The Dual Eligible Demonstration Projects:
State and Health Plan Readiness

Introduction

The Medicare-Medicaid Coordination Office (MMCO), created by the Affordable Care Act (ACA), is tasked with improving care for Medicare-Medicaid enrollees ("dual eligibles") by better aligning Medicare and Medicaid benefits and improving coordination between the two programs to ensure dual eligibles receive full access to benefits and services they deserve. The MMCO launched the Financial Alignment Initiative[1] in 2011 that gives states the option of testing two payment models – the "capitated" and "managed fee-for-service" approaches.[2] These approaches are designed to help states improve quality of care for dual eligibles and share in the lower costs that should result from better care coordination. One important element in reaching these goals is state and (for those states pursuing the capitated approach) health plan readiness. The Centers for Medicare and Medicaid Services (CMS) has outlined a multi-pronged oversight strategy that includes a comprehensive health plan readiness review process.[3] While the process CMS has highlighted is detailed, the real test lies in implementation and oversight. To date, only one state, Massachusetts, has developed a readiness review tool,[4] which they have just begun to implement.

The purpose of this issue brief is to highlight key consumer concerns around state and health plan (referred to as managed care plans) capacity and readiness in the dual eligible demonstration projects.[5] The issue brief also provides recommendations for evaluating readiness based on what matters most to dual eligible beneficiaries. For advocates and other interested stakeholders it will be imperative to urge states and CMS to adopt rigorous readiness standards that will ensure that the right systems are in place before enrolling beneficiaries into these new models of care.

State Readiness Concerns

Nearly half the states have demonstration proposals pending before CMS. They are eagerly pursuing these demonstration projects, in part, as a way to curb health care costs and keep a balanced state budget.[6] With an interest driven primarily by fiscal pressure, the concern is that the need for having a strong state infrastructure and oversight mechanism will be overlooked. Furthermore, majority of the state proposals lack sufficient detail about how the demonstrations will work. For example, most do not have clear plans for consumer engagement and lack sufficient standards to hold managed care plans accountable for providing the best possible care for beneficiaries. In addition, very few proposals include definitive plans for increasing the use of community-based long-term services and supports (LTSS), which is an essential element of comprehensive care and also is an avenue to reducing preventable hospital admissions and readmissions and nursing home placements. In fact, in at least one state, Missouri, the proposal contained an explicit goal of *reducing* LTSS.

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Plan Readiness Concerns

Similarly, managed care plans view these demonstrations as an enormous money-making opportunity.[7] And yet, it is unclear that they are adequately prepared to serve the medical and nonmedical needs of dual eligibles, particularly the 20 percent with the most complex needs. Some of the key concerns about managed care plan readiness include:

- limited experience in serving the frail elderly and people with disabilities
- lack of capacity to serve dual eligibles with LTSS needs
- inadequate provider networks and provider capacity to serve the population
- aggressive timeline that does not allow for adequate preparation of providers and systems
- inadequate accessibility for people with disabilities
- insufficient plans for meaningfully engaging members
- lack of system oversight

Recommendations

<u>State Readiness</u>

- States should be required to make public the assessment of their readiness, including:
    - sufficient staff to manage the project
    - financial sustainability to carry out the demonstration[8]
    - fully developed rates and payment systems
    - appropriate IT systems
    - infrastructure for outreach and enrollment
    - experience in overseeing care for high-need beneficiaries
    - detailed plan for an ongoing system of oversight with meaningful consumer representation.[9]

- States should be required provide CMS and the public with this information on an annual basis.

<u>Plan Readiness</u>

Primary Care
The most critical element of plan readiness is the presence of a robust primary care practice, which provides the anchor for a delivery system that effectively serves dual eligibles. This practice must have the capacity and expertise to manage multiple, complex medical and behavioral issues effectively over time and across care settings. For example, many dual eligibles over 65, and especially those over 85, require more extensive acute care and long-term care services, particularly those who have disabling chronic conditions.[10] Dually eligible individuals with complex care needs need an organized mechanism that will track their health outcomes as they age to ensure good quality of life.

A health plan must demonstrate that it can provide each member with the following services before being approved to participate in a demonstration project:

- A comprehensive health assessment process to identify enrollees' medical and LTSS needs[11]
- A primary care physician who can offer integrated primary care and behavioral health services as needed
- An experienced care coordinator that will play the role of a facilitator in an interdisciplinary care team where the member is the center of that team
- An individualized care plan available to the member and his/her care team which is reviewed on a regular basis to ensure it is meeting the needs of the member

In order to minimize unnecessary complications in care setting transitions and prevent hospital readmissions, the plan must also have procedures in place to monitor transfers and conduct effective pre- and post-discharge planning. There must be evidence of data sharing agreements between hospitals and plans, and the care coordinator must play a strong role in monitoring transitions.[12]

