1444 I Street, NW
Suite 1105
Washington, DC 20005
Ph. (202) 289-7661
Fax (202) 289-7724
nhelpdc@healthlaw.org

# NHeLP Guide for Evaluating State Duals Integration Demonstration Proposals

Prepared by: David Machledt and Leonardo Cuello

| ENROLLMENT | |
|---|---|
| **Topics** | **Issues** |
| **Timing** | • When is the demonstration scheduled to begin? If it is scheduled to begin on January 1, 2013, will the plan be ready on time? Does the plan have enough time to complete all of the relevant processes (state comment periods, federal comment periods, 1115 processing periods, managed care negotiations and contracting, readiness review, etc.)? |
| **Voluntariness** | • Most states have chosen opt-out, or "passive," enrollment, meaning beneficiaries are auto assigned. Has your state proposed an opt-out system? What authority have they claimed allows them to waive Medicare and Medicaid Freedom of Choice rules that prohibit mandatory enrollment? (e.g., 1115 authority)?<br>• Once beneficiaries are enrolled into the new demonstration program, can they freely exit the demonstration or are they subject to lock-in? How long are they locked in for? How long does it take them to get out of the demonstration? Regardless of lock-in, is there clear disenrollment for cause that allows immediate disenrollment, including explicitly for the lack of availability of needed services or providers? |
| **Auto-enroll** | • What is the timing of auto-enrollment? Is it phased-in/staggered? Are the most vulnerable populations enrolled at the beginning of the process?<br>• How is the auto-enrollment conducted? Is there an assignment system (for an MCO or a health home) that matches to a beneficiary's primary care physician (PCP), specialists, hospitals, medications and pharmacies and, if there is no record of health history, considers geographic proximity, primary language? |

| ENROLLMENT | |
|---|---|
| **Topics** | **Issues** |
| **Notice** | • How does a beneficiary find out about her auto-assignment? Does she receive a written notice? What does it say? Are beneficiaries fully informed of consequences of staying in the demonstration (e.g., restricted provider networks, impact on current treatment plans)? Does the notice provide information or tell them to contact their doctors?<br>• Who designs the notice? Does the designer have a stake in enrollment (e.g., was it designed by an MCO or an independent broker)? What role do beneficiaries/advocates play in the notice design process? Has the notice been tested for readability and grade level and found to be appropriate? Are notices translated into primary languages/formats used by beneficiaries in the service area? |
| **Assistance** | • When a beneficiary is making her enrollment decision, who can she turn to for help? Will there be an unbiased source of information (i.e., independent enrollment broker as opposed to MCO)? Does that enrollment broker have real-time access to the networks of the demonstration plan to inform beneficiaries of the PCP, specialists, hospitals, medications and pharmacies that are in each MCO or a proposed health home model? Will beneficiaries be informed about how current treatment plans will be impacted? Are beneficiaries provided with information that allows them to compare their options per Medicaid law (see § 1396u-2(a)(1)(5))? |
| **Marketing** | • What limits, if any are placed on marketing? What kind of content and accessibility reviews are required for managed care entity marketing materials or correspondence to beneficiaries? |

| CONTINUITY | |
|---|---|
| **Topics** | **Issues** |
| **Providers** | • Will beneficiaries continue to have access to the full range of providers they already see, including PCPs, specialist, hospitals, home care providers, and pharmacy? Is there a time-limited continuity provision (for example, allowing beneficiaries to go out of network during the first months of enrollment)? NHeLP recommends a six-month open-network transition period, which begins after their first visit under the new coverage. What happens when the continuity period ends? Who can a beneficiary contact to find out whether her current providers are in the new network, and which other networks would be available to cover all of her providers? Is a real-time on line service available to allow beneficiaries to know which plans are accepting new enrollees?<br>• What steps is the managed care entity required to take in order to contract with the providers during the transition period? What kind of relationships could be encouraged or required after the transition period (such as non-participating provider payments). |

