

# RECOMMENDATIONS FOR BENEFICIARY PROTECTIONS IN MODELS APPROVED BY THE CENTER FOR MEDICARE AND MEDICAID INNOVATIONS

## Introduction

The Affordable Care Act includes a provision establishing a Center for Medicare and Medicaid Innovations (CMMI) that is authorized to test models to reduce Medicare and Medicaid expenditures while preserving or improving quality for beneficiaries of those two programs. The provision includes appropriations of \$5 million for fiscal year 2010 and \$10 billion for fiscal years 2011 through 2019.<sup>1</sup>

The provision identifies types of models that *may* (but are not required to) be tested where the Secretary determines “that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” One identified model would allow states to test and evaluate fully integrating care for those individuals dually eligible for Medicare and Medicaid coverage, *including the management and oversight of all relevant Medicare and Medicaid dollars.*

The Act gives the Secretary authority to waive such requirements of Title XVIII (Medicare) and Title XI (general provisions, administrative simplification, civil money penalties/fraud and abuse) of the Social Security Act as may be necessary “*solely for the purpose of carrying out this section with respect to testing models described in subsection (b).*” The authority granted to waive provisions of Title XIX (Medicaid) applies to only three sections of the law: the requirement that Medicaid programs must be operated statewide; the requirement that states must have a public process to determine provider payment rates; and the requirement, within a section pertaining to Medicaid managed care, that no federal funds are available to pay for managed care except under a contract with the State under which prepaid payments are made on an actuarially sound basis.

The Act also gives the Secretary the authority, through rulemaking and after evaluation and other designated processes, to expand any model, including expanding a model nationwide. The Act precludes judicial review of models chosen, organizations chosen to test the models, and other aspects of the model designation and expansion process.

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<sup>1</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148 (March 23, 2010), Sec. 3021 (Affordable Care Act)

## The Dually Eligible Population

The nearly nine million individuals<sup>2</sup> dually eligible for Medicare and Medicaid nationwide are poorer and sicker than the rest of the Medicare population.<sup>3</sup> They are younger – 42% of duals are under age 65 compared with 11% of non-duals; more likely to be minorities – 41% of duals are minorities compared with 17% of non-duals; and more likely to be institutionalized – 19% of duals are institutionalized compared with three percent of non-duals.<sup>4</sup> They use more resources in both programs than others in those programs: they represent 16% of Medicare, and use 27% of Medicare dollars;<sup>5</sup> they represent 18% of Medicaid and use 46% of Medicaid dollars.<sup>6</sup>

Frequently, dual eligibles are discussed as if they were a monolithic group, as reflected in the above paragraph – sicker, poorer, younger, costlier, etc. What is also critical to notice in considering policy options and models to promote dual eligibles' access to health care is that, in the words of the Medicare Payment Advisory Commission, “[w]ithin the dual-eligible population, there are distinct groups of beneficiaries with widely different care needs. They vary considerably in the prevalence of chronic conditions, their physical and cognitive impairments, and whether they are institutionalized.”<sup>7</sup> Notably, the least costly 50% of dual eligibles account for only eight percent of Medicare spending on duals and nine percent of total spending on duals, while the costliest 20% account for 68% of Medicare spending on duals and 62% of total spending on duals.<sup>8</sup>

## Center for Medicare and Medicaid Innovations

The Secretary's authority to waive provisions of Medicare, Medicaid and Title XI is strictly limited by the law to that which is necessary “*solely for the purposes of carrying out this section with respect to testing models. . . .*”<sup>9</sup> The purpose of the section is “*to test*

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<sup>2</sup> Kaiser Family Foundation, State Health Facts “Dual Eligible Enrollment, 2005” at <http://www.statehealthfacts.org/comparemaptable.jsp?ind=303&cat=6>

<sup>3</sup> Medicare Payment Advisory Commission (MedPAC), *A Data Book: Healthcare Spending and the Medicare Program*, Chapter 3 (June 2010), available at <<http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf>> (site visited Sept.21, 2010) (hereinafter MedPAC 2010 Data Book). 92% of dual eligibles have incomes at or under 200% of federal poverty limits compared with 36% of non-duals; 20% of duals report poor health compared with seven percent of non-duals. Dual eligibles have greater incidence of cognitive impairments, mental disorders, diabetes, pulmonary disease, stroke and Alzheimer's disease.

<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> John Holahan, Dawn M. Miller and David Rousseau, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005* Kaiser Commission on Medicaid and the Uninsured (Feb. 2009), available at <[www.kff.org/medicaid/upload/7846.pdf](http://www.kff.org/medicaid/upload/7846.pdf)> (site visited May 4, 2010) (hereinafter *Enrollment and Spending*).

