

December 2012

# MEDICARE AND MEDICAID

## Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems, and States



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## Why GAO Did This Study

Dual-eligible beneficiaries are low-income seniors and individuals with disabilities enrolled in Medicare and Medicaid. In 2010, there were about 9.9 million dual-eligible beneficiaries. Both programs have requirements to protect the rights of beneficiaries. These requirements are particularly important to dual-eligible beneficiaries, who must navigate the rules of both programs and generally have poorer health status.

To help inform efforts to better integrate the financing and care for dual-eligible beneficiaries, GAO (1) compared selected consumer protection requirements within Medicare FFS and Medicare Advantage, and Medicaid FFS and managed care, and (2) described related compliance and enforcement actions taken by CMS and selected states against managed care plans.

GAO identified consumer protections of particular importance to dual-eligible beneficiaries on the basis of expert interviews and literature, including protections related to enrollment, provider networks, and appeals. GAO reviewed relevant federal and state statutes, regulations, and policy statements, and interviewed officials from CMS and four states selected on the basis of their share of dual-eligible beneficiaries and use of managed care (Arizona, California, Minnesota, and North Carolina). GAO analyzed data on compliance and enforcement actions in Medicare Advantage and Medicaid managed care from January 1, 2010, through June 30, 2012.

View [GAO-13-100](#). For more information, contact Kathleen King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

## MEDICARE AND MEDICAID

### Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary across Programs, Payment Systems, and States

## What GAO Found

Medicare and Medicaid consumer protection requirements vary across programs, payment systems—either fee-for-service (FFS) or managed care—and states. Within Medicare, enrollment in managed care through the Medicare Advantage (MA) program must always be voluntary, whereas state Medicaid programs can require enrollment in managed care in certain situations. For example, Arizona requires nearly all beneficiaries, including dual-eligible beneficiaries, to enroll in managed care, but in North Carolina all beneficiaries are in FFS. In addition, Medicare and state Medicaid programs require managed care plans to meet certain provider network requirements to ensure beneficiaries have adequate access to covered services. For example, MA plans in rural counties must have at least one primary care provider per 1,000 beneficiaries. Subject to federal parameters, states establish network requirements for their Medicaid programs. For example, in California every plan must have at least one primary care provider per 2,000 beneficiaries. Finally, Medicare and Medicaid also have different appeals processes that do not align with each other. The Medicare appeals process has up to five levels of review for decisions to deny, reduce, or terminate services, with certain differences between FFS and MA. In Medicaid, states can structure appeals processes within federal parameters. States must establish a Medicaid appeals process that provides access to a state fair hearing and Medicaid managed care plans must provide beneficiaries with the right to appeal to the plan, though states can determine the sequence of these appeals. For example, Arizona requires beneficiaries to appeal to the managed care plan first, while a beneficiary in Minnesota may go directly to a state fair hearing without an initial appeal to the managed care plan.

Both the Centers for Medicare & Medicaid Services (CMS), the agency that administers the Medicare program and oversees states' operation of Medicaid programs, and states took a range of compliance and enforcement actions to help ensure that MA and Medicaid managed care organizations complied with their consumer protection requirements. Between January 1, 2010, and June 30, 2012, CMS took 546 compliance actions against MA organizations on the issues GAO identified as generally related to consumer protections of particular importance to dual-eligible beneficiaries. Compliance actions included notices, warning letters, and requests for corrective action plans (CAP). During the same period, CMS took 22 enforcement actions against MA organizations, including the imposition of 17 civil money penalties—nearly all for late or inaccurate marketing materials. For five serious violations, CMS suspended enrollment into the MA plan and suspended the MA plan's ability to market to beneficiaries. Similarly, states used notices, letters, fines, and CAPs to improve Medicaid managed care plan compliance with Medicaid consumer protection requirements. During the same period, Arizona, California, and Minnesota required managed care plans to undertake 91 corrective action plans, 52 percent of which related to problems with plans' appeals and grievances processes.

In commenting on a draft of the report, the Department of Health and Human Services noted that the report was an accurate assessment of the programs we reviewed.