| CONTINUITY | |
|---|---|
| **Topics** | **Issues** |
| **Services** | • Will the transition period also include services review without the new managed care entity's utilization management? Will services be subject to different copays, prior authorization criteria, step therapy, formularies, quantity/frequency limits, medical necessity limitations, etc.? How would the new entity know and apply the criteria that previously applied? |
| **Treatment continuity** | • Is the managed care entity required to continue all current treatment plans? Is the entity prohibited from applying new utilization management such as new copays, prior authorization criteria, step therapy, quantity/frequency limits, medical necessity limitations, etc.? For example, what happens if a patient has a prescription that is not in the drug formulary for a participating plan? How would the new entity know and apply the previous treatment plans?<br>• Continuity of treatment should apply to all current treatment plans, and the continuity protection should not be broken because of the end of an authorization period for an on-going service. For example, if a beneficiary has a home attendant service that is re-authorized every 3 months, the authorization in place at the beginning of a 6-month transition period would clearly expire in mid-transition period; that expiration should not end the continuity requirement if, in the physician or clinician's opinion, a re-authorization is part of the same treatment. The same should apply to any treatment addition or change that is a reasonable, foreseeable or necessary part of a current treatment plan. |
| **On-going** | • Is there provision for maintaining the approved level of services if the beneficiary changes provider in the middle of an approval period?<br>• Authorization periods should be realistic. When a beneficiary has a permanent disabling condition that requires ongoing treatment of a certain type, the authorization period should be annual or six-months, not 90 days, and, for other services, the treating provider should be able to certify a longer authorization period if appropriate. |

| CAPACITY | |
|---|---|
| **Topics** | **Issues** |
| **Network adequacy** | • Are provider networks robust enough to meet the unique service needs of the new populations being enrolled, especially beneficiaries with physical, mental, and/or intellectual disabilities, older adults, and individuals needing LTSS? Does the network include enough primary care providers, and enough with specialization (such as geriatrics), to meet the needs of the population? Does the network include adequate coverage of the diverse range of specialists necessary to treat the needs of people with physical, intellectual and developmental disabilities? Are the network's providers' facilities accessible for people with disabilities and those with Limited English Proficiency? Who does the accessibility assessment using what standards? Is there a choice of qualified providers?<br>• What specific standards exist to guarantee access to services? Are there standards for acceptable travel distances and appointment waiting times, by provider type, and patient to provider ratios? For example, does the entity do geo-mapping to assure they have sufficient numbers of providers based on travel time/distance for all enrolled members? Does the network evaluate wait times? (Many entities that do geo-mapping fail to monitor wait times and thus do not identify whether the providers are truly available). Does the entity set maximum limits on panel size to ensure access (for example, one PCP per 500 patients)?<br>• If there is a list of approved medical equipment and supplies, how can the beneficiary obtain needed equipment/supplies that are not on the list? |
| **Monitoring** | • How does the managed care entity monitor its network capacity? Is the providers list available? How often is it reviewed and updated? How does the entity determine if providers are accepting new patients or have long wait times, and how does it make this information available to beneficiaries? Who can a beneficiary contact if they have network adequacy problem? |
| **Dual Providers** | • Is there a guarantee that every network provider will accept both Medicare and Medicaid? Beneficiaries should never face a problem with regard to providers who don't accept Medicaid. |
| **Readiness review** | • Has the state articulated what the readiness review process will be like? How will the state work with HHS/MMCO? How will beneficiaries be included in the readiness review process? Who develops the readiness review target criteria? |

