



NSCLC

National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

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Dual Eligible Demonstrations

A Critical Moment

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Dual Eligible Demonstrations: A critical moment

Today's webinar will:

- Give an overview of what is in the 26 state proposals to integrate care for dual eligibles
- Detail strengths and concerns in the proposals
- Provide an update of recent activity in Washington, D.C.
- Suggest next steps for advocates

The National Senior Citizens Law Center 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, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.



The mission of the National Committee to Preserve Social Security and Medicare, a membership organization, is to protect, preserve, promote, and ensure the financial security, health, and the well being of current and future generations of maturing Americans.

The National Committee to Preserve Social Security and Medicare acts in the best interests of its members through advocacy, education, services, grassroots efforts, and the leadership of the Board of Directors and professional staff.

The efforts of the National Committee to Preserve Social Security and Medicare are directed toward developing better-informed citizens and voters.



Easter Seals' Mission

Easter Seals provides exceptional services to ensure that all people with disabilities or special needs and their families have equal opportunities to live, learn, work and play in their communities.

July 16, 2005

Demonstration overview

- Background:
 - The Affordable Care Act (ACA) created the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) to integrate care for individuals who receive both Medicare and Medicaid (dual eligibles).
- The need:
 - Currently, most dual eligibles receive health and long-term services and supports (LTSS) in two systems, Medicare and Medicaid. For many, care is uncoordinated and the system is difficult to navigate.

Demonstration overview

- The goal:
 - According to the Medicare-Medicaid Coordination Office (MMCO), the goal is “to make sure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible.”

The process: What happened so far

December 2010

Pursuant to Sec. 2602 of the Affordable Care Act (ACA), the MMCO was established within the Centers for Medicare and Medicaid Services

April 2011

The Centers for Medicare and Medicaid Services (CMS) awarded contracts to 15 states to design and implement new integrated systems for dual eligibles

July 2011

CMS released a “State Medicaid Director Letter” offering all states the opportunity to participate in a financial integration demonstration for dual eligibles

October 2011

38 states and DC sent MMCO a letter of intent to apply to participate in the demonstration

The process: What happened so far

2011-2012

States crafted demonstration proposals

Spring 2012:

States released draft proposals for 30 day state public comment period

Summer 2012:

26 states submitted proposals to CMS, with a 30 day federal comment period

July 2, 2012:

Federal comment period closed on all proposals

The process: What's next

CMS reviews comments and negotiates with each state to develop state-specific Memorandum of Understanding (MOU)



MOU is finalized between state and CMS and then made public

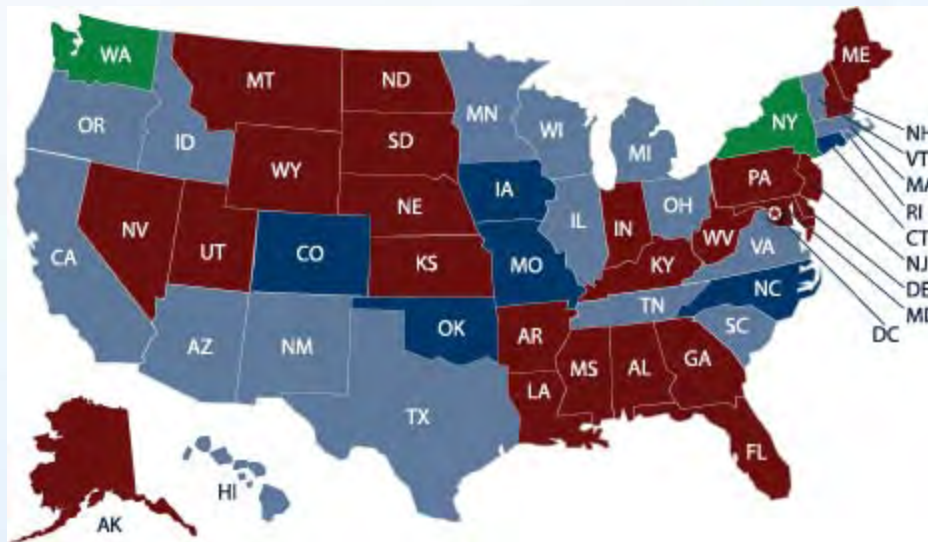


In capitated model states, CMS and state work together to select plans and develop three way contract

