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The Voice for Health Care Consumers

Testimony of
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On behalf of Families USA, I thank Chairman Smith, Ranking Member Kohl, and members of the Senate Special Committee on Aging for the opportunity to present testimony to this round- table discussion on Medicaid managed care. This Committee plays a critical role in exploring ways the federal government can improve health care services for our low-income seniors. The expansion of managed care within the Medicaid program creates some important opportunities for improved care—but managed care must be implemented with care and caution to ensure that the most vulnerable populations of all ages are protected.

Our testimony focuses on 1) the potential of managed care to produce better health outcomes for Medicaid recipients and better coordination between Medicaid and Medicare, and 2) the important consumer protections that are needed to ensure the care of the most vulnerable Medicaid populations.

Our role here today is on behalf of health care consumers, including the more than 50 million Americans who rely on Medicaid for their health care. Medicaid plays a critical role in our nation's fragile health care system, and Families USA is committed to strengthening and preserving the program on behalf of everyone who relies on it. We understand, however, the need to look for efficiencies, where possible, and to maintain the integrity of the program. We applaud the Special Committee on Aging for continuing this dialogue.

Unfortunately, Medicaid—in particular, its financing—has been under attack in recent years. There have been proposals to convert the program from an entitlement to a block grant and efforts to reduce benefits and eligibility in the name of saving money. Sadly, too few conversations have been focused on how to serve the needs of the beneficiaries and how to provide streamlined and effective care.

Managed care is not a magic bullet for Medicaid; nor is it a panacea for health care in general. However, when implemented carefully and effectively, managed care may provide better care and may be one possible tool for achieving better coordination of care. In the process, it may create efficiencies that have a positive fiscal impact.

I am heartened that this conversation is focused on good policy changes that protect beneficiaries and

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provide for supports and systems that will improve the care of the most vulnerable Americans—and not on cutting services or eligibility. In the long run, more preventive care, early intervention, and appropriate levels of care may yield long-term savings.

Today's discussion focuses on the expansion of the role of managed care in Medicaid to new populations: to people eligible for both Medicaid and Medicare (the so-called "dual-eligibles") and Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) recipients. When dealing with such vulnerable populations, thoughtful deliberation is essential. At least 11.7 million people receive Medicaid services based on their age or disability—maybe more as some children who receive Medicaid are recipients but would not be included in this count. Of these, 7.5 million are dual-eligibles; the remainder are not duals and may only receive SSI or SSDI.

The dual-eligibles and other disabled recipients make up almost 23 percent of the total Medicaid population, but account for about 67 percent of total Medicaid expenditures. Clearly, this is a population that has very complex health needs and for whom the entire panoply of health and long-term care supports and services is needed. Good managed care for these beneficiaries could result in quality care and better health outcomes.

There are several important considerations that should be taken into account when expanding Medicaid managed care to new populations, in particular the consumer protections that are necessary. Dual eligibles and SSI/SSDI recipients often have multiple or complex conditions and needs that may require dedicated specialty care. Since only about 35 percent of dual eligibles are already in some form of managed care, an expansion could transfer an additional 4.9 million dual-eligibles into managed care. However, depending on how this expansion is implemented and the type of changes made to the system, it is very possible that all 11.7 million dual-eligibles and beneficiaries receiving SSI would experience some type of disruption or change to their care.

I urge the Committee to focus on who the individuals are who fall into this population: the sickest and frailest seniors; children with complex health needs; and people who require carefully coordinated care to maintain their health. I urge you to consider these changes in light of the larger Medicaid debate and to work towards preserving and strengthening the Medicaid system as a whole.

Background On Medicaid Managed Care

Currently, states can mandate enrollment of some populations directly into Medicaid managed care, but states cannot mandate the enrollment of people eligible for both Medicaid and Medicare (dual eligibles), children receiving Supplemental Security Income (SSI) benefits, some other children with special health care needs, or American Indians except in specified circumstances. These populations may remain in traditional fee-for-service Medicaid or voluntarily enroll in managed care.