| LTSS & CONSUMER CONTROL | |
|---|---|
| **Topics** | **Issues** |
| **Experience** | • Do the managed care entities have experience with the full process of the LTSS system: LOC assessments, care planning, service authorization, provider connections, etc.? Do they have the full range of experienced providers in network? Do they have well-developed criteria for the management of services? |
| **Relationships** | • Does the managed care entity have adequate relationships with providers (esp. community based providers, medical equipment suppliers, CILs, AAAs, etc.) who have expertise providing LTSS services? Will the entity forgo those providers in their networks? What will the contractual relationship with those providers be? Will the entity do a broad assessment of the providers in their expected networks, to see if they include the providers? |
| **Process** | • At exactly what point or points will the managed care entity exert its utilization management (LOC determination, care planning, service approval, all of the above?)? Who does the LOC assessment, care planning, service provision? Are beneficiaries involved in that process?<br>• Are new standardized assessment tools being introduced and, if so, are these appropriate to the population being subjected to them? Are they being explained to beneficiaries? Are due process rights protected for beneficiaries denied services? |
| **Consumer control** | • How do beneficiaries participate in the assessment process? Who chooses the care management team? What role do beneficiaries and families play in selecting the care management team and developing and maintaining plans of care, especially those involving long term care services? What representatives can a beneficiary add to the team? What resources will the beneficiary have access to, such as ombudsmen? How are services and hours based on the care plan staffed? How can a beneficiary dispute LOC, care plan, and service decisions? Ultimately, what assurances will there be that the care plan is primarily a vehicle for getting a beneficiary the services they need, as opposed to a tool for managed care entities to justify denials of needed care?<br>• Does the managed care entity have any experience with consumer directed/cash and counseling models of care? How will the managed care entity comply with requirements to allow beneficiary directed hiring, firing, and training of staff, control over budgets, etc.? How will the managed care entity shift from "gatekeeper" to empowerer? |
| **Good incentives** | • Is the demonstration structured to disincentivize cost-shifting and promote LTSS? For example, if the managed care entity does not bear risk for institutional care, could it then structure health assessments to push individuals with LTSS needs towards the institutional system? |

| STAKEHOLDERS/TRANSPARENCY/PUBLIC REPORTING | |
|---|---|
| **Topics** | **Issues** |
| **Design phase** | • Was the design proposal sufficiently detailed to enable meaningful response? (General goals such as "ensuring robust networks" provide little room for comment). What activities are/were conducted for stakeholder participation in design of proposals? What kind of notice/mailing list was used for these events? What evidence shows that the outreach worked? What evidence demonstrates that the outreach touched the full spectrum of the impacted communities – older adults, persons with physical disabilities, DD, mental illness, etc.? What proportion of the stakeholder feedback comes from beneficiaries as opposed to provider or industry representatives? How were beneficiary recommendations recorded, reported and acted on? Do the states provide responses to public comment, including explanations of how comments were or were not incorporated in the program design? Is there evidence that the recommendations were truly evaluated and impacted the design? |
| **Comment periods** | • Does the state's timeline allow for beneficiaries to understand the full scope of the process and where they will have opportunities to comment? MMCO requires 30-day notice and comment periods at the state and federal level. Does the scheduling of comment periods reflect realistic consideration of stakeholder feedback? For example, how long after the comment period will the state send its final proposal to MMCO? After the federal comment period, how long until the state issues RFPs? Do the time periods between each step indicate only minimal evaluation and incorporation of beneficiary comments? |
| **Implementation and governance** | • Does the proposal describe how beneficiaries will be involved in implementation?<br>• Beyond the initial design and implementation phases, does the proposal create an advisory board for the on-going governance of the demonstration? For example, is there a requirement to consult with the state MCAC? What power does the advisory board have? What proportion of members represent beneficiary stakeholders? How is the full range of the aging and disability community represented? |
| **Public reporting** | • How will states collect and analyze data on the demonstration's impact on health disparities based on age, functional status, disability status, income, race, ethnicity or geographic region? Will this information be reported and available to the public? On-line? What sort of reports will the state publish evaluating its demonstration? Will these reports be available on-line? |
| **Memorandums of Understanding** | • Does the proposal omit critical details and save them for a future MOU between the state and MMCO? How will beneficiary have a chance to review and comment upon these details? At what point in the process will beneficiaries even be able to see the MOU? |

