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Integration of Care for Dual Eligibles
Comments on DMAS Demonstration Project*
March 21, 2012

As DMAS revisits integration of care for dual eligibles, I urge you to incorporate strong consumer protections throughout your model. As you know, dual eligibles are the most high-need individuals in the health system. Due, in part, to their very low incomes, they are extremely vulnerable and medically fragile. If the project is implemented with the beneficiaries in mind, you can improve care, decrease unnecessary institutionalization and slow the health care cost curve. But if cost savings and administrative efficiencies are the primary goals – especially with the capitated rate model planned by DMAS - there could be new barriers to care and new financial incentives for limiting necessary care. Even though CMS requires "upfront savings to both CMS and the State" to allow the demonstration to go forward, this must be structured very carefully.

The most essential consumer protections include the following ten items:

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. This is key to preserving continued access to specialists and other providers that may not participate in the integrated model – especially for people with complex medical conditions. Our successful PACE program is an opt-in model. You want participants to be engaged, committed and willing to use the care coordination services proposed. An enrollment broker and Area Agencies on Aging (VICAP programs) should be enlisted to assist individuals make choices about participating in the project and/or choosing the right plan.

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. Coverage should include the highest and least restrictive level of services offered by either Medicaid or Medicare. (e.g. Medicare so-called "improvement standards" do not work in this model). Enhanced benefits offered should be clearly defined and standardized, but still allow for creative approaches to supportive services. New cost-sharing rules will need to be established and should never exceed the amount that is currently allowed. All Medicaid-eligible QMBs must be enrolled in that program and protected from most out-of-pocket costs.

There must be continuity of care, allowing access to current providers, services, treatments and drug regimens during the transition process. Beneficiaries must be allowed to continue successful drug and treatment regimens and continue with even non-network providers with whom they have an existing relationship during a transition period to the new plan. Time will also be needed to ensure development of adequate provider and specialist networks.

Enrollees must be able to appeal decisions made by the integrated model and to file complaints about problems encountered in dealing with the program. Since Medicaid and Medicare appeal systems are completely different, I believe you will need to develop a new appeal system for this project. You should include the best aspects offered by both programs, including due process protections, meaningful and clear notices (language and ADA access), coverage of services pending appeal, opportunities for expedited review, a quick path to review by an independent decision maker (i.e. make internal review optional as in Medicaid today), time limits on decisions and judicial review.

An integrated model must provide enrollees with meaningful notices and other communications about enrollment rights and options, plan benefits and rules. DMAS should use and require communications written at no higher than 7th grade level.

Services must be culturally and linguistically appropriate and physically accessible. This is a good opportunity to improve language access and services for the visually, hearing and physically impaired. Certain financial supports should be built into the reimbursement system.

An integrated model must provide adequate access to providers who are able to serve the unique needs of dual eligibles. While absolutely critical to the project's success, this could be a major challenge in Virginia because many providers continue to resist serving Medicaid recipients, and many continue to resist participation in managed care. However, the reduction in paperwork and single reimbursement should be a real incentive for providers to participate. In its contract with health plans, DMAS must establish very clear and strict standards on network adequacy that include: primary care providers with geriatric training; adequate numbers of specialists in the right specialties; providers willing to take new patients; geographic accessibility; travel time requirements; and appropriate exceptions for services from non-network providers. Rigorous standards for wait times, appointments and customer service should be set.

Oversight must be comprehensive and coordinated to ensure that integrated models are performing contracted duties and delivering high quality services. This 3-way contract (DMAS, CMS & health plans) must include clear systems and standards for oversight and enforcement of all requirements. Public disclosure of program assessments and evaluations should be a part of this oversight. I also strongly recommend that an ombudsman-type office be established for assisting consumers with questions, complaints and appeals and for documenting problem areas.

Payment structures must promote delivery of optimal care, and not reward the denial of needed services. Your risk-based capitated model must have payment structures that encourage the appropriate utilization of care and reward the provision of preventive care, intensive transition supports, and community-based care. Overall rates will need to based on Medicare rates to encourage provider participation, and your payment structures should incorporate longer appointment times necessary for the dual population. Plans must assume the risk for nursing home admissions, and there should be no financial reward when patients are placed in an institution.

Integration efforts must be designed and implemented thoughtfully and deliberately, taking into consideration the structures and readiness of existing service delivery systems. DMAS is proposing to implement the model for 78,000 dual eligibles in Northern Virginia, Richmond/Charlottesville and Tidewater in December 2012. This timeframe seems extremely ambitious. I would encourage a longer and slower phase-in period to ensure this is done right, perhaps starting in one region instead of all three.

Other initial questions:

Will people in institutions be allowed to participate?

Will people who qualify for Medicaid via a spend-down be allowed to participate?

How will Medicaid estate recovery be handled in a fully integrated model with a single capitation rate?

Thank you for this opportunity to comment. I look forward to learning more details about the DMAS proposal and discussing it further.

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Staff Attorney

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* Many of my comments come from a series of four papers on dual eligibles prepared by the National Senior Citizens Law Center, http://www.nsclc.org/index.php/health/dual-eligibles/ I strongly urge you to consider these reports and NSCLC's recommendations.