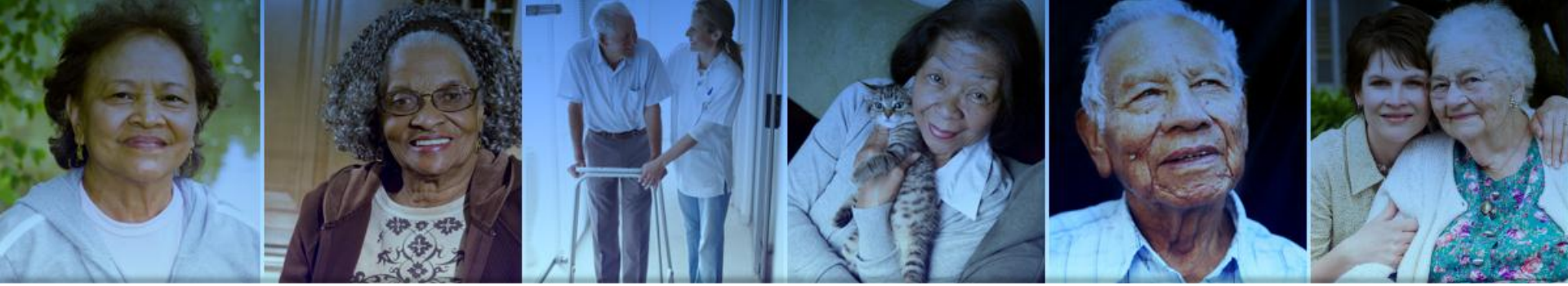

NSCLC

National Senior Citizens Law Center

Protecting the Rights of Low-Income Older Adults

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Ensuring Protections for Dual Eligibles in Integrated Models

Kevin Prindiville, National Senior Citizens Law Center

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.

Our project

- Four technical issue briefs describing and providing recommendations on important issues facing dual eligibles
  - Ensuring Consumer Protections in Integrated Models
  - Addressing ‘Bump-ups’ in program rules and benefits
  - Aligning appeals systems
  - Improving delivery of the QMB benefit

Our support

- Supported by a grant from The SCAN Foundation, dedicated to creating a society in which seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs. For more information, please visit www.TheSCANFoundation.org.

Dual Eligibles Demographics

- Roughly 9 million people with Medicare and Medicaid
  - 59% 65 and over; 41% people with disabilities
- More likely to be:
  - low-income, women, African American or Hispanic; to lack a high school diploma; to have limitations in ADLs; and to live in an institution, alone or with someone other than a spouse.

Medicare Payment Advisory Committee (MedPAC), "Healthcare Spending and the Medicare Program," MedPAC Data Book, Chapter 3, (2010)

Dual Eligibles Demographics

- High Cost Population:
  - 16% of Medicare beneficiaries: 27% of all Medicare program costs.
  - 15% of Medicaid beneficiaries: 39% of Medicaid costs.
  - 20% of duals: 68% Medicare spending on duals
  - 50% of duals: 8% Medicare spending on duals
  - 70% of Medicaid spending on duals is for long term care
  - 20% of duals are in institutions

Kaiser Family Foundation. "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," (2011)
Medicare Payment Advisory Committee (MedPAC), "Healthcare Spending and the Medicare Program," MedPAC Data Book, Chapter 3, (2010)

Dual Eligibles Demographics

- Big picture:
  - Poor health
  - Low-Income
- Impact of each on system design
  - High care needs
  - Care goals may be different than for other populations
  - Home and Community Based Services are key
  - No room for error; this is the safety net

Why Consumer Protection?

- Tremendous interest in the population and their costs
- New integration efforts underway
  - 15 state contracts
  - State Medicaid Director Letter
- Efforts offer promise and risk
  - Protections necessary to limit risk; increase potential to provide promise

Why Consumer Protection?

- Rights, rules and requirements that assure access to needed services
  - Preserve current protections
  - Strengthen to limit risk; fulfill potential
- Keep focus of new programs on serving the individual
- Protections take many forms; most effective when woven throughout the program

Our Process

- Assessment of consumer protections in existing systems
- Ongoing dialogue with other advocacy organizations
- Review of recommendations by other organizations

Key Consumer Protections

- Choice
- Access to All Support and Services
- Continuity of Care
- Appeals and Grievance Procedures
- Meaningful and Clear Notices
- Accessible Services
- Provider Networks
- Oversight and Monitoring
- Financial Structures
- Phased Implementation

Choice

- Dual Eligibles Must Retain Their Right to Choose
  - Choose all of one's providers;
  - Choose whether and how to participate in care coordination services;
  - Decide who will be part of a care coordination team;
  - Self direct care (with support necessary to do so effectively); and
- Choose, ultimately, which services to receive and where to receive them.