<sup>7</sup> Medicare Payment Advisory Commission (MedPAC) Report to Congress: Aligning Incentives in Medicare, Chapter Five – Coordinating the care of dual-eligible beneficiaries (June 2010).

<sup>8</sup> MedPAC 2010 Data Book

<sup>9</sup> Affordable Care Act, § 3021(d)

*innovative payment and service delivery models*”;<sup>10</sup> thus the waiver authority is limited to matters of payment and service delivery, not beneficiary coverage, benefits or appeal rights.

The eighteen specific models identified in the law are not required to be tested by the Secretary. The Secretary *may* select from among those models, but the overarching criterion governing her decision is that a model that is chosen “addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.”<sup>11</sup>

### **Recommendations**

The undersigned organizations and individuals embody decades of experience in representing Medicare and Medicaid beneficiaries and in providing legal and policy analysis and scholarship related to the Medicare and Medicaid programs. All have been actively engaged in the conversation about health care reform leading up to the passage of the Affordable Care Act in March of this year. All have been involved in ongoing discussions and activities relating to implementation of the law. The recommendations offered here were informed by decades of daily contact with Medicare and Medicaid advocates and beneficiaries and of experience writing about and analyzing the two programs. The recommendations and the letter transmitting them to the Secretary were prepared with support from the O’Neill Institute at Georgetown University Law Center. The Institute’s support included the convening of a conference call with a small group of legal scholars and Medicare advocates. The recommendations are endorsed by the signers of the letter and this paper; they do not reflect the views or endorsement of the O’Neill Institute.

**We do not favor models that would give Medicare dollars to states to manage and oversee. However, should such models go forward, we urge the Secretary to exercise strategically and narrowly her authority in approving such models.**

We believe that giving states without specific and narrowly defined parameters control of Medicare dollars is very likely to undermine the universality of the Medicare program by taking control of program expenditures away from the federal entity charged with their oversight. Moreover, while control of the dollars would reside with the state, the federal government would still, ultimately, be responsible for assuring that Medicare beneficiaries received all services to which they are entitled under the law. The task of enforcing Medicare beneficiaries’ rights would be more complex than it already is as payment and coverage issues are often inextricably linked.

States are generally accustomed to programs like Medicaid and CHIP in which benefits and coverage decisions are within their general control. Medicare, by contrast has guaranteed all beneficiaries uniform coverage throughout the 50 states and the District of Columbia. While Medicare private plans, offered through the Medicare Advantage program, have some flexibility with respect to cost-sharing and delivery design (for

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<sup>10</sup> Id. at § 3021(a)

<sup>11</sup> Id. at §. 3021(b)(2)(A)

example, they can use closed provider networks), they must cover all services required by the Medicare statute and regulations.

State budgetary difficulties also raise concerns about the possible deleterious effects of allowing states to manage and oversee the dollars from the fully federal Medicare program. Most states are required to have balanced budgets; state Governors routinely point out to Congress and the President the significant impact of the Medicaid program on their overall budgets. Even those states with the most experience with Medicare and the best intentions for their dually eligible beneficiaries may succumb to budgetary pressures to supplant Medicaid funds with Medicare dollars.

If States are to wade into the uncharted territory of managing Medicare monies, the Secretary, through CMS, must institute stringent monitoring, oversight, and enforcement mechanisms to ensure the protection of beneficiary rights with respect to scope of and access to services. This will be a formidable task. We are concerned that CMS's oversight of state Medicaid programs has often been less than some believe is necessary.<sup>12</sup> Adequate monitoring and oversight of state-managed programs for dual eligibles seems unlikely under current operations and agency norms.

**Regardless of her intention to test the model discussed above, we recommend that the Secretary promulgate regulations governing all models implemented through the Center for Medicare and Medicaid Innovations.**

Such regulations should first clarify the limitations on waiver authority granted under the CMMI and acknowledge that the Secretary is not bound to test any particular model. *Beyond that, they should enumerate beneficiary protections and other principles that govern all models tested under the CMMI authority.* Regulations should require that:

- **Beneficiaries who are dually eligible for Medicare and Medicaid must be provided access to the full coverage, benefits and appeal rights of each program, regardless of the delivery system used to provide benefits and regardless of the entity administering the funds. Dually eligible beneficiaries should always have access to the most beneficial standard of coverage and process for appeal.** Moreover, because the estate of any dually eligible beneficiary who was age 55 or older when she received Medicaid services is subject to recovery for the cost of those services, beneficiaries should always get the fullest coverage available to them under the Medicare program to minimize their Medicaid estate recovery liability. If Medicaid's coverage is more generous, a determination must be made that Medicare coverage standards have been accurately applied (e.g., that Medicare benefits have not been incorrectly denied to due erroneous application of a coverage

