Stakeholder Survey Results

June 2012

A survey was posted on the Department of Health and Welfare's Medicaid website for integrating care for dual eligibles, www.MedicaidLTCManagedCare.dhw.idaho.gov. Stakeholders were encouraged to submit responses to eight survey questions. The intent of the survey was to obtain input and recommendations for Medicaid staff as they drafted the *Demonstration Proposal to Integrate Care for Dual Eligibles*. There were a total of 14 respondents to the survey. They included two Medicaid participants, four Medicaid providers, one Health Plan Administrator, four advocates, two interested citizens, and one respondent who marked "other." Below is a complete list of all responses to the survey.

What should Medicaid consider to ensure dual eligible individuals have full access to the full array of benefits under the Medicare and Medicaid programs? 11 Responses Total

- 1. The needs of the recipient, their location, availability of services where they live, access to transportation for non-local services
- 2. Easier communication between Medicaid and Medicare. Comprehensive understanding of both entities between each program.
- 3. Universal evaluation for services. Competitive reimbursement for physicians based upon outcomes.
- 4. Do not disallow any providers.
- 5. Voluntary Opt in and opt out. Person centered choice and self-direction, choice to access doctors and services not in managed care plan. Choice to access case management if needed but not required. Choice to access self-directed personal assistance services.
- 6. The low payments to physicians have resulted in physicians no longer seeing people with Medicare/ Medicaid. Regulatory burden is so high as to prevent competent physicians from seeing patients. The low pay/regulatory burden has resulted in untrained nurse practitioners, PA's, and counselors right out of school being the core mental health providers for the most ill population.
- 7. The State of Idaho should drop my son from Medicare and instead use the \$\$ they pay for Medicare premiums to offer a low cost dental insurance to adults like him who have very little dental coverage.
- 8. Ensure Providers are reimbursed adequately. The big fear with managed care is cutting cost to your already drastically underpaid providers like home care agencies.
- 9. Because Medicare covers the skilled care of the clients and that is paid at a higher rate, and because Medicaid is a program that doesn't allow companies to make a profit, it would be to the benefit of the client if the companies could make a profit and not be penalized for making a profit. Companies have to survive and that is what they are in business for and they cannot continue to provide quality care if they cannot afford to offer their employees decent benefits that profits allow they to do.
- 10. It will be tough to see what benefits are available under both plans. This is an excellent plan so that there isn't duplication.
- 11. 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)? We recommend 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 realtime on line service available to allow beneficiaries to know which plans are accepting new enrollees? 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). 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? 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)? 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?

How can Medicaid simplify the processes for dual eligible individuals to access the items and services from the Medicare and Medicaid programs? 10 Responses Total

- 1. Standardize and eliminate a lot of the conflicting eligibility and participation requirements, for instance a Medicare program may not have co-pay and the identical Medicaid program will.
- 2. GOOD case management agencies that have comprehensive information about items and services available from Medicare and Medicaid and understanding of how they work together. These case management agencies should be able to relay this information to participants in a clear, timely manner.
- 3. Have access to trained counselors.
- 4. Simplify eligibility processes. The SOC system is terribly broken.
- 5. Single Payer. We no longer see dual enrollees since we have to bill 2 times. Our Physician stopped seeing Medicaid people all together and opted out of Medicare. DO NOT ALLOW A STATE EMPLOYEE TO EXPLAIN BENEFITS TO PEOPLE. Require online certification to be knowledgeable of all programs available and let private providers do it. Pay them based upon the amount of new services that are medically necessary a recipient receives.
- 6. My son has health insurance through his dad/guardian from the State of Idaho for one more year (my son is 25 years-old) or longer because of his disabilities. He also has health insurance through me, his mom/guardian, and a retiree with the federal government. His coverage through the Federal Employees Health Program will last until he dies (even if I pre-decease him) because of his permanent disabilities acquired prior to age 22. I do not see why our son has to also be signed up for Medicare. He is covered by Medicaid as a last resort. Even when my husband retires and his health benefits expire, he will still be covered by my retired federal employee health insurance. Why can't he stop being covered by Medicare until his father's

