

Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles

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Foreword

This paper about differences in Medicare and Medicaid program rules and coverage standards is the second in a series of four papers that highlight pressing issues facing dual eligibles and provide recommendations to the Medicare-Medicaid Coordination Office (MMCO), state Medicaid agencies and other interested policymakers and stakeholders on how to address them. The first paper addressed consumer protections needed in delivery system models that integrate Medicare and Medicaid.¹ Future papers

¹ Available at www.nsclc.org.

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will focus on ideas for integrating the appeals systems of the two programs, and opportunities for improving the delivery of the Qualified Medicare Beneficiary (QMB) benefit.

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Executive Summary

Dual eligibles, individuals who qualify for both Medicare and Medicaid benefits, rely almost entirely on government programs to meet their health needs. By definition they have low incomes and demographic data show that they also are disproportionately vulnerable compared to other Medicare beneficiaries, suffering from multiple chronic conditions, cognitive impairments, low literacy and housing isolation. Their needs are great and their resources are few.

The benefit packages of the Medicare and Medicaid programs are meant to complement each other and provide full wraparound coverage for this vulnerable population. Yet beneficiaries, advocates, providers, and the varying state and federal agencies administering the two programs have long recognized that there are areas of friction, gaps and misalignment between the two programs. This paper examines four areas—

durable medical equipment (DME), prescription drugs, skilled nursing services, and language access—where the programs bump up against each other or gaps occur. The paper reviews each area from the beneficiary’s point of view. It considers partial solutions already in place and proposes further improvements.

Although there are many places where the Medicaid and Medicare programs do not line up well, sometimes the practical impact on dual eligibles is insignificant. In these four areas, however, advocates report that dual eligibles often encounter serious obstacles to needed care. These also are areas where practical solutions are available that would bring relief to dual eligibles within current systems.

With DME, Medicare and Medicaid coverage overlap with some equipment covered by both programs and other equipment only covered by Medicaid. This overlap leads to a tangled web of authorization requirements that get in the way of obtaining needed equipment.

Dual eligibles receive prescription drug coverage through the Medicare Part D benefit, but new dual eligibles have difficulties navigating transitions from Medicaid coverage to Medicare coverage. Dual eligibles also experience gaps because of the structure of the Medicare drug program and because of its inherent complexity.

Dual eligibles transitioning from hospital to skilled nursing and/or to the community use Medicare and Medicaid benefits sequentially, with Medicaid taking over after Medicare benefits are exhausted. Although the change in payment source should not affect the amount or quality of care delivered, the transitions in fact often result in a precipitous drop in care, especially rehabilitative services.

Dual eligibles who have limited English proficiency need language assistance every time they have an interaction with the Medicare or Medicaid program and whenever they use covered services. Neither program sufficiently addresses those needs and the inconsistencies between programs create confusion for the beneficiary.

This paper finds that many of these challenges, which are among the most persistent and vexing for dual eligibles, arise from procedures and policies that could be adjusted without fundamental system overhaul. These include:

- **Authorization procedures.** For DME, federal and states agencies should revise authorization procedures so that the multiple agencies work out their respective payment obligations without putting dual eligibles in the middle of the negotiation.
- **Data exchange.** State Medicaid agencies can prevent gaps in Medicare prescription drug coverage for new dual eligibles by transferring data to the Centers for Medicare and Medicaid Services (CMS) more frequently. CMS also can collect language preference data for dual eligibles and use data from Medicaid agencies and the Social Security Administration to help ensure that dual eligibles receive information about their benefits in a language that they can understand.
- **Transition policies.** When individuals who have been receiving all their health care through Medicaid also become eligible for Medicare, there needs to be adequate transition policies and procedures in place so they can adjust to coverage changes while they learn to navigate both systems, particularly when using DME and prescription drug coverage.
- **Enforcement.** Problems that dual eligibles face in getting needed language services in both programs and in getting appropriate rehabilitation services in skilled nursing facilities arise, in part, because state and federal agencies have not aggressively enforced existing statutory and regulatory requirements.

- **Gaps.** Readjustment and reassessment of payment methodologies are needed by both Medicare and Medicaid for language services and by Medicaid for skilled nursing services. Unless provider payments are targeted to and appropriate for needed services, access problems will persist.

While broader initiatives could enhance both programs, cooperative efforts between CMS and state Medicaid agencies to implement these relatively simple fixes would go a long way to lifting the barriers that dual eligibles face when trying to access needed health care services.

Introduction

Medicare and Medicaid, both established in 1965, are two very different programs. Medicare, with neither asset nor income requirements to qualify, provides health insurance benefits with cost-sharing through premiums, deductibles and copayments. Medicare’s cost-sharing reflects an assumption that beneficiaries have the financial resources to supplement benefit coverage. The bulk of Medicare coverage and spending is for physician and hospital services, and prescription drug coverage, as well as skilled services at home or in an institution, usually following acute events.

Medicaid, in contrast, serves people with very low income and resources and covers more comprehensive services, including long-term supports and services and some transportation, without premiums and with only minimal cost-sharing obligations for beneficiaries

The statutory mandates of the two programs drive these program differences. The Medicare definition of medical necessity requires that a service be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”² The Medicaid appropriation

² 42 U.S.C. § 1395y(a).

statute sets out a much broader purpose for that program: helping individuals to “attain or retain capability for independence or self-care.”³

For people who are eligible for both Medicare and Medicaid benefits, known as dual eligibles, Medicare and Medicaid coverage are largely complementary. Medicare is the primary payer for doctors, hospitals, post-hospitalization skilled nursing, home health care and prescription drug costs. With Medicaid coverage, dual eligibles get additional services where Medicare leaves off, including long-term services and supports, and also get significant help with Medicare premiums and co-payments.

There are, however, areas where Medicare and Medicaid do not mesh well. In some cases, both programs cover the same service, but they have differing coverage standards that can make navigating the two systems difficult (e.g., an individual needs a wheelchair but the specific characteristics and uses of the wheelchair could determine whether it is covered by Medicare or Medicaid). In other cases, the problem for beneficiaries is more about frictions when transitioning from coverage by one program to the other (e.g., a dual eligible transitioning from Medicaid to Medicare drug coverage finds that her prescription will not be honored at the pharmacy). In other cases, beneficiaries find gaps in coverage and cannot get the care and supports they need, even when fully utilizing both programs (e.g., a Chinese speaking dual eligible cannot get interpreter service when visiting a specialist who accepts payment from both Medicare and Medicaid).

The Medicare-Medicaid Coordination Office (MMCO) recently launched an Alignment Initiative “to identify and address conflicting

requirements between Medicaid and Medicare that potentially create barriers to high quality, seamless and cost-effective care for dual eligible beneficiaries.”⁴ MMCO, newly established under the Patient Protection and Affordable Care Act (ACA),⁵ is tasked with leading activities within the agency to better align Medicare and Medicaid benefits and to improve coordination between the Federal government and the states in order to ensure that dual eligibles get full access to items and services they are entitled to under each program.⁶ The Alignment Initiative is central to that effort.

As part of the Alignment Initiative, MMCO identified 29 “alignment opportunities” in six broad categories: coordinated care, fee-for-service benefits, prescription drugs, cost sharing, enrollment and appeals.⁷ Through a Request for Information, public listening sessions and participation in many forums, MMCO has engaged stakeholders in a discussion about how the agency could simplify processes for dual eligibles, whether there are additional issues to address, and what actions the agency could take to ensure care continuity and eliminate cost shifting between programs and among health care providers.