Overall Plan Quality
In accordance with recent CMS guidance,[13] the plan selection process should take into account past performance in Medicare and Medicaid, including sanctions and whether the plan has been designated as consistently low performing, based on the Medicare star rating process. While CMS has set the minimum standards of readiness requirements, it is important for plans to reach beyond these standards to offer quality care. Plans must:

- have a record of high-quality service, defined by at least three stars on Medicare rating, or similar score on the NCQA[14] ratings. Plans that fail to demonstrate competence and capacity to serve more complex duals should not be permitted to enroll them into their plan.[15]
- show how they will comply with the Mental Health Parity and Addiction Equity Act of 2008.[16]
- incorporate consumer satisfaction and independent living goals as a part of quality improvement. This can be done through surveying consumers and family caregivers about satisfaction and whether their individual goals have been met.
- have strong leadership and experienced staff and require staff and providers to be trained on critical areas such as: person-centered care, culturally competency, ADA compliance, managing care for the elderly and frail, and the independent living and recovery philosophies[17]

Plan performance should be tested before enrollment begins and should be assessed at regular intervals thereafter.

Communications
- Plans must maintain a toll-free, 24/7 telephone hotline staffed by qualified customer representatives to triage beneficiary questions including contact information that will give direct access to the beneficiary's care team. Customer representatives must have access to

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the member's medical records. The hotline must also include special lines devoted to behavioral health. In addition to a beneficiary hotline, plans must also make available a provider hotline that is accessible to providers and pharmacies.

- Plans or a subcontractor to the plan must maintain a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency enrollees.[18]
- Plans must maintain an updated and compliant website on the demonstration for enrollees.[19]
- Plans must communicate to enrollees on an annual basis about their rights and protections, including information on their grievance and appeal rights.[20]

Long Term Services and Supports (LTSS)
- Plans must explicitly show how they will expand use of community-based LTSS. LTSS capacity must be assessed on a quarterly basis.
- Plans must maintain a robust LTSS provider network by contracting with community based organizations, such as with independent living centers or Area Agencies on Aging.
- Plans must demonstrate their level of experience in providing LTSS to people with complex medical and non-medical needs, and especially, the sub-groups within the dual eligible population.
    o If plans have a low level of LTSS experience, they should be permitted to enroll only those dual eligibles with no LTSS needs unless and until they demonstrate the competency and capacity to serve duals with LTSS needs.
    o If a plan has demonstrated experience in serving one sub-population, it should be limited to enrolling that population, unless and until it demonstrates the competency and capacity to serve additional sub-populations.
    o Before expanding to additional sub-groups, plans must provide a detailed description of how they will assemble staff with specific expertise and the systems needed to manage the additional care.
- Plans must demonstrate experience or willingness to enable consumers to self-direct their care and services.

Provider Networks
- Plan must have robust provider networks, including safety net providers, LTSS providers and specialty providers—such as qualified substance use disorder treatment providers and geriatric providers—that will meet the needs of the more complex dual eligibles.
- Plans must maintain a network of providers that takes into account several key factors, including:
    o the ability to serve a large number of people who have multiple chronic conditions, including dementia, are very frail, have disabilities, and are limited English proficient
    o the number of providers who actually are accepting new patients
    o wait times for appointments
    o physical and programmatic accessibility in terms of facilities, equipment and scheduling[21]
    o travel times required for those dual eligibles using public transportation, rather than cars[22]

- Plans must have policies in place for providing staff and provider networks with training that builds their capacity to care for specific sub-populations of dual eligibles, such as those with substance use disorders and people with LTSS needs. Training should include instruction in the independent living and recovery learning philosophies.[23]
- Plans must maintain a document process for provider credentialing of physician providers and all other licensed or certified providers who participate in the plan network.[24]
- Provider networks should be reviewed before a plan is permitted to enroll patients and then on a quarterly basis. Site visits should be conducted by the State and CMS to the health plans administrative and regional offices.
- Plans should conduct "secret shopper" visits and calls to providers before any patients are enrolled and quarterly thereafter to confirm their availability to enroll new patients. The visits and calls should check for adequate accessibility to buildings and offices, access to interpreters for those who are blind, deaf or with limited English proficiency.

