National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

July 2, 2012

Via Electronic Mail: VA-MedicareMedicaidCoordination@cms.hhs.gov

Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Mail Stop Room 315-H
Washington, DC 20201

Re: Comments on Dual-Eligible Integration Proposal from Virginia

Dear Ms. Bella:

The National Senior Citizens Law Center appreciates the opportunity to comment on the proposal submitted by Virginia for its demonstration to integrate care for dual eligible individuals. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation, and the education and counseling of local advocates.

Enrollment

Recommending Affirmative, Voluntary Enrollment

Enrollment procedures should be designed to honor beneficiary choice. Any transition into a managed care system should be voluntary, driven by a beneficiary's affirmative decision to have services provided through an ICO. Enrollment should occur only when a beneficiary affirmatively opts into a managed care system.

Virginia unfortunately is proposing passive enrollment with an opportunity to opt out. We believe that this process is unfair to beneficiaries, as it makes a decision for them and then forces them to go through administrative procedures to reverse a choice that they never made in the first place.

We request that Virginia's opt-out process be rejected, and that CMS require that Virginia implement an opt-in process that truly honors consumer choice. ICOs should build their enrollment on meeting consumers' needs, not on taking advantage of the inertia and confusion inherent in an opt-out model.

If, nonetheless, CMS approves passive enrollment, we urge CMS to ensure that beneficiaries have wide opportunities to opt out of managed care enrollment. Beneficiaries should not be locked into managed care service delivery for any period of time, consistent with the recent decision by your office to uphold the right of Medicare beneficiaries to change their

managed care choices at any time. To this point, Virginia has left many details unexplained,[1] and we urge CMS to require more specific consumer protections prior to any proposal being approved.

> *Recommendation:* Enrollment should be voluntary. An opt-in model honors a beneficiary's right to choose, and also creates a strong incentive for an ICO to meet beneficiary needs.

Beneficiary Protections

In a bullet-point list, the Proposal lists five specific protections relating to a beneficiary's transfer to a managed care model. These protections include the transfer of pre-authorizations, and use of reports that alert ICOs to new members who have significant health care needs. The Proposal both gives and takes away, however, as the introductory language to the list states that the protections "may" include the listed items.[2]

CMS should require that the State provide the listed protections, at a minimum. There is no reason why the State at this point cannot make a solid commitment to providing these protections for beneficiaries. Also, it is unfair for the State to put these protections forward as selling points for the Proposal, if the State is not prepared to implement those protections going forward.

> *Recommendation:* Virginia must require the enrollment protections that it currently says "may" be provided.

Outreach and Marketing

As a managed care model depends in many ways on beneficiary choice, it is vital that beneficiaries have adequate information, and that the information is provided in an understandable form. Unfortunately, Virginia has taken a step back in this regard. The Proposal put out for state-level comment required that ICO marketing material be translated into other languages and also made available in an audio format. The Proposal submitted to CMS, however, does not require translation or audio recording.[3]

We urge that CMS require, in Virginia and other states, that ICO marketing materials be translated into other languages and made available in an audio format. A substantial percentage of dual eligibles are limited-English-proficient or blind, or have a very low literacy level. The required information must be provided to them in an understandable format; disclosure to them in other formats does not allow for the informed choice that is vital to a managed care model.

> *Recommendation:* ICOs should be required to translate marketing materials into appropriate languages, and make those materials available in an audio format.

[1] Virginia Proposal at 11-12.
[2] Virginia Proposal at 11.
[3] Virginia Proposal at 13.

Appeals

We note here an improvement made by Virginia after the state-level comment period. Virginia's original proposal required that a beneficiary exhaust an ICO's internal appeals process prior to proceeding with external appeals. The current Proposal, however, does not appear to contain any such requirement.[4]

Internal appeal procedures should be provided to beneficiaries as an option, not as an additional barrier to external appeals. We thank Virginia for eliminating this requirement, and urge CMS to not approve any state proposal that would require exhaustion of internal procedures as a predicate to external appeals.

> *Recommendation:* In its evaluation of states' dual integration proposals, CMS should not allow internal ICO grievance procedures to be prerequisites for external appeals processes.

Standards for Approving or Rejecting Services

It is vital that ICO members retain the same legal right to services that they have had under Medicare and Medicaid rules and procedures. Savings should come from coordination of services, not by denying necessary services. This right must be consistent within each of the participating ICOs.

The Proposal, however, states that ICOs "will determine the utilization management tools, including prior authorization requirements, for all services, and will have procedures for determining medically necessary services."[5] Such a procedure would give far too much discretion to ICOs, and would deprive members of the legal rights which they have under Medicare and Medicaid. We note that the Proposal requires that appeals follow Medicare and Medicaid standards for medical necessity;[6] the same requirement should be applied to initial utilization review decisions.

> *Recommendation:* Medical necessity standards and procedures should be consistent across ICOs. At a minimum, these standards and procedures should give enrollees the same right to services that they would have under fee-for-service Medicare and Medicaid.

[4] *See* Virginia Proposal at 14.
[5] Virginia Proposal at 14.
[6] Virginia Proposal at 14.

Lack of Ombudsman

The Proposal does not mention an ombudsman, although one was requested by the Virginia Poverty Law Center during the state-level comment period. As we have mentioned in our comments relating to other states, the assistance of an ombudsman is a crucial consumer protection. We cannot overstate how daunting appeals and other facets of a health care system can be to the dual-eligible population.

> *Recommendation*: CMS should require that Virginia provide an independent and adequately funded ombudsman program to assist consumers with navigating the system, including but not limited to assistance with grievances and appeals.

Inadequate Quality Assurance Procedures

The Proposal lists various quality measures that may be utilized, but also says that the State "would like to explore with CMS the feasibility of using the quality measures required under the PACE program, which are not as extensive as those required under the § 1915(c) waiver."[7] We would urge CMS to reject any proposal to substitute the PACE quality measures for the HCBS waiver quality measures, as the PACE measure are inadequate to measure the effectiveness and quality of at-home services, given that many PACE services are provided in an adult day health care center.

Quality improvement needs to be heightened, not watered down. It has been our experience that HCBS quality measures have been of limited efficacy, and that observation is supported by the recently released report from the HHS Office of Inspector General.[8] A principal problem is that measures are not visible to the public, so that consideration of the measures becomes a general private interchange between CMS, the states, and (to a more limited extent) service providers. Also, connection between measurement and improvement is often tenuous, as measures do not compel any particular step, and even verified reports of poor quality are lost within institutional inertia.

Quality measures should be visible to the public. Also, they should be collected within a system that is prepared to issue incentives and disincentives in order to improve the quality of care provided to beneficiaries.

> *Recommendation*: CMS should require that quality measures be easily accessible to the public through a well-maintained and up-to-date website. The system overall should focus not only on gathering data, but on giving ICOs incentives, disincentives and penalties in order to improve the quality of care.

[7] Virginia Proposal at 28-30.
[8] *See* HHS Office of Inspector General, Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs, Report OEI-02-08-00170 (June 2012).

Conclusion

Thank you for the opportunity to comment on the Virginia proposal. Thank you for your attention to these issues, and for your continuing work in the development of dual integration programs that work for beneficiaries. Dual-eligible individuals in general are extremely vulnerable, in regards both to health care needs and finances. Safeguards are needed to ensure that managed care models provide the coordinated and comprehensive attention that dual eligibles need and deserve.

Sincerely,

Kevin Prindiville
Deputy Director

Eric Carlson
Directing Attorney