Overview of state proposals

- 26 states crafted a proposal for a new integrated care system, with a range of ideas and experience in areas like:
 - Financing
 - Demographics and populations to be included
 - Contracting and governance
 - Enrollment
 - Timeline and financial models
 - Supplemental benefits
 - Experience in managed care
 - Assistance with enrollment
 - Care coordination and assessment
 - Appeals
 - Part D

State proposals: Model



Light blue: capitated managed care
Dark blue: managed fee-for-service
Green: pursuing both models
Maroon: not seeking demonstration

State proposals: Demographic Variety

Geography:

- Implementation statewide
- Implementation in targeted geographic areas and counties

Populations:

- All full benefit Medicare-Medicaid individuals
- Carve outs: institutional level of care, developmental disabilities, behavioral health, PACE and SNP enrollees
- Individuals 21-64, or just individuals over 65

State proposals: Contracting and Governance

- Proposals include a variety of contracting and governance requirements for plans, such as:
 - Including consumer representatives on demonstration governing boards
 - Requiring managed care organizations to contract with community based organizations for LTSS
 - Meeting Medicare Advantage contracting rules
 - One state has already selected the plans it wants to participate (CA); others are beginning the process

State proposals: Enrollment

State	Passive Enrollment	Mandatory Medicaid Managed Care	Medicare Lock-In Period
Arizona	Yes	Yes	None, can opt out at anytime but only to original Medicare.
California	Yes	Yes	Once enrolled, locked in for 6 months
Colorado	Yes	No	Can opt out during the first 90 days, then locked in until AEP.
Connecticut	Yes	No	None, can opt out at anytime
Hawaii	Yes	Yes	Can opt out during the first 60 days, undecided about lock-in after that.
Idaho	Yes	Yes	None, can opt out at anytime
Illinois	Yes	No	None, can opt out at anytime
Iowa	Yes	No	None, can opt out at anytime
Massachusetts	Yes	No	None, can opt out at anytime
Michigan	Yes	No	Can opt out in first 3 months then lock in until AEP.
Minnesota	Yes	No	None, can opt out at anytime
Missouri	Yes	No	None, can opt out at anytime
New York	Yes	Yes (FIDA) No (Health Home)	None, can opt out at anytime but can only re-enroll in FIDA in January or July.
North Carolina	Yes	No	None, can opt out at anytime
New Mexico	Yes	Yes	Once enrolled, locked in for 6 months
Ohio	Yes	Yes	Once enrolled, locked in for 90 days
Oklahoma	Yes	No	None, can opt out at anytime
Oregon	Yes	No	None, can opt out at anytime
Rhode Island	Yes	Yes	None, can opt out at anytime
South Carolina	Yes	No	Can opt out during the first 90 days, then annual opt-out option
Tennessee	Yes	Yes	Once enrolled, locked in for 6 months
Texas	Yes	Yes	None, can opt out at anytime
Vermont	Yes	Yes	None, can opt out at anytime
Virginia	Yes	No	None, can opt out at anytime
Washington	Yes	No	Once enrolled, locked in for 90 days
Wisconsin	Yes	No	Once enrolled, locked in for 6 months

State proposals: Timeline

State	2012	January 2013	March 2013	July 2013	January 2014	Financial Model
Missouri	x					FFS
Minnesota	x (Seniors)			x (Disabilities)		Capitation
New York		x (Health Home)			x (FIDA)	Both
Massachusetts		x				Capitation
Ohio		x				Capitation
Wisconsin		x				Capitation
Colorado		x				FFS
Connecticut		x (Model 1)	x (Model 2)			FFS
Iowa		x				FFS
North Carolina		x				FFS
New Mexico					x	Capitation
Washington		x (FFS)			x (capitation)	Both
California			x (March - June)			Capitation
Michigan				x		Capitation
Oklahoma				x		FFS
Arizona					x	Capitation
Hawaii					x	Capitation
Idaho					x	Capitation
Oregon					x	Capitation
Rhode Island					x	Capitation
South Carolina					x	Capitation
Tennessee					x	Capitation
Texas					x	Capitation
Vermont					x	Capitation
Virginia					x	Capitation