- health benefits expire? It would save the State of Idaho \$\$ and it would save many, many hours of unneeded paperwork to process his claims.
- 7. Make a one stop access point for services. Provide each participant with one-on-one counseling for the services they may receive and give them quick access to providers.
- 8. Most clients that are dual eligible have access to companies that provide both services. The services that are covered by Medicaid should be billed accordingly and Medicare charges should be done likewise. When clients have to pick the aide that gives them their baths, they usually want the Medicaid aide to do that for them because they are used to them. However because Medicaid has cut reimbursements certified nurse aides are going to facilities where they can make more money and get longer hours. That causes issues with Personal Care Agencies and Home Health Agencies. When an aide (C.N.A.) works for an agencies that Provides Medicare and Medicaid, they get the benefit of getting paid a higher rate of pay for the short time that Medicare is providing services. They can give the Medicare services of a bath and other A.D.L.'s to the client and then remains in the home and provides the necessary homemaker services that clients need during the rehabilitation period. This is a very nice arrangement that the clients respond to in a positive manner. The problem is getting a C.N.A. that will work for Medicaid and the lower rate that they pay. If they modify the rates like we think they are going to do, it is going to make it more difficult to keep quality care in the homes in the form of C.N.A.'s. Aides also act as the watchdogs for the companies to let them know of any issues that can become problems with Medicare clients.
- 9. This plan is the perfect solution.
- 10. The MCO should be required to handle all requests for covered services and the respective obligations of Medicaid or Medicare programs for service.

What should Medicaid consider in the plan development to improve the quality of health care and long-term services for dual eligible individuals? 9 Total Responses

- 1. Consider a capitated rate and encourage networking. Ask providers to design systems that reward cost savings while insuring access.
- 2. Allow good case management agencies the ability to act as objective advocates for participants and help facilitate appropriate health care referrals and long-term services.
- 3. Ensure that plans save money by reducing duplication and unnecessary utilization of services-rather than simply reducing reimbursement.
- 4. Listen to the Doctors. Look at the pharmacy costs, tests ordered and hospitalization rates by NP, PA's. Make the system viable such that recipients who have chronic problems can see the correct provider type. Pay a psychiatrist more to see a patient than a NP, GP or ER doctor. Right now the system steers the mentally ill to the least trained, least competent providers.
- 5. Offer dental benefits.
- 6. Again, you must pay your providers much better. If you can spend less money on state employees and more on providers...good but if all you get is a swap of the same amount of money being spent and an insurance company trying to get their money then we have a problem that will lead to poorer services for dual eligibles.
- 7. Adjust the rules for making profit under the Medicaid rules. Keep the rates at a level that quality care is not an issue. When you can keep the clients at home it is cheaper and more cost effective.
- 8. Providers are not happy with Medicaid reimbursement. The reimbursement should be based on the higher of Medicare or Medicaid. Providers should have an incentive (other than money) to participate with the health plans. Maybe providers that don't participate will only be reimbursed the lower of Medicaid or Medicare from the plans?????
- 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 (Level of Care (LOC) determination, care planning, and service approval, all of the above)? Who does the LOC assessment, care planning, service provision? Are beneficiaries involved in that process? 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? 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 dis-incentivize 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? Does the proposal describe how beneficiaries will be involved in implementation? 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 proportions 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?

How can Medicaid work with providers to improve their quality of performance of services and supplies under the Medicare and Medicaid programs? 10 Total Responses

- 1. Eliminate multiple contracts, certification requirements; allow mixed use facilities such as swing beds between SNF and RALF.
- 2. Allow case management agencies to act as go-betweens, to alleviate unnecessary stress and time that providers have to spend on Medicaid paperwork.
- 3. Measure outcomes such as re-hospitalization

