March 19, 2012

Dual Capitation Initiative
Delivered via e-mail to HFS.carecoord@illinois.gov

Re: State of Illinois Proposal to the Center for Medicare and Medicaid Innovation: Illinois Medicare-Medicaid Alignment Initiative

Dear Dual Capitation Initiative Staff:

The Center for Medicare Advocacy offers the following comments on the State of Illinois’s proposed “Illinois Medicare-Medicaid Alignment Initiative.”

The Center is a twenty-five year old national advocacy organization promoting fair access to Medicare and Medicaid services for older people and people with disabilities. Through direct client services, including legal representation, education and policy advocacy, we seek to ensure that Medicare and Medicaid beneficiaries receive the services to which they are entitled and that the programs are maintained and strengthened to promote the health and well-being of their beneficiaries.

The Center neither endorses nor opposes this proposal; we believe it is not yet sufficiently developed and wish to highlight areas where we believe the State needs to provide more thought and information before submitting the proposal to the Centers for Medicare & Medicaid Services.

Our comments are not comprehensive; they are intended to point the state in the direction of particular areas of focus. Our failure to comment on any given aspect of the proposal should be taken as neither endorsement nor repudiation of that aspect.
Comments

Overarching. We are pleased with certain aspects of the proposal such as its apparent focus on increasing access to home and community based services, its stated intent to use the services of an independent enrollment broker and its commitment to providing clear and accessible information to enrollees and prospective enrollees. We also like the state’s objective to ensure real network adequacy before plans begin operating. We like that plans are required to have telephonic help available 24 hours a day for eligibility confirmation, prior approval and a Nurse Advice line. Nonetheless, the proposal is vague, even in its discussion of some of the aspects we have just identified. Nor is there discussion of how Medicare and Medicaid dollars will be accounted for, once a plan has received the capitated amounts from each program.

The proposal should clearly state that all Medicare and Medicaid requirements apply except for those explicitly waived and should identify those specific requirements for which Illinois will seek waivers. (For example, p. 10 includes references to using “Medicaid and Medicare requirements as appropriate” for outreach and marketing, and incorporating “relevant Medicare Advantage, Part D, and Medicaid managed care requirements” for grievances and appeals. It is difficult to assess the proposal without knowing specifically which requirements of which program will be utilized.) It should also describe a rigorous state and federal level of oversight as well as a more clearly defined and described evaluation, since the project will be supported through authorities in the Affordable Care Act relating to testing and evaluating new financing and delivery systems.

The proposal needs to discuss plan and provider compliance with the Americans with Disabilities Act and discuss in greater detail how the state will ensure that plans are operated and care is delivered in a culturally and linguistically competent manner.

Standards for plans operating in the demonstration. According to the proposal, no specific standards are identified that would govern the structure of the plans. Standards for both Medicaid and Medicare managed care organizations have been developed through statute, regulation and guidance over decades, including decades of advocacy to improve them. We propose that any plan in the demonstration should be governed by existing Medicare and Medicaid regulations except where individual requirements are explicitly waived for purposes of better aligning the programs or to provide expanded benefits. We propose that the Medicare regulations be those governing Medicare Advantage Dual Eligible Special Needs Plans, although we also understand that additional requirements may apply.

Enrollment. The proposal is based on the assumption that all those eligible will be passively enrolled into a plan participating in the program if they do not make an active choice either in or out during the enrollment period. It asserts that they could opt out at any time but does not clarify what that means – what services would be available to them.
under which program. But more importantly, mandatory enrollment into private plans, even with an option to change at any time, is not required of any other Medicare beneficiary and thus this proposed method discriminates, among all Medicare beneficiaries, against dual eligibles, who are the poorest, sickest and greatest users of health care services. Those who have complex medical and health care situations may also have care regimens carefully worked out over time with their providers and disruptions could be dangerous. While we appreciate the inclusion of a specific 180-day period in which an enrollee can maintain a course of treatment with an out of network provider and of a provision to allow out of network providers to participate in the plan with Single Case Agreements, these features will need to be explained to enrollees at a time and in a manner that they will be able to understand and act on them. How would an enrollee know that she was beginning a 180-day grace period? When does the 180 days begin? How would her provider know to bill the plan? How would the provider know to apply for a Single Case Agreement if the provider so chose? And how would the beneficiary be informed of her rights to opt out if the provider did not wish to be part of the plan and the individual wanted to stay with the provider? We do not favor this opt out approach, which discriminates against dual eligibles and could cause them harm. Its features may be very difficult to communicate to those who most need the information. To the extent that plans are offering services otherwise unavailable to the target population -- care coordination, medical homes and greater access to home and community based services, among others -- beneficiaries should find them attractive and choose to enroll.

Use of Enrollment broker. We are pleased that Illinois plans to use an enrollment broker but we wish for greater clarity in the discussion of the enrollment broker’s role. The state says “to help facilitate enrollment choices” it will use a neutral broker “to help deliver Plan information and to conduct outreach and education sessions for potential enrollees.” We believe the broker should be the one conducting the enrollments, not merely the education and counseling. Moreover, we believe there need to be additional resources available -- such as targeted funding to state health insurance counseling programs, among others, to help people navigate the plan choices.

Exclusion of Spenddowners from demonstration. We are curious and somewhat concerned about the decision to exclude those on Medicaid with a spenddown from the demonstration. This is because it is often people needing nursing facility care or long-term supports and services whose eligibility is based on spending down. These are individuals likely to benefit from the demonstration’s focus on expanded access to home and community based services. We assume the state is concerned about people moving in and out of eligibility and thus in and out of the demonstration, but many people have regularly known medical bills that make their eligibility more like to remain stable. We hope Illinois will reconsider this decision or at least provide some justification for it before submitting its proposal to the Centers for Medicare & Medicaid Services.