State proposals: Supplemental Benefits

- Some states seizing opportunity to provide supplemental benefits:
 - All Medicare and Medicaid covered services, including long-term services and supports (LTSS) institutional and home and community-based services (HCBS)
 - Dental and vision
 - Expanded personal care services
 - Expanded durable medical equipment (DME)
 - Respite supports to family caregivers
 - Transportation
 - Unspecified supplemental benefits

State proposals: Prior Experience with Managed Care and Rebalancing

- State are entering demonstration with a variety of experience in managed care:
 - Administering integrated programs for dual eligibles
 - Managed care organizations (MCO) for specific needs: acute care, behavioral health, intellectual or developmental disabilities
 - MCO for LTSS
 - Participating states range in percentage of Medicaid LTSS dollars spent on HCBS, from nearly 70% to less than 10%

State proposals: Consumer Assistance

Choice Counseling

- Help beneficiaries decide whether or not to join the demo
- Provided through an independent enrollment broker and community-based organizations
- Some state proposals say inclusion of an enrollment broker is contingent on CMS funding

Ombudsman

- Ombudsman provides necessary consumer assistance and oversight for enrollees in the demo
- Some state proposals say ombudsman is contingent on CMS funding.

State proposals: Care Coordination and Assessment

- Proposals vary on purpose of care coordinator: bridging health and social services or managing service utilization?
 - Care coordinator appears in proposals in several roles:

As a long-term care coordinator to run a level of care assessment

No inclusion or vague language on coordinator's role

MCO provides a care coordinator to assist in care planning and case management

State proposals: Care Coordination and Assessment

- Unclear what entity will be assessing the individual for services, and what standard will be used:
 - For example, will a medical necessity standard be used for long-term services and supports?
 - Introduces *Olmstead* concerns

State proposals: Appeals and Consumer protections

- **Range of detail:**

Retain an appeals process consistent with Medicaid and Medicare standards

Include a service coordinator who provides members with information on appeals

Protect right to aid paid pending

Provide an independent ombudsman

State proposals: Part D

- Most states promise to retain current Part D systems for providing prescription drug coverage:
 - Two states (Oregon and Vermont) have proposed giving the state more control over drug benefit

Comments and concerns from beneficiary advocates

Promising Ideas

Coordination and
integration of
services

Better managed care
and potential to
streamline services
for easier access

Create a pathway to
a full spectrum of
available services

Stakeholder
involvement in the
design of care
structures

Strengths

Allow out of network providers to continue to provide service if they are willing to accept the in-network fees

Using an independent consumer ombudsman

Focus on cultural competency

Strengths

Proposals consistently frame demonstration as an opportunity to rebalance and improve delivery of care

Proposals frequently discuss need for strong consumer protection

Size

- MMCO's target enrollment is one to two million of the six million full benefit dual eligible individuals
- Much larger than a typical Medicare demonstration, raising concerns about:
 - Transition process – potential for Part D-like disruption
 - Difficult to evaluate with lack of control groups

Speed

- States and CMS are moving very quickly. First states could enroll people in 8 months:
 - Critical policy decisions, like benefit packages, financing, consumer assistance, enrollment processes, must be made before the demonstrations can begin to be operationalized.
 - Building the systems and working out the details to operationalize takes time.
 - Then beneficiaries, advocates, and providers will need to get educated. *Will there be time for outreach?*

Enrollment

Voluntary enrollment

- Free choice of provider adheres to the Medicare statute

Passive enrollment

- Allows plans to guarantee enrollment without demonstrating product works

Lock-in or “stable enrollment”

