Five Key Standards for Dual Eligible MOUs

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Date: October 28, 2012

Pursuant to authority created by the Affordable Care Act (ACA), the Medicare-Medicaid Coordination Office (MMCO) is supporting state demonstration programs to integrate Medicare and Medicaid services for individuals who are dually eligible for both programs. About half of the states are seeking to implement such dual integration demonstrations, with the first demonstrations scheduled to begin on January 1, 2014 (assuming the demonstrations are ultimately approved). In these demonstrations, individuals will be enrolled into some kind of managed care entity (MCE), such as a managed care organization, that will be responsible for providing and coordinating care.

The process MMCO laid out for state demonstrations began with design and proposal phases followed by state and federal public notice and comment periods. Although many consumer stakeholders provided comments to the integration proposals, many state proposals were vague with respect to core policies and standards and deferred these details to subsequent phases of the process. Currently, MMCO and states are signing Memorandums of Understanding (MOU), which are an opportunity to set out some of these details. Other details may subsequently be addressed through the three-way contracts which will be signed between MMCO, the states, and the MCEs delivering the integrated benefit.

As consumer stakeholders struggle to ensure that consumer protections are included with sufficient specificity in state demonstration programs for dual eligibles, NHeLP has developed five key contractual standards for all demonstrations. Advocates should work to have these terms included in their state's Memorandum of Understanding, or failing that, included as a contractual term in the three-way contract.

1. Continuity of Care

Why it is important: MMCO is authorizing states to "passively enroll" individuals into new integrated managed care demonstrations. In many cases, these enrollees will be individuals with serious health issues who already have carefully calibrated treatment plans and a team of doctors, specialists, hospitals, home care workers, etc. If they are suddenly transitioned into a new managed care entity, which may have a different

network or treatment criteria, these individuals can suddenly lose access to the providers they depend upon or face denials of services they need.

What the MOU should say:

> *If there are multiple managed care entities, the state must use a "smart assignment" process when assigning enrollees to an MCE. The smart assignment system must place the enrollee in the MCE which includes the greatest number of the individual's providers in its network. MCEs not meeting or exceeding all annual performance measures will not be eligible for auto assignments. Individuals will not be auto-assigned to MCEs whose providers have reached the acceptable provider to patient ratios or have stated they are not accepting new enrollees (unless the person is already a patient of the provider at the time of assignment).*
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> *All enrollees who are auto-assigned to an MCE must be allowed to continue to see their existing providers, including those outside the MCE network, during a transition period. The transition period shall last at a minimum for twelve months after enrollment. During the continuity period, the enrollee shall have access to all providers and on-going treatments, without additional cost-sharing or utilization requirements. This continuity period cannot be broken at the end of an authorization period if continued treatment or related treatment is a reasonable, foreseeable or necessary part of an on-going treatment plan. The MCE's continuity period must apply with equal force to all of the MCE's subcontractors, including independent practice associations. During the transition period, non-participating providers will be reimbursed for covered items and services at the higher of the FFS rate or the plan network rate.*
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> *Enrollees must receive the required notice of their assignment or auto-assignment and the state must make available to them independent consumer assistance which can help the enrollee determine the plan that will best meet their ongoing health care needs, including participation of providers and service coverage policies. . The MCE must use available information, including application, diagnosis, and claims data, to identify new enrollees with special needs and make a "rapid contact" to those members. This contact must help enrollees coordinate continuation of their on-going treatments and providers and*

coordinate referral to the MCE's formal health needs assessment.[1] *Notices, consumer assistance, and rapid contacts must all specifically inform enrollees of their right to opt-out of the demonstration.*

2. Network Adequacy

Why it is important: The population of older adults and persons with disabilities who will be enrolled into dual eligible demonstrations is incredibly diverse and relies on a wide range of medical providers. Many individuals in this population are also in poor health and need speedy and dependable access to providers. Network adequacy standards will help ensure the managed care network can meet the needs of the enrolled population.