Provider credentialing or certification. The proposal discusses provider credentialing on page 9 and directs that plans must use National Committee for Quality Assurance (NCQA) credentialing standards. The proposal does not suggest that providers must be either Medicare or Medicaid-certified, if they meet the NCQA and plan-specific
standards. The matter of what standards must be met for providers to be reimbursed by the plan is of great concern to dual eligibles as many in the fee for service systems find that their Medicare providers cannot get Medicaid payments for Medicare cost-sharing if they are not Medicaid providers. The proposal should explicitly state that providers participating in the plans are eligible to receive payments for both Medicare and Medicaid services that they provide.

Cost-sharing and Qualified Medicare Beneficiary enrollment. The proposal makes no mention of cost-sharing, even though widespread mis-information about cost-sharing responsibilities are one of the issues that make access to care difficult for dual eligibles. (The federal Centers for Medicare & Medicaid (CMS) reports receiving a high volume of calls about this issue.) As a general matter, dual eligibles should not have cost-sharing since Medicaid should pay most of their Medicare cost-sharing and the state is only permitted to charge dual eligibles nominal co-pays. But more specifically, most individuals who are dually eligible are also eligible for (even if not enrolled in) the Qualified Medicare Beneficiary (QMB) program and QMBs are excused from all Medicare cost-sharing. States do not necessarily enroll all those who are eligible for it into their QMB programs. Illinois should make clear in this proposal that it will ensure that all full benefit dual eligibles who are eligible for QMB are enrolled in the program. In addition, it should require participating plans to provide clear instructions to all participating providers concerning cost-sharing obligations. We wish to see discussion of these issues by Illinois in its proposal.

Care Coordination. Care coordination is a central element of this proposal, but the discussion of it, from page 11 through page 15, includes a great deal of redundancy and is a bit confusing. For example, care coordination seems to be required of the medical home, but it is presented as a requirement in addition to the medical home. The proposal should make clear that plans and their providers must offer care coordination, including an assessment and care plan, either to all participants or to all who request it, regardless of whether they fit a "profile" for care coordination. Our experience with private Medicare plans that are designated as coordinated care plans is that they deny care coordination to all but those they specifically identify as needing it. We know from focus groups, including those reported on in a report released recently by AARP, that most people who have care coordinators are happier with their health care than those who do not; such an important feature should be easily accessible by anyone who has enrolled in the program.

Expansion of Access to long term supports and services. The proposal identifies improved access to community based care as one of six expected impacts of the demonstration. Yet the discussion of such services does not make clear how that will happen. On page 11, the proposal identifies Attachment C as the statement of home and community based waiver services that are included in the demonstration. Attachment C, while including many services, reveals that some of those services are available only to certain categories of individuals. Moreover, there is no discussion of whether caps exist on the number of people who can receive such services. If plans are required to follow the specific restrictions listed in Attachment C, they will be hard pressed to describe, in a
meaningful way, the services they are offering. Does the demonstration expand access to these services by removing caps that otherwise apply? More clarity is needed for readers to understand how the service expansion will actually work. Such clearer descriptions will be important as the expanded access is likely to be a real selling point of the demonstration.

**Access to Medicare Data.** One of the essential features of the initiatives from the Medicare and Medicaid Coordinating Office is the expanded access to Medicare data that is provided to states to help them in planning. The Illinois proposal does not discuss whether the state has signed a new data use agreement, how far along implementation is and so forth. This will be an essential element in the success of the demonstration and should be discussed.

**Budget for Monitoring.** The proposal does not discuss a budget for implementation of the demonstration. It is clear from the proposal that Illinois has many expectations of plan behavior and of plan oversight of its own providers. It will be critical for Illinois to have a strong budget for its own oversight of the implementation.

**Transparency.** Because the private plans through which care will be delivered will be conduits for an enormous amount of public money and will be, in essence, performing a public function, all participating plans and all of their participating providers should be required to agree to be bound by state and federal Freedom of Information Act requirements as if they were public entities.

**Estate Recovery and maximizing Medicare coverage.** The proposal does not discuss how plans will account for Medicare and Medicaid expenditures for purposes of future capitated payments from each program and for purposes of assigning to one or the other program the cost of “extra” benefits the plan might offer beyond those required by Medicare and Medicaid. Such accounting will be important to beneficiaries who are subject to mandatory Medicaid estate recovery whose families may suffer the loss of needed funds if there is not a specific accounting of services the enrollee received from Medicaid. This is because their estates will be liable for the cost of services received through Medicaid but only for such amounts (not for Medicare services or “extra services” that are available due to plans’ ability to offer them under the blended rate). Because of Medicaid estate recovery, it is beneficial for those participating to get as much of their care "covered" by (and attributable to) Medicare as possible, as well as to be able to receive a proper and accurate accounting of services for which the state seeks recovery from their estate. Illinois should address this issue in its proposal.

**Due Process and Appeals.** The proposal says that the state will develop a unified grievance and appeal process, without more explication. We believe the features of Medicaid that allow for aid continuing appeal (a constitutional requirement) and for quicker access to an administrative law judge hearing and the Medicare features that require expedited appeals in some circumstances should be incorporated into the unified system. These are essential protections.
We appreciate this opportunity to comment and welcome conversation with those in Illinois who are developing this proposal.

Sincerely,

Patricia B. Nemore
Senior Policy Attorney

David A. Lipschutz
Policy Attorney