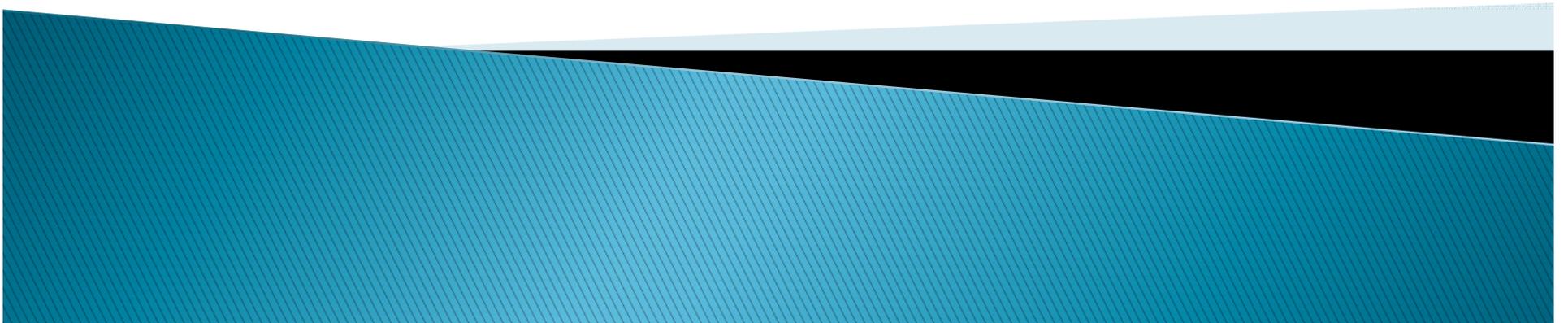


*Dana Gover*

Dual Eligible since 1980



What should Medicaid consider to ensure dual eligible individuals have full access to all Medicare and Medicaid services?



Participants should be offered healthcare options that are as good as the care they would receive if they were not in the integrated model.



***BEST of BOTH WORLDS***



# ***OUR CHOICE....***



## ***“OPT-IN” ENROLLMENT***

*MANAGED CARE  
MODEL*

Based on the  
Principle of Personal Choice

# ***Focus Stays on the Individual and on our Unique Health Care Needs***



# The ***Opt-In Enrollment*** Model

Supports an Important Principle  
of the Medicare Program-

**THE RIGHT TO CHOOSE**



- ▶ The **RIGHT TO DECIDE** who will be part of the healthcare coordination team.
  - ▶ The **RIGHT TO SELF-DIRECT** all aspects of healthcare including **Personal Assistance Services**.
  - ▶ The **RIGHT TO CHOOSE**, which services to receive and where to receive them.
- 

- ▶ **The RIGHT TO RETAIN ACCESS** to providers that are **NOT** an approved managed care provider.
- ▶ Programs and services **MUST ATTRACT** enrollees.
- ▶ Enrollees must be **WILLING INDIVIDUALS** in their healthcare coordination plan.
- ▶ Enrollees can **CHOOSE TO LEAVE THE PROGRAM AT ANYTIME.**



- ▶ Providers must have **Extensive Knowledge on Disability and Aging Culture Prior to service delivery.**
- ▶ Providers must have the capacity to respond to disability related needs for **Reasonable Accommodation and Policy Modification as Required by Federal and State Laws.**
- ▶ Service providers must provide **Public Notice of Enrollees' Right to Request Reasonable Accommodation and/or Policy Modification.**



# *The Managed Care Model*

Must be **Free of Discriminatory Barriers**  
in **All Programs, Services, Policies** and  
**Procedures.**



# ***QUALITY HEALTH CARE***

What should Medicaid consider in the plan development to improve the quality of health care and long-term services for dual eligible individuals?



# **QUALITY**

- ▶ Individuals often have **Long-Standing Relationships** with primary care, specialty and durable medical equipment providers.
- ▶ Many individuals are **Stabilized** on complex treatment or drug regimen. A **Significant Disruption in Care** may have **Life Threatening Consequences**.
- ▶ A managed care model **Must Focus** on **Interventions** that will have the **Biggest Impact** on the **Quality of Life** of **Enrollees**.



# ***Quality Assurance Measures Must be in Place***

- ▶ **A Pilot Program** should be initiated that includes **Readiness Reviews** to ensure that managed care entities are **Ready** to perform their contracted duties.
- ▶ **Network Adequacy, Disability Access, Assessment Tools, Care Coordination Models, and Care Transition Policies** are just a few of the elements that need to be in place and **Functioning Properly Before Implementation.**



# ***Simplification***

How can Medicaid simplify the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs?



- ▶ Make Medicaid coverage for Home and Community Based Services (HCBS) a **Right**.
- ▶ Harmonize eligibility standards for coverage of nursing home care and HCBS.
- ▶ Permanently mandate Medicaid spousal impoverishment protections for spouses of HCBS enrollees.
- ▶ Establish income guidelines to allow enrollees to afford to live and participate in the community.



# ***SHARED SAVINGS***

What are your thoughts on how to eliminate cost-shifting between the Medicare and Medicaid programs and related health care providers?



# ***SHARED SAVINGS***

- ▶ In an environment where **Home and Community Based Services** are being cut, managed care must **Focus on Increasing Access to Services that Support People's Choice to Live in the Community.**
- ▶ If Medicare dollars are blended, we need to make sure that Medicare doesn't just replace Medicaid dollars, but that the **Money Saved is Put Back into the System of Community Based Services and Supports.**



***Community Based Systems  
Currently in Place***

***Should be Built Upon,  
NOT Dismantled.***



- ▶ Payment structures must encourage appropriate utilization of care and reward the provision of preventive care, intensive transition supports, and home and community based services.
- ▶ The rate structure should Encourage the provision of home and community based services. For example, entities should not receive a higher rate for enrollees simply because they have been admitted to nursing homes.



# ***Outreach and Education***

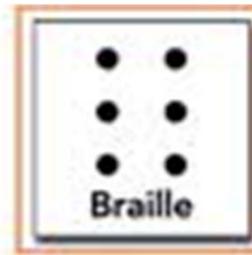
- ▶ What will increase dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs?



Aggressive Outreach and Education Strategies must be implemented to ensure that individuals have the information about the programs and services available.



# ***All Information Must Be Accessible In A Number of Alternative Formats***



# ***LOCAL COMMUNITY ENGAGEMENT***

How should the managed care entity work with local communities to address conflicts, complaints and obtain feedback?



**Coordination Strategies  
and Assessment Tools  
must place the  
Individual at the  
CENTER of the  
OPT-IN Enrollment Model.**



**Monitoring and Evaluation  
Measures must start with the  
Impact on the Individual's Experience and Must  
include Feedback Directly from Individuals.**



**Beneficiaries must be Directly Involved in the Decision Making Process.**

**Suggestions, Complaints and Feedback from Beneficiaries and Service Providers should be the Foundation for Decisions to Improve Services.**



**T**OGETHER  
**E**VERYONE  
**A**CHIEVES  
**M**ORE



**Healthy Lifestyles**