What the MOU should say:

State Medicaid standards shall be utilized for long-term supports and services or for other services for which Medicaid coverage is exclusive, and Medicare standards shall be utilized for pharmacy benefits and for other services for which Medicare is exclusive. Any services for which Medicaid and Medicare may overlap, regardless of which is primary (e.g. home health and durable medical equipment), shall be subject to state Medicaid standards, if such standards are more protective than Medicare standards; otherwise, Medicare standards or an alternative standard that is more protective than the Medicare and Medicaid standards shall apply.[2]

In establishing a network, the MCE shall include all classes of providers necessary to furnish covered services, including but not limited to hospitals, physicians (specialists and primary care), nurse midwives, nurse practitioners, pediatric nurse practitioners, federally qualified health centers, medical specialists, dentists, pharmacy, mental health and substance abuse providers, allied health professionals, ancillary providers, DME and prosthesis providers,

[1] For more information about rapid response and assessment in the auto-enrollment context, *see* Sara Rosenbaum et al., *Managed Care and Medi-Cal Beneficiaries with Disabilities: Assessing Current State Practice in a Changing Federal Policy Environment* (June 2006), *available at*: http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/ManagedCareMedi-Cal062706.pdf.

[2] Language based on Massachusetts' Memorandum of Understanding for dual eligible demonstration, p. 60, *available at* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf.

home health providers and transportation providers.[3] Members with special health care needs who need a specialized course of treatment or regular care monitoring must have direct access to specialists.[4] Members may use a specialist as their PCP, at their choice.[5] The MCE's network shall include adequate numbers of providers with the training, experience, and skills necessary to furnish quality care to enrollees. MCEs are required to maintain the following within 20 minutes (urban) or 45 minutes (rural) travel time from an enrollee's residence:

- *At least two PCPs;*
- *At least two specialists in every medical and surgical specialty, including at least two obstetricians and two gynecologists;*
- *At least two outpatient mental health providers;*
- *At least two hospitals;*
- *At least two nursing facilities; and*
- *At least two community LTSS Providers per covered service; and*
- *At least two pharmacies.[6]*

Providers who are not accepting new patients shall not be considered in determining compliance with the above network adequacy standards. Providers must be able to demonstrate that they can accept patients while maintaining their overall patient load within professional and industry norms and community standards.[7]

In addition, MCEs must also monitor and comply with access to care for the providers listed above.[8] An enrollee must have the option of at least one provider who meets the following access to care standards:

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[3] Language based on 2008 District of Columbia Medicaid managed care contract with DC Chartered Health Plan, Inc., DCHC-2008-D-5052, § C.9.1.5., p. 124.
[4] Language from Arizona Health Care Cost Containment System contract, p. 66, *available at* http://www.medicaid.gov/mltss/docs/azcontractnew.pdf.
[5] Maryland incudes this as a regulatory requirement. *See* the Code of Maryland Regulations at MD. CODE REGS § 10.09.65.04(C)(5)(d).
[6] *See supra* note 2.
[7] Language based on 2008 District of Columbia Medicaid managed care contract with DC Chartered Health Plan, Inc., Contract No. DCHC-2008-D-5052, § C.9.1.2.3.1., p. 127.
[8] Language is modeled after Pennsylvania Medicaid managed care contract waiting periods for access to maternity care, HealthChoices Physical Health Agreement (July 1, 2010), Exhibit AAA(2)(e), available at: http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002106.pdf. *See also* note 10. Waiting periods are essential to ensuring real access because they force plans to have enough providers to meet the waiting period limits.

