

ENSURING CONSUMER PROTECTION FOR DUAL ELIGIBLES IN INTEGRATED MODELS

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Foreword

This paper is the first in a series of four papers designed to highlight pressing issues facing dual eligibles and provide recommendations to the Medicare-Medicaid Coordination Office, state Medicaid agencies and other interested policymakers and stakeholders on how to address them. This first paper provides recommendations for consumer protections in delivery system models that integrate Medicare and Medicaid. Future papers will focus on differences between Medicare and Medicaid program rules and coverage standards, ideas for integrating the appeals systems of the two programs, and opportunities for improving the delivery of the Qualified Medicare Beneficiary (QMB) benefit.

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Executive Summary

The implementation of the Patient Protection and Affordable Care Act (ACA) has brought a new wave of attention to the problems that dual eligibles—those who qualify for both Medicare and Medicaid—encounter in the current health system. The ACA created a new office at the Centers for Medicare and Medicaid Services

(CMS) focused explicitly and exclusively on dual eligibles. For the first time, there is a central place within the federal government where the unique challenges of this population can be studied and remedied. Officially named the Medicare-Medicaid Coordination Office (MMCO), the new office is tasked with leading activities within the agency to better align Medicare and Medicaid benefits and to improve coordination between the Federal government and the states in order to ensure that dual eligibles get full access to items and services to which they are entitled under each program.

In its first year, a primary focus of MMCO has been to develop and replicate new models for integrating the delivery of Medicare and Medicaid benefits with the goal of better coordinating the care that dual eligibles receive. MMCO, working with the Center for Medicare and Medicaid Innovation (CMMI) at CMS, has awarded contracts to 15 states to design and, ultimately, implement new models for integration.

These integration efforts bring both great promise and risk. Implemented with the beneficiary in mind, they promise to improve care, decrease unnecessary institutionalization and slow the cost curve in the health system. Implemented with cost savings and administrative efficiencies as primary goals, however, they risk creating new barriers to care and new financial incentives for limiting the care provided to the most high need individuals in the health system.

To ensure that the focus stays on beneficiaries, strong consumer protections must exist within all integration models. While agreement on the need for consumer

protections is widespread, there may be different perspectives among stakeholder groups on exactly which protections need to exist and how they should be implemented.

Essential Consumer Protections

This paper provides an overview of consumer protections most essential to building a successful model for integrating the care of dual eligibles.

- Dual eligibles must have a right to choose how, where, and from whom they receive care. Choice begins with a truly voluntary, “opt in” enrollment model.
- An integrated model must include all Medicaid and Medicare services as well as enhanced benefits, especially those designed to keep individuals living at home and in the community.
- There must be continuity of care, allowing access to current providers and services, treatments and drug regimes during the transition process.
- Enrollees must be able to appeal decisions made by the integrated model and to file complaints about problems encountered in dealing with the program.
- An integrated model must provide enrollees with meaningful notices and other communications about, for example, enrollment rights and options, plan benefits and rules and care plan elements.
- Services must be culturally and linguistically appropriate and physically accessible.
- An integrated model must provide adequate access to providers who are able to serve the unique needs of dual eligibles.
- Oversight must be comprehensive and coordinated to ensure that integrated models are performing contracted duties and delivering high quality services.
- Payment structures must promote delivery of optimal care, and not reward the denial of needed services.
- Integrated efforts must be designed and implemented thoughtfully and deliberately, taking into consideration the structures and readiness of existing service delivery systems.

Introduction

The implementation of the Patient Protection and Affordable Care Act (ACA) has created new opportunities to improve the delivery of health care benefits and services to those who are dually eligible for both Medicare and Medicaid, also known as dual eligibles. In addition to enacting various changes to Medicare and Medicaid that will have a positive impact on those eligible for both, the ACA created a new office at the Centers for Medicare and Medicaid Services (CMS) to focus specifically on dual eligibles and their unique needs and challenges. Named the Medicare-Medicaid Coordination Office (MMCO), the new office is tasked with leading activities within the agency to better align Medicare and Medicaid benefits and to improve coordination between the Federal government and the states in order to ensure that dual eligibles get full access to items and services they are entitled to under each program.¹

One area of focus for MMCO will be to work with states to develop new care models for delivering benefits and improving care for dual eligibles. In April 2011, in cooperation with the also newly created Center for Medicare and Medicaid Innovation, MMCO awarded contracts to 15 states “to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals.”² The stated goal of these contracts “is to identify and validate delivery system and payment coordination models that can be tested and replicated in other states.”³

Each of the 15 states will be working to design

distinct models. Many of them will be exploring ways to blend Medicare and Medicaid funds into a single entity responsible for delivering services covered under both programs to enrollees.⁴ To do this, these states will be relying on an ACA provision that permits CMMI to test and evaluate fully integrated care models for dual eligibles and allows the state to manage and oversee both Medicare and Medicaid funds.⁵ A separate ACA provision permits CMMI to test and evaluate “all payer payment reform” for state residents, including dual eligibles.⁶ These provisions allow for a level of integration not found in existing systems.