Choice

- Choice begins with a truly voluntary, “opt in” enrollment model.
  - Key to maintaining access to providers
  - Ensures ‘buy-in’ from individual
  - Retains an existing protection
  - Part of many current models

Access to All Supports and Services

- An Integrated Model Must Provide Access to All Necessary Supports and Services.
  - All Medicaid and Medicare services
    - Access to distinct benefits offered by each program
    - Where a service s covered by both, access to the full benefits entitled to under each
  - Enhanced services not currently available under either program
    - Potential to increase access to home and community based services
  - Clear standards for all services

Continuity of Care

- Continuity of Care Must Be Maintained.
- Access to:
  - Current services, treatments and drug regimes
  - Providers
- Examples of effective transition models exist
- Key issue for the population; transitions can be very disruptive

Appeals and Grievances

- Right to appeal:
  - Eligibility for or enrollment in the model
  - Assignment to a provider or care team
  - A decision regarding provision of a particular service
  - Elements or non-elements of a care plan
  - For a second opinion or evaluation of eligibility for a service
  - A denial of coverage of a service
- Right to file a grievance/complaint about the integrated model and/or its providers.

Meaningful and Clear Notices

- Enrollees must receive meaningful and clear notices about programs, services and rights. For example:
  - Enrollment rights and options;
  - Plan benefits and rules;
  - The individual's care plan (including care options that were considered but not included in the plan of care);
  - Coverage denials;
  - Appeal rights and options;
  - Transition protections and
  - Potential conflicts that may arise from relationships between providers, suppliers and others.

Accessible Services

- Services must be culturally and linguistically appropriate and physically accessible.
- Language and cultural accessibility at every level
- Physical accessibility
  - Includes programmatic accessibility

Provider Networks

- Robust provider networks able to serve the unique needs of duals.
  - Primary care providers with geriatrics training
  - Specialists with expertise in conditions common among duals
  - Mental health and home and community based services providers
- Providers must be committed to the care coordination model
- Access should include geographic considerations
- Process for getting care out of network when necessary

Oversight and Monitoring

- Comprehensive and coordinated oversight to ensure that integrated models are performing contracted duties and delivering high quality services.
  - State Medicaid and other agencies
  - CMS
  - Independent advocate
  - Stakeholder committees

Financial Structures

- Promote delivery of optimal care
- If capitated, rates adjusted for health needs of population
- Emphasize and reward provision of home and community based services
- Provider rates high enough to guarantee access
- Encourage participation of non-profit and safety net providers

Phased Implementation

- Designed and implemented thoughtfully and deliberately, taking into consideration the structures and readiness of existing service delivery systems.
- Phase enrollment
- Phase geographic or population expansion
- Phase service/benefit integration
  - Do no harm to existing, effective systems

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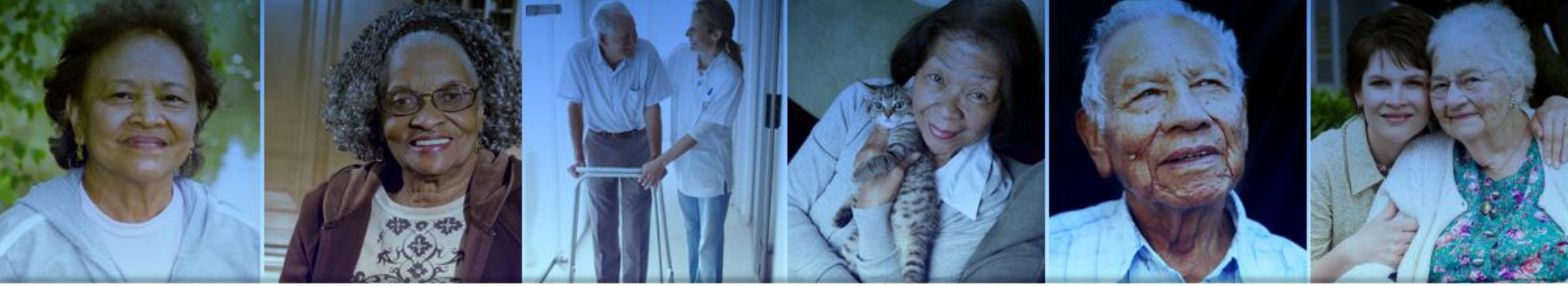

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