Tales from the Field: Case Managers Help Clients Navigate the Health Care System

Introduction and Background

Illinois' move towards Medicaid coordinated care and coordinated care for people dually eligible for Medicaid and Medicare has increased the complexity of the services case managers are now expected to provide. Illinois is transitioning its health care delivery system from a predominantly fee-for-service model to one built on risk-based care coordination. The State legislature's passage of the 2011 SMART Act initiated this push by calling for savings of $16.1 million though integrating care for the most complex Medicaid beneficiaries. In addition to the SMART Act, Public Act 96 1501 also moved Illinois in the direction of coordinated care by mandating that 50% of the Medicaid population be enrolled in a coordinated care program by 2015. According to the law, care coordination involves patients receiving care "from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care."

Illinois is experimenting with various models of coordinated care that differ based on the population served and on whether the managed care entity receives a capitated rate (per member per month fee) to provide care, or still receives fee-for-service payments as was traditionally the case for the Medicaid program. The two major programs serving older adults and people with disabilities are the Medicare Medicaid Alignment Initiative (MMAI), and the Integrated Care Program (ICP). MMAI provides coordinated care for "dual eligibles"—people enrolled in both Medicare and Medicaid. Enrollment began in the fall of 2013. ICP serves older adults and people with disabilities eligible for Medicaid but not eligible for Medicare. Participation in the ICP program is mandatory for those living in five mandatory regions, including Cook County. Enrollment began in May, 2011.

Staff from Health & Disability Advocates (HDA) field calls from community based medical and social service providers who face barriers assisting clients with issues related to Medicaid and Medicare. The assistance HDA provides falls under the scope of its leadership of the Make Medicare Work (MMW) Coalition, a role it shares with AgeOptions and Progress Center for Independent Living (PCIL). The MMW Coalition promotes access to affordable health care options in Illinois by building capacity of professionals serving older adults and people with disabilities. MMW assists professionals to better help clients access health care, prescription drugs, and other services through provision of materials, trainings, technical assistance, and advocacy support.

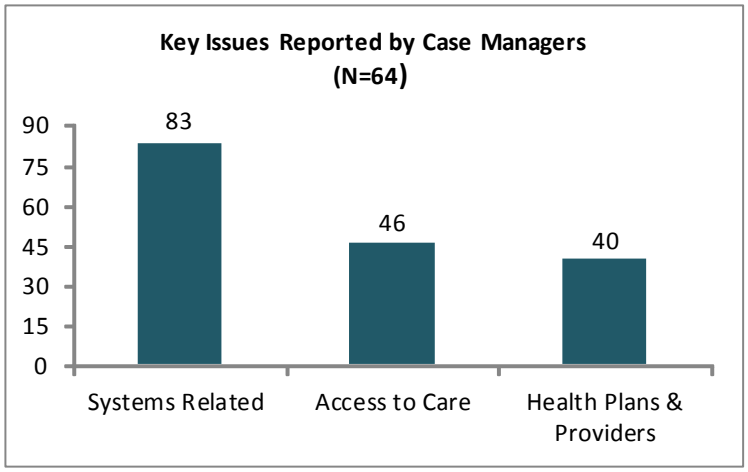
In an effort to inform the MMW leadership team's advocacy agenda and the development of future trainings, a survey was conducted to identify the challenges faced by Coalition members who provide direct service support for seniors and people with disabilities in navigating the health care system. The survey—administered electronically over a seven-week period beginning in March 2015 — covered topics including Medicare and Medicaid enrollment, Medicaid redeterminations, and Medicaid managed care. The survey was sent to 1,068 case managers in agencies serving the greater Chicagoland area. While the response rate was relatively low at 6%, the information received from respondents was rich and insightful.

Top Concerns of Case Managers

Case managers were asked to identify the top three issues they face when trying to assist clients with accessing health care services. Across 65 respondents, 169 key concerns were identified within three broad categories. Issues related to the larger health system accounted for 49% of responses, while issues specific to access to care and health plans and providers accounted for 27% and 24% of responses respectively.

Systems Related Issues: A significant number of respondents raised concerns about communications at the systems level. Many expressed frustration with the difficultly of simply reaching someone within the Illinois Department of Human Services (DHS), while others complained of staff providing inaccurate or inconsistent information.