- 4. Look at individuals unique needs when it comes to preventative and long- term services. Look at ways to encourage healthy life styles and put programs in place to help people access and pay for these services. Improve your community based services and supports to enable people to stay in their homes. Increase the living allowance for people who are on the A&D waiver do they can afford to live in their own homes.
- 5. Get rid of the regulatory burden. Out of every dollar paid, over 25% goes towards compliance with Idaho Health and Welfare with absolutely no benefit to the patient. Increase the standards necessary for the provider type allowing access to PSR, case management etc. Right now someone who has a master's degree (LMSW) right out of school can sign up a patient for PSR costing the state 1000/month.
- 6. Make sure that some services are not being charged to Medicaid that could be done by other services. For example Medicaid will not allow caregivers to trim my son's toenails. So he has to go to a podiatrist to get his nails trimmed if not guardians are available. The podiatrist charges \$70 for an appointment to get his nail trimmed!
- 7. Be realistic. Medicaid cannot expect providers to make an 80 year old man with home care services get better, stop smoking or eat right for his diabetes. Medicaid and managed care can expect providers to treat people with respect but that's about it. Your savings will come from stopping people form going into nursing homes.
- 8. When a client is duel eligible and they are under the Medicare guidelines they are surveyed by Medicare for any problems. Medicare procedures have been in place and are effective so if would seem more effective to use that system that is already in place. When a Medicaid agency does not have a Medicare license they should align themselves with an agency that will work with them to provide the quality level of care that they have been providing their clients.
- 9. Incentives!!!! Look for health plans that have provider incentive programs that work.
- 10. Intensively utilize consumer satisfaction methods. Monitor complaints, grievances and appeals. Require the MCO to track objective data indicators of quality of care (ER visits, pressure sores, behavioral problems)

What will increase dual eligible individuals' understanding of, and satisfaction with, coverage under the Medicare and Medicaid programs? 10 Total Responses

- 1 Seamless system that takes care of their needs without them having to navigate multiple programs.
- 2 Allowing good case managers with comprehensive understanding of Medicare/Medicaid coverage to be able to parse this information to participants in a simple, concise manner, with the understanding that each client has their own cognitive abilities in which to process information.
- 3 Effective case management
- 4 EDUCATION EDUCATION!! If you have a good program THAT REALLY HELPS PEOPLE and MEETS THEIR NEEDS. The public has a stigma against government programs. IMPROVE your public image and public relations. Your customer service is a joke. Many of the staff are like little Nazi's they don't believe in the Medicaid programs and make sure you feel like you are the lowest to even be on the program. Not all staffs are like this you do have some great staff but they usually quit!
- 5 A Private Provider incentivized to meet with that person every month. Case management is the key. Health and Welfare is currently demonstrating how to restrict children with disabilities from access to care by removing CSC from developmentally disabled kids and taking it on themselves. LOOK AT CHILDRENS REDESIGN AND GO THE OPPOSITE DIRECTION.
- 6 Provide training to guardians providers on what health care (medical) services are offered by Medicaid and Medicare and what the differences between those coverages include.

- 7 Pay your providers decent money so that they are motivated to provide good service. The nickel and dime stuff makes for unhappy providers and participants.
- 8 Clients need to understand that they Medicaid company that they are working with can be supplemented with a Medicare company. They don't have to completely change agencies to get the dual coverage. Medicare and Medicaid can work together and that should be a requirement for Medicare agencies that they work hand in hand with Medicaid agencies.
- 9 Look for health plans that educate members and enroll one by one.
- 10 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? 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"?

What methods or systems can be implemented to improve care continuity and ensure safe and effective care transitions for dual eligible individuals? 11 Total Responses

- 1. Provide incentives for innovation, cooperation and networking, sensible pricing matrix that is not related to which payer source you have. Medicare and Medicaid integration.
- 2. Better information and communication between Medicaid and Medicare. One State hub that handles dual eligibles in which each worker has the same, consistent information to provide to participants and their case managers.
- 3. Effective case management and align incentives
- 4. First look at what is not working, ask people in the field who actually work with people. Then change your system. This is an evolving process. Each person is different and may need a different approach to help with their medical needs. That is what I mean by person centered care. The person and their health care needs will direct the process. Not a system of rules. For example, the system you have in place is for hospital transition doesn't have any procedures in place to prevent institutionalization. Make the system easier for people to access increased personal care hours. Right now the process for Change in Condition takes too long in case of an emergency.
- 5. Private Case Managers that have a certification.
- 6. The State of Idaho needs to stop dropping the amount that they reimburse doctors and other health care professionals and facilities for services provide to patients covered under the Medicaid and Medicare programs. It is very difficult to find health care providers who accept new patients covered by Medicaid and/or Medicare.
- 7. Good management of services whereby all provider types have staff who are compensated for working together.
- 8. Better Medicaid office to advocates
- 9. When agencies work together it can work very effectively. There needs to be a partnership with companies that are not Medicare certified. I do not mean that a Medicaid agency work "only" with one agency, I mean that the companies work with each other with mutual respect.
- 10. Standard reports from plans, incentive plans.
- 11. Beneficiaries must 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)? We recommend 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? Require the managed care entity to take steps in order to contract with the providers during the transition period. Relationships could be encouraged or required after the transition period (such as non-participating provider payments).