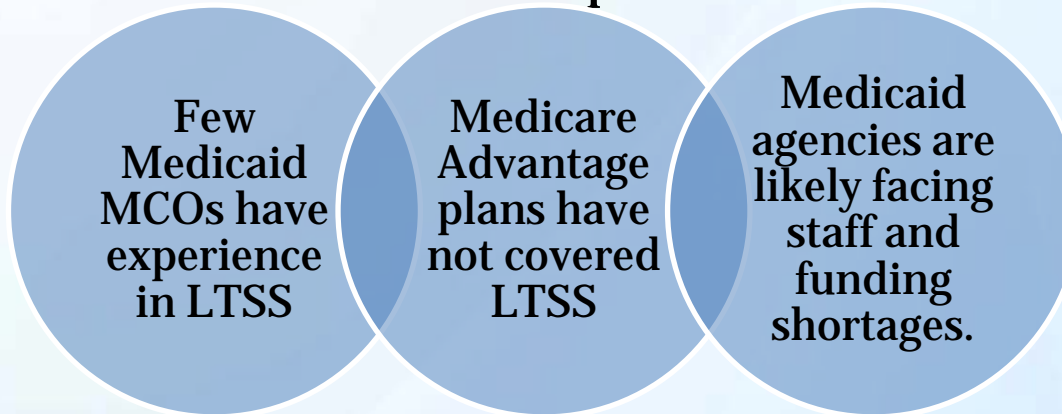
- CMS will not allow for the Medicare side

Medicaid managed care enrollment

- Not clear how state will seek approval for this component or who will monitor it within CMS

LTSS Integration

- Plans and states have little experience with LTSS integration



- Many proposals lack LTSS coordinator or other LTSS specific element in care team
- What explicit, specific requirements and consumer protections related to LTSS will be built into the demonstrations?
- Will the opportunity to rebalance and build person-centered programs be fulfilled?

State Readiness

- **Aggressive timeline for enrollment raises concerns:**
 - Do states have the expertise, prior experience, staff and financial resources to dedicate to properly implement and oversee this population?
 - CMS is working on a readiness review plan for the states and health plans.

Plan Readiness

- **Concern that plans:**
 - Do not have and will not have time to establish networks for this population
 - Contractors may have little or no LTSS experience-with individuals or services
 - Will not have capacity to handle the influx a passive enrollment would bring

ADA Compliance

- **Concern that provider offices and business may not currently be ADA compliant.**

Quality Measurement

- Quality must be monitored throughout the demonstration
 - The state proposals provide little detail on quality
 - CMS is developing an independent quality review tool
 - Existing quality measure focus on medical side
 - Inadequate information about measure for long-term services and supports.

Plan Quality

- Integrating LTSS, Medicaid services and Medicare is a complex task
- Only plans with a proven track record of providing high quality services should be permitted to participate in the demonstration
- Poor performing plans should not be included

Consumer Protections

- **Most proposals missing details:**
 - **ex. appeals: proposals have good language on preserving protections, but little detail:**
 - **Very difficult to integrate appeals until more is known about how plans will work**
 - **Until then, need to preserve protections like aid paid pending and fair hearing rights for Medicaid services**

Consumer Protections

- **Proposals are missing critical details on consumer protection:**
 - **ex. care continuity: proposals varied in specificity in ensuring care continuity and transition. This must be thought out from:**