Nationally, in 2003 (the last year for which data are available), about 35 percent of dual eligibles were in some form of Medicaid managed care. In many of these cases, however, the plan was only responsible for primary and acute care; the state still paid for long-term care on a fee-for-service basis.

Only a handful of states have experimented with managed long-term care. In fact, there is very little experience in the private market with managed long-term care on which to build. So far, studies have *not* shown great savings to states from these arrangements. It is not clear whether managed care for physical and acute services for dual eligibles and other vulnerable populations will result in major savings for Medicaid, particularly now that drug costs are paid through Part D. Plans have very little room, if any, to achieve savings by cutting provider reimbursements. Already, in many states, Medicaid reimbursement

rates are less than Medicare allowable charges. A number of state Medicaid programs do not pay 20 percent copayments to providers because of this rate difference, and advocates across the nation report that this impedes access to providers.

States should look at the potential of managed care to better coordinate physical and long-term care services, encourage home and community-based services instead of institutional care, and integrate Medicare and Medicaid funding to achieve better care. In time, this may result in long-term savings to the program. For example, savings could come be realized—and better care provided for the dual eligible population—but only if managed care plans actively provide care coordination services and states and the federal government integrate Medicare and Medicaid administrative and regulatory systems. The potential to expand managed long-term care only exists in states with relatively high managed care penetration and willing, comprehensive provider networks. Rural states and those states with low managed care penetration will present particular challenges requiring careful attention.

Needed Consumer Protections

The special needs of the vulnerable populations who rely on Medicaid and Medicare make it extremely important to ensure adequate protections are in place in order to guarantee comprehensive appropriate care. The Balanced Budget Act of 1997 (BBA) contains a number of consumer protections related to Medicaid managed care. All of these protections continue to be vital to ensure the protection of beneficiaries in Medicaid managed care and must remain in effect if Medicaid managed care is expanded. Among the consumer protections that currently exist under the BBA:

- Enrollees must have a choice of plans; and they must have the right to change enrollment within the first 90 days and once every 12 months thereafter;
- Default enrollments must take into account existing provider relationships;
- Information must be provided to enrollees and prospective enrollees about rights, benefits, cost-sharing, grievances, quality, and what benefits are provided outside of managed care;
- Emergency services must be provided without prior authorization using the prudent-layperson definition and plans must reimburse out-of-network emergency providers as well as in-network emergency providers;

Due to the unique needs of the dual-eligible and SSI recipients, there are additional protections that must be written into federal law if more populations are to be moved into a managed care system.

- **Ombudsman:** There is a need for neutral counseling about Medicaid managed care and how it can coordinate with the various Medicare plan options, as well as counseling to help beneficiaries navigate the programs. Dual-eligibles and SSI recipients should have access to an ombudsman outside of the managed care plan who can help them navigate care and assert their rights; this ombudsman should be familiar with both Medicaid and Medicare enrollment, certification and administration requirements. CMS has required this in a number of states with waivers to enroll Medicaid beneficiaries in managed care, and it has proved important. In Texas, for example, people on SSI and dual-eligibles make up the highest proportion of callers to a nonprofit that contracts with the state to provide ombudsman services. Minnesota, one of the states experimenting with integrated care for dual-eligibles, uses an ombudsman; administrators and advocates alike believe that its function is extremely important.

- **Care Coordination:** Plans should assign care coordinators within the plan to each beneficiary to help coordinate care received by multiple providers and to help find the appropriate people to contact for care within the plan. Care coordination is probably the most

important service a managed care plan can offer to improve services to the dual-eligible population and to ensure duals a full continuum of care. It is essential that plans have realistic staffing standards for care coordination. Some states only assign duals to care coordinators once problems emerge; or they assign 3,500 cases to one "exceptional needs care coordinator" —an untenable caseload. Possible solutions are to set standards about the number of cases per worker or how often care coordinators must be in touch with members (e.g., a Texas plan requires that, for people with chronic conditions not under control, care coordinators visit weekly or monthly and that, for people with chronic conditions that are under control, care coordinators phone monthly.)