| DUE PROCESS & APPEALS | |
|---|---|
| **Topics** | **Issues** |
| **Integration** | • A unified appeals system should never provide beneficiaries with less than their full Medicaid due process and appeals rights, and should be modeled after Medicaid standards. (Medicare standards involve complex layers and lack several core protections, such as timeliness standards and continued benefits during appeal. Federal (Medicare) ALJs will also lack practical experience with varying state Medicaid systems.)<br>• Does the proposal incorporate the 42 CFR part 431.200 regulatory requirements for fair hearing (which explicitly implement the constitutional requirements of Goldberg v. Kelly)? |
| **Advance Notice** | • Advance notice and notice are foundational due process principles in Medicaid. Does the proposal affirm that Medicaid advance notice and notice requirements will apply?<br>• Does the proposal specify that the notice must include effective date of the action, explicit reasons, citations to specific regulations, and information about how to initiate an appeal and expedited appeal, as per Medicaid requirements?<br>• Are there protections to ensure that notices are made accessible to people with Limited English Proficiency and to people with disabilities? |
| **Continued benefits (a.k.a. aid paid pending)** | • Does the proposal specify that beneficiaries must be provided notice and access to continued benefits while an administrative appeal is adjudicated?<br>• Does the proposal specify that aid paid pending attaches to the completion of the full treatment, regardless of whether a specific service may have a periodic re-authorization requirement (such as home care hours)? |
| **Amount in Controversy** | • Does the proposal specify that Medicare amount in controversy requirements cannot apply to anyone who has Medicaid (including an individual who is dually eligible)? |
| **Fair hearings** | • Does the proposal specify that the beneficiary should have full access to Medicaid due process protections, such as the right to present witnesses and evidence, the right to examine records and cross-examine witnesses, and the right to present new evidence at all stages of appeal?<br>• Does the proposal specify that managed care entities cannot use the administrative appeals process to challenge decisions favorable to the beneficiary? |
| **Timelines** | • Does the proposal specify that beneficiaries will have the full applicable Medicaid appeals timeframes?<br>• Does the proposal state that the minimum timeframe for an appeals decision is 90 days from the request for a hearing as in Medicaid?<br>• Does the proposal specify that beneficiaries have full rights to expedited review or external review per the requirements of Medicaid, at the beneficiaries' choice (i.e., not mandatory exhaustion of managed care grievance processes), with the full time limits allowed? |

| "BEST OF BOTH WORLDS" | |
|---|---|
| **Topics** | **Issues** |
| **Full scope of benefits** | • Does the proposal demonstrate a firm commitment to providing beneficiaries with the full content of both their Medicare and Medicaid benefits? Is there an affirmative statement that all unified standards will be based on the more generous of the Medicaid and Medicare standards, such that an beneficiary in a demonstration will never have less than another beneficiary who was eligible for only Medicare or only Medicaid? What process will the demonstration governance and managed care entity use to unify Medicare in Medicaid standards? |
| **Examples** | • Wheelchairs and home health should never be denied using the more restrictive Medicare standard where Medicaid would offer coverage.<br>• No beneficiary should ever have cost-sharing that exceeds the limits dictated by Medicare or Medicaid.<br>• Women with disabilities should not be denied access to family planning services which are not covered by Medicare if they are covered by Medicaid.<br>• For more examples, see HHS Request for Information, "Medicare and Medicaid Programs; Opportunities for Alignment under Medicaid and Medicare," at 76 Fed. Reg. 28196. |

| AUTHORITY & WAIVERS | |
|---|---|
| **Topics** | **Issues** |
| **Authority** | • Does the proposal clearly identify what authority the state believes is necessary to conduct the various important pieces of the demonstration? For example, if the state is pursuing "passive enrollment" (aka, "opt-out"), does the proposal delineate what authority it does that under? Does the proposal identify what other authorities (e.g., § 1115, § 1915(b), § 1915(c), § 1115A, § 1932) it will rely on to implement the proposal? How will the demonstration interact with existing HCBS programs that duals participate in? |
| **Timelines** | • Does the proposal include a description of the timeline and public process to pursue those authorities? How might the public process requirements for an § 1115 or §§ 1915(b) and (c) waiver impact the timeline for demonstration implementation? |