ADA Compliance
- Plans must have strategies to regularly monitor, including through site visits, medical facilities' and physician offices' compliance with the Americans with Disabilities Act.[25]

Health Equity & Cultural Competency
- Plans must provide detailed plans for how they will address racial and ethnic health disparities.
- Plans must guarantee beneficiaries choice of providers who speak and understand their culture and language, including the use of American Sign Language and braille.
- Plans must provide written materials that are culturally sensitive and available in the languages of the members they serve.
- Plans must provide staff and providers with cultural competency and disability training to ensure the delivery culturally-competent services in both oral and written member communications.[26]

Consumer Engagement
It is essential that managed care plans have a detailed plan for how they will meaningfully engage members and their families on an ongoing basis. These plans should include engagement on multiple levels, from shared decision-making in the exam room to consumer involvement in developing care plans to organizational advisory and governance roles such as consumer membership on the board of directors. [27]

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[1] Centers for Medicare and Medicaid Services. Financial Alignment Initiative. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html
[2] Centers for Medicare and Medicaid Services. "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees," January 2011. Retrieved:
http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

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[3] Centers for Medicare and Medicaid Services. "Medicare-Medicaid Capitated Financial Alignment Demonstration MMP Readiness Review," December 17, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP_ReadinessReview_Presentation.pdf

[4] See Massachusetts Readiness Review tool: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[5] Since the majority of the state demonstration projects are pursuing the capitated financing model, this issue brief primarily focuses on that model. However, a few states are pursuing the managed fee-for-service financing model, to which the majority of the readiness concerns and recommendations in this fact sheet are also applicable.

[6] Phil Oliff, Chris Mai, and Vincent Palacios, "States Continue to Feel Recession's Impact," June 27, 2012. http://www.cbpp.org/cms/?fa=view&id=711

[7] See e.g. "WellPoint's Amerigroup Deal Marks Big Push for 'Dual' Patients," Wall Street Journal, July 9, 2012.

[8] CMS announced a funding opportunity to support implementation activities in the 15 states that received design contracts. See http://www.grants.gov/search/downloadAttachment.do?afn=att1388132155-f212713.pdf&amt=application/pdf

[9] For a good model see Massachusetts plans for developing a statewide "Implementation Council." http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/121102-presentation.ppt

[10] Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors," January 2013. Retrieved: http://www.kff.org/medicaid/upload/8403.pdf

[11] See Massachusetts Readiness Review tool: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[12] Ibid

[13] Centers for Medicare and Medicaid Services. Guidance to "Organizations Interested in Participating as Medicare-Medicaid Plans in States Seeking to Implement Capitated Financial Alignment Demonstrations in 2014," January 10, 2013. Retrieved: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf

[14] The National Committee for Quality Assurance (NCQA) rates Medicare and Medicaid plans in 3 domains: consumer satisfaction, prevention and treatment. At a minimum, plans must be required to score a 3 or higher to participate in the demonstration. See http://www.ncqa.org/ReportCards/HealthPlans/HealthInsurancePlanRankings/HealthInsurancePlanRankings201213/2012MedicaidandMedicareHealthPlanRankings.aspx

[15] It is widely acknowledged the Medicare star rating process is imperfect. At *a minimum,* plans should meet the 3 stars or above rating, but that is by no means the only measure of quality. There are efforts underway to improve quality ratings applicable to plans serving duals eligibles. See e.g. The National Quality Forum MAP Dual Eligible Workgroup. http://www.qualityforum.org/Setting_Priorities/Partnership/Duals_Workgroup/Dual_Eligible_Beneficiaries_Workgroup.aspx

[16] Community Catalyst and Health Law Advocates, "Consumer Rights to Mental Health Treatment: State Responsibility for Enforcing the Federal Parity Act," June 2012. Retrieved: http://www.communitycatalyst.org/doc_store/publications/Consumer-Rights-Mental-Health-Treatment-Parity.pdf

[17] See Massachusetts Readiness Review tool: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[18] Ibid

[19] Ibid

[20] Ibid

[21] See Disability Rights Education & Defense Fund, "Dual Eligible Demonstration Projects: Accessibility Related Network Readiness Review Criteria-High Level with Detail," October 2012. Retrieved: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

[22] See Massachusetts Readiness Review tool: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[23] A state may develop learning opportunities for plans and providers geared towards building their capacity. For example, Massachusetts is contracting with the University of Massachusetts Medical School to design a new learning collaborative and training program for plans and providers. Through webinars and online courses, the training program will work to help plans and providers build competency around key programmatic areas such as

disability culture and experience in the healthcare system, ADA compliance, and the recovery model and independent living philosophy.

[24] See Massachusetts Readiness Review tool for further benchmarks on provider credentialing. http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[25] See Disability Rights Education & Defense Fund, "Dual Eligible Demonstration Projects: Accessibility Related Network Readiness Review Criteria-High Level with Detail," October 2012. Retrieved: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf. See also Center for Independence of the Disabled, NY, "ADA Compliance by Managed Long-term Care Plans in New York State," October 5, 2012. Retrieved: http://dredf.org/healthcare/2012-docs/Analysis-of-ADA-Compliance-by-Managed-Long-Term-Care-Plans-in-New-York-State.pdf

[26] See Massachusetts Readiness Review tool: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/readiness-review-tool.pdf

[27] Community Catalyst, "Best Practices for Meaningful Consumer Input in New Health Care Delivery Models," September 2012. Retrieved: http://www.communitycatalyst.org/doc_store/publications/meaningfulconsumerinput_healthcaredeliverymodels.pdf