

Recommendations for a Beneficiary-Centered Federal Coordinated Health Care Office

May 26, 2010

A beneficiary-centered Federal Coordinated Health Care Office (CHCO) at the Centers for Medicare and Medicaid Services (CMS) provides the welcome opportunity both to address longstanding eligibility and access issues facing dual eligibles and to develop new models of integration and care coordination for this vulnerable population. Below are some recommendations for a beneficiary-centered agenda for CHCO.

Key priorities for the office. We believe the scope of CHCO's agenda should start with a promise of real improvements in the way care is delivered to duals, addressing longstanding access and eligibility issues that need to be remedied and deserve the full attention of the new office. A fully engaged CHCO dedicated to addressing these concrete problems by bringing together the Medicaid and Medicare offices of CMS could have a tremendous impact on improving care outcomes for dual eligibles.

Only about 15% of dual eligibles are in Medicare managed care and about 30% in Medicaid managed care; as a result, few plans have experience serving duals and few duals have experience in managed care. While experiments in integration are important and, with the right consumer protections and requirements for Medicare, states and plans in place, CHCO's efforts should not be limited to experimenting with new models for integrating and organizing care.

1. Increase enrollment in the Medicare Savings Programs and the Low Income Subsidy.

- *Coordinate **application pathways** for MSP, LIS, SNAP, LIHEAP for elders and younger adults living with disabilities.*
 - Start by making the Medicare Improvements for Patients and Providers Act (MIPPA), LIS to MSP process work. Increase oversight and enforcement by CMS of State Medicaid agency actions regarding MIPPA compliance and CMS promotion and technical assistance regarding best practices. Encourage and support working relationships between State Medicaid Agencies and MIPPA grantees funded to engage in outreach and enrollment (application) assistance regarding LIS and MSP. Build on the successful models in Medicaid/CHIP.
- *Encourage states to **align eligibility criteria** for MSP and the LIS (and other assistance programs).*
 - For example, encourage states to use the flexibility provided by 1902(r)(2) to eliminate counting of cash surrender value of life insurance as countable assets and ISM as countable income.
 - Going one step further, the office should be encouraging states to deploy their authority to eliminate asset tests entirely for aged & disabled Medicaid programs and the MSPs, offering research demonstrating the cost-

effectiveness of such a move. Effective 2014, asset tests will be applied to dual eligibles, but not other Medicaid recipients or individuals seeking subsidies in the Exchange. This inequity needs to be addressed.

- *Fix lags between MSP and LIS eligibility and receipt of MSP and LIS benefits.*
 - Various data sharing systems to facilitate timely enrollments into Medicare Savings Programs and the Part D Low-Income Subsidy should operate in real time. States are authorized but not required to share data daily. CHCO should work with states to ensure that they all share data on a daily basis.

2. Developing and testing integration and coordination models.

- *Models for organizing care should include diverse options, and not just be limited to private managed care plans. CHCO should:*
 - Evaluate the effectiveness of current managed care plan models and address problems.
 - For example, advocates have noted persistent problems at some D-SNPs including insufficient networks (providers that accept both Medicaid and Medicare), provider billing issues (inappropriate balanced billing by providers), a lack of access to required “models of care” (not available on plan websites or even by request) and benefit packages that are not tailored to the needs of the target “special needs” population.
 - Support managed care plan models that have a proven track record of improving outcomes.
 - Invest in non-plan organized care systems that can be made available to duals in other than managed care delivery systems. For example, Medical homes and Primary Care Case Management.
 - Recognize that a one-size-fits-all approach will not work. Models that work well in one place, may not work in another. Not all successful models can be taken to scale.
 - Assist states and work with advocates to promote access to supports and services in the least restrictive and appropriate setting for functionally and cognitively impaired dual eligibles.
- *CHCO will need to employ a deliberative, transparent **process** for implementing and evaluating models.* Successful models, such as PACE, have taken years to design at the local level with key input from beneficiaries and coordination between various branches of CMS. Key elements of a process would include:
 - Formal beneficiary input into the activities of the office. Beneficiary advocates must have the same channels for raising problems and ideas as are provided to states and plans. Beneficiary advocates must also be kept informed of and provided an opportunity to provide input on new projects and initiatives. We recommend a regularly scheduled meeting with beneficiary advocates which would include the opportunity for advocates to develop agendas.

- Clear procedures for considering, approving, implementing and evaluating pilots, demos, etc. Processes should be transparent. Beneficiary input must be sought throughout. Plans, contracts, reports, etc. should be available on-line.
 - Coordination with the Part D/Medicare Advantage group at CMS. CHCO should be participating in policy setting re: D-SNPs and should be involved in the D-SNP approval process. CHCO should also be participating in policy development of Part D issues related to dual eligibles.
 - Coordination with the Medicaid waiver approval process and with the Center for Medicare and Medicaid Innovation. Many states are in the process of developing waiver requests to experiment with integration/coordination. CHCO should play a prominent role in the review of these proposals.
- *Efforts to develop new models for integrating and organizing care must include appropriate **consumer protections**, including:*
- No reduction in benefits. Any attempt to integrate benefits should not result in a reduction of the Medicare and/or Medicaid benefits dual eligibles are entitled to receive.
 - Where Medicare and Medicaid provide two different coverage standards for providing the same benefit, the integration effort must ensure beneficiaries access under the more favorable standard. See more on these differences below.
 - Where due process, notice and appeal rights diverge, the integration effort must provide beneficiaries access to the most favorable standard.
 - Enrollment rights that maintain beneficiaries' freedom of choice and provide opportunities to make enrollment changes as necessary.
 - Transition protections that ensure access to providers and treatments as beneficiaries enroll and disenroll from integration and coordination models.
 - Linguistically and culturally appropriate information and care.
 - Meaningful state/local stakeholder process (during both development and implementation).
 - Adequate provider networks and the ability to seek exceptions to network requirements.
 - Clear standards for care coordination and assessments to ensure that new models actually deliver these important benefits.
 - Well-defined requirements for new models with meaningful oversight provided by an entity willing and able to hold participants accountable.