- *For primary care:*
  - *20 days for preventive visits;*
  - *10 days for non-urgent symptomatic visits;*
  - *48 hours for urgent symptomatic visits;*
  - *And immediate (24/7) availability for urgent care.*[9]
- *For specialists, outpatient behavioral health providers (generally), hospitals, nursing facilities, and community LTSS Providers: 30 days for an appointment;*
- *For an initial behavioral health assessment with a qualified mental health provider: 10 days for an appointment ;*
- *For an appointment with a mental health provider for members discharged from an inpatient psychiatric hospital stay: 3 days; and*
- *For an (non-urgent, or routine) appointment with a dental health provider: 90 days.* [10]

The MCE must maintain a provider network with the following minimum provider to member panel size ratios [ratios to be inserted based on the situation in the state; Wisconsin ratios provided in parentheses only as samples]:[11]

Provider Type	**Provider to Member Ratio**
Primary Care Provider	1:_____ (1,000)
Allergy	1:_____ (5,000)
Cardiovascular Disease	1:_____ (1,000)
Dentist	1:_____ (1,600)
Dermatology	1:_____ (4,200)
ENT – Otorhinolaryngology	1:_____ (1,800)
Gastroenterology	1:_____ (1,400)
General Surgery	1:_____ (1,000)
Nephrology	1:_____ (3,000)
Neurological Surgery	1:_____ (4,500)
Neurology	1:_____ (1,500)
Nuclear Medicine	1:_____ (35,000)

[9] Washington State Hospital Association, Legal Standards for Network Adequacy for Medicaid Managed Care Plans, § 2.f., (August 29, 2012) available at: http://www.wsha.org/files/83/LegalStandardsforNetworkAdequacy_2.pdf.
[10] Language in last three bullets is based on Wisconsin Medicaid standards, Contract For BadgerCare Plus, Art. III(H)(3), p. 49-50, (August 1, 2010), *available at* http://www.dhs.wisconsin.gov/rfp/DHCF/pdf/Appendix%20A%20-%20Contract%20for%20BadgerCare%20Plus%20HMO%20Services%202010-2013.pdf.
[11] *Id*. at 54.

Provider Type	Provider to Member Ratio
Oncology & Hematology	1:_____ (1,600)
Obstetrics & Gynecology	1:_____ (1,000)
Ophthalmology	1:_____ (1,400)
Orthopedic Surgery	1:_____ (1,400)
Pathology	1:_____ (1,800)
Physical Medicine & Rehab	1:_____ (2,200)
Psychiatry	1:_____ (900)
Pulmonary Disease	1:_____ (2,000)
Radiation Therapy	1:_____ (3,500)
Thoracic and Cardiology Surgery	1:_____ (3,500)
Urology	1:_____ (3,000)

Participating MCOs must pay out-of-network providers for required services that the MCO is not able to provide within its own provider network. The MCE must have a procedure for identifying providers willing to provide medical home services and offer access to these providers.[12] The MCE must also contract with nonprofit community health clinics, community mental health centers, community health services agencies, and all essential community providers.[13] The MCE must also comply fully with 42 U.S.C. § 1396u-2(b), requiring the MCE to provide coverage for emergency services without regard to prior authorization or the emergency care provider's contractual relationship with the MCE, and to pay at least the state fee-for-service rate (or other rate) required by the statute.

The MCO is required to provide enrollees with common carrier transportation to the out-of-network provider if necessary. If a particular specialty service is not available within the MCO's immediate service area, the MCO must provide transportation. Treatment and transportation are provided at no cost to the enrollee except for permitted cost sharing arrangements.[14]

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[12] Language based on Arizona Health Cost Containment System contract/RFP No. YH02-0018, § D.11., p. 28, (January 1, 2007), *available at* http://www.azahcccs.gov/commercial/Downloads/ContractAmendments/AcuteCare/YH02-0018/CYE07_CMDP_FinalAMEND9.pdf.

[13] Language based on Minnesota Senior Health Options and Senior Care Plus Services Contract, §§ 9.3.10-12, *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_166538.

[14] Language based on Minnesota Department of Human Services *Managed Care Public Programs 2012 Quality Strategy*, p. 13, (2011), *available at* https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4538-ENG.

