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**U.S. Senate Special Committee on Aging**

***Medicare and Medicaid Coordination for Dual Eligibles***

**Wednesday, July 18, 2012**

The National Senior Citizen Law Center (NSCLC) and the National Committee to Preserve Social Security and Medicare (NCPSSM) thank the members of the U.S. Senate Special Committee on Aging for holding this important hearing regarding Medicare and Medicaid coordination for dual eligible individuals. On July 18, we joined 31 national aging and disability organizations in a letter to Melanie Bella, Director of the Medicare-Medicaid Coordination Office (MMCO), that raised consumer concerns and made recommendations for the demonstrations. A list of those organizations is attached. As beneficiary advocates, we support MMCO's goal of ensuring that dual eligible individuals have seamless access to high quality care. We believe that the integrated care program demonstrations offer tremendous promise for states to develop innovative, person-centered systems of care, and we are hopeful that the demonstrations will succeed. There are, however, several key issues that we believe require attention to prevent negative outcomes for beneficiaries and for the overall success of the demonstrations. The letter to Director Bella, available at <http://www.ncpssm.org/Portals/0/pdf/dual-eligible-demonstrations.pdf>, details each of these concerns, which we will summarize here:

**Specificity and clarity of the proposal:** The Centers for Medicare and Medicaid Services (CMS) is currently reviewing the state demonstration proposals for integrated care. The public had an opportunity to comment on the proposals at the state and federal level; however, many are frustratingly vague in critical areas, like beneficiary protections and plan accountability. Further, some proposals lack specificity on plan assignment, education of enrollees to help them make appropriate decisions, plan capacity, and network adequacy. This lack of clarity leaves advocates concerned about what this will mean when the demonstration is operational. Finally, many states are proposing to work out the details of the demonstration through Memoranda of Understanding (MOU), which are not guaranteed to include stakeholder input or public transparency. CMS should require that the MOUs development process be transparent and include stakeholder input.

**Size and scope:** CMS established a target of enrolling two million of the nine million dual eligibles nationwide into integrated programs, mostly through managed care organizations (MCOs). We are concerned that for an initiative operating under demonstration authority, this is much larger than a typical Medicare demonstration, raising concerns about unrealistic rapid growth, lack of control groups, and inability to account for other demonstrations. We urge MMCO to approve more genuine demonstrations, and limit the total demonstration population nationally to no more than one million beneficiaries. We ask that MMCO not allow states to enroll all dual eligibles, or all dual eligibles in a large metro area, into a demonstration, and that MMCO ensure that each state and metro area have a clearly identifiable, size appropriate, control group. 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. Before implementation, each demonstration must have a strategy to avoid contamination of other payment and delivery system reform demonstrations and initiatives so that the impact of the demonstration can be accurately evaluated.

**Enrollment:** We urge CMS to require voluntary (opt-in) enrollment as we oppose state proposals to passively enroll beneficiaries into the demonstrations. Passive enrollment allows plans guaranteed enrollment without demonstrating that their product is worth having. Free choice of provider has been a tenet of the Medicare program since its beginning and people dually eligible for Medicare and Medicaid have been protected by statute from mandatory Medicaid managed care enrollment except when that right is explicitly waived through a statutorily-defined process. We support the CMS position that beneficiaries may not be locked into a demonstration for any period of time. We believe the enrollment process should be facilitated by an independent enrollment broker in all the demonstrations. We further request that adequate funding be provided to community-based organizations to educate beneficiaries about their enrollment options. The enrollment process should be supported by linguistic 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:** The aggressive timeline that many states are proposing for enrolling large number of dual eligibles (beginning in 2013) raises several concerns about state readiness. We ask CMS to slow down the demonstrations, as noted in the size and scope discussion. CMS should require states to provide CMS with a detailed statement/assessment of readiness and to demonstrate their expertise, prior experience, and current and future capacity (such as staff and financial resources) to adequately undertake their oversight responsibilities in managing new care models for the dual eligible population. This statement should be made public and should

identify the different approaches that the state will use to oversee service to diverse groups of dual eligibles, such as those requiring long-term services and supports.

**Plan readiness:** There are many unanswered questions about whether the plans will have the experience, network adequacy, access protections, and integrated long-term services and supports (LTSS) necessary to successfully integrate care for dually eligible individuals. Dual eligibles are a complex, heterogeneous group, whose only unifying characteristic is that they are eligible for two publicly-financed health insurance programs. Developing effective models of care for dual eligibles takes an intensive, long-term commitment from providers, payers, and beneficiaries of the services. Because the population is diverse with high needs, plans must have robust networks of providers, including primary care providers, specialists in conditions that affect the population, LTSS providers, and other services to address their needs. Networks must be physically and programmatically accessible to persons with disabilities in terms of facilities, equipment and scheduling, and be linguistically and culturally competent.

There is real concern that states and plans that are unfamiliar with LTSS systems may deny or reduce LTSS because lack of familiarity with LTSS needs. States and plans may also reduce LTSS in order to achieve quick savings instead of investing in services that improve health and reduce costs over time. States must require and plans must demonstrate verifiable proposals to ensure access to LTSS funded through Medicare and Medicaid, with sufficient appeals, advocacy, and ombudsperson options for consumers that are specifically tailored to LTSS..

**Plan quality:** The integration of long-term services and supports, other Medicaid services and Medicare is a complex and delicate task that requires extensive knowledge of local resources and the ability to provide quality care. Only plans with a proven track record of providing high quality Medicare and/or Medicaid services should be permitted to participate in the demonstration. Medicare plans that are poor performing—any plan below three stars—should not be included.