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<sup>12</sup> See, e.g., Government Accountability Office, "Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement", GAO-10-810 (Aug. 4, 2010) available at <http://www.gao.gov/new.items/d10810.pdf> (site visited Sept. 28, 2010); Office of Inspector General, "Most Medicaid Children in Nine States are not receiving All Required Preventive Screening Services," OEI-05-08-00520 (May 21, 2010), available at <http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf> (site visited Sept. 28, 2010).

standard such as confined to the home) before turning to Medicaid for coverage.

- **Beneficiaries’ rights under both programs to free choice of provider must be fully protected such that beneficiaries are not required to participate in any demonstration or particular type of service delivery system in order to receive services.** Medicare beneficiaries have never been required to receive their benefits through private plans; sometimes, dually eligible Medicaid beneficiaries have been so required. The freedom to choose one’s provider and one’s “delivery system” is an inviolable Medicare right that must be protected. Beneficiaries must be given the choice to “opt in” to any program – including a program in which the state is managing the Medicare money -- or delivery system designed to serve dual eligibles.
- **All models approved under this provision must be subject to rigorous financial audit of the use of program monies to assure that Medicare dollars are not used by states to supplant Medicaid dollars.** If Medicare and Medicaid dollars are co-mingled by states in efforts to provide seamless, integrated services covered by both programs, the Secretary must know that Medicare dollars are being spent appropriately and are not supplanting Medicaid spending. Savings, if any, must come from better coordinated care, not from reductions in needed (and covered) services.
- **The processes and criteria for developing and selecting models, demonstrations and waivers under authority of this section of law must be fully transparent and available to the public.** The Affordable Care Act amends current waiver authority to require the Secretary to promulgate regulations regarding public processes at the state and federal levels with respect to the development and approval of waiver and demonstration projects.<sup>13</sup> Similarly, open processes should govern implementation of authority of the CMMI. Existing successful models of integration of services for the dually eligible are the result of open processes at the state level, including engagement by the advocate and beneficiary community.<sup>14</sup> Such openness may be critical to the success of any model tested.
- **Provider payment rates under any approved model must be sufficient to assure access to needed providers.** Medicaid payment rates are generally lower than Medicare rates for the same service. The Balanced Budget Act of 1997 authorized (but did not require) states to pay Medicare cost-sharing for

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<sup>13</sup> Sec. 10201(i) of the Affordable Care Act. Proposed regulations published at 75 Fed. Reg. 56946 (Sept. 17, 2010), available at <http://www.gpo.gov/fdsys/pkg/FR-2010-09-17/pdf/2010-23357.pdf> (site visited Sept. 27, 2010)

<sup>14</sup> Alissa Halperin, et al, “What’s So Special About Medicare Advantage Special Needs Plans? Assessing Medicare Special Needs Plans for Dual Eligibles,” *Marquette Elder’s Advisory*, Vol. 8, No. 2 (Spring 2007) available at <http://www.medicareadvocacy.org/Projects/SNP%20Conference/BackgroundInfo/HalperinNemoreGottlichMarquette.Spring2007.WhatsSoSpecialAboutSpecialNeedsPlansAssessingMedicareSpecialNeedsPlansForDualEligibles.pdf> (site visited Sept. 27, 2010)

Qualified Medicare Beneficiaries at their Medicaid rate, if that rate was lower than Medicare's. Since that time, at least 15 states have reduced their cost-sharing payment to the lower rate.<sup>15</sup> (About 20 states paid at the lower Medicaid rate even before the BBA provision allowed them to do so.) A Congressionally-mandated study released in 2003 reported that access to physicians and to providers of mental health services had been adversely affected by the change in payment rates.<sup>16</sup> Approved models must include assurances of adequate payment that comports with Medicare rates.