These integration efforts bring both great promise and risk. Implemented with the beneficiary in mind, they offer the potential to improve care, decrease unnecessary institutionalization, and bend the cost curve in the health system. However, implemented with cost savings and administrative efficiencies as their primary goals, they risk creating new barriers to care and new financial incentives for limiting the care provided to the most high need individuals in the health system. To ensure that the focus stays on beneficiaries throughout this process, strong consumer protections must exist within all integration models.

While there seems to be widespread agreement on the need for consumer protections, there may be different perspectives among stakeholder groups on exactly which protections need to exist and how they should be implemented. This paper is an attempt to provide a beneficiary advocate perspective on the consumer protections which are most essential to building a successful model for integrating the care of dual eligibles.

¹42 U.S.C.A. § 1315b. The statute refers to the Office as the “Federal Coordinated Health Care Office.” In May 2011, CMS announced that the Office would be referred to as the Medicare-Medicaid Coordination Office.

²Ctr. for Medicare and Medicaid Servs., “15 States Win Contracts to Develop New Ways to Coordinate Care for People with Medicare and Medicaid,” available at www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp. The 15 states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. MMCO has indicated that it will also provide technical support to states that were not awarded contracts, but are interested in developing or enhancing models to better serve dual eligibles.

³Id.

⁴Families USA has provided a helpful summary of the proposals each of the 15 states submitted to the Office. “A Guide for Advocates: State Demonstrations to Integrate Medicare and Medicaid,” available at <http://familiesusa2.org/assets/pdfs/health-reform/State-Integration-of-Medicare-and-Medicaid.pdf>.

⁵ 42 U.S.C.A. § 1315a(b)(2)(B)(x).

⁶ 42 U.S.C.A. § 1315a(b)(2)(B)(xi).

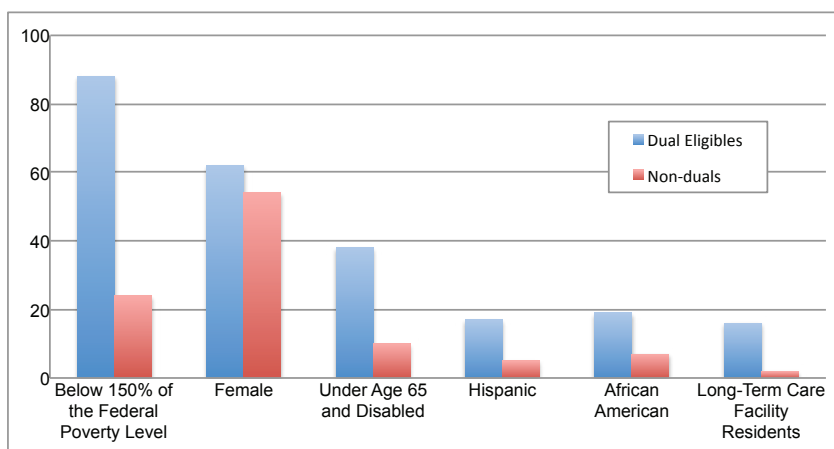
Dual Eligibles: Background and Demographics

“Dual eligible” is a term used to refer to an individual who qualifies for both Medicare and Medicaid benefits. Full benefit dual eligibles are Medicare recipients who qualify for full Medicaid benefits. Partial dual eligibles are Medicare recipients who receive assistance from Medicaid with Medicare premiums and cost-sharing, but not full Medicaid benefits.

Roughly nine million individuals qualify for both Medicare and Medicaid.⁷ Most (59%) are individuals aged 65 and over. The others (41%) are persons with disabilities who qualify for Social Security Disability and, by definition, have functional impairments. Of the over 65 group, 44 percent are aged 65–74, 33 percent are aged 75–84 and 22 percent are over age 84.⁸

Dual eligibles are universally acknowledged to be an extremely vulnerable and medically fragile group. Compared to those who are only eligible for Medicare, dual eligibles are more likely to be low-income, women, African American or Hispanic; to lack a high school diploma; and to live in an institution, alone or with someone other than a spouse.⁹ Dual eligibles are more likely to have greater limitations in activities of daily living and to report poor health status. Nearly one-fifth

Dual Eligibles More Likely Than Other Medicare Beneficiaries to be Female, Disabled, Minorities, or Long-Term Care Facility Residents, 2006



Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

live in institutions.¹⁰ Their medical fragility is demonstrated by the high costs associated with providing care to the population. Dual eligibles represent just 16% of Medicare beneficiaries, but account for 27% of all Medicare program costs.¹¹ Dual eligibles represent 15% of Medicaid enrollees but account for 39% of Medicaid costs.¹²

A closer look at the distribution of these costs, however, reveals that not all dual eligibles have the same health needs or contribute equally to the high cost of providing care to this group. Some have high needs that require intensive and expensive care. A relatively small portion of dual eligibles (20%) accounts for a large part of all Medicare spending on dual eligibles (68%).¹³ In contrast, some duals have their health conditions

⁷ Kaiser Family Foundation, “Dual Eligibles: Medicaid’s Role for Low-Income Medicare Beneficiaries,” (2011) available at www.kff.org/medicaid/upload/4091-08.pdf.

⁸ Medicare Payment Advisory Committee (MedPAC), “Healthcare Spending and the Medicare Program,” MedPAC Data Book, Chapter 3, at 34 (2010) available at www.medpac.gov/documents/jun10databookentirereport.pdf.

