

/54/ Id.

/55/ Id. at 12 -- 14.

/56/ Starr, supra note 4, at 63.

/57/ Weiner & Skaggs, supra note 6, at 14.

/58/ Id.

/59/ Id. at 15. The Medicare capitated rate is somewhat higher than that the 95 percent of the adjusted average per capita cost paid to Medicare managed care plans delivering only acute care services. Id.

/60/ Id.

/61/ Id.

/62/ Typically, regulations concerning open enrollment, covered services, payment methods and rates, and the permissible percentage of Medicare or Medicaid beneficiaries that an HMO may enroll must be altered. Weiner & Skaggs, supra note 6, at 8.

/63/ See generally 42 U.S.C Sec. 1315 (Medicaid demonstration and research waivers), 42 U.S.C. Sec. 1396n (Medicaid program waivers); 42 U.S.C. Sec. 1395b-1 (Medicare waivers).

/64/ See Jane Perkins, The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor, 28 Clearinghouse Rev. 864 (Dec. 1994), for a discussion of waiver issues that can be argued on behalf of clients.

/65/ Starr, supra note 4, at 68 -- 69.

/66/ Id. at 69. See also National Academy for State Health Policy, Federal Barriers to Managed Care for Dually Eligible Persons (1995); Charpentier v. Belshe, 1994 WL 792591 (E.D. Cal. 1994).

/67/ 42 U.S.C. Sec. 1396b(m).

/68/ Starr, supra note 4, at 69 -- 70.

/69/ See Finkelstein, supra note 1, at 35 -- 74.