- **Any model designed to meet the special needs of the dually eligible population or a subpopulation of those dually eligible must actually provide services to meet those special needs.** Medicare Advantage Special Needs Plans for Dual Eligibles, in existence since 2004, have yet to be shown to offer anything special for the population they serve. In fact, a memo from the Centers for Medicare & Medicaid Services, released in 2010, states that some regular Medicare Advantage plans have more robust benefit packages than those of Special Needs Plans.<sup>17</sup> Models approved under CMMI authority must require plans and providers to demonstrate their special services.
- **Any private plans used in delivering services under any model approved under this provision must subject themselves to Freedom of Information Act requirements for public access to information.** Medicare and Medicaid are public programs that use billions of taxpayer dollars to ensure that certain benefits are available to certain citizens. The programs are accountable, in part, through the public's access to information about them and how they are administered through the Freedom of Information Act. Private entities intricately engaged in the provision of services under these programs should be similarly accountable.
- **All models approved under this provision must be subjected to rigorous monitoring of beneficiary protections by the Centers for Medicare & Medicaid Services and other oversight entities.** CMS has an enormous amount of work before it that comes from new authority and programs included in the Affordable Care Act, in addition to its ongoing responsibilities to administer Medicare and Medicaid. Its oversight of state Medicaid programs is often less than some believe is necessary.<sup>18</sup> If States are permitted

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<sup>15</sup> Patricia Nemore, "Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries: A 1999 Update," Kaiser Family Foundation (December 1999), available at <http://www.kff.org/medicaid/1566-index.cfm> (site visited Sept. 27, 2010)

<sup>16</sup> Tommy G. Thompson, Secretary of HHS, "Report to Congress, State Payment Limitations for Medicare Cost-Sharing," transmitted by letter of May 20, 2003 to Speaker of the House of Representatives, J. Dennis Hastert. Available at <http://www.rti.org/pubs/StatePaymentLimits.pdf> (site visited Sept. 27, 2010)

<sup>17</sup> January 11, 2009 (sic) guidance from Danielle Moon, Director, Medicare Drug and Health Plan Contract Administration Group, Subject: CMS Expectations of Special Needs Plans for 2010. Available at [http://www.medicareadvocacy.org/InfoByTopic/MedicareAdvantageAndHMOs/10\\_01.11.SNPMemo.pdf](http://www.medicareadvocacy.org/InfoByTopic/MedicareAdvantageAndHMOs/10_01.11.SNPMemo.pdf) (site visited Sept. 27, 2010)

<sup>18</sup> See, e.g., Government Accountability Office, "Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement", GAO-10-810 (Aug. 4, 2010) available at <http://www.gao.gov/new.items/d10810.pdf> (site visited Sept. 28, 2010); Office of Inspector General,

to administer not only Medicaid, with which they have more than four decades of experience, but also Medicare, with which they have almost no experience, CMS as well as the Office of Inspector General must be actively engaged in monitoring their activities. Specific systems that would help beneficiaries directly and would provide CMS with tools with which to monitor plans are: 1) a beneficiary complaint process that involves a hotline to an independent entity; and 2) a requirement that all plans included in the model report encounter data for all services delivered to members of the plan.

- **All models approved must provide for the delivery of care and services in a culturally competent manner as defined in the HHS National Standards on Culturally and Linguistically Appropriate Services (CLAS)<sup>19</sup> with attention to race, gender, and sexual identity concerns<sup>20</sup> as well.** Dual eligibles disproportionately comprise ethnic and racial minorities many of whom have limited English proficiency and cultural understandings of the role of medicine and health care that differ from those of the majority population. Special programs to address the needs of this population cannot be deemed successful or even worth testing as models if they do not demonstrate capacity to provide culturally competent services.
- **Any state considered for operating a model in which it would manage and oversee Medicare funds must demonstrate that it has been a good steward of Medicaid dollars and must promise to use at least some of any savings generated to expand services.** States that have in any way demonstrated that they do not respect and enforce beneficiaries' rights or that they in other ways do not properly manage Medicaid monies should not be allowed to test a model in which they administer Medicare dollars.

## Conclusion

The waiver authority given to the Secretary under the CMMI provision of the Affordable Care Act is significant, although circumscribed by the purposes of the Center itself. The possibility afforded by this provision of giving all Medicare and Medicaid dollars to states to design programs integrating care under both programs for dual eligibles is unprecedented. We recommend that the Secretary not exercise her authority to develop this particular model unless it is affirmatively demonstrated that the demonstration will enhance health coverage and care for dual eligibles. In any event, we recommend that strong beneficiary protections are included in regulations governing how the Center will select and implement all innovative models.

Respectfully submitted,

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“Most Medicaid Children in Nine States are not receiving All Required Preventive Screening Services,” OEI-05-08-00520 (May 21, 2010), available at <http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf> (site visited Sept. 28, 2010).

<sup>19</sup> The 14 standards can be viewed in the entirety at: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>

<sup>20</sup> See Healthcare Equality Index [http://www.hrc.org/about\\_us/9805.htm](http://www.hrc.org/about_us/9805.htm).

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