⁹ Id. at 36.

¹⁰ Id. at 35-36.

¹¹ Id. at 36.

¹² Kaiser Family Foundation, “Dual Eligibles: Medicaid’s Role for Low-Income Beneficiaries.”

¹³ MedPAC, “Healthcare Spending and the Medicare Program,” at 38.

under relative control and require much less costly care. The least costly 50% of dual eligibles account for just 8% of Medicare spending for dual eligibles.¹⁴

On the Medicaid side, the largest cost, by far, is for long-term care provided to dual eligibles (70%), for which Medicare provides only limited coverage.¹⁵

If there is a unifying feature among all dual eligibles, it is their poverty. Since they all qualify for Medicaid, dual eligibles, by definition, have limited income and resources. Just over half of all duals have incomes below the federal poverty level and 93% have incomes below 200% of the federal

poverty level. It is important, however, to recognize even by this measure there are differences among dual eligibles. Some dual eligibles worked in low wage jobs and have lived in or near poverty throughout their lives. They qualify for Medicaid because they receive Supplemental Security Income or limited Social Security Retirement or Disability benefits. For others, poverty may have come in connection with the onset of a disability or illness. In most states, individuals with high health needs can “spend down” their income on health care costs to qualify for Medicaid, but only after depleting all but a small portion of their savings.

¹⁴ Id.

¹⁵ Kaiser Family Foundation, “Dual Eligibles: Medicaid’s Role for Low-Income Beneficiaries.”

Recommendations on Consumer Protections

When designing consumer protections for integrated services, it is important to avoid thinking of consumer protections as separate from the other rules and policies that will govern integration models. Enrollees will be served best if consumer protections are incorporated at every level of the process, from model design and development to implementation to evaluation. Consumer protections can take many forms. Some protections guarantee an explicit right or service to enrollees. Other protections require or prohibit specific policies and practices of the integration model. Still other protections are implicit, incentivizing behavior that ultimately protects enrollees. Each of these types of protections is important and none is sufficient alone.

This paper lays out general principles for consumer protections that can and should be applied in any

model designed to integrate care for dual eligibles.¹⁶ The list of principles is not exhaustive, but serves as a baseline for evaluating proposed models. In developing new models worthy of investment, MMCO and states should include at least these protections.

Dual Eligibles Must Retain Their Right to Choose. Dual eligibles interacting with integration models must retain their right to choose how, where and from whom they receive care. The principle of choice begins with a truly voluntary, “opt in” enrollment model, but also includes the right to:

- Choose all of one’s providers;
- Choose whether and how to participate in care coordination services;
- Decide who will be part of a care coordination team;
- Self-direct care (with support necessary to do so effectively); and
- Choose, ultimately, which services to receive and where to receive them.

Choice in Enrollment. A completely voluntary

¹⁶ These principles reflect a review of consumer protections in existing programs that serve dual eligibles and ideas coming from the rich dialogues among stakeholders that have occurred in many forums since the launch of the MMCO.

system in which dual eligibles must “opt in” to the integration model provides the preferred, highest level of consumer protection. An “opt-in” enrollment system honors the autonomy and independence of the individual by preserving for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. Preserving that choice is key to maintaining continued access to specialists and other providers that may not participate in the integrated model, particularly for those with complex medical conditions.

Voluntary, “opt in” enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an “opt in” model.¹⁷ Massachusetts’ Senior Care Options, Minnesota’s Senior Health Options and Wisconsin’s Family Care Partnerships all use an “opt in” enrollment model.¹⁸ Advocates in those states report that the enrollment mechanism ensures that participating plans attract and retain enrollees by offering each enrollee a higher quality, more coordinated experience than the one they have in the fee-for-service system. The “opt in” model also ensures that program participants are committed and willing to use the care coordination services that the model is designed to provide.

Federal and state policymakers as well as managed care plans that provide integrated models are increasingly advocating for “opt out” enrollment processes. In an “opt out” system, dual eligibles would automatically be enrolled into an integrated care model, but would retain the ability to “opt out” of that enrollment. “Opt out” rights and rules under discussion vary, but issues

being discussed include: whether “opt out” enrollment would apply to both the Medicaid and Medicare enrollment; when “opt out” rights could be exercised; and how automatic enrollment would occur where there is more than one integrated provider or model from which to choose.¹⁹

The right to “opt out” alone is not adequate to protect dual eligibles from harm. A dual eligible who is automatically enrolled into an integrated model may not realize that the model is not a good fit (for example, that current providers are not part of the network) until after the enrollment has taken effect. By that time the individual may have experienced a disruption in care that opting out in the following month comes too late to remedy.

An “opt out” model is particularly problematic if applied to new, untested integration models. At their start, the ability of such models to deliver beneficiary-centered care coordination is unconfirmed. As models are implemented and thoroughly evaluated, it may be appropriate to consider more aggressive enrollment strategies. Until then, an “opt in” enrollment system provides the best way to ensure that the new models grow into effective, beneficiary-centered programs. Other concerns that an “opt out” policy could address, such as adverse selection and marketing costs, can be addressed in other ways (for example, through appropriate rate setting, strict marketing rules and the use of independent enrollment brokers).