Several case managers noted that systems level communications often exceeds the health literacy levels of their clients. Information about health care options, covered benefits, eligibility and application processes is not always clearly communicated and thus results in further confusion among clients. These challenges are exacerbated when information is not provided in the client's primary language, including American Sign Language (ASL) for persons who are deaf. Specific concerns were also raised about notifications from the State. A lack of clarity in letters sent to clients and, at times, an overall failure to send notifications about such key processes like redetermination result in missed deadlines, and for some, a loss of benefits.



A large number of cases managers also identified challenges related to enrollment and disenrollment. Several specifically noted that automatic placements into MMAI/managed care organizations leaves their clients without access to the medical providers with whom they have established relationships. The delays in the Medicaid application process—often in excess of three months— leave many without coverage for too long and the 'churn' factor of having coverage and then losing it poses a threat to both continuity of care and family stability.

Access to Care Issues: Overwhelmingly, the largest number of access to care challenges identified by case managers pertained to costs for all coverage options, including Marketplace plans, Medicare, and Medicaid. Several respondents noted that even with tax credits that could be obtained through the Marketplace, premiums remain costly, while co-pays and high deductibles deter Medicare enrollment. The high costs of prescriptions was frequently noted, with clients having either inadequate coverage or, for some medications, no coverage at all. Medicaid spend-down and the rising costs of Medicare supplements as clients age present a financial burden to clients, and the expense of Medigap supplemental policies restrict people from purchasing coverage.

Communication and cultural barriers to accessing care were also identified, particularly for those for whom English is not their primary language. Transportation challenges were also raised by case managers whose clients needed support to get to and from medical appointments.

Finally, several respondents noted that clients had specific challenges accessing dental care. They reported that limited dental benefits, particularly for those with serious oral health needs, are negatively affecting their clients' overall health status.

Issues with Health Plans and Providers: Challenges related to medical networks were repeatedly identified by case managers. Clients are being told that their doctors are in a specific network only to find their doctor no longer participates in their plan. Further challenges are faced when clients try to find a physician and a specialist within the same managed care plan network, an issue more prevalent for clients with limited English. Case managers specifically noted challenges with MMAI, as providers frequently change the plans they accept, creating confusion.

The communication challenges experienced at the systems level are also occurring when dealing with specific plans and providers. Case managers report that their clients receive no communication or informational materials when they sign up with a managed care organization, nor are they notified in advance of significant benefit changes. Clients are often unclear about whether they need a referral to see a specialist and have trouble understanding what their doctors are telling them. In some cases, the message is clearer, but false, as with the case of a Medicare beneficiary who was told she "must improve" in order to remain in nursing home for treatment.

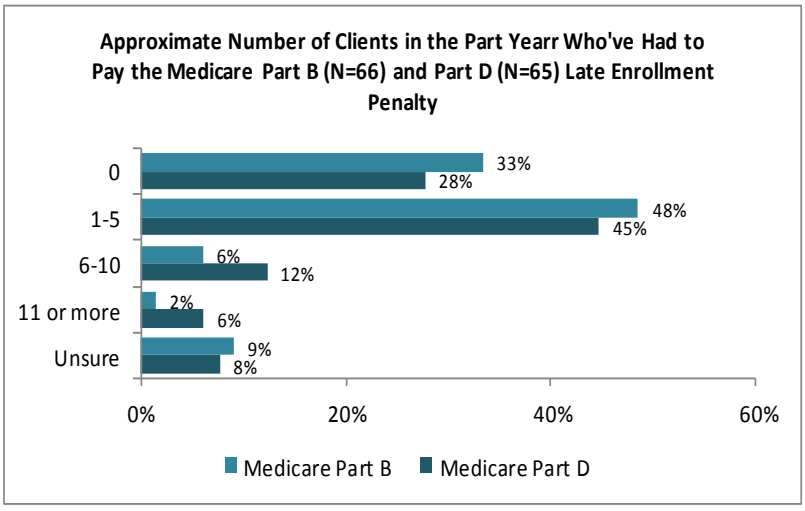
Survey responses also reflect inadequate knowledge on the part of the plans and providers. Survey respondents expressed concern that customer service representatives are not sufficiently trained and that medical providers are not educated about Illinois Medicare care coordination. Clients receiving misinformation from their physicians often end up with out of network bills.