This paper seeks to contribute to that discussion by focusing on how Medicare and Medicaid work together—or don’t work together—for dual eligibles who receive their benefits primarily through fee-for-service Medicare and Medicaid, including those who receive their Medicare drug benefit through Part D prescription drug plans. The paper looks at four areas where dual eligibles, particularly those receiving services in the fee-for-service system, have difficulties navigating the two programs:

³ 42 U.S.C. § 1396.

⁴ 76 Fed. Reg. 28196, 28197 (May 16, 2011).

⁵ Patient Protection and Affordable Care Act, Pub. L. No. 111-148 & 111-152: Consolidated Print (ACA).

⁶ 42 U.S.C. § 1315b. The statute refers to the Office as the “Federal Coordinated Health Care Office.” In May 2011, CMS announced that the Office would be referred to as the Medicare-Medicaid Coordination Office.

⁷ 76 Fed. Reg. at 28198.

durable medical equipment (DME); prescription drug coverage; skilled nursing and rehabilitation; and language access. These areas were chosen because reports by advocates over many years, as well as recent interviews with advocates and providers who serve dual eligibles, point to them as flashpoints where dual eligibles face frequent and persistent problems that affect their access to care. They also are areas that do not require massive systems change in order to significantly improve beneficiary experience. Changes in procedures and modifications in regulations or subregulatory guidance could, without statutory change or extensive program redesign, make real differences in how services are delivered to dual eligibles.⁸

In these four areas, this paper explores both where the Medicare and Medicaid programs bump up against each other in ways that impede access for beneficiaries and where, in contrast, the problems are gaps in services. It examines the direct impact on beneficiaries and proposes concrete steps that federal and state agencies can take to improve the beneficiary experience.

Durable Medical Equipment

How the Programs Operate

DME provides an example of a service where there is overlapping coverage by both Medicare and Medicaid, but where differences in standards, processes and reimbursement rates for the service can create access barriers.⁹

DME includes such items as wheelchairs, walkers, oxygen tanks, and associated supplies. In Medicare, some DME can be provided as part of the home health benefit or independently under Part B.¹⁰ DME is a state plan benefit under Medicaid.¹¹

Medicare limits coverage for DME to items appropriate for use in the home.¹² This “use in the home” limitation does not apply to Medicaid, which also covers DME that helps an individual function in the community.¹³ Thus, for example, Medicare will only cover wheelchairs needed for a person to navigate within the house while

⁸ On two issues important to dual eligibles that are not discussed in this paper, CMS has already started taking the kind of practical steps proposed in this paper. A persistent problem in the area of home health services has been the incorrect imposition of the Medicare “homebound” requirement by some states for recipients of Medicaid home health services. CMS recently published proposed rules that would clarify that states are prohibited from imposing such a requirement. 76 Fed. Reg. 41032, 41033 (July 12, 2011). For nursing home residents, misaligned incentives have contributed to unnecessary hospital admissions of nursing home patients. CMS recently launched a demonstration project to address that problem through targeted interventions. See CMS Fact Sheet (July 8, 2011), available at www.cms.gov/apps/media/press/factsheet.asp?Counter=4022&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date.

⁹ Although “DME” is the commonly used acronym, many regulatory documents also refer to DMEPOS (durable medical equipment, prosthetic, orthotic and supply items).

¹⁰ 42 C.F.R. §§ 409.45(e) and 410.38.

¹¹ DME is covered as part of the Medicaid home health benefit, 42 C.F.R. § 440.70(b)(3), and may also be covered under other Medicaid benefits such as rehabilitative services. 42 C.F.R. § 440.130(d).

¹² 42 C.F.R. § 410.38(a).

¹³ 42 U.S.C. § 1395m(j)(2)(B); CMS, Medicare Benefit Policy Manual, Ch. 15, § 110 (2010), available at www.cms.gov/manuals/Downloads/bp102c15.pdf (Medicare standard); 42 U.S.C. § 1396-1 (Medicaid standard).

Medicaid covers heavy duty wheelchairs that could be used both at home and out-of-doors.

Medicare also can have quantity limits on supplies such as adult incontinence products that typically are more restrictive than those found in Medicaid programs. Further, unlike Medicare, state Medicaid programs must provide all medically necessary and non-experimental DME and may not categorically exclude types of items without individually assessing whether a requested item has a medical purpose.¹⁴

In all cases, Medicaid is the payer of last resort.¹⁵ Medicaid programs are required to “cost avoid” claims that may be payable by a third party, such as private insurance or Medicare.¹⁶ For services that may be covered by either Medicare or Medicaid, state Medicaid agencies generally require that a bill be submitted first to Medicare, and only after Medicare has rejected the claim or paid its share will Medicaid process a payment. Medicare, however, will only authorize payments *after* a good or service has been delivered to the beneficiary. State Medicaid programs use prior authorization procedures but in many cases will not make such an authorization before receiving notice of Medicare’s actions.

The process may be further complicated depending on the payment rates for the two programs and how a state processes Medicaid payments. There may be instances where Medicare will pay an amount for a wheelchair, for example, and Medicaid will pay the Medicare cost-sharing portion (usually 20% of the cost), but Medicaid may also pay an additional amount

above the Medicare rate, because its own rate for the object is higher than Medicare’s. In some states, the supplier might have to make an additional claim to Medicaid if the supplier wants the additional payment.

Impact on Dual Eligibles

- *Procedural obstacles when navigating different coverage standards cause denials and delays for dual eligibles needing DME.* Because dual eligibles qualify for coverage under either program’s standards, the differences themselves are not a barrier to getting needed DME. Instead, it is the procedural maze that must be navigated which often blocks timely access. Medicare will provide prior authorization of coverage of DME only in rare instances and, for dual eligibles, Medicaid will not generally do so without a Medicare determination. Because suppliers are unwilling to provide DME without knowing whether either agency will make payment, beneficiaries must either incur liability for the DME—liability that a dual eligible cannot afford due to their limited income and the high cost of many types of DME (wheelchairs, for example)—or go without. Dual eligibles can be caught in a netherworld between the two agencies. Individualized advocacy and manual system overrides can break the logjam on a case-by-case basis but many beneficiaries lose access altogether or face delays in access to necessary goods and services.

¹⁴ See CMS, State Medicaid Director Letter (SMDL) (Sept. 4, 1998) (“Desario letter”), available at www.cms.gov/smdl/downloads/smd090498.pdf.

¹⁵ 42 U.S.C. § 1396a(a)(25); 42 C.F.R. § 433.139.

¹⁶ CMS, SMDL #03-004 (Apr. 8, 2003), available at www.cms.gov/smdl/downloads/smd040803.pdf.

- *DME suppliers become gatekeepers.* Advocates report instances where suppliers have recommended particular equipment, not because it best suits the needs of the beneficiary, but to maximize payment rates and ease their administrative burden. The approval criteria of the two programs are complex and difficult to access and, as reported by many advocates and prescribers, often only understood by the equipment suppliers. Physicians and other prescribers, frustrated and confused by complex and differing standards, cede decision making to suppliers who, though knowledgeable, are not disinterested advisors.¹⁷
- *Dual eligibles who had Medicaid coverage before qualifying for Medicare experience disruptions in care because of these overlaps and conflicts.* In keeping with Medicaid’s statutory authority to promote independence and self-care, Medicaid coverage standards for DME are generally less restrictive than standards for Medicare coverage. As a result, individuals who had been Medicaid-eligible first and had established networks of suppliers and routine patterns of purchase often find that, when they become eligible for Medicare as well, they suddenly must have DME requirements processed through Medicare first. They encounter rejections or delays in getting DME that before had been routinely authorized. Serious care disruptions can result.