Choice Within an Integrated Model. The right to choose does not end with enrollment. Once in an integrated model, dual eligibles must maintain their rights to choose what care to receive, where to receive it, how and from whom to receive it. The right to make these

¹⁷ 42 C.F.R. § 460.90. See also www.cms.gov/PACE/Downloads/PACEFactSheet.pdf.

¹⁸ Mass. Office of Health and Human Servs., “Senior Care Options Review,” available at www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Provider&L2=Insurance+%28including+MassHealth%29&L3=MassHealth&L4=Senior+Care+Options&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_sco_overview&csid=Eeohhs2. (Massachusetts Senior Care Options); Minn. Dept. of Health and Human Servs., “Minn. Senior Health Options,” available at www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271; Wis. Dept. of Health Servs., “Family Care Partnership Program,” available at www.dhs.wisconsin.gov/wipartnership/index.htm.

¹⁹ Comparisons have been made between an “opt out” enrollment process and the automatic-enrollment process used to enroll dual eligibles into Medicare Part D prescription drug plans. There are important differences between Part D and fully integrated models. Dual eligibles are automatically enrolled into Medicare Part D plans because, if they did not enroll in a plan, they would have no prescription drug coverage. In contrast, dual eligibles will still have Medicare and Medicaid coverage even if they do not enroll in an integrated model. In addition, the question of where to automatically assign an individual when more than one option is offered in a region is much more difficult when the model includes all benefits, not just the drug benefit. Dual eligibles would be at risk of being enrolled into a program that does not include their existing providers or does not cover the services they are currently receiving.

decisions is essential to a beneficiary-centered program, complementing and improving care coordination efforts and services. PACE gives participants the right to make many decisions related to their care.²⁰ The Wisconsin Family Care Partnership (WFCP) does as well and also provides support to enrollees who choose a Self-Directed Supports option.²¹

An Integrated Model Must Provide Access to All Necessary Supports and Services. An integrated model must ensure that enrollees have access to all Medicare and all Medicaid covered services. In addition, the model should deliver “enhanced” benefits, especially those designed to keep individuals living at home and in the community. Provision of all services should be made based on clearly defined standards and an assessment of the particular needs and health status of the individual.

Medicare and Medicaid Services. Medicaid and Medicare covered services should be provided based on standards no more restrictive than those applied to individuals not in the integrated model. Where both Medicare and Medicaid cover the same service, the enrollee should have access to the full degree of service provided by each program. Where the programs employ different criteria for providing the same service (e.g., home health), the integrated model should rely on the less restrictive criteria to provide the service.²²

Enhanced Benefits. One of the promising elements of integration is the potential to redirect savings to provide services and supports that may not be covered

by either Medicaid or Medicare, but that are essential to improving, restoring or maintaining the health of the individual. These enhanced benefits should also be clearly defined. Standards for providing the service should be outlined in contracts with the integration model and in informational materials provided to enrollees.

Clear Standards. Coverage standards for all services must be based on a specific determination of whether the service is medically necessary for that individual. “Rules of thumb” like Medicare’s so-called “improvement standard” must not migrate into new models.²³

There is the potential for tension between requiring defined services with specific standards for coverage and creating a more flexible benefits package that will cover all services deemed medically necessary, including those that may not traditionally be covered by either Medicare or Medicaid. Several existing integration models have adopted contract or regulatory language that resolves this tension by preserving the advantages of each approach.

In Wisconsin, for example, the WFCP requires participating plans to provide coverage for Medicaid state plan services that is no more restrictive than the coverage provided in the fee-for-service setting.²⁴ Contracts include detailed descriptions of state plan services that must be included, with cites to their source in the state’s Medicaid law.²⁵ Plans are required to provide these services in “sufficient amount, duration, or scope to reasonably be expected to achieve the

²⁰ 42 C.F.R. § 460.112.

²¹ Wis. Dept. of Health Servs., Wisconsin Family Care Partnership (“WFCP”) contract, 69-72. available at www.dhs.wisconsin.gov/LTCare/StateFedReqs/cy2011mcocontract.pdf.

²² It is important to note that Medicaid imposes estate recovery on certain individuals (including many dual eligibles), while Medicare does not. In models where Medicare and Medicaid finances are not integrated, it is essential that Medicare coverage for a service be exhausted before Medicaid coverage is provided to limit the estate recovery liability of beneficiaries. In models where a Medicaid capitation is set, it is common for states to recover the total amount of the capitation regardless of the amount or cost of services provided. In a fully integrated model where Medicare and Medicaid payments would be blended with a single capitation rate, it is unclear how estate recovery would be handled. Equitable policies should be developed to limit estate recovery liability.

²³ Medicare beneficiaries are often denied services based on the “improvement standard.” This standard, which has no basis in the Medicare statute, is used to deny care to individuals for whom it is determined that their condition will not improve or if the care they need is only to maintain function. The Medicare statute does not require improvement as a condition for coverage of services and the Medicare regulations make clear that the concept of improvement is not dispositive when making coverage determinations. See Ctr. for Medicare Advocacy, “Removing a Major Barrier to Necessary Care: The Medicare ‘Improvement Standard’ Advocacy & Education Initiative” available at www.medicareadvocacy.org/InfoByTopic/ChronicConditions/09_12.17.Improvement.htm.