Medicare Penalties and Appeals

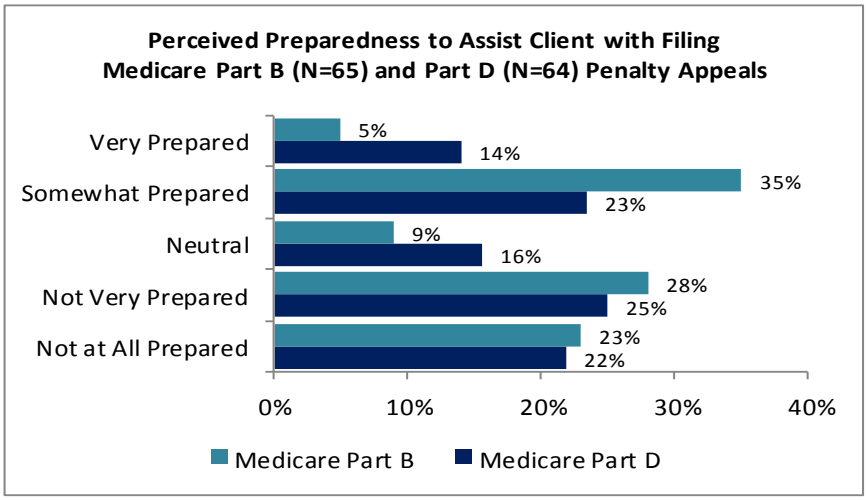
As previously noted, challenges posed by the health care system often have a negative impact on the ability of clients to access care and receive benefits. Poor communication on behalf of the system and relatively low levels of health literacy among clients and those who serve them often result in penalties.

Case managers were asked about the extent to which their clients have had to pay the Medicare Part B (outpatient services) and Part D (prescriptions) Late Enrollment Penalties (LEPs) in the past year. Notably, 67% of respondents reported that at least one of their clients had to pay the Part B penalty. While the majority of case managers reported that penalties were applied to just one to five of their clients, 8% noted that penalties were paid by six or more of their clients.

Respondents reported that an even a great proportion of their clients (72%) had to pay a Part D LEP in the prior year. Twelve percent (12%) of respondents reported that between six and 10 of their clients paid a Part D LEP, while 6% noted they had 11 or more clients who had to pay.



When faced with Medicare penalties, clients frequently turn to their case managers for support. However, the survey responses suggest that case managers are generally unprepared to assist clients in filing Part B and Part D penalty appeals. When asked how prepared they felt to assist with these appeals, just 5% of respondents reported they felt 'very prepared' to assist with Part B appeals, and 14% felt 'very prepared to assist with Part D appeals. Of greater concern is the number of case managers who felt 'not very' or 'not at all prepared' to assist clients with filing a Part B (51%) or Part D (47%) appeal.



CASE EXAMPLE

Health & Disability Advocates' (HDA) work on behalf of a deaf couple facing a lifetime Part D Late Enrollment Penalty (LEP) illustrates how complex enrollment procedures can pose serious consequences. Both husband and wife must pay a monthly $13 LEP that is equivalent to their Part D premium. For a couple on a very limited income, this additional expense, which must be paid on a monthly basis for the rest of their life, presents a significant burden. They are subject to this monthly penalty for no fault of their own. Notices regarding their enrollment responsibilities and interactions with Senior Health Insurance Program (SHIP) Counselors did not account for their special communication needs. The couple is profoundly deaf and communicates through American Sign Language (ASL). Information regarding their upcoming Part D enrollment was only presented to them in writing. In addition, the couple learned of their LEP years later when they visited a SHIP counselor, who communicated the news by writing notes on paper. The couple would meet with this SHIP Counselor over the course of five years and the counselor never made an effort to secure an interpreter during that time period. An interpreter would only be present after the wife's mother took on the responsibility of finding one. The health insurance system and its representatives repeatedly failed to relay eligibility and enrollment information to this couple in an accessible manner. HDA believes that this profoundly deaf couple should not bear the consequences of this failure and is currently appealing the LEP while also escalating the issue with the Centers for Medicare and Medicaid Services and the Administration on Community Living.

Key Challenges

Respondents were asked to share specific challenges they face regarding different aspects of Medicaid. When helping clients apply for Medicaid, several challenges were identified. A majority of case managers (56%) identified that application processing time as difficult, with clients having to wait more than 45 days for a response from the state. They also noted that clients with disabilities and older adults often have their household incomes counted incorrectly on their applications (15% for each client group) which can lead to erroneous denials of coverage. 21% have had clients placed into the wrong eligibility category, which can lead to discontinuities in care.