- **States should meet "readiness" standards before expanding Medicaid managed care to new populations:** For example, they should have quality standards in place appropriate to populations with disabilities; be able to show that there are enough interested HMOs that have the capacity and equipment to serve special needs populations—including adequate primary care and specialty care networks, physically appropriate facilities, and equipment, etc; show that they will not disrupt existing care arrangements; and show that they are able to pay a capitation rate that encourages care.

- **Meaningful consumer input:** The government should accept and review consumer input on draft requests for proposals for managed care plans serving duals and special needs populations and should encourage plans to develop consumer advisory committees. States should show that they have provided a public input process for their overall plans to expand Medicaid managed care to duals and special needs populations.

- **Require that services be considered "medically necessary" if they maintain, improve, or prevent the deterioration of functioning:** Plans and providers need to define "medical necessity" as appropriate to the needs of people with disabilities in order to authorize home and community-based care that preserves or helps people attain maximum functioning, not just restorative services. For example, many elderly people and consumers with disabilities use personal care services to help them with activities of daily living or use physical therapy to keep their ambulatory skills from further deterioration. Plans should continue to authorize these services (absent a change in the person's condition) as long as the services continue to assist the person to maintain functioning, rather than requiring the person to show physical improvement.

- **Establish a coordinated appeal system for Medicare and for Medicaid services that affords the right to continued benefits pending a hearing decision:** Currently, the Medicaid hearing process affords more rights to beneficiaries than does the Medicare hearing process. The right to continued benefits is essential to low-income people who have no means to pay for care up front pending the outcome of an appeal. Further, beneficiaries need one coordinated system through which to pursue appeal rights—they should not be expected to sort out which insurer should handle an appeal.

- **Make sure that the beneficiary does not get caught in payment disputes between Medicaid and Medicare:** The state or plan should bill Medicare as appropriate and handle any disputes about payment, rather than leaving the beneficiary without a service such as home health that the plan or state thinks should be reimbursed by Medicare.

- **Prohibit "passive enrollment" into Special Needs Plans:** As Medicare Part D was implemented last fall, Medicaid managed care enrollees in some states such as Pennsylvania were "passively enrolled" into Special Needs Plans under which all of their Medicare services were furnished through managed care. Previously, many of these consumers had used Medicaid managed care plans for their non-Medicare covered services but had used either traditional Medicare or other Medicare Advantage plans to pay for doctor visits. Many duals found that the doctors they had always used were not in the new plans' networks, and the passive enrollments thus resulted in great disruptions in care and were the subject of a lawsuit, *Erb v. McClellan*.

- **Require specific quality measures for the dual and special needs populations.** Regularly examine a plan's performance and conduct audits to make sure that rate structures and provider payments are appropriate. The Center for Health Care Strategies has developed good recommendations for performance measures for the dual population, including measures of their functional status, access to care coordination, preparation for care transitions (that is, were they adequately prepared to move from a hospital to another care setting and did the next facility receive appropriate information about their care needs), and access to behavioral health services.

- **Exceptions for the spend-down population:** People spending down to Medicaid, who may go on and off of Medicaid rolls periodically, should not be required to enroll in plans that will only serve them while they have Medicaid.

- **Out-of-network care:** Under current rules, plans are required to reimburse out-of-network emergency providers under some circumstances. Using similar concepts, plans that provide long-term care should be required to reimburse out-of-network long-term care facilities under some circumstances. For example, plans should be required to pay out-of-network nursing homes that members must use to be close to family, or that continue care that people received before spending-down to Medicaid, or that offer specialized services not available within the network.

Thank you for the opportunity to testify before you today. The expansion of managed care within Medicaid may be an important component to improving health services for the most vulnerable seniors, but only if implemented properly. We urge the committee to ensure current consumer protections remain in place and to further expand protections if managed care expands to cover dual eligible seniors. Families USA looks forward to continuing to work with the Special Committee on Aging to explore ways to improve and strengthen the Medicaid program and to improve health care for America's low-income seniors