Partial Solutions

Some measures are currently in place that partially address these problems. The Medicare program has a voluntary prior approval procedure that is limited to certain high cost customized items, primarily wheelchairs and other mobility devices.¹⁸ An individual or a supplier submits a request for an Advance Determination of Medicare Coverage (ADMC) to the Medicare Administrative Contractor (MAC) for the region where the individual resides.¹⁹ The request must include support for the medical necessity of the item.²⁰ The MAC has 30 calendar days in which to make a decision and the approval is valid for six months.²¹ An affirmative ADMC does not address the price that Medicare will approve when a bill is submitted.²²

Although the ADMC offers some certainty to suppliers for a narrow range of items, suppliers still must submit claims after delivering the DME item and they do not have assurance about the level of payment they will receive until after they deliver the item. Moreover, most states still require that, after delivery of the item, the invoice must be submitted to Medicare for formal approval or denial before the state will authorize Medicaid payment.

A few states, including Connecticut and New York, have developed workarounds to address the bottlenecks. Connecticut’s Medicaid statute provides that Medicaid-covered DME “shall

¹⁷ An unknown added to the mix is the introduction of the Competitive Bidding Program for certain DME mandated by Section 302 of the Medicare Modernization Act of 2003, 42 U.S.C. § 1395w-3. Some suppliers have argued that the program, which would limit purchases of some Medicare-authorized DME to a list of suppliers chosen through a competitive bidding process, would further complicate access. Many dual eligibles rely on a single supplier for all their DME and non-durable supply needs—both those covered by Medicare and those covered by Medicaid. The new procedures might require dealing with multiple suppliers and could create confusion and obstacles to access. While it is too soon to assess whether these concerns are valid, CMS should monitor the operation of the new program and, if necessary, take steps to mitigate any adverse impact on dual eligibles.

¹⁸ CMS, Medicare Program Integrity Manual, Ch. 5 at 5.16, available at www.cms.gov/manuals/downloads/pim83c05.pdf.

¹⁹ Id.

²⁰ Id. at 5.16.2.

²¹ Id. at 5.16.3 and 5.16.4

²² Id.

not be denied to a recipient on the basis that a Medicare coverage determination has not been made prior to the submission of request for preauthorization to the commissioner.”²³ As applied to a DME item requiring prior authorization, the Connecticut process is straightforward. The individual first requests prior authorization from the state Medicaid agency. If approved, the provider delivers the equipment to the individual and then bills Medicare. If Medicare pays, the claim is then crossed over to Medicaid to pay Medicare’s cost-sharing for the dual eligible and, usually, the transaction is then complete. If Medicare does not pay, the provider then bills the Connecticut Medicaid agency, which has already agreed to pay through the prior authorization process. In this way, providers have the assurance that they will get paid, although they do not have certainty about which agency will pay and at what rate.

New York’s Medicaid program has taken a different approach. The state exempts five categories of DME from the normal requirement of a prior Medicare claim denial: 1) DME that is not on the list of Medicare covered items; 2) DME that is the same or similar to equipment received by the individual within the prior five years that had been rejected by Medicare previously; 3) DME used outside the home; 4) DME that has received a negative ADMC; or 5) DME where Medicare has denied a claim because quantities exceed Medicare payment screens. In the last case, New York’s Medicaid agency requires that the supplier or beneficiary file a Medicare appeal.²⁴

Recommendations for Improvement

- **All states should adopt streamlined procedures similar to those used by Connecticut and New York.** CMS should work with the states to develop uniform protocols that combine the benefits and efficiencies of those models.
- **Individuals with Medicaid coverage who newly qualify for Medicare should have transition rights that guarantee continued access for a reasonable period of time to all goods and services that they were receiving through Medicaid.** These transition rights would be similar to those available in Medicare Part D for individuals stabilized on a drug regime. For DME and other goods and services, a six-month transition period would be appropriate, allowing time for individuals and their treating professionals to adjust to new procedures and requirements. During the transition, Medicaid would pay the supplier, but the state would use established mechanisms to recoup charges for Medicare-covered equipment.²⁵
- **CMS should review Medicare coverage criteria with a view toward making coverage requirements more consistent with the goal of assisting individuals to remain at home and in the community as long as possible.** CMS should examine whether it can more broadly interpret the “in the home” requirement. For example, the agency has interpreted the requirement

²³ Conn. Gen.Stat. § 17b-281a(b)(2009)

²⁴ See “Prior Approval Process For Enrollees Eligible For Both Medicare And Medicaid For Durable Medical Equipment, Prosthetic, Orthotic And Supply Items,” available at www.emedny.org/providermanuals/dme/pdfs/prior_approval_process_12_29_2008.pdf.

²⁵ See, e.g., CMS, State Medicaid Manual, Ch. 2 at 2850 et seq., available at www.cms.gov/manuals/PBM.

that individuals be “homebound” in order to receive Medicare home health services to permit trips to medical appointments, church services and occasional family gatherings.²⁶ CMS should consider whether DME that is necessary for travel to those limited extensions of “home” can be covered by Medicare consistent with existing statutory restraints. In the longer term, the Medicare statute should be revised to explicitly provide coverage that facilitates, rather than discourages, maximum participation in the community by beneficiaries.

- **CMS and the states should collaborate in creating simple fact sheets that lay out coverage criteria for items where overlaps create the most confusion.** Prescribers and beneficiaries need to be able to independently understand approval criteria both for purposes of prescribing DME and for purposes of appeal. If care is to be person-centered and beneficiaries are to be empowered in participating in their own health care decisions, then coverage criteria must be less opaque than prescribers and advocates currently report.
- **Longer term comprehensive approaches, such as transferring coverage of all DME for dual eligibles to Medicare or Medicaid are worthy of study.** Having a single payer for all DME for dual eligibles would create administrative efficiencies and cost savings and improve predictability for beneficiaries and their prescribers. Whichever payer is chosen, however, it is critically important that dual eligibles under a single system get the more expansive coverage options for any item

covered by both programs and that provider reimbursement policies ensure genuine access to covered DME. Any unified benefit would need to be carefully crafted so that it does not leave dual eligibles worse off or, because they are treated separately from other Medicare and Medicaid beneficiary groups, make them a more vulnerable target for future program cuts. In the shorter term, however, the simple workarounds described above that can be accomplished at the regulatory and subregulatory level will significantly improve beneficiary access.

Prescription Drug Coverage

How the Programs Operate

Prescription drug coverage is almost entirely a Medicare benefit for dual eligibles and has been since the Medicare Part D program was introduced in 2006.²⁷ Like all Medicare beneficiaries, dual eligibles must join a stand-alone Medicare prescription drug plan (PDP) or a Medicare Advantage plan with prescription drug coverage (MA-PD) in order to get their drugs covered. When Medicaid-eligible individuals become dually eligible, their Medicaid drug coverage stops for nearly all drugs. They automatically become eligible for the Low Income Subsidy (LIS or “extra help”), which protects them entirely from premium liability if they join plans with premiums at or below “benchmarks” set by CMS annually. They also are exempted from deductibles and from the coverage gap (the “doughnut hole”). Dual

²⁶ Id., Ch. 7 at 30.1.1. Note also that starting in 2005, CMS conducted the “Home Health Independence Demonstration” that, for purposes of a demonstration in three states, interpreted the definition of “homebound” even more expansively. See CMS, Pub. 100-19 “Demonstrations,” Transmittal 18 (Feb. 4, 2005), available at www.cms.gov/Transmittals/Downloads/R18demo.pdf. CMS could explore a similar approach for DME.

