STATE DUAL ELIGIBLE DEMONSTRATION PROJECTS - SUMMARY OF KEY CONSUMER ISSUES AND RECOMMENDATIONS

SPECIFICITY/CLARITY OF STATE PROPOSALS - 1) Require that the Memorandum of Understanding (MOU) development processes are transparent and include stakeholder input. Make MOUs public.

SIZE/SCOPE - 1) Approve only real demonstrations, comprising fewer than one million beneficiaries. 2) Have a clearly identifiable, size appropriate, control group. 3) Have a clearly identified strategy to account for and, in evaluation, avoid contamination of other payment and delivery system reform demonstrations and initiatives. In areas where other significant delivery reform efforts are underway, dual eligible integration demonstrations should be scaled back or should exclude duals participating in those other initiatives.

ENROLLMENT - 1) Require voluntary (opt-in) enrollment. 2) Use an independent enrollment broker, skilled in working with this population, to facilitate the demonstration. 3) Provide adequate funding to community-based organizations to educate beneficiaries about their enrollment options. The enrollment process should be supported by excellent linguistically and culturally competent written materials that are also available in alternative formats such as Braille, CD, large-font print, and sign language translation.

STATE READINESS - 1) Slow down demonstrations as noted in the SIZE/SCOPE discussion. 2) Require that states provide CMS with a detailed statement/assessment of readiness to demonstrate their expertise, prior experience, current and future capacity (such as staff and financial resources) to oversee their responsibilities in managing new care models for the dual eligible population. This statement should be publicly available and identify the different approaches that will be used to serve diverse groups of dual eligibles, such as those requiring long-term services and supports.

PLAN READINESS - 1) Slow down and scale back to allow time to develop a) appropriate networks that are physically and programmatically accessible as well as linguistically and culturally competent to meet the diverse needs of the target populations; b) enrollment targets that do not outpace network capacity; and c) systems for plans to monitor vigorously network capacity during the life of the demonstrations. 2) Require plans to demonstrate in advance that they have the expertise, systems, capacity and networks to serve all the beneficiaries in the demonstration target population. The standards and detailed results of the review should be made public. 3) All managed care demonstrations must include a detailed explanation of how contracting plans will meet the diverse needs of the targeted populations. 4) Require that prescription drug coverage complies with all of the protections required in the Part D program, including all formulary requirements. 5) Require plans to demonstrate their methods to ensure access to long-term services and supports (LTSS) funded through Medicare and Medicaid, with sufficient appeals, advocacy, and ombudsmen options for consumers that are specifically tailored to LTSS.

PLAN QUALITY - 1) Permit only the highest performing plans, on both the Medicare and Medicaid side, to participate in the demonstrations. Medicare plans that are poor performing plans -- any plan below three stars -- should not be included.

CONTINUITY OF CARE AND TRANSITIONS - Promote maximum opportunity for continuity of care and safe transitions by requiring plans to 1) Identify all current providers of each enrollee and invite them to join the network. 2) Inform enrollees, in writing and orally, which of their providers are not in the plan network and the period of time they have to complete transitions to network providers. 3) Allow up to 12 months of continued coverage with pre-existing non-network providers and allow for the completion of an on-going treatment plan. 4) Provide transition supplies of pre-existing prescription drugs at the same cost-sharing level for at least 90 days. 5) Continue any service, supply or drug that was authorized prior to enrollment in the demonstration under the same terms and conditions.

QUALITY MEASUREMENT - 1) Use existing Medicare quality standards as a floor for quality measurement. 2) Use these demonstrations to work with measure stewards and others to develop and refine measures most appropriate to the needs of the dual eligible population. 3) Build in other ways to assess quality and access, including encounter data, regular reporting from stakeholders and a user-friendly complaint reporting system.

APPEALS - 1) Create a single appeal process relying on the most beneficiary-friendly elements from both program systems. 2) Include aid-pending appeals not just for those with Medicaid services.

OVERSIGHT AND EVALUATION - 1) Collect sufficient data to determine if plans are maintaining or expanding access to care, providing high-quality care, addressing health disparities, and lowering costs. 2) Develop and implement systems of oversight at multiple levels to ensure that beneficiaries are adequately protected. 3) Make data collection, evaluation, and oversight efforts timely, transparent and available to the public. 4) Fund an ombudsperson program for each demonstration to receive and respond to complaints and to monitor overall demonstration activity.

REBALANCING AND REINVESTMENT OF SAVINGS - 1) Ensure meaningful aging and disability stakeholder engagement in developing financial incentives to rebalance. 2) Encourage states to provide options for self-direction of home and community-based services. 3) Prohibit carve outs of nursing home and institutional services. 4) Encourage states to use demonstration savings to reinvest in home and community-based services and supports.

SAVINGS – 1) Do not require demonstrations to show savings in the first year.

For a more detailed description of the issues and recommendations, please refer to the full document.