Protecting the Rights of Low-Income Older Adults
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

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

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<tr>
<td>Missouri</td>
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<td>FFS</td>
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<tr>
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<td>x</td>
<td>(Seniors)</td>
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<td>(Disabilities)</td>
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<tr>
<td>New York</td>
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<td>(Health Home)</td>
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<td>x</td>
<td>(FIDA)</td>
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<tr>
<td>Massachusetts</td>
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<td>Capitation</td>
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<td>Ohio</td>
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<td>Capitation</td>
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<td>FFS</td>
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<tr>
<td>Connecticut</td>
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<td>(Model 1)</td>
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<tr>
<td>Iowa</td>
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<td>North Carolina</td>
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<td>New Mexico</td>
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<td>Capitation</td>
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<tr>
<td>Washington</td>
<td>x</td>
<td>(FFS)</td>
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<td>(capitation)</td>
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<tr>
<td>California</td>
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<td>(March - June)</td>
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<td>Oklahoma</td>
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<td>Capitation</td>
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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

<table>
<thead>
<tr>
<th>Choice Counseling</th>
<th>Ombudsman</th>
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</thead>
</table>
| • 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 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

<table>
<thead>
<tr>
<th>Voluntary enrollment</th>
<th>Free choice of provider adheres to the Medicare statute</th>
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<tbody>
<tr>
<td>Passive enrollment</td>
<td>Allows plans to guarantee enrollment without demonstrating product works</td>
</tr>
<tr>
<td>Lock-in or “stable enrollment”</td>
<td>CMS will not allow for the Medicare side</td>
</tr>
<tr>
<td>Medicaid managed care enrollment</td>
<td>Not clear how state will seek approval for this component or who will monitor it within CMS</td>
</tr>
</tbody>
</table>
LTSS Integration

- Plans and states have little experience with LTSS integration
  - Few Medicaid MCOs have experience in LTSS
  - Medicare Advantage plans have not covered LTSS
  - Medicaid agencies are likely facing staff and funding shortages.

- 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:

  When protections are created, where do they live?

  If regulations and statutes are waived, will they be in the MOU?

  Will new protections be in the plan contract?

  How will these protections be enforced?
Oversight and Evaluation

<table>
<thead>
<tr>
<th>Oversight</th>
<th>Evaluation</th>
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<tbody>
<tr>
<td>• Stakeholders involvement</td>
<td>• Stakeholder involvement</td>
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<tr>
<td>• Ability to address problems in</td>
<td>• Need to evaluate outcomes and experience</td>
</tr>
<tr>
<td>real time</td>
<td>• Requires a comparable control group</td>
</tr>
<tr>
<td>• Timely collection, review and</td>
<td>• Must include LTSS specific measures</td>
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<tr>
<td>public availability of data</td>
<td></td>
</tr>
<tr>
<td>• State capacity</td>
<td></td>
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<tr>
<td>• An independent ombudsperson</td>
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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**

**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](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](http://1.usa.gov/Pnijs6).
Recent federal level activity: comments and advocacy

- **June 27**

- **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/R0F3kt](http://1.usa.gov/R0F3kt).

- **July 18**
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:

<table>
<thead>
<tr>
<th>Transparency</th>
<th>Workgroups</th>
<th>Preparation</th>
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<tbody>
<tr>
<td>• Demand from your state an ongoing stakeholder engagement process and ombudsman</td>
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<td>• MOU process raises transparency issues</td>
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<tr>
<td>• Continue to participate in your state’s workgroups</td>
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<tr>
<td>• Communicate with your state agency</td>
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<td>• Ask to be involved in the plan selection and readiness review process</td>
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<tr>
<td>• State and local networks should help design outreach and educational campaign on enrollment</td>
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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
Contact Information

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• Mary Andrus: MAndrus@easterseals.com
• Brenda Sulick: Sulickb@ncpssm.org

More information available at
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