The MCE must provide reasonable accommodations to persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities for obtaining services from the MCE or its providers and subcontractors in a manner that is fully compliant with the requirements of the Americans with Disabilities Act and culturally and linguistically competent in compliance with Title VI of the Civil Rights Act of 1964.[15] *The MCE must provide training for its employees about special communication requirements for individuals with disabilities, including developmental disabilities.*[16] *The MCE must ensure that enrollee handbooks and other materials are available, including in alternative formats and through internet based IP Relay or Video Conferencing and TDD/TTY services and that it has sufficient capacity to provide transportation for individuals in wheelchairs.*[17]

An MCE will be in default of its contract if it fails to correct actions by one of its subcontractors which implement barriers to care. If an MCE identifies a problem involving discrimination by one of its providers, the MCE must intervene and implement a corrective action plan, or otherwise be in default of the contract.[18]

The above standards are intended to supplement any existing Medicaid and Medicare network adequacy standards, and do not replace those standards. In all cases, enrollees shall have access to the most generous network standards (including time, distance, and/or minimum number of providers or facilities) described above or otherwise available in Medicaid or Medicare.

3. Definition of Medical Necessity

Why it is important: MCEs typically use "medical necessity" to manage which individuals access which services. Many MCEs only have experience using this definition to control access to *medical* services for *healthier* populations. The duals demonstrations, however, will enroll many individuals in poor health status who will need both medical and functional services. The medical necessity definition must be sufficiently broad to ensure that these individuals can access all of the care they need.

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[15] Language based on Massachusetts MassHealth Senior Care Options Program, p. 35, § 2.6.E. *See supra* note 2.
[16] Language is based on the Code of Maryland Regulations at MD. CODE REGS § 10.09.65.07(D).
[17] *See* Wisconsin Medicaid contract Standard Member Handbook Language, Contract For Wisconsin Badgercare Plus, Addendum II, p. 188, 195, (August 1, 2010). *See supra* note 9.
[18] Language from Arizona Health Care Cost Containment System contract, p. 67, § (D)(41). *See supra* note 4.

What the MOU/contract should say:

A service is medically necessary if:

- *It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure a condition, illness or disability that endangers the health or life of the enrollee, causes suffering or pain, causes physical deformity or malfunction, threatens to cause or to aggravate a disability, or results in illness or infirmity;*[19] *or*
- *It is reasonably expected to help assist the enrollee to achieve or maintain maximum functional capacity or perform daily activities, taking into account both the functional capacity of the enrollee and those functional capacities that are appropriate for enrollees of the same age.*[20]

The above definition of medical necessity should apply to all integrated services regardless of whether it is being reimbursed by Medicare or Medicaid. In no instance should an enrollee be subject to more stringent criteria for one program when the service is reimbursable under both programs.

Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity. Such criteria can be the basis for approving services, but cannot by themselves be the basis of a denial. All requests for services not satisfying these criteria must be individually reviewed and may not be denied unless the request does not meet the definition of medical necessity and, for anyone under 21, does not meet the EPSDT medical necessity standards.[21] *Under EPSDT, children and youth under age 21 are entitled to necessary services, care and treatment needed to correct or ameliorate their health care conditions.*

[19] Language based on Massachusetts' Memorandum of Understanding for dual eligible demonstration, pp. 27, 68. *See supra* note 2.
[20] Language is modeled after Pennsylvania HealthChoices Physical Health Agreement, p. 23 (July 1, 2010). *See supra* note 7.
[21] Language is modeled after Connecticut Public Act 10-3, § 22(b), (2010), codified at Conn. Gen. Stat. § 17b-259b, available at http://www.cga.ct.gov/2011/pub/chap319v.htm#Sec17b-259b.htm. *See also* CT Behavioral Health Partnership – Child Psychiatric Level of Care Guidelines, p. 1, (May 2012), *available at* http://www.ctbhp.com/providers/pdfs/Child_BHP_Level_of_Care_Guidelines.pdf.