²⁴ Wis. Dept. of Health Servs., WFCP contract at 73.

²⁵ As Medicare Advantage Special Needs Plans, participating plans must provide all Medicare covered services under rules governing MA-SNPs.

purpose for which the services are furnished.”²⁶ In addition, the plan’s Medicaid benefit package “must be no more restrictive than the Medicaid fee-for-service coverage.”²⁷ In addition to the specific services outlined in the benefit package, plans in the Wisconsin program are permitted to provide an “alternative” support or service if it is an alternative to a support or service in the standard plan benefit package, is cost-effective when compared to the standard benefit package supports and services and is “appropriate to support th[e] member’s long-term care outcomes and needs.”²⁸

PACE rules lift various Medicare and Medicaid benefit limitations and conditions, generally in favor of providing more coverage to enrollees.²⁹ PACE plans are required by regulation to provide all Medicaid and Medicare covered services. The regulations include a detailed list of services that must be provided.³⁰ In addition, plans are instructed to provide “other services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.”

The approaches used by both WFCP and PACE maintain enrollees’ clear entitlement to Medicaid and Medicare services while also allowing opportunities for plans to provide new and more effective services. Outlining standards for when those alternative or enhanced services are covered gives enrollees a clear understanding of what they can expect and also sets out the basis for appealing a denial of enhanced services.

Cost Sharing Protection. Enrollees in the integrated model must be protected from cost-sharing for any service that would exceed the cost-sharing they would pay for the same service in the Medicaid or Medicare fee-for-service system. The majority of full-benefit

dual eligibles are Qualified Medicare Beneficiaries or otherwise qualify for state coverage of Medicare cost sharing.³¹ Ensuring that dual eligibles actually receive this benefit has been an ongoing problem. Many Medicare providers refuse to see these beneficiaries or charge them for cost-sharing. Integrated models must address this problem and remove the access barriers it creates.

Continuity of Care Must Be Maintained. Dual eligibles often have long-standing relationships with primary care, specialty and durable medical equipment providers; many are stabilized on complex treatment or drug regimes. The transition to a new model, which may involve changes in providers and coverage of different services, treatment and drugs, can represent a significant disruption in care. Even brief disruptions can have a serious impact on the health of this medically vulnerable population. To limit the potential for disruption and ensure care continuity, policies must be put in place to ease transitions into the model by maintaining access to current providers and services, treatments and drug regimes.

Care continuity rights can be broken into two categories. The first is the right to maintain access to current *services*, including prescription drugs, during a defined transition period. Medicare Part D provides an example of a transition policy. Under Part D, new enrollees in a plan are entitled to a one-time fill of an ongoing medication within the first 90 days of plan membership even if the drug is not on the plan’s formulary.³² The purpose of the transition supply is to provide the enrollee with the additional notice and time necessary to switch to an appropriate formulary drug or to seek and receive an exception for coverage

²⁶ WFCP contract at 73 & 256-269.

²⁷ Id at 73.

²⁸ Id at 74.

²⁹ Benefit limitation and conditions that do not apply are those related to “amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing.” 42 C.F.R. § 460.90. There is also a waiver of certain Medicare restrictions on coverage such as those that limit coverage of nursing home and home health care. 42 C.F.R. § 460.94.

³⁰ 42 C.F.R. § 460.90-94.

³¹ Qualified Medicare Beneficiaries are Medicare recipients who qualify to receive assistance with Medicare premiums, deductibles, and cost-sharing. Assistance is provided by the Medicaid program. To qualify, the individual must generally have income below 100% of the Federal Poverty Level and resources below \$6,680 for an individual and \$10,020 for a couple. (Asset numbers are for 2011; they are indexed annually to the Consumer Price Index.)

³² 42 C.F.R. § 120(b)(3).

of the non-formulary medication. If the transition has not been completed by the end of the transition period, plans may be required to continue to provide coverage.³³

The second type of care continuity right provides continued access to a current *provider* who is not part of the integrated model's network. During a defined transition period, new enrollees should be permitted to receive services from non-network providers with whom they have an existing relationship. The integrated model needs to have processes for paying these non-network providers and for reaching out to them to encourage enrollment in the network. If these outreach efforts are unsuccessful, a process should exist for the enrollee to secure approval to continue seeing that provider.

California's new mandatory Medicaid enrollment program for seniors and persons with disabilities who are not eligible for Medicare provides an example of a provider transition process that may ease the impact on enrollment transitions on beneficiaries. Under California's 1115 waiver's Special Terms and Conditions, CMS is requiring the state to ensure that managed care plans provide "seamless care with existing providers for a period of at least 12 months after enrollment—and established procedures to bring providers into [the plan's] network."³⁴ Details of how this transition will occur are still being finalized by the state.

Appeals and Grievance Procedures Must Be Comprehensive and Accessible. Enrollees in integrated models may disagree with decisions the integrated model and its providers make about what services are needed and whether coverage for those services will be provided. They may also have concerns about treatment by providers or members of their care team. Enrollees must have the ability to appeal decisions made by the integrated model and to file complaints about problems encountered in dealing with the model. Appeal rights encompass many issues including:

- Right to appeal eligibility for or enrollment in the model;

- Right to appeal an assignment to a provider or care team;
- Right to appeal a decision regarding provision or a particular service;
- Right to appeal elements or non-elements of a care plan;
- Right to request a second opinion or evaluation of eligibility for a service (to support an appeal);
- Right to appeal a denial of coverage of a service; and
- Right to file a grievance/complaint about the integrated model and/or its providers.