²⁷ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, created the Medicare Part D program. The program began January 1, 2006.

eligibles receiving an institutional level of care either in a facility or in the community do not have copayment obligations but all others are subject to copayment requirements ranging from \$1.10 and \$6.30 per 30-day supply.²⁸

Once they qualify for Medicare coverage, the only Medicaid drug coverage available to dual eligibles consists of the few categories of prescription drugs that state Medicaid programs may cover but Medicare Part D does not. Coverage varies by state but in all cases is quite limited. Typical examples include over-the-counter drugs, as well as benzodiazepines and barbiturates.²⁹

Medicare Part D formularies, which are not required to include all Part D drugs, tend to be less expansive than Medicaid formularies and typically impose more utilization management controls, such as prior authorization. They also are more difficult for physicians to navigate. Though many states have one Medicaid formulary with which physicians who treat Medicaid patients become familiar, each Medicare plan has its own formulary and those formularies differ markedly, particularly when it comes to prior authorization and other utilization management requirements. Moreover, Part D formularies have been shrinking over the life of the program while utilization management controls have been increasing.³⁰

Medicare's rules about coverage of drugs for off-label uses also are more restrictive than Medicaid's.³¹ Off-label prescribing is particularly important for individuals with rare or unusually difficult conditions. CMS regulations, based on the agency's interpretation of statutory authority, prohibit Part D coverage of an off-label use unless the use is supported by one of three drug compendia.³² The compendia are large reference compilations of information on drugs, including information on dosage and usage. They are commercially produced, expensive, and not widely used by treating physicians or readily available to the public. Medicaid law, in contrast to Medicare regulations, specifically allows Medicaid agencies to accept both peer-reviewed literature, such as medical journal articles, and the compendia to support coverage of drugs for off-label usages.³³

Enrollment procedures for Part D create access issues for dual eligibles. If a dual eligible does not choose a Medicare drug plan on her own, CMS randomly assigns her to one of the "benchmark" plans in her region, that is, one of the Part D plans that dual eligibles and others with the Low Income Subsidy can join without a premium liability (the process is called "auto-enrollment"). The assignment is random because of CMS's strict interpretation of statutory language. Thus, CMS makes no attempt to

²⁸ The zero copayment provision for individuals receiving an institutional level of care in the community will become effective January 1, 2012. 42 U.S.C. § 1395w-144(a)(1)(D).

²⁹ Starting in 2013, Medicare will cover all benzodiazepines and will cover barbiturates for certain conditions. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. 110-275, § 175. In 2014, Part D will cover all barbiturates. See ACA, § 2502

³⁰ GAO, "Medicare Part D: Changes In Utilization Similar For Randomly Reassigned And Other Low-Income Subsidy Beneficiaries," pp. 9-10 (2011) available at www.gao.gov/new.items/d11546r.pdf.

³¹ Once a drug has been approved by the Food and Drug Administration for a particular use, physicians may legally prescribe the drug for that use ("on-label") or for other uses that have not been specifically approved by the FDA ("off-label"). Off-label prescribing is most common when treating cancer, psychiatric problems, extreme pain, and autoimmune or central nervous systems diseases. See Irene Levine, "Off-Label Drugs: What They Are and What It Means for You," AARP Bulletin (2008), available at www.aarp.org/health/drugs-supplements/info-04-2009/off-label_drugs_what.html.

³² 42 C.F.R. § 423.100. The statutory provision on which the regulation is based is 42 U.S.C. § 1395w-102(e)(4).

³³ 42 U.S.C. § 1396r-8(g)(1)(B).

match beneficiaries to plans that cover their prescribed drugs. Because the designation of a plan as a benchmark plan can change from year to year, dual eligibles may need to change plan enrollment in order to fully benefit from the subsidy.

In addition, although Medicaid programs can impose copayment requirements, beneficiaries who are unable to pay those amounts usually still receive their drugs. Medicare Part D copayments, though reduced by the Low Income Subsidy, cannot be waived except in rare instances.

Impact on Dual Eligibles

- *Dual eligibles have less access than other Medicaid beneficiaries to needed medications because of formulary limitations.* The overtaxed safety net providers who typically treat dual eligibles complain that they cannot keep track of the various Part D formularies and their restrictions, resulting in denials of coverage for their patients. When a prescription is denied at the pharmacy, the dual eligible does not have the financial means to pay out-of-pocket and is likely to leave without her needed medication. Unlike middle class beneficiaries, dual eligibles cannot pay with cash or credit cards and fight over coverage later. Because dual eligibles often rely on complex drug treatment regimes to manage their multiple chronic conditions and associated functional impairment, leaving the pharmacy without a prescription can result in untreated conditions and, ultimately, costly health care services, such as emergency room visits and hospitalization.
- *Dual eligibles have less access than other Medicaid beneficiaries to needed off-label drugs. For individuals with rare or particularly intractable conditions, use of prescription drugs for off-label indications can be critical, sometimes life-saving.* Compendia listings lag important research findings, sometimes by years. Most treating physicians, as well as consumer advocates, are unfamiliar with the compendia and may not have ready access to them, particularly because they are commercial publications requiring subscriptions that cost several thousand dollars annually.³⁴
- *New dual eligibles experience problems transitioning to Medicare drug coverage.* Individuals who first qualify for Medicaid and then qualify for Medicare struggle the most with adjusting to the Part D benefit. With the random assignment process, they might be enrolled in plans that do not cover their drugs. Advocates repeatedly see clients who are newly dually eligible and do not understand why the pharmacy has suddenly rejected a prescription they have filled routinely for years.
- *State data transmission practices can create gaps in coverage for new dual eligibles.* Many states send Medicaid enrollment information to CMS only once a month in batches. Because CMS relies on this information to conduct the auto-enrollment process and Low Income Subsidy deeming process, this practice can delay recognition of an individual's dual eligible status in the Medicare program. If the file needs to be sent back to the state and corrected, e.g., for a spelling error or a transposed number, delays can stretch for several months, a not uncommon occurrence.

³⁴ For a detailed discussion of barriers caused by the compendium requirements, see Ctr. for Medicare Advocacy, "CMA Report: Medicare Coverage for Off-Label Use," at www.medicareadvocacy.org/2010/09/cma-report-medicare-coverage-for-off-label-drug-use/.

- *Dual eligibles pay more than other Medicaid beneficiaries and get a less robust benefit.* The imposition of co-payments in the Medicare prescription drug program that are not part of the Medicaid program leaves dual eligibles paying more for a benefit that, for all the reasons presented here, is worse than the benefit they would receive if they qualified for Medicaid alone.

Partial Solutions

CMS has made efforts to address formulary complexity by increasing scrutiny of utilization requirements in plan formularies and has also sought to reduce the number of plans offered in any region. In addition, the agency requires plans to spell out on their websites what specific criteria providers must meet to comply with a prior authorization requirement for a particular drug.³⁵ Safety net providers report, however, that they continue to struggle with the resource commitments necessary to comply with myriad utilization management requirements and cannot search the internet for prior authorizations each time they write a prescription.