Final determinations must be made by a physician or other qualified medical or mental health professional, in concert with the following persons: the enrollee's PCP; a consultant with experience appropriate to the enrollee's age, disability and chronic condition; and the enrollee and/or family.[22]

4. Due Process

Why it is important: There is potential for individuals to be improperly denied a provider's care and health services as they are transitioned into managed care entities as MCEs manage their ongoing utilization. The fundamental standards which can protect such individuals are those related to due process. Medicaid has a minimum set of critical due process protections which are absent or diminished in Medicare. It is therefore essential that contracts require MCEs, at a minimum, to fully comply with all Medicaid due process requirements.

What the MOU/contract should say:

Denials

Enrollees must receive written notice for any denial (and advance written notice where there is a termination, reduction, or modification of a previously authorized service) of service which includes at a minimum: the name of the service/provider denied, the amount/frequency/duration of the requested service, an explanation of the reason for the denial and the evidence used to make the determination, a statement of the standards or criteria upon which the denial was based, a description of the rights to present evidence and challenge the denial in an impartial appeal, a statement of the deadline for filing an in-plan grievance or appeal or right to a Medicaid fair hearing and the deadline for filing an appeal while maintaining services pending such appeal, and the name of a caseworker and ombudsperson they can contact for assistance with the grievance and/or appeal process. All notices must be written in plain English (5th grade reading level), comply with the ADA (including providing notices in alternative formats), and be translated in all required threshold languages for limited English proficient enrollees. All plans must also be required to provide Interpreter services and toll-

[22] Language based on recommendation in report on difficulties IDD enrollees have with medical necessity definitions. Henry T. Ireys et al., Nat'l Ctr. for Educ. in Maternal and Child Health, *Defining Medical Necessity: Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation, and Other Special Health Care Needs,* p. 19, (1999), *available at* http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/cshcn-MedicalNecessity.pdf.

free numbers that have adequate internet based IP Relay or Video Conferencing and TTY/TTD and interpreter capability.

Appeals

Any service covered by both Medicaid and Medicare, regardless of which coverage is primary, may be appealed through the State Medicaid agency fair hearing process (and/or the Medicare IRE process, if the enrollee so chooses). Enrollees may not be discouraged from using the Medicaid appeals system. In the case of a decision where both the Medicaid agency adjudicator and the IRE issue a ruling, the MCE shall be bound by the ruling that is most favorable to the Enrollee, as determined by the Enrollee.

While the MCE (or state) may maintain a "grievance" or "complaint" system, any contact concerning a service denial must be classified as an appeal in the MCE's internal appeals process or the integrated appeals process, per the enrollee's selection. The MCO must not require submission of a written appeal as a condition of the MCO taking action on the appeal.

Enrollees or their providers shall have 90 days from the denial of a service (whether in whole or in part) to file an appeal, unless there is good cause for the delay.[23] *Enrollees may, at their option, use an MCE's internal appeals process, but will not be required to do so to use the integrated appeals process. Enrollees or their providers may request an expedited appeal. The MCE must not take punitive action against a provider who requests an expedited resolution, supports an enrollee's appeal, or otherwise appeals an MCE decision as permitted by the program.*

Appeals shall be decided within 30 days of the date the request for a hearing is filed, and 72 hours in the case of expedited appeals.[24] *Hearing decisions must be implemented by the MCE promptly.*

[23] Paragraph generally based on Massachusetts' Memorandum of Understanding for dual eligible demonstration, p. 85. *See supra* note 2. Special 90-day exception for cause based on Minnesota Senior Health Options and Senior Care Plus Services Contract, p. 178. *See supra* note 12.

[24] Language based on Massachusetts' Memorandum of Understanding for dual eligible demonstration, p. 86. *See supra* note 2.