Challenges Faced When Working With Clients Applying for Medicaid (N=62)	
Application response exceeds 45 days	56%
Clients are placed into the wrong eligibility	21%
Clients with disabilities have their household income counted incorrectly on their applications	15%
Older adults have their household income counted incorrectly on their applications	15%
Other challenges	18%

Once applications are approved, case managers face a whole new set of challenges related to Medicaid coordinated care. The vast majority of respondents (83%) specifically noted that the notices sent out are confusing, while nearly a third (63%) pointed to the inadequacy of available provider networks. Health care providers seen by their clients are either not familiar with Medicaid coordinated care, or they lack information about it (67%). Case managers report clients have difficulty reaching the care coordinators from their health plans (59%) and that their clients simply do not know how to enroll (61%).

Medicaid redeterminations are another key focus of case managers' support to clients . Consistent with the information provided earlier in this report, major challenges relate to communications. Respondents reported that their clients often do not receive redetermination notices (60%) nor any notice or explanation when coverage is terminated. Case managers also reported that they have difficulty in finding the correct entity to assist with reinstatement of coverage (54%) and specifically note that neither the managed care plans (48%) nor State agencies (44%) are able to direct them to the appropriate resource to address redeterminations.

Challenges Faced When Addressing Medicaid	
Confusing notices	80%
Inadequate provider networks	63%
Providers are unfamiliar with Medicaid Coordinated Care	67%
Clients have difficulty accessing care coordinators	59%
Client enrollment brokers cannot answer clients' questions	47%
Clients do not know how to enroll	61%
Other	28%

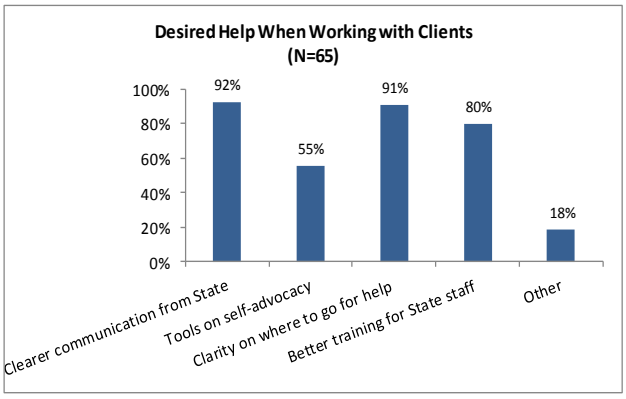
Challenges Encountered When Working With Clients on Medicaid Redetermination (N=63)	
	%
Not receiving redetermination notices	60%
Not provided a reason for termination of coverage	65%
Difficulty finding the correct entity to reinstate coverage	54%
Coverage terminated without notice	63%
SNAP terminated without notice	49%
Managed care plans unable to direct clients to the appropriate entity to address redeterminations	48%
State agencies unable to direct clients to appropriate entity to address redeterminations	44%
Other challenges	22%

Recommendations

Case managers were asked what specific type of help would assist them in serving clients. Consistent with information presented throughout this report, respondents are seeking improvements in several areas. Based on that feedback, and the experiences that HDA has had in its efforts to support both clients and supportive service staff, the following actions are recommended:

1. Written and verbal information from the State should be clear and developed with appropriate literacy (and health literacy) levels in mind. This is particularly important when notices regarding process, eligibility and deadlines are sent out.

2. The State should increase its capacity to provide services to clients whose primary language is not English. In addition to hiring more bi-lingual staff, protocols should be in place so that case managers can easily receive the support of interpreters, including those who speak American Sign Language.



3. Sources of assistance should be made apparent for both case managers and clients. Resources should be posted on the State website and identify which entities have primary responsibility for specific issues. This is already done. State staff should be well versed in the available resources to facilitate referrals.

4. A new and improved training curriculum should be developed for State employees and volunteers responsible for interacting with clients and responding to inquiries. This training should include education about specific managed care Medicaid health plans, appropriate resources to which callers can be referred, and basic customer service.

MMW Members need support from the State and its agencies as they connect seniors and people with disabilities to necessary health insurance and health care. The pay off is significant: helping MMW Members and their fellow direct service providers in the field ultimately supports the health, well-being, and independence of their clients.

Resources

MakeMedicareWork.Org

IllinoisHealthMatters.org

HDAdvocates.org