For off-label drugs, a recent federal district court decision, *Layzer v. Leavitt*, held that the CMS regulation misinterprets the statutory language.³⁶ The court found that the listed compendia were examples of authorities that could be consulted but that the Part D statute did not mean them to be the exclusive authorities for determining coverage.³⁷ The agency has filed

an appeal. Congress has provided some statutory relief, but only for beneficiaries with cancer who need off-label drugs. The Medicare Improvement and Patient Protection Act of 2008 (MIPPA) added a provision that specifically permitted peer-reviewed literature as support for use of cancer chemotherapy drugs.³⁸

In response to the problem of enrollment in “benchmark” prescription drug plans that do not cover the drugs an individual needs, a few states with State Pharmaceutical Assistance Programs (SPAPs) have received permission from CMS to enroll their members in plans aligned to their prescription drug needs.³⁹ Maine, for example, assigns and reassigns its dual eligibles to benchmark plans based on their prescription drug usage history.

The difficulties that people transitioning from Medicaid drug coverage to Medicare coverage face are partially addressed by a Medicare drug transition policy. The policy provides that, within the first 90 days of membership in a plan, any beneficiary (not just dual eligibles) can get one 30-day supply of a drug that that is an ongoing prescription, even if that drug is not on the plan’s formulary or is subject to utilization management requirements.⁴⁰ The policy is meant to give new plan members time to switch to a drug on the formulary or to apply for a formulary exception.

To address the problem of delays in getting dual eligibility status recognized, CMS modified its own systems so that the agency can receive data from the states as frequently as daily. The

³⁵ CMS, 2012 Call Letter at 100, available at www.cms.gov/PrescriptionDrugCovContra/Downloads/Announcement2012final.pdf.

³⁶ 770 F. Supp. 2d 579 (S.D. N.Y. 2011).

³⁷ Id.

³⁸ 42 U.S.C. § 1395w-102(e)(4)(A)(i).

³⁹ See GAO, “Medicare Part D, Enrolling New Dual-Eligible Beneficiaries in Prescription Drug Plans,” p. 8, n. 8 (May, 2007) (Statement of Kathleen M. King before the Senate Finance Committee), available at www.gao.gov/new.items/d07824t.pdf.

⁴⁰ CMS, Prescription Drug Benefit Manual, Ch. 6 at 30.4.4 available at www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

agency also put into place systems to turn that information around and get it to plans within 24 hours of receipt from the states. Despite these initiatives and encouragement by CMS, more than half the states have failed to alter their own systems and continue to transmit data files only once per month, a process that can leave new dual eligibles without plan enrollment and/or low income subsidy coverage for three months or even longer.⁴¹

CMS also set up a safety net, the Limited Income New Eligible Transition (LI-NET) program,⁴² which is designed so that new dual eligibles who are not yet enrolled in a Part D plan and who show proof of their Medicaid status at the pharmacy can be enrolled in a plan immediately. Although the LI-NET system works relatively well when used, advocates report that many pharmacists are reluctant to use it or do not know that it exists. For new dual eligibles who are already enrolled in a Part D plan, CMS also has established a “Best Available Evidence” policy that requires plans to accept alternate evidence of dual eligibility when an enrollee’s new LIS status does not show on plan systems and to assist members in obtaining such evidence if necessary.⁴³

Recommendations for Improvement

- **CMS should increase its oversight of utilization management requirements by prescription drug plans with an eye toward simplification and additional uniformity among plans.**
- **CMS should issue regulations consistent with the *Layzer* decision and allow use of peer-reviewed articles to support coverage of prescription drugs for off-label use.** The agency should also support legislation that clearly aligns the Medicare standard for off-label use with the Medicaid standard.⁴⁴ In the absence of the above measures, CMS should make sure that dual eligibles who are denied Part D coverage for off-label drugs understand that they have the right to pursue coverage through their state Medicaid program because the denial constitutes a decision that the drug is not a “covered Part D drug” and thus potentially covered by Medicaid. Any dual eligible who has been denied Part D coverage for a drug because of lack of compendium support should be informed, in the notice of denial, about the option of pursuing Medicaid coverage.
- **CMS should assign dual eligibles to Part D plans that cover the drugs they are taking. Often called “intelligent assignment” or “beneficiary-centered assignment,” this approach is preferable to the random assignment currently in use.** For dual eligibles who have been enrolled in Medicaid for some period of time prior to becoming eligible for Medicare, the procedure would require cooperation with the states to obtain information on an individual’s prescription drug usage in the Medicaid program. For dual eligibles who are being reassigned because their Part D plans have

⁴¹ As of August 2010, 20 states have elected to transmit data to CMS more frequently than once a month.

⁴² The Limited Income Newly Eligible Transition (LI-NET) program is operated under contract by Humana.

⁴³ Prescription Drug Benefit Manual, Ch. 13 at 70.5, available at www.cms.gov/PrescriptionDrugCovContra/Downloads/R7PDB.pdf.

⁴⁴ The Part D Off-Label Prescription Parity Act, H.R. 1055, is one piece of legislation that has been introduced to address these issues.

lost benchmark status, CMS can use its own Medicare records to support an intelligent reassignment decision.⁴⁵

- CMS should create a notice, written in plain English and translated into multiple languages, specifically for Medicaid eligible individuals who are switching to Medicare drug coverage. The notice should clearly and simply explain that they are losing Medicaid drug coverage and explain what they need to do. Currently, the auto-enrollment notices that CMS sends to new dual eligibles talk only about the Medicare program and do not address the loss of Medicaid drug coverage.⁴⁶
- Dual eligibles who had Medicaid coverage before qualifying for Medicare should have a special six month transition period when they first become eligible for Medicare. During that period, they would have access to up to a 90-day supply of on-going medications. For many dual eligibles, the current transition rule allowing for one 30-day supply is not sufficient. They have difficulties adjusting to the new system and do not take timely action. As a result they find themselves without needed medications. This modest extension of the current CMS transition policy offers a targeted approach to address the needs of this relatively small subset of dual eligibles.
- CMS should aggressively work to get all states to transmit eligibility data daily. CMS should provide states with technical assistance to facilitate needed upgrades. States are undertaking massive computer system upgrades in connection with the introduction

of the new health care reform exchanges and are expanding the data transfer capabilities between state and federal agencies. CMS should insist that, in the course of these upgrades, states address lags in submitting Medicaid eligibility information to CMS.

Skilled Nursing and Rehabilitation Services

How the Programs Work

When a dual eligible enters an acute care hospital after, for example, a stroke or a broken hip, it is common for her to need a period of rehabilitation after the hospital stay. In the typical scenario, Medicare coverage precedes Medicaid coverage. Medicare pays for her hospital care and, if the hospital stay extends for at least three nights, Medicare might pay for necessary rehabilitation or other skilled services in a nursing home, depending on the person's care needs.⁴⁷ When Medicare does not pay for nursing home care—either because the resident's care needs are insufficient, or Medicare's 100-day maximum has been reached—Medicaid pays for necessary nursing home care.

During the period of her stay covered by Medicare, a dual eligible has no payment liability for her care. When she transitions to Medicaid funding, she is required to contribute almost all of her monthly income to her care, keeping only a small allowance (federal regulations set

⁴⁵ For a discussion of potentially effective ways to structure beneficiary-centered assignment see Jack Hoadley, Laura Summer et al, "The Role Of Beneficiary-Centered Assignment For Medicare Part D" (2007), available at www.medpac.gov/documents/June07_Bene_centered_assignment_contractor.pdf.