All MCE decisions regarding internal appeals and expedited internal appeals that involve services denials or terminations/reductions/modifications must be based on the clinical judgment of a health care professional with appropriate expertise in treating the enrollee's condition or disease.

The MCE must give enrollees any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate internet based IP Relay or Video Conferencing and TTY/TTD and interpreter capability and providing contact information for independent ombudspersons and consumer support organizations.[25]

Aid Paid Pending

If an enrollee files an appeal of any kind within 10 business days of receipt of a notice of action reducing or terminating benefits, the MCE may not reduce or terminate the service until ten (10) days after a written decision from the impartial hearing is issued in response to the appeal.[26]

The provision of continued benefits pending appeal may not be altered, suspended or terminated, nor may an appeal be terminated or mooted, due to the end of a previously authorized period for the service under appeal (for example, a 3-month authorization for home health supports) or any reauthorizations of such service.[27]

5. Transparency

Why it is important: MMCO is expected to require MCEs to collect and report to government agencies significant data and information regarding complaints and appeals totals, quality measurement and management, provider networks, care coordination, service utilization, and many other areas which are critical to consumer stakeholders. States and MCEs must be required to publicly report this valuable information, including on the plan's own website and a public website, so that consumer stakeholders can evaluate the effectiveness of integration programs and suggest improvements.

[25] Language based on Minnesota Senior Health Options and Senior Care Plus Services Contract, p. 174, §§ 8.2.4(D). *See supra* note 12.
[26] Language based on Minnesota Managed Care Public Programs 2012 Quality Strategy, § 8.3.3., p. 39. *See supra* note 14.
[27] For further details about this issue, *see* National Health Law Program Letter to Cindy Mann (September 24, 2012), on file with Leonardo Cuello, National Health Law Program.

What the MOU/contract should say:

MCE will provide information to the state on a quarterly basis and the state will publicly report the information within 30 days of receipt, including by posting on a public website, including:

- *Service utilization data, including how many of each service was requested, delivered, and denied, subtotaled by age, disability status, functional status, race, gender, geographic location, type of services.*
- *Results of network adequacy reviews, including geo-mapping and waiting times, stratified by factors including provider type, geographic location, and urban/rural, and any findings of adequacy/inadequacy and remedial actions taken. This also includes any findings with respect to the accuracy of networks as published by MCEs, including providers found to be not-participating and not accepting new patients.*
- *Care coordination data including how many assessments and care plans were conducted, in what timeframes, and for which populations, as well as data related to how many enrollees received disease management services and what the populations and diagnoses were for the enrollees.*
- *Data regarding complaints, grievances and appeals, including numbers of complaints, grievances and appeals filed, stratified by factors including age, disability status, functional status, race, gender, geographic location, type of services, and detailing the timeframe data for hearings and decisions made and the dispositions and resolutions of complaints/grievances/appeals;*
- *Plan disenrollment data by cause and by months with MCE plan prior to disenrollment;*
- *Provider change data indicating how many enrollees changed PCP, by cause, months of enrollment, and form of enrollment (passive enrollment, enrollee election, etc.);*
- *Quality measurement data, including all stratified and granular sub-data;*
- *Consumer satisfaction surveying data;*
- *Enrollee Telephone Access Report including: number of unduplicated calls by enrollees, average wait time before Contractor response, number of unduplicated enrollees requiring language interpretation services, and enrollee services telephone abandonment rate;*
- *Data indicating requests and approvals for consumer direction;*
- *Data identifying HCBS workforce reliability, including the number of hours prescribed and successfully filled for each type of service, subtotaled by service provider and recipient age, disability status, functional status, race, gender, and geographic location; and*

- *Any data related to preventable hospitalizations, hospital acquired infections, "never events", and emergency room admissions.*
- *Data concerning the number of enrollees who received continuity of care with an existing provider outside of the plan's network, including indicating separately those cases where continuity of care was provided by multiple providers for a particular enrollee.*