3. Ensure that all integrated models, as well as traditional Medicaid and Medicare deliver the full benefits of both programs. Below are some concrete examples of current problems that impact dual eligibles' access to care and recommendations for addressing them.

- *Enforcing current rules and regulations regarding billing of dual eligibles.*
 - Providers (in both the traditional Medicare program and Medicare Advantage plans) need to know they are prohibited from billing QMBs; they also need an easy way to bill Medicaid, if they are not full Medicaid providers. Such systems exist in a few states but are not widely used by states and are not known by providers. CHCO should make sure states know they are supposed to have such systems and help the states set them up; CHCO should communicate with providers their responsibilities toward QMBs. CHCO should ensure greater oversight by CMS of plans' provider networks and of improper billing of dual eligibles.

- *Increasing access to providers.*
 - Many states pay providers serving QMBs at the Medicaid rate, which is usually lower than the Medicare rate. States are authorized but not required to pay at the Medicare rate. A 2003 report to Congress identified access issues caused by the lower payment; further research should be undertaken. (See, [State Payment Limitations on Medicare Cost-Sharing: Impacts on Dually Eligible Beneficiaries and Their Providers](#), Haber & Gage, July 31, 2003). CHCO could encourage states to pay at the Medicare rate and could undertake a broad study of access issues created by current law.
 - Many managed care plans serving duals fail to offer robust networks of providers participating in both Medicare and Medicaid. This has been a recurring issue with some D-SNPs. CHCO should work with CMS to ensure that plans with inadequate networks are not approved to serve duals.

- *Refining Part D auto-enrollment and deeming for dual eligibles*
 - Dual eligibles continue to face instability in the Part D program, struggling to transition both during the initial enrollment and annually as plan offerings change. CHCO should join and expand existing efforts to study the feasibility and potential design of intelligent assignment, taking into account formulary coverage of drugs prescribed to new dual eligibles and other LIS beneficiaries auto-assigned to Part D plans.

- *Resolving differences in Medicare and Medicaid benefits, coverage standards and appeal rights and preventing the creeping of more restrictive Medicare standards into the Medicaid program and vice versa.* Below are a few examples of this variance.
 - Medicare pays for covered services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; Medicaid pays for necessary medical services, rehabilitation and other services to help individuals attain or retain capability for independence or self-care.
 - Home health care. Medicare requires beneficiaries to be “confined to the home” to receive home health services; Medicaid prohibits use of such a standard. CHCO should ensure that all states adhere to this prohibition.

- Nursing home care. Medicare covers skilled nursing care; Medicaid covers both skilled nursing care and nursing care. CHCO should promote full certification for both programs of all certified nursing home beds.
 - Therapy caps. Medicare places a dollar limit on therapy services within a year; Medicaid has no such limit, but individual states may cap numbers of visits or require prior authorization. CHCO should promote best practices for optimizing coverage under both programs to ensure that dual eligibles get the full range of therapy services available.
 - Medicare denials. Some states require a denial from Medicare before the state will consider a claim under Medicaid. CHCO should assess if such requirements create access problems for dual eligibles; if so, it should promote alternative systems.
 - Aid Paid Pending. Medicaid law requires that services continue pending an appeal; Medicare does not. Such protection is critical to low-income individuals. CHCO should ensure that duals have such protections regardless of the delivery system through which they get care.
- *Increasing dual eligibles' access to home and community based services.*
 - Ensure that integration/coordination efforts incentivize the provision of HCBS services.
 - Address Medicare and Medicaid rules and regulations that favor institutional care.

4. Learn more about dual eligibles and current access problems. Before addressing any of the above, it is essential that CHCO obtains or develops good data about dual eligibles, which is not now generally available. This data will provide an understanding of who dual eligibles are and the challenge they face while supplying a baseline for evaluating the success of various efforts undertaken by the office. For example, we need to know:

- The number of duals and their categories;
- The extent to which duals are in Medicaid managed care, SNPs, other MA plans, PACE, etc.;
- The percentage of providers in MA plans that are Medicaid providers and vice versa,
- Information on what benefits state Medicaid programs cover for full dual eligibles (both medical and non-medical) that are not covered by Medicare that states are providing via supplemental coverage, if that is available.
- State-by-state provider rates in Medicaid compared to Medicare for services provided to duals.

The organizations below contributed to this memo and look forward to working with CHCO to improve the care provided to dual eligibles.

AARP
Alzheimer's Association

Center for Budget and Policy Priorities
Center for Medicare Advocacy
Families USA
Health Assistance Partnership, a Project of Families USA
Medicare Rights Center
National Council on Aging
National Health Law Program
National Senior Citizens Law Center