⁴⁶ CMS notices are available at www.cms.gov/LimitedIncomeandResources/LISNoticesMailings/list.asp#TopOfPage.

⁴⁷ This paper uses the term "nursing home" to refer to the facilities that are termed "skilled nursing facilities" and "nursing facilities" in Medicare and Medicaid law, respectively.

the minimum amount at \$30) for personal care expenses and, in some instances discussed below, an additional minimal amount for home expenses.⁴⁸

The Nursing Home Reform Act prohibits facilities from discriminating against residents based on payment source. Uniform standards, including a requirement that facilities provide therapies and other services necessary for the resident to attain or maintain the highest practicable level of functioning,⁴⁹ apply whether the care is funded by Medicare, Medicaid or by the resident herself (private pay).⁵⁰

Impact on Dual Eligibles

- *Many dual eligibles face an abrupt drop in rehabilitation services when Medicare coverage stops.*⁵¹ Because Medicare pays higher daily nursing home rates than Medicaid,⁵² the reality for dual eligibles can be less than what the Nursing Home Reform Act requires. Advocates report that beneficiaries receiving services under the Medicare benefit often get significantly more intensive rehabilitation than those who have similar needs but are receiving care funded by Medicaid. When Medicare-covered skilled nursing services for a dual eligible end and Medicaid-covered services begin, access to needed rehabilitation services can decrease dramatically, which can seriously set back progress toward recovery and delay return to the community.
- *When Medicare coverage stops, some dual eligibles are forced to move to a different facility.* Some nursing homes are certified for Medicare but not for Medicaid. Also, in some states, nursing homes are allowed to restrict Medicaid coverage by only authorizing some of their beds for Medicaid certification. In such nursing homes, a resident may sometimes be subject to eviction when Medicare coverage ends, because Medicaid coverage may not be available in the particular nursing home, or in the particular bed within a nursing home. A forced move can add transfer trauma on top of a diminution of service level.
- *Many dual eligibles lose Medicare coverage prematurely.* Although Medicare rules set specific criteria for nursing home coverage, advocates see many cases where those criteria are not followed and individuals are incorrectly denied Medicare coverage. In some cases, coverage is denied because an arbitrary rule of thumb (e.g., x days of physical therapy for a hip fracture) is applied without an individualized assessment of the patient's needs. In other cases, the reason given is that the patient has "plateaued" or is no longer "improving." Sometimes referred to as the "improvement standard," this standard has no basis in Medicare law under which therapy can be provided to *maintain* a person's condition.⁵³ The use of an invalid "improvement standard" is a problem in

⁴⁸ 42 C.F.R. § 435.725(c)(1)(i). The situation is somewhat better for a married resident, who often can allocate some income to the non-institutionalized spouse.

⁴⁹ 42 U.S.C. §§ 1395i-3(b)(4)(A)(i) and 1396r(b)(4)(A)(i); 42 C.F.R. § 483.45(a).

⁵⁰ 42 U.S.C. §§ 1395i-3(c)(4), and 1396r(c)(4)(A); See also 42 C.F.R. § 483.12(c)(1)

⁵¹ For a more detailed discussion of the issue, see Eric M. Carlson, LONG-TERM CARE ADVOCACY (Matthew Bender, 2010) at §2.10.

⁵² See Amer. Health Care Assn., "A Report on Shortfalls in Medicaid Funding for Nursing Home Care" (2010), available at www.ahcanca.org/research_data/funding/Documents/2010%20Medicaid%20Shortfall%20Report.pdf.

⁵³ For an extensive discussion of the improper application of the improvement standard, see Ctr. for Medicare Advocacy, "Improvement Standard," at www.medicareadvocacy.org/medicare-info/improvement-standard-2/.

home health services as well as nursing home coverage and most seriously disadvantages individuals with chronic or degenerative conditions who need therapy to maintain function or to slow decline.

- *Many dual eligibles risk loss of their homes because they have no money to pay for rent or home maintenance during their convalescence.* Advocates report that these individuals, who otherwise could return to their homes, can end up unnecessarily institutionalized because they have no home to return to.

Partial Solutions

Some nursing homes comply with statutory requirements and provide needed rehabilitation without regard to payment source; some states enforce requirements more vigorously than others. Advocates report, however, that the loss of services is widespread.

A significant number of states do not allow partial Medicaid certification for nursing homes. In these states, nursing homes seeking Medicaid certification must designate all beds as available to Medicaid patients.

Some states have Medicaid policies in place that mitigate the problem of home maintenance by allowing a more substantial home maintenance allowance for individuals expected to return to the community. CMS regulations permit states to deduct a Medicaid home maintenance allowance for a period not to exceed six months when a physician certifies that the individual is likely to return to the home during that period.⁵⁴

The CMS regulation is permissive only so states are not required to provide this allowance. In practice, home allowance policies are uneven and, even when they exist, can be grossly inadequate. The California home maintenance allowance, for example, is limited to \$209 per month, an amount that has not changed in 20 years.⁵⁵ For recipients of Supplemental Security Income (SSI), the Social Security Administration provides Temporary Institutionalization Benefits that protect SSI income for up to three months of nursing home residence if a physician certifies that return to the community is anticipated within that period.⁵⁶

Recommendations for Improvement

- **CMS and state Medicaid agencies should consistently enforce the requirements of the Nursing Home Reform Act requiring nursing homes to provide needed rehabilitation services, regardless of payment source.**
- **CMS should issue clear instructions that the “improvement standard” is contrary to the Medicare statute and not applicable to Medicare coverage determinations, and also should ensure that states do not permit such a standard in their coverage of skilled and rehabilitative services.** The agency should closely monitor Medicare coverage denials to ensure that Medicare requirements are properly interpreted and enforced.

⁵⁴ 42 C.F.R. § 435.725(d).

⁵⁵ 22 C.C.R. § 50605(c); see also Ca. Dep’t of Health Care, “Medi-Cal Home Upkeep Allowance for an Individual Temporarily Residing in a Nursing Home or Other Medical Facility,” available at [www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/DHCS9110\(Eng\).pdf](http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/DHCS9110(Eng).pdf).

⁵⁶ POMS SI 00520.140, available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0500520140>.

- **All states should require full certification for nursing homes that seek Medicaid reimbursement.** No partial certification should be permitted.
- **Both the states and CMS should review Medicaid payment structures.** Payment rates should be set at a level that will support the provision of rehabilitative services needed by Medicaid patients.
- **All states should put in place policies that allow reasonable living allowances for individuals in Medicaid-funded skilled nursing who are expected to return to their homes.** As a longer term response, Medicare should consider retaining payment responsibility for skilled nursing care for a dual eligible who is expected to return to the community within six months of the expiration of the usual Medicare coverage limits. Having one payer for a single stay would provide continuity of care and oversight and eliminate the need for Medicaid programs to address the issue of special living allowances. This change would require legislative action.

Language Access

How the Programs Operate

For dual eligibles with limited English proficiency (LEP), the Medicare and Medicaid programs offer an inconsistent patchwork of language assistance. Medicare and Medicaid program rules

and practices differ on three levels: 1. payment for interpreter services when communicating with a health care provider, 2. data collection, and 3. translation requirements.⁵⁷

Both Medicare and Medicaid providers, as recipients of federal funds, are subject to Title VI of the Civil Rights Act of 1964 and are required to take reasonable steps to ensure that limited English proficient individuals have meaningful access to their services.⁵⁸ For some Medicare Part B providers, this requirement is a new one. Prior to the passage of ACA, Part B providers, including physicians in private practice, had been exempt from Title VI if Part B payments were the only federal funds they received. Section 1557 of the ACA eliminated that exemption.⁵⁹

Other federal laws such as the Hill-Burton Act, addressing hospital care, and the Emergency Medical Treatment and Active Labor Act, also have provisions that directly or indirectly require language services.⁶⁰

Although these laws impose similar requirements on both Medicare and Medicaid providers to offer language services to their patients, the programs differ in their approaches to payment for those services.