**Continuity of Care and Transitions:** The relationship between dual eligible beneficiaries and their providers must be preserved during the demonstration plan transition period in order to avoid disruptions in care. Dual eligibles who are undergoing a course of treatment, whether short-term or longer-term, or who have a plan of care for long-term services and supports should not have an interruption in care because a provider is not in their network. To promote safe transitions, plans must identify all current providers for each enrollee and invite them to join the network; inform enrollees, in writing and orally, which of their providers are not in the network and the period of time they have to complete transitions to network

providers; 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; provide transition supplies of pre-existing prescription drugs at the same cost-sharing level for at least 90 days; and continue any service, supply or drug that was authorized prior to enrollment in the demonstration under the same terms and conditions.

**Quality measurement:** It is essential that quality be monitored continually throughout the demonstration to ensure that, at the very least, minimal standards are met, and to assess whether promised improvements in quality occur. Existing quality measures are limited, especially for the dual eligible population and for long-term supports and services. Moreover, even the best measures can only provide a limited picture of patient care. These demonstrations are an opportunity to develop better measures, and must go beyond traditional metrics, with existing Medicare quality standards as a floor for quality measurement.

We suggest domains where CMS, states and plans should go further to develop specialized measures. These domains are: 1) care coordination, 2) access/availability, 3) patient-centered care, 4) prevention, and 5) effectiveness of care. We have additional thoughts on specific measures within each domain. All data should also be publicly reported and stratified by demographic group, to allow transparency and monitoring. Where no good measures exist, CMS must use the demonstrations as an opportunity to work aggressively to develop them.

**Appeals:** We urge CMS to require states to create a single appeal process relying on the most beneficiary-friendly elements from both Medicare and Medicaid systems. The beneficiary should continue receiving benefits pending the outcome of the appeal. Dual eligibles are not in a financial position to pay for their care while an appeal is processed. This is true whether the service is covered by Medicare or Medicaid.

**Oversight and evaluation:** We believe that quality oversight of the demonstrations depends on the timely collection, review and public availability of data. Data collection must capture whether the plans are limiting access to care or providing low quality care. The data must measure evidence to determine if the demonstrations are improving overall quality and lowering cost. Data collection and evaluation should include a comparable control group to determine if the intervention was successful. The state should collect data sufficient to determine if the plans are maintaining or expanding access to care, providing high quality-care, addressing health disparities, and lowering costs.

Oversight should occur at multiple levels and involve consumers and their

caregivers. To guard against limits to care, all plans should report to an independent state ombudsperson. The state should fund the ombudsperson program to receive and respond to complaints and to monitor overall demonstration activity. CMS should require all data collection, evaluation and oversight efforts to be timely, transparent, and available to the public.

**Rebalancing and reinvestment of savings:** Medicare and Medicaid integration provides opportunities to promote greater rebalancing of long-term services and supports from institutional settings to home and community-based services. While most states clearly articulate goals to rebalance, proposals are often vague about financial incentives to promote rebalancing. We encourage CMS to ensure meaningful aging and disability stakeholder engagement in developing financial incentives to rebalance. CMS should also encourage states to offer options for self-direction of home and community-based services. Finally, some states have proposed carving out long-term services and supports in nursing homes and other institutional settings. This will significantly decrease their ability to incentivize rebalancing and preventable hospital admissions from such facilities. CMS should not approve demonstrations that carve out nursing home and institutional services.

As states and CMS determine savings targets, we ask that CMS not require the demonstrations to show savings in the first year. We also ask that states be encouraged to use demonstration savings to reinvest in home and community-based services and supports.

NSCLC and NCPSSM value CMS' effort to better coordinate care for dual eligibles and appreciate the Aging Committee's attention to the demonstration. Thank you for the opportunity to submit our recommendations on this issue.

If any questions arise about this submission, please contact Fay Gordon, [fgordon@nsclc.org](mailto:fgordon@nsclc.org), or Brenda Sulick, [sulickb@ncpssm.org](mailto:sulickb@ncpssm.org).

**Consumer Advocate Organizations**  
**Signed-on to July 18, 2012 letter to MMCO**

1. American Association on Health and Disability
2. Association of University Centers on Disabilities (AUCD)
3. American Network of Community Options and Resources
4. B'nai B'rith International
5. Center for Medicare Advocacy, Inc.
6. Community Catalyst
7. Direct Care Alliance
8. Disability Rights Education and Defense Fund
9. Easter Seals
10. Families USA
11. Leading Age
12. Lutheran Services of America Disability Network
13. Medicare Rights Center
14. Mental Health America
15. National Alliance on Mental Illness
16. National Academy of Elder Law Attorneys
17. National Association of Area Agencies on Aging
18. National Association for Hispanic Elders
19. National Association of Nutrition and Aging Services Programs
20. National Association of Professional Geriatric Care Managers
21. National Association of State Long-Term Ombudsman Programs
22. National Caucus and Center on Black Aged, Inc.
23. National Council for Community Behavioral Healthcare
24. National Council on Aging
25. National Committee to Preserve Social Security and Medicare
26. National Health Law Program
27. National Senior Citizens Law Center
28. Older Women's League
29. PHI – Quality Care through Quality Jobs
30. Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE)
31. The Arc
32. The National Consumer Voice for Quality Long-Term Care
33. United Spinal Association