What are your thoughts on how to eliminate cost-shifting between the Medicare and Medicaid program and among related health care providers? 8 Total Responses

- 1 Allow recipients to access all benefits in RALFs as well as nursing homes. There are more duals in RALFs and CFH than in the rest of HCBS home care.
- 2 Allow intelligent, capable case managers the ability to assist the State with ensuring that participants are utilizing programs in a cost-effective, non-duplicative manner.
- 3 Plans will have to manage each case to reduce cost-shifting
- 4 Single payor.
- 5 Medicare should pay first and Medicaid second. Dual eligibles should have services paid for by need and provider type with the provider types segmented between whether they do Medicare or Medicaid.
- The rule that you can only change agencies at the beginning of each month is a good idea. It eliminates hasty changes and it makes the clients and the agencies aware of situations that need to be changed. Eliminating cost shifting is a question that I would like to ask? I have heard rumors and I would like to know if you are planning on lowering the rates for the skilled services on the dual eligible clients?
- 7 This plan is perfect!
- 8

How should the managed care entity work with local communities to address conflicts, complaints, and obtain feedback? 9 Total Responses

- 1 They need to actually visit the communities and see what services are actually available and work to find ways to keep people in their communities, also they need to contract with all providers, not just a select few which forces people to move or travel a lot and restricts choice.
- 2 Allow case managers to act as advocates on behalf of participants, and educate participants on their rights and methods of addressing conflicts and complaints. Often, participants are unhappy due to misinformation. Case managers can often ameliorate participant unhappiness before it reaches a level that needs to be taken further; e.g., to the State.
- The state should develop a customer service unit to address conflicts, complaints and obtain feedback INDEPENDENT from the plans
- WORK TOGETHER!! I have been at many stakeholder meetings for Medicaid basically we are told what you are going to do and our ideas are not listened to! Many of us feel we waste our tome but this is the only avenue to learn about new events. Administrators have to have people in leadership positions that have the ability to listen effectively, mediate, and really want to do system change to address complaints and conflicts. Also Medicaid needs leadership in discussing issues with the legislature. Stand up for the people who you serve explain what your programs can really do to improve the lives of people who have COMPLEX health care needs.
- 5 The Department is so unresponsive to feedback it wastes Providers time to fill out forms or call giving feedback is a waste of time. Even when outright fraud is reported, it is ignored.
- 6 There needs to be an ombudsman program in each area of the state to address problems with

- managed care on behalf of participants and providers who have problems with managed care insurance companies.
- 7 The companies should be available for comments and complaints from the community. Medicare and Medicaid clients can notify the companies of situations and if not satisfied they can complain to the Medicare & Medicaid offices. There are other ways of getting more community activity but those are comments for later negotiating.
- 8 Complaints should be monitored by the state.
- 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. Medicaid systems.) The proposal must incorporate the 42 CFR part 431.200 regulatory requirements for fair hearing. Advance notice and notice are foundational due process principles in Medicaid. The proposal must affirm that Medicaid advance notice and notice requirements will apply. Specify that the notice must include effective date of the action, explicit reasons, and citations to specific regulations, and information about how to initiate an appeal and expedited appeal, as per Medicaid requirements. Ensure that notices are made accessible to people with Limited English Proficiency and to people with disabilities. Specify that beneficiaries must be provided notice and access to continued benefits while an administrative appeal is adjudicated. 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)? Specify that Medicare amount in controversy requirements cannot apply to anyone who has Medicaid (including an individual who is dually eligible). 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. Specify that managed care entities cannot use the administrative appeals process to challenge decisions favorable to the beneficiary. Specify that beneficiaries will have the full applicable Medicaid appeals time frames. State that the minimum timeframe for an appeals decision is 90 days from the request for a hearing as in Medicaid? 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.