The Medicare program does not compensate providers for the additional cost of language services. Medicaid rules, in contrast, permit states to treat language services as a separate optional covered Medicaid service with its own billing code. About a dozen states have taken advantage of this option. Most state Medicaid

⁵⁷ In this paper, “interpreter services” refer to oral assistance and “translations” refer to written materials.

⁵⁸ Title VI, 42 U.S.C. § 2000d, prohibits discrimination, including discrimination based on national origin, by recipients of federal funds. The Supreme Court has treated discrimination based on language as national origin discrimination. *Lau v. Nichols*, 414 U.S. 563 (1974). See also Exec. Order No. 13166, 76 Fed. Reg. 50121 (Aug. 16, 2000) and HHS, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311 (Aug. 8, 2003), both available at www.lep.gov.

⁵⁹ ACA § 1557, 42 U.S.C. § 18116. CMS has not yet issued proposed regulations to implement Section 1557 but they are expected before the end of 2011.

⁶⁰ See 42 U.S.C. § 291c(e), 42 C.F.R. § 124.603 (Hill-Burton); 42 U.S.C. § 1395dd, 42 C.F.R. § 489.24 (Emergency Services).

programs, however, have not adopted this approach and instead subsume the costs of language services into general payments to providers for administrative expenses. By so doing, they disadvantage those providers who disproportionately serve LEP beneficiaries and thus disproportionately incur language service costs.

Medicaid and Medicare also differ in their approaches to identifying the language needs of beneficiaries. On the Medicare side, CMS does not routinely collect language preference information from Medicare beneficiaries and there is no language identifier attached to an individual's Medicare file. The Social Security Administration (SSA), which is responsible for enrolling individuals in the Medicare program, does not collect language preference information as part of the Medicare enrollment process. Although SSA has language preference information in its files for some Social Security beneficiaries who also are eligible for Medicare, SSA does not attach that information to a beneficiary's Medicare files. When individuals enroll in Medicare Advantage plans and Medicare Prescription Drug plans, the application form must list the languages into which the plan translates documents and ask the applicant whether she prefers to receive information in

those languages. However, because plans have limited translation obligations (usually only Spanish or no translation obligation at all, see discussion below), this question is very limited in scope and, in the case of plans that have no translation obligation, is not even required. Plans are not otherwise required to inquire about an individual's language needs.⁶¹

Medicaid regulations, in contrast, require that states collect information on the race, ethnicity, and primary language spoken by Medicaid enrollees in Medicaid managed care plans and transmit that information to the plans.⁶²

Obligations to provide written translations of documents also differ in the two programs. Medicare marketing regulations for Part C and D plans, adopted in April 2011, require plans to translate certain marketing materials into any non-English language that is the primary language of at least 5% of the general population of the plan benefit package service area.⁶³ The regulations only cover marketing materials and do not extend to other types of documents such as notices of appeal rights. Regulations also require that call centers for Part C and D plans offer interpreter services in all languages.⁶⁴

For its own translation obligations as an agency, Medicare holds itself to a 10% threshold of "the CMS customer population." The agency

⁶¹ Application forms also contain a statement, written in English, telling applicants to call the plan's toll free number if they need information in another language. If a plan receives such a call, its only obligation is to provide oral interpretation assistance. There is no obligation to add that language preference information to the individual's file. The model application form for Prescription Drug Plans is found at Prescription Drug Benefit Manual, Enrollment and Disenrollment, Ch. 3, Exh. 1, available at www.cms.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage. The model application form for Medicare Advantage plans is found at Medicare Managed Care Manual, Ch. 2, Exh. 1, available at www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=10.

⁶² 42 C.F.R. § 438.204(b)(2).

⁶³ 76 Fed. Reg. 21432 at 21569, and 21577 (April 15, 2011); 42 C.F.R. §§ 422.2264(e), and 423.2264(e). The service areas for stand-alone Prescription Drug Plans (PDPs) are generally one entire state (in some cases two smaller states are combined into one service area). For Part C Medicare Advantage (MA) managed care plans, the service area usually is based on county coverage.

⁶⁴ 76 Fed. Reg. at 21563 and 21573; 42 C.F.R. §§ 422.111(h)(1)(iii) and 423.128(d)(1)(iii).

plans to translate “vital documents” into any language meeting the threshold.⁶⁵ The agency also offers interpreter services in all languages through its 1-800-Medicare line.

In the Medicaid program, states must make written information available in “prevalent” non-English languages spoken by “a significant number or percentage of enrollees or potential enrollees.”⁶⁶ This requirement is not limited to marketing documents. Medicaid managed care plans must provide translated materials in prevalent languages in their service area; both states and plans must provide oral interpretation in all languages.⁶⁷ Several states also impose their own, more specific translation requirements on Medicaid contractors. (See, e.g., California’s Dymally-Alatorre Bilingual Services Act⁶⁸ with a 5% translation standard for Medicaid managed care plans, and New York’s Patients’ Bill of Rights⁶⁹ with a 1% translation requirement for hospitals.)⁷⁰

Impact on Dual Eligibles

- *Dual eligibles needing language assistance cannot consistently access interpreter services when using health care providers.* The requirement to provide language services is not well understood by many providers. The lack of compensation discourages compliance. A dual eligible is particularly unlikely to get language assistance when accessing services from a provider who only accepts Medicare.
- *Many dual eligibles receive Medicaid information in their primary language, but receive Medicare information only in English.* To illustrate, the new Medicare translation regulations for marketing materials, when applied to Medicare prescription drug plans, requires Spanish translations by plans in only 27 states and do not require translations by prescription drug plans (PDPs) into any language other than Spanish in any state.⁷¹ In

⁶⁵ See CMS, “Strategic Language Access Plan (Lap): To Improve Access To CMS Federally Conducted Activities By Persons With Limited English Proficiency,” p. 9, (2009), available at www.cms.gov/EEOInfo/Downloads/StrategicLanguageAccessPlan.pdf.

⁶⁶ 42 C.F.R. § 438.10(c)(1).

⁶⁷ 42 C.F.R. § 438.10(c)(3)-(c)(4).

⁶⁸ Ca. Gov’t Code § 7290 et seq.

⁶⁹ 10 N.Y.C.R.R. § 405.7(a)(7).

⁷⁰ For a comprehensive list of state laws affecting both translation and interpretation requirements for providers and health plans, see Jane Perkins and Mara Youdelman, National Health Law Program, Summary Of State Law Requirements Addressing Language Needs In Health Care (2008), available at www.healthlaw.org/images/stories/issues/nhelp.lep.state.law.chart.final.0319.pdf.