Another paper in this series will discuss in more details what an integrated appeals system would look like. Given the high level of vulnerability in this population, any system should include the best protections provided by the collective Medicare and Medicaid appeals processes.³⁵ Elements should include:

- due process protections,
- clear notices in a language the enrollee can understand,
- coverage of care pending the appeal (referred to in Medicaid as "aid paid pending"),
- opportunities for expedited review,
- a path to a review by an independent decision maker and the right to appeal to an administrative law judge and, if necessary, federal court.

Regardless of how the process for filing and prosecuting an appeal is built, the first step must be meaningful notice, as discussed below, informing plan enrollees that they have been denied a service and providing enough information to mount an appeal.

Enrollees Must Receive Meaningful and Clear Notices About Programs, Services and Rights. To ensure that enrollees in integrated models understand the model and their rights within it, enrollees must receive notices and other documents that explain, for example, enrollment rights and options, plan benefits and rules, the individual's care plan (including care options that were considered but not included in the plan of care), coverage denials, appeal rights and

³³ Ctr. for Medicare and Medicaid Servs., "Medicare Prescription Drug Benefit Manual," Chapter 6 § 30.4.4.3.

³⁴ Ctr. for Medicare and Medicaid Servs., "Special Terms and Conditions; California Bridge to Reform Demonstration," at 38, available at www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Special%20Terms%20%20Conditions.pdf.

³⁵ The third paper is set for release in September 2011.

options, transition protections and potential conflicts that may arise from relationships between providers, suppliers and others.

Without meaningful notice, important protections such as choice and appeals and grievances lose their effectiveness. To be meaningful, a notice must be written at a level that the typical dually eligible enrollee can understand. For example, Minnesota requires all written materials created by plans that participate in its Minnesota Senior Health Options and Minnesota Senior Care Plus programs to be understandable to a person who reads at a seventh grade level.³⁶ As discussed in more detail below, notice must also be provided in a format and language that the enrollee understands.

Notice is particularly important in a coordinated care environment or where there is a close financial relationship between the provider delivering the service and the integration model responsible for making payments. In these situations, the provider may recommend a course of care based on which services are more likely to be covered or which are most cost-effective instead of offering all possible options to the enrollee so that the enrollee and provider can together decide the best path to pursue. Procedures must be in place to ensure that enrollees are informed of all services that are available so that they can request that a particular service be considered by the care team or provider. Opportunities must exist to appeal or seek second opinions based on the notice received.

Services Must Be Culturally and Linguistically Appropriate and Physically Accessible. Dual eligibles in integrated models have a right to receive services, including notices, in a culturally appropriate manner, accounting for their race, ethnicity, language, sex, disability, sexual orientation and gender identity. Integration models must ensure that the services are accessible to all enrollees, whether supplied directly or through contractor networks. Entities must also be held responsible for collecting data on the race, ethnicity,

and language of its enrollees.

Language access. Integrated models must comply with Title VI of the Civil Rights Act and other federal and state laws providing language access services to dual eligibles.³⁷ Where state and federal laws impose different translation or interpretation requirements on health care providers and plans, the stricter standard should apply to the model.

Pursuant to these laws, models should be required to set out a language access plan. They should incorporate specific language access requirements for both their internal procedures and their provider networks that could include: specific training or certification requirements for interpreters; availability of “I speak” cards in provider offices;³⁸ training for providers in language access procedures and in cultural competency; procedures to ensure that limited English proficient (LEP) callers to customer service phone lines get needed interpreter services; and identification of specific documents and correspondence subject to translation requirements.

Disability Communication Access. Integrated models must have in place systems for effective communication with individuals who are deaf or hard of hearing. These may include: qualified interpreters, note-takers, computer aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, Text Telephone (TTY), videotext displays, and exchange of written notes.

For effective communication with persons who are visually impaired, entities should be required to use systems which may include qualified readers, taped texts, audio recordings, Braille materials, large print materials, and assistance in locating items. Systems for effective communication with persons with speech impairments should also be required, which may include TTY, computer terminals, speech synthesizers,

³⁶ Minn. Dept. of Human Servs., “Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services” at 42 available at www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterupt=1&noSaveAs=1&dDocName=dhs16_156513.

³⁷ 42 U.S.C.A. § 2000d. See also “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” available at www.justice.gov/crt/about/cor/lep/DOJFinLEP-FRJun182002.php.

³⁸ “I speak” cards are language identification flashcards. To preview the flashcards, see www.lep.gov/ISpeakCards2004.pdf.

and communication boards.

Physical Accessibility. Providers in the integrated model must be accessible to the significant numbers of dual eligibles with physical disabilities. Facilities must be physically accessible. Full physical access includes at least the following: accessible entry doors, accessible parking and entry pathways, clear floor space and turning space in exam rooms, positioning and transferring space in exam rooms, accessible exam tables, patient lifts, staff assistance with transfers, accessible medical equipment, and accessible health information technology.