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## Abbreviations

ADL	activities of daily living
ALJ	administrative law judge
CAM	Compliance Activity Module
CAP	corrective action plan
CMP	civil money penalties
CMS	Centers for Medicare & Medicaid Services
D-SNP	dual-eligible special needs plan
FFS	fee-for-service
FTE	full-time equivalent
HCBS	home- and community-based services
IADL	instrumental activities of daily living
MA	Medicare Advantage
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSC+	Minnesota Senior Care Plus
MSHO	Minnesota Senior Health Options
PACE	Program for All-Inclusive Care for the Elderly
PCCM	primary care case management
QIC	qualified independent contractor
SNF	skilled nursing facility

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## Congressional Requesters

About 9.9 million low-income seniors and persons with disabilities were enrolled in both the Medicare and Medicaid programs in 2010.<sup>1</sup> Known as “dual-eligible beneficiaries,” many of these individuals have significantly more health care needs than other beneficiaries in either program. In fiscal year 2008, dual-eligible beneficiaries accounted for about 17 percent of the Medicare population but 29 percent of Medicare spending,<sup>2</sup> and 16 percent of the Medicaid population but about 35 percent of Medicaid spending.<sup>3</sup> Health care spending for dual-eligible beneficiaries in 2010 exceeded \$300 billion.<sup>4</sup>

Both Medicare and Medicaid can be provided in a fee-for-service (FFS) or managed care payment system. Under FFS, healthcare providers are paid on a per-service basis. Under managed care, either the Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, or the state Medicaid agency contracts with managed care organizations to provide covered health care services in return for a fixed monthly payment per enrollee. Under Medicare managed care, private

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<sup>1</sup>Medicare Payment Advisory Committee (MEDPAC), *Report to Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 2012). Medicare is the federal health insurance program for seniors, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is the joint federal-state health care program that provides health care coverage for certain categories of low-income adults and children. The estimated number of dual-eligible beneficiaries includes both those who qualified for full Medicaid benefits (“full” duals) and those who received only assistance with Medicare premiums and cost sharing (“partial” duals). About 80 percent of dual-eligible beneficiaries were full duals. In this report, unless otherwise stated, the dual-eligible beneficiaries to which we refer are those entitled to full Medicaid benefits.

<sup>2</sup>MEDPAC, *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: June 2012). Spending is for dual-eligible beneficiaries in Medicare fee-for-service (FFS) only. Under a FFS system, providers are paid on a per-service basis.

<sup>3</sup>Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress: The Evolution of Managed Care in Medicaid* (Washington, D.C.: June 2012). These data include both full and partial dual-eligible beneficiaries.

<sup>4</sup>Melanie Bella, Director, the Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services (CMS), *Examining Medicare and Medicaid Coordination for Dual Eligibles*, testimony before the Special Committee on Aging, 112th Cong., July 18, 2012. Total includes spending for both full and partial dual-eligible beneficiaries.

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organizations offer health plans through the Medicare Advantage program. These plans are referred to as Medicare Advantage, or MA, plans.

Whether within the context of FFS, managed care, or both, dual-eligible beneficiaries navigate both the Medicare and Medicaid programs to access services. Under Medicare, dual-eligible beneficiaries have access to coverage for most acute care services, such as care provided by physicians or inpatient hospitals, postacute skilled nursing facility (SNF) care, and prescription drugs. Under state Medicaid programs, dual-eligible beneficiaries who qualify also have access to coverage for long-term nursing facility care and home- and community-based services. These beneficiaries may also qualify for payment of Medicare premiums and cost sharing.<sup>5</sup>

Both the Medicare and Medicaid programs have consumer protection requirements to help ensure that beneficiaries have access to health care providers and services covered under the programs. Such protections generally apply to all beneficiaries, but some are of particular importance to dual-eligible beneficiaries. Dual-eligible beneficiaries may have a greater need for health care services because of increased physical and mental health needs. Further, dual-eligible beneficiaries, because they are in both programs, face navigating the different requirements in the two separate programs. For instance, a dual-eligible beneficiary who wants to appeal a denial of benefits must first determine which program denied the benefit, because the entity to which he or she needs to appeal and the time frames they have for making that appeal may differ depending on whether the service was covered by Medicare or Medicaid, or which program has primary responsibility for payment.

To integrate benefits more effectively under the Medicare and Medicaid programs, and to improve the coordination between the federal government and states to ensure that dual-eligible beneficiaries get access to the items and services to which they are entitled, the Patient Protection and Affordable Care Act established the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination

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<sup>5</sup>In general, Medicare beneficiaries pay monthly premiums and a portion of their health care costs as coinsurance or deductibles. In the case of dual-eligible beneficiaries, their state Medicaid program covers some or all of these costs.

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Office) within CMS.<sup>6</sup> CMS administers the Medicare program as well as oversees the design and operation of state Medicaid programs. Goals for the Medicare-Medicaid Coordination Office include increasing dual-eligible beneficiaries' understanding of and satisfaction with coverage under Medicare and Medicaid and aligning the requirements between the two programs. To support these efforts, CMS is working with states to develop demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries. Key objectives are to improve beneficiary experience in accessing care, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for states and CMS. Twenty-six states have proposed demonstrations to integrate the care of dual-eligible beneficiaries, starting in either 2013 or 2014.