⁷¹ This is an improvement from prior CMS guidance which only resulted in Spanish translation requirements for PDPs in 10 states. For CMS’s methodology for determining translation obligations of plans, see Memo from Cynthia Tudor “Contract Year 2012 Translated Marketing Materials Requirements and Methodology“ (June 15, 2011), available at www.cms.gov/PrescriptionDrugCovContra/Downloads/2012TranslatedMaterialsRequirementsFinal_06.15.11.pdf.

contrast, California translates state-generated Medicaid documents into 13 threshold languages; Medicaid managed care plans in the state, depending on their service area, typically translate documents into several languages.⁷²

- *Most LEP dual eligibles who speak a language other than Spanish get no written information about their Medicare benefits in a language they can understand.* The Part C and D standards adopted by CMS mean, for example, that a Chinese-speaking dual eligible who is assigned to a benchmark prescription drug plan, no matter where he lives, does not have the right to translated materials in his language.⁷³ Advocates report that they repeatedly see situations in which LEP individuals are harmed because they cannot read important information that is available to them only in English. As a result, they may miss an important appeal deadline or sign up for a Medicare or Medicaid plan that is inappropriate for their needs. Much of the time, they simply put the communication aside or throw it out, even though at least some level of oral interpretation assistance is available in many cases.

Partial Solutions

To address the costs to providers serving beneficiaries who need language services,

approximately 13 states have taken advantage of the option to treat interpretation as a separate Medicaid covered service, rather than subsuming interpretation in general administrative costs. These states use different mechanisms to make interpreter services available. Iowa, for example, pays providers when they use interpreters in fee-for-service Medicaid; other states, including Vermont and Utah, contract with interpreter services so that doctors and other Medicaid providers can use the services without charge. Those states pay the language agencies directly.⁷⁴

Most states continue to treat language services as an administrative cost and do not pay for them separately. In 2009, Congress took a step toward encouraging these states to change by adopting legislation that increased the federal financial match for Medicaid services for children to 75% when states cover interpreter services separately.⁷⁵ Since few dual eligibles are children, however, the measure's impact on the dual population has been minimal.

For data collection, CMS has indicated that the agency is looking into ways to improve identification of Medicare beneficiaries who need language assistance but has not developed details.

To improve quantity, quality and uniformity of documents that Medicare plans use with their members, CMS has undertaken the task of itself translating some model documents into Spanish

⁷² For California's instructions to plans on translation obligations, see Ca. Dep't of Health Serv., MMCD All Plan Letter 02003 (June 7, 2002) available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2002/MMCDAPL02003.pdf.

⁷³ A handful of Medicare Advantage prescription drug plans (MA-PDs) that serve counties with ethnic concentrations will have translation obligations for languages other than Spanish.

⁷⁴ For a review of different state approaches, see "How California Can Pay For Language Assistance Services, Recommendations From The Medi-Cal Language Access Services Task Force," p. 4 (2010), available at www.healthlaw.org/images/stories/MCLAS_Language_Assistance_Services.pdf.

⁷⁵ 42 U.S.C. § 1396b(a)(2), added as part of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

and Chinese.⁷⁶ The agency also creates some consumer fact sheets in additional languages.⁷⁷

Recommendations for Improvement

- **Both Medicare and all state Medicaid agencies should either develop reimbursement mechanisms that compensate providers for the cost of language services, whether provided by interpreters or bilingual providers and their staff, or provide those services directly.** On the Medicaid side, this change could be achieved if all states took advantage of the current option to treat interpretation services as a separate covered Medicaid service. Legislative action to extend the enhanced 75% Federal Medical Assistance Percentage (FMAP), currently available only for Medicaid services to children, would be an additional step that would make the option significantly more attractive to states.
- **CMS should explore whether it could establish interpreter services as a separate covered service under Medicare without legislation.** If legislation is needed, the agency should seek Congressional action. CMS could also undertake a demonstration project in which it contracts with language agencies directly and makes interpreter services available to both Medicare and Medicaid providers. Such a demonstration would be particularly helpful to small medical offices unused to taking responsibility for communicating with clients in languages other than English.⁷⁸ It would also especially
- benefit dual eligibles because their providers could access the same language services without having to first determine whether the underlying health care service is covered by Medicare or Medicaid.
- **When enacting regulations implementing Section 1557 of the ACA, CMS should set the language assistance obligations of Medicare providers so that they are parallel to those of Medicaid providers.** Beneficiaries should be able to expect the same access regardless of the source of government payment. Regulations should be clear and detailed so that providers, particularly physicians in private practice who may have little experience or understanding of civil rights requirements, will know their obligations. Once the regulations are established, CMS should also undertake a thorough provider education campaign for physicians and other Part B providers that explains their language obligations and provides them with tools and best practices for serving their LEP patients.
- **CMS should better align Medicare and Medicaid translation thresholds without weakening current standards.** Since Medicaid thresholds are generally better, the first step towards alignment would be for the Medicare program to set translation thresholds for itself, for fee-for-service providers, and for Part C and Part D plans that are more inclusive. Setting translation requirements based on numbers of individuals in a Medicare Advantage or

⁷⁶ Memorandum from Cynthia Tudor, “Contract Year 2012 Translated Marketing Materials Requirements and Methodology” (June 15, 2011) available at www.cms.gov/PrescriptionDrugCovContra/Downloads/2012TranslatedMaterialsRequirementsFinal_06.15.11.pdf.

⁷⁷ Translated consumer materials are available at www.medicare.gov/multilanguage.aspx.

⁷⁸ For a detailed set of recommendations on how Medicare could structure such payments, see Leighton Ku, “Paying For Language Services In Medicare: Preliminary Options And Recommendations” (2006), available at www.healthlaw.org/images/stories/issues/Medicare.Reimbursement.Issue.Brief.2006.pdf.

Prescription Drug Plan as well as based on population percentages is a more realistic way to ensure that translations are adequate for the population served. The gap in Spanish language coverage in almost half of the states and the needs of large groups of speakers of languages other than Spanish, who often are more linguistically isolated, need particular attention.

- **All relevant agencies should coordinate to more systematically identify dual eligibles needing language assistance.** Once the need for language assistance has been identified by Medicaid, Social Security or Medicare,

the language preference information should be attached to the individual's file so that all three agencies, as well as participating health and prescription drug plans, can provide better and more consistent language assistance.

In both Medicare and Medicaid, there are many opportunities to improve the quality, consistency, and amount of language services delivered to dual eligibles. This brief focuses only on a few areas where program differences are most evident and have significant impact on the ability of dual eligibles to access the services they need.

Conclusion

Dual eligibles can face significant loss of benefits when the two programs on which they rely, Medicare and Medicaid, do not work together smoothly. Some problems arise from program overlaps, but many of the difficulties dual eligibles face arise when they transition between program benefits and encounter delays or gaps. In addition, even when fully utilizing both programs, dual eligibles find that the benefits as actually delivered are insufficient to meet their needs.

This paper recommends changes that CMS and the states, working together, could implement in the short run. The changes would not require fundamental redesign of the programs, but would have real impact on dual eligibles who currently have difficulties getting the benefits to which they are entitled. Many of the proposed solutions build on procedures and models already in place in some states. Some simply require better enforcement of existing

requirements or fuller utilization of options that already are available. All would improve the experiences of dual eligibles and give them better access to needed care.

The proposals in this paper come with an important caveat. Even perfect synchronization of benefits will not meet the needs of dual eligibles if the underlying benefits are inadequate, if payment structures are insufficient to assure an adequate provider network, or if eligibility criteria are so restrictive that individuals cannot qualify for the services they need. Consumer advocates report that their dual eligible clients increasingly have difficulty finding providers for services for which they qualify. Recent budgetary pressures at the state and federal levels have led to multiple proposals that would seriously erode Medicare and Medicaid benefits. If the benefits themselves are eviscerated, alignment improvements will be of little value.



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