In addition, providers in the models' network must provide programmatic accessibility. Policies, procedures and practices must include modifications designed to meet the unique needs of persons with disabilities. This means having accessible equipment in the office and staff that is trained in how to use it. Another example is appointment policies that recognize that people with disabilities rely on para-transit services that can be unpredictable and delayed.³⁹

Dual Eligibles Need Robust Provider Networks.

When building new models for serving dual eligibles, it is essential that those models provide adequate access to providers that are able to serve the unique needs of dual eligibles. In particular, measures of network adequacy need to take into account the high number of dual eligibles who have multiple chronic conditions, including dementia, who are very frail, who have disabilities, and who are limited English proficient. Integrated model networks must include appropriate ratios of primary care providers with training in geriatrics to the population to be enrolled, an adequate specialist network including a sufficient number of specialists in diseases

and conditions affecting the dual eligible population and a range of high quality nursing facility and home and community based provider options.⁴⁰

When setting standards for network adequacy, it is important that the standards take into account the number of network providers who actually are accepting new patients, wait times for appointments, cultural competency, physical accessibility, and geographic accessibility. The fact that many members of this population do not drive and may instead rely on public transportation must be taken into account.

In urban and suburban areas with public transportation, accessibility criteria should be based on times required when using public transportation and not rely solely on drive times.

In addition to having expertise and being available for appointments, network providers must be prepared to provide special accommodations to dual eligibles. For example, the integrated model should enforce policies and payment structures that incorporate longer appointment times than are typically allocated for the general population. For many reasons—complex health conditions, limited English proficiency, disability, mental health condition—many members of this population require longer appointments if their needs are to be fully understood and appropriately addressed.

Finally, integrated models must ensure that they can provide 24/7 access to non-emergency care help lines staffed by medical professionals and to non-emergency room medical services. Rigorous standards for wait times, appointments, and customer service should be set.⁴¹

Even where integrated models have met these standards for network adequacy, there must still be a process for granting exemptions to receive services from

³⁹ For more information about and examples of programmatic accessibility see, Nancy R. Mudrick and Silvia Yee. "Defining Programmatic Access to Healthcare for People with Disabilities," (Disability Rights Education and Defense Fund 2007) available at www.dredf.org/healthcare/Healthcarepgmaccess.pdf.

⁴⁰ For example, integrated models should ensure access to nursing facilities with at least a three star rating on the Five Star Quality Rating System. More information on the rating system is available at: www.cms.gov/CertificationandCompliance/13_FSQRS.asp.

⁴¹ The following are examples of required appointment standards for enrollees in California managed care plans: "[w]ithin 48 hours of a request for an urgent care appointment for services that do not require prior authorization and [w]ithin ten (10) business days of a request for a non-urgent primary care appointment. See Dept. of Managed Health Care, Timely Access Regulation, Rule 1300.67.2.2 (implementing California Health and Safety Code section 1367.03), available at www.dhmc.ca.gov/dhmc_consumer/br/br_timelyacc.aspx. Although these standards offer examples, they were not developed specifically for dual eligible populations. More rigorous requirements may be appropriate for integrated models. The Medicare Advantage program provides instructive standards for call center wait times. "Average hold time must not exceed two (2) minutes. The average hold time is defined as the average time spent on hold by a caller following an interactive voice response (IVR) or touch tone response system and before reaching a live person. Eighty (80) percent of incoming calls must be answered within thirty (30) seconds." Ctr. for Medicare and Medicaid Servs., "Medicare Marketing Guidelines," Chapter 3 § 80.1 available at www.cms.gov/manuals/downloads/mc86c03.pdf.

out-of-network providers when those are the only providers capable of providing the needed care. No closed network will be able to meet all of the medical needs of this diverse and often medically fragile population.

Oversight must be comprehensive and coordinated. Structures must be in place to ensure that integrated models are performing contracted duties and delivering high quality services. Oversight and monitoring should be a coordinated and complementary effort by state Medicaid agencies, CMS, an independent advocate for enrollees, and stakeholder committees.

A three-way contract between the state Medicaid agency, CMS, and the integration model in which the state and CMS each retain responsibility for overseeing the plan provides the most beneficiary protections by utilizing the respective expertise of each government agency. Both the state and CMS should retain the authority to issue corrective action plans, impose enrollment and marketing sanctions, levy civil monetary penalties and, if necessary, terminate an integrated model. Federal and state investigative bodies should also have authority to monitor and report on the models.

It is particularly important that CMS, with its expertise in Medicare services and in Medicare managed care, continue to be active in setting standards and monitoring program compliance. There is a large body of existing Medicare regulation and guidance, including, for example, the entire Medicare Managed Care Manual, which developed and evolved in response to specific needs or abuses. Although a new model might waive or adapt some of these procedures, it is important not to undertake a wholesale waiver of provisions that have been hammered out over many years. And it is equally important that systems currently in place for CMS monitoring and enforcement of compliance not be abandoned.