As CMS's integrated care demonstrations proceed, you were interested in understanding the requirements related to consumer protections of particular importance to dual-eligible beneficiaries. Such an understanding will help policymakers assess the demonstrations and any future integration efforts. You were also interested in information on enforcement tools available to CMS and states to ensure that managed care organizations comply with these requirements, as well as the recent compliance and enforcement actions taken by CMS and states against Medicare and Medicaid managed care plans. This study

1. compares selected consumer protection requirements in Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid managed care; and
2. describes recent compliance and enforcement actions generally related to these consumer protections taken by the federal government and selected state governments against Medicare Advantage plans and Medicaid managed care plans.

To compare consumer protections associated with Medicare and Medicaid, we identified and defined categories of consumer protections that are particularly important to dual-eligible beneficiaries on the basis of a review of the literature and interviews with researchers knowledgeable about the experiences of dual-eligible beneficiaries. We identified and

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<sup>6</sup>Pub. L. No. 111-148, § 2602. 124 Stat. 119, 315 (2010).

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defined six such categories: enrollment choice,<sup>7</sup> continuity of care, provider networks, marketing, scope of home health and nursing facility services,<sup>8</sup> and appeals.<sup>9</sup> With respect to continuity of care, provider networks, and marketing, we reviewed those requirements only with respect to their application in managed care.<sup>10</sup> We reviewed relevant federal statutes, regulations, and policy statements and interviewed federal officials to describe requirements in Medicare FFS, Medicare Advantage,<sup>11</sup> Medicaid FFS, and Medicaid managed care plans.<sup>12</sup>

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<sup>7</sup>For enrollment choice, we reviewed federal requirements relating to (1) a beneficiary's choice between mandatory and voluntary enrollment in Medicare Advantage (MA) and Medicaid managed care, (2) the ability of beneficiaries to select primary care providers, (3) the ability of beneficiaries to switch between managed care and FFS, and (4) informing and counseling beneficiaries on enrollment choices.

<sup>8</sup>We focused on the scope of the nursing facility and home health benefits, among all benefits, specifically because both Medicare and Medicaid cover these services, though under different circumstances, and a disproportionately large number of dual-eligible beneficiaries use these services. In this report, we limited our review to federal requirements related to circumstances under which beneficiaries can obtain nursing facility or home health services under Medicare or Medicaid.

<sup>9</sup>We reviewed federal requirements related to certain aspects of appeals defined as (1) how beneficiaries are notified of their right to appeal a denial of benefits, (2) the appeals process for when beneficiaries have a benefit denied, reduced, or terminated, (3) whether there is continuity of benefits during the appeals process, and (4) whether beneficiaries are required to receive help when navigating appeal options.

<sup>10</sup>For purposes of this report, we defined continuity of care as federal requirements relating to (1) the ability of beneficiaries to continue seeing historical providers not in the plan's network when transitioning to managed care or between plans and (2) whether beneficiaries have access to assistance with coordination of care options. For provider networks, we reviewed federal requirements related to (1) the adequacy of the number and types of providers and (2) coverage of out-of-network services. With respect to marketing, we reviewed federal requirements addressing (1) whether marketing materials are permitted to promote enrollment and (2) the readability, reading level, and translation of marketing materials.

<sup>11</sup>Under MA, Medicare beneficiaries may choose to have their benefits provided by private entities that offer plans under contract with CMS. In this report we only looked at requirements applicable to MA organizations that offer one type of plan: coordinated care plans. We refer to these entities as "MA organizations" or "MA plans." Coordinated care plans include traditional managed care plans such as health maintenance organizations, preferred provider organizations, and provider service organizations. As this report is for consideration of future integrated plan models that coordinate care for dual-eligible beneficiaries, we do not include other types of MA plans such as private fee-for-service plans or Medicare savings accounts. We also did not consider requirements that may apply to the Medicare Part D prescription drug benefit specifically.



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We also selected four states for review to provide illustrative examples of the variation in consumer protection requirements among state Medicaid programs. We chose the four states to achieve a range in terms of the share of dual-eligible beneficiaries in each state's Medicaid population and each state's overall use of managed care within Medicaid. The four states we selected were Arizona, California, Minnesota, and North Carolina. (See app. I for information on each state's Medicaid program.) For each of these states, we focused on state requirements as related to the federal requirements summarized above. To describe these state requirements, we interviewed state Medicaid officials, and reviewed relevant state statutes and regulations, state contracts with health plans, and policy manuals.

To describe recent compliance and enforcement actions generally related to the six categories of consumer protections taken by the federal government and selected state governments, we interviewed CMS officials about federal compliance and enforcement actions the agency can take against MA plans or Medicaid managed care plans, respectively. For the Medicare program, we also analyzed data from CMS's Compliance Activity Module (CAM) for the period January 1, 2010, through June 30, 2012. The CAM includes information on all federal compliance actions taken against MA plans. To assess the reliability of the CAM data, we interviewed CMS staff and reviewed the system documentation. We determined that the data were sufficiently reliable for the purposes of this report. In addition, we analyzed the MA enforcement letters posted on the CMS website. To describe recent state compliance and enforcement actions in the Medicaid program, we interviewed Medicaid officials in each of the same four states. We received information from those states with managed care programs on the numbers and types of compliance and enforcement actions taken against Medicaid managed care plans, as well as the general reasons for these actions.

The categories of consumer protections we examined in both Medicare and Medicaid are generally applicable to all beneficiaries in these two programs, not just dual-eligible beneficiaries. We note those cases where specific protections for dual-eligible beneficiaries are different than for

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<sup>12</sup>For purposes of this report, we only reviewed requirements that are applicable to managed care plans that offer the full range of Medicaid benefits. Accordingly, we did not address requirements that may apply to limited benefit plans which may provide only a single service, such as dental or behavioral health.

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other beneficiaries in Medicare or Medicaid. We did not evaluate the adequacy of the consumer protections we examined in terms of achieving their intended goal. The data on compliance and enforcement actions, both at the federal and state level, allowed us to report actions taken in response to issues that were generally related to a broad category of the consumer protection requirements we identify in this report and that affected or could have affected any Medicare or Medicaid beneficiary. We were unable to identify those actions that addressed the specific type of consumer protection requirements discussed in this report or that only affected dual-eligible beneficiaries. We did not evaluate the adequacy of the federal or state oversight systems or the specific performance of managed care plans in either program.

We conducted our work from June 2012 to December 2012 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

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## Background

Dual-eligible beneficiaries—individuals eligible for both Medicare and Medicaid—generally fall into two categories: low-income seniors (those aged 65 years old and over) and individuals with disabilities under the age of 65 years. Requirements to protect the rights of beneficiaries under both programs are of particular importance to dual-eligible beneficiaries because of their generally greater health care needs. Several efforts have been made in the past to better integrate care for dual-eligible beneficiaries.

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## Medicare

Medicare is a federally financed program that in 2011 provided health insurance coverage to nearly 49 million beneficiaries—people age 65 and older, certain individuals with disabilities, and those with end-stage renal disease. In Medicare FFS, beneficiaries may choose their health care providers among any enrolled in Medicare. However, CMS also contracts with MA organizations, private entities that offer managed care plans to Medicare beneficiaries. As of 2011, about 25 percent of Medicare beneficiaries were enrolled in a MA plan.

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As part of the agency's oversight of MA plans, CMS responds to complaints from beneficiaries and other parties, conducts surveillance, and conducts compliance audits. CMS responds to complaints from beneficiaries, health care providers, and other parties that come into the agency through a 1-800-MEDICARE phone line. It is through this mechanism that CMS generally resolves issues that are beneficiary-specific.<sup>13</sup> CMS conducts surveillance by having routine discussions with managed care organizations, monitoring plan-submitted data, and tracking and monitoring complaint rates by MA plan and complaint category. CMS uses compliance audits to assess whether a managed care organization's operations are consistent with federal laws, regulations, and CMS policies and procedures. Audits typically involve a combination of desk reviews of documents submitted by MA organizations, and, at CMS's discretion, site visits.

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## Medicaid

Medicaid is a joint federal-state program that finances health care coverage for certain low-income individuals.<sup>14</sup> To receive federal matching funds for services provided to Medicaid beneficiaries, each state must submit a state Medicaid plan for approval by CMS. The state Medicaid plan defines how the state will operate its Medicaid program, including which populations and services are covered.

States must operate their Medicaid programs within broad federal parameters. While complying with these federal requirements, however, states have the flexibility to tailor their programs to the populations they serve, including the imposition of additional protections for beneficiaries. For example, states generally are required by federal Medicaid law to cover certain benefits, while other benefits may be included at a state's option. Subject to CMS approval, states may choose to operate a portion of or their entire Medicaid programs as FFS or managed care. With

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<sup>13</sup>MA organizations are required to respond to grievances, which are complaints that come directly to the MA organization from beneficiaries. CMS oversees MA organizations' grievance processes through the review of plan-submitted data.

<sup>14</sup>Under federal law, states must cover certain populations such as low-income children, pregnant women, and individuals with disabilities under their Medicaid programs. Subject to federal approval, states also have the option of extending Medicaid coverage to additional populations, beyond these mandatory categories.

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respect to managed care, states vary widely in terms of the scope of services they provide and the populations they enroll.<sup>15</sup>

States have certain options when considering whether to enroll Medicaid beneficiaries into managed care, including whether enrollment is voluntary or mandatory. States may obtain the authority to mandatorily enroll Medicaid beneficiaries into managed care plans with CMS approval of a state plan amendment. However, under federal law, states cannot require certain categories of beneficiaries, including dual-eligible beneficiaries, to mandatorily enroll under this authority.<sup>16</sup> Alternatively, states may obtain the authority to enroll Medicaid beneficiaries, including dual-eligible beneficiaries, into managed care through the approval of two types of Medicaid waivers:<sup>17</sup>

- Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with the authority to grant states waivers of certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for the purpose of demonstrating alternative approaches to service delivery.<sup>18</sup>
- Under a 1915(b) waiver, the Secretary may waive certain Medicaid requirements, allowing states to operate a managed care program to the extent it is cost-effective and consistent with the purposes of the program.<sup>19</sup>

Historically, states have been more likely to require beneficiaries who are not dually eligible, such as children and families, to enroll in Medicaid

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<sup>15</sup>States commonly contract with managed care organizations to provide the full range of covered Medicaid services to certain enrollees. States may also rely on other arrangements, such as primary care case management programs in which enrollees are assigned to a primary care provider who is responsible for providing primary care services and for coordinating other needed health care services.

<sup>16</sup>See 42 U.S.C. § 1396u-2(a)(1)-(2).

<sup>17</sup>States must comply with the specific terms and conditions of an approved waiver, which in some cases may be different than the federal requirements that would otherwise apply.

<sup>18</sup>See 42 U.S.C. § 1315(a).

<sup>19</sup>See 42 U.S.C. § 1396n(b). Under these waivers, the Secretary has the authority to waive the requirement that Medicaid beneficiaries can obtain services from any qualified Medicaid provider, thereby allowing states to limit beneficiaries' choice to a network of providers.

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managed care plans. However, more recently states are beginning to move dual-eligible beneficiaries into managed care plans as well. In 2010, about 9.3 percent of dual-eligible beneficiaries were enrolled in Medicaid managed care plans.<sup>20</sup>

Another type of waiver, the 1915(c) waiver, is the primary means by which states provide home- and community-based services (HCBS) to Medicaid beneficiaries. Under a 1915(c) waiver, states can provide HCBS that may not be available under the state's Medicaid plan to beneficiaries that would, if not for the services provided under the waiver, require institutional care.<sup>21</sup> Home health care is one of the services that states may provide under a 1915(c) waiver or through the state's Medicaid plan, in addition to other services such as respite care, personal care, and case management.

At the federal level, CMS oversight of state Medicaid programs includes monitoring the programs and providing guidance to states. States must provide assurances to CMS that they have mechanisms in place to ensure that any managed care organization with which the state contracts complies with federal regulations in order to obtain approval for enrolling Medicaid beneficiaries into managed care. Though CMS is not a party to the contract, states are required to obtain CMS approval of the contracts between states and managed care organizations in order to qualify for federal funding. States administer the day-to-day operations of their Medicaid programs. At the state level, requirements for Medicaid managed care plans are often included as part of the contract between the state and the managed care plan and may derive from federal or state law, regulations, or policies. States generally oversee managed care plans through a combination of informal and formal monitoring that may

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<sup>20</sup>Marsha Gold, Gretchen Jacobson, and Rachel Garfield, "There is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles," *Health Affairs*, vol. 31, no. 6 (June 2012). This percentage does not include dual-eligible beneficiaries enrolled in managed care plans that provide a single or limited set of services, such as dental or behavioral health.

<sup>21</sup>States may also receive CMS approval for a state plan amendment to provide access to home- and community-based services to Medicaid beneficiaries under section 1915(i) authority or section 1915(k) authority. Section 1915(i) authority provides states with the option to furnish home- and community-based services to Medicaid beneficiaries who do not meet institutional level-of-care requirements. Section 1915(k) allows states to cover home- and community-based attendant services for Medicaid beneficiaries who would otherwise qualify for institutional care.

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include regular meetings, reviews of plan-submitted reports, audits, and financial reviews.<sup>22</sup>

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## Selected Consumer Protection Requirements

Medicare and Medicaid have a number of requirements intended to protect the rights of beneficiaries, some of which are of particular importance to dual-eligible beneficiaries.

### Enrollment Choice