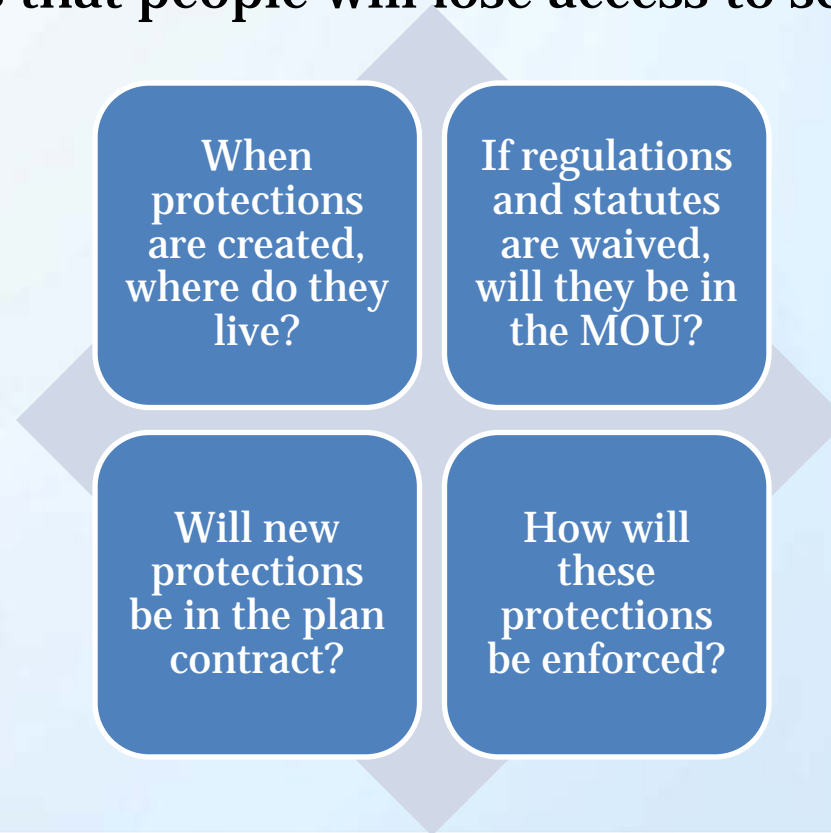
Policy

Operations

Education of beneficiaries
and providers

Consumer Protections

- The major risk with these models and enrollment mechanisms is that people will lose access to services and providers:



Oversight and Evaluation

Oversight

- Stakeholders involvement
- Ability to address problems in real time
- Timely collection, review and public availability of data
- State capacity
- An independent ombudsperson

Evaluation

- Stakeholder involvement
- Need to evaluate outcomes and experience
- Requires a comparable control group
- Must include LTSS specific measures

Financing

- Integration provides an opportunity to promote greater rebalancing of LTSS from an institutional setting to HCBS. In a [letter](#) organized by Community Catalyst, state and national advocates expressed three financing concerns to CMS:

Savings targets are not transparent

Assumptions for projected savings are opaque or overly optimistic

Insufficient safeguards to protect against the potential of windfall profits or catastrophic losses

Process

- CMS and states fostered stakeholder engagement through requirement of 30 day public comment period at both levels
 - Since the proposals were submitted, and comments closed, there is little opportunity for stakeholders to participate in MOU negotiation
- Once MOU is released, what will the process be for continuing to develop, operationalize and implement details?

Recent federal level activity: Hill

June 11

- Seven Senate Finance Republicans send letter detailing size, scope and Part D concerns to Marilyn Tavenner, CMS Acting Administrator: <http://bit.ly/OJVLjE>.

July 10

- Senator Rockefeller (D-WV) sends letter to Secretary Sebelius urging HHS to halt the initiative as currently structured and develop a thoroughly evaluated model that meets standards outlined in the statute: <http://bit.ly/SCyOTe>.

July 18

- The Senate Special Committee on Aging hosts a hearing, “Examining Medicare and Medicaid Coordination for Dual-Eligibles.” Testimony and video available here: <http://1.usa.gov/Pnijs6>.

Recent federal level activity: comments and advocacy

June 27

- State and federal advocates, led by Community Catalyst, detail concerns about savings targets in letter to HHS Secretary Kathleen Sebelius: <http://bit.ly/PqFFii>.

July 11

- MedPAC sends letter to Administrator Tavenner detailing five key areas of concern: scope, passive enrollment, plan requirements, monitoring and evaluation, and program costs and savings.
- <http://1.usa.gov/ROF3kt>.

July 18

- 33 national aging and disability groups send a letter to MMCO detailing recommendations for the duals demo: <http://bit.ly/NBHKEE>.

Next steps: What can advocates do?

Next Steps

- **Stay informed:**
 - MMCO likely to release the first MOU soon
 - Review the MOU
 - The next big step is plan selection. Then readiness review.
 - Review any new MMCO guidance

Next Steps

- **Communicate with your state:**

Transparency

- Demand from your state an ongoing stakeholder engagement process and ombudsman
- MOU process raises transparency issues

Workgroups

- Continue to participate in your state's workgroups
- Communicate with your state agency

Preparation

- Ask to be involved in the plan selection and readiness review process
- State and local networks should help design outreach and educational campaign on enrollment

Next Steps

- **Educate legislators:**
 - **Talk to your Senators and Representatives— they are home in their state and district until September 10.**
 - **Schedule a time to meet with them and discuss your recommendations regarding your state’s dual eligible demonstration proposal**

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