In addition to determining its role in relation to CMS, the state Medicaid agency will need to define what roles different divisions within its own agency will play in providing oversight and monitoring. A state Medicaid agency may have divisions related to managed care, delivery system reform, long term care, behavioral health, and home and community based services that could all provide valuable insight and expertise. The state agency may also consider other state agencies, such as departments committed to monitoring managed care organizations or regulating insurance and marketing,

that could participate to ensure a comprehensive oversight and monitoring scheme.

However oversight and monitoring are divided, agency authority must be clear and agencies must have systems in place that allow them to respond quickly to problems that impede access to benefits. This rapid response capability will be especially important as these new models are being introduced or expanded.

Establishing an independent member advocate for enrollees can create a valuable complement to oversight and monitoring provided by the authorizing state and federal agencies. The enrollee advocate's primary task would be to advocate for enrollees in the model by collecting and reviewing complaints, assisting enrollees in appeals processes and helping enrollees understand their rights under the plan. The enrollee advocate could also assist enrollees in maintaining eligibility for the model (for example, maintaining Medicaid eligibility) and help with advising potential members on enrollment options. In addition, the enrollee advocate can report to state and federal agencies on dual eligible experiences within the integrated model in order to assist the oversight functions of those agencies.

A final layer of oversight and monitoring is provided by stakeholder committees. Each integration model should have a process for soliciting and incorporating stakeholder input. Actual beneficiaries and their advocates must be part of any stakeholder group and need to be provided the opportunity to provide input on the group's agenda. Stakeholder input is necessary both during development of the model and when it is fully operational. Effective stakeholder involvement incorporates standing stakeholder committees with a mandate to monitor the performance of the model and to contribute to policies and model design, as well as broader opportunities for involvement by any members of the community, such as periodic open forums and on-going invitations to community members to comment on plans and procedures. To ensure informed stakeholder participation, MMCO, the state and the integrated model must operate in a transparent manner disclosing publicly contract terms, models of care, assessment tools and program evaluation results.

Financial structures must promote delivery of optimal care. While integrating responsibility and payment for all Medicare and Medicaid services into one entity has the potential to improve care coordination and improve the health of dual eligibles, dangers exist.

Poorly designed risk-sharing and capitated payment models could lead to delays and denials of medically necessary care or “cherry-picking” of healthy, less costly enrollees. If the incentives to share savings are not structured carefully, the result can be decisions that are neither person-centered nor likely to improve care.

Whenever risk-based, capitated models are used, payment structures must encourage appropriate utilization of care and reward the provision of preventive care, intensive transition supports, and home- and community-based services. Rates should be adjusted for health status of the population using a variety of measures to facilitate this goal. Integrated models that function as managed care organizations must ensure that the rates they pay network providers are high enough to create and maintain adequate and sustainable networks as described above. This will likely mean basing most provider payments on Medicare rates since experience shows that current Medicaid rates, in many cases, have led to critical provider shortages.⁴² In addition, nothing in the rate structure should discourage the provision of home and community based services. For example, entities should not receive a higher rate for enrollees simply because they have been admitted to nursing homes. There must be some risk for the integrated model associated with that admission. Finally, the rate structure should encourage participation of non-profit and safety net providers by offering access to capital to start integrated models and by utilizing risk-sharing strategies that level the playing field between non-profit and larger, for-profit entities.

Implementation Should be Phased. The Medicare-Medicaid Coordination Office and many of the 15 contracted states are proposing to integrate models and services in ways and at a level that have not been tried before. Care must be taken to ensure that working delivery systems are not dismantled or interrupted before new systems have proved that they can reliably deliver care. It is important that MMCO, the states, and the integrated models continue to design and implement plans thoughtfully and deliberately. Where possible, integration should take place in phases,

starting with simple steps that build off of the current structures in place, and then progressing towards more significant changes as necessary and appropriate.

Phases can vary depending on the circumstances. For example, the enrollment process may be phased. The first year of the implementation could target a smaller number of enrollees with increasing goals for enrollment in future years. Another option may phase in expansion by the geographic area that a model serves, starting in a community where it is rooted before reaching out to other areas. Yet another approach could be to integrate more and more services into the model over time. For example, an integration model might take over financial responsibility for all services in its first year of implementation, but contract with existing mental health and home and community-based service structures in the early years. Over time, the model may find ways to introduce uniform assessments and other tools that would increase the degree to which these services are integrated.

Conclusion

The contracts awarded by the Medicare and Medicaid Coordination Office to design new models for serving dual eligibles provide an opportunity to integrate the financing and provision of Medicare and Medicaid benefits in ways that current systems do not. As new levels of integration are designed, the inclusion of strong consumer protections will be key to ensuring that programs maintain a primary focus on improving the delivery of services to the people enrolled. Instead of being thought of as a separate element of new models, specific, enforceable consumer protections should be woven into all elements of the program. This paper has outlined what some of those protections should be and offers ideas for how they can be incorporated into new models. Inclusion of the protections discussed will be essential to helping move new integrated models closer to their goal of providing person-centered care, decreasing unnecessary institutionalization and slowing the cost curve for this important population.

⁴² United Health Center for Reform and Modernization noted that approximately 49% of primary care physicians would be willing to increase their Medicaid patient roster if Medicaid reimbursement rates were matched to Medicare rates. “Coverage for Consumers; Savings for States: Options for Modernizing Medicaid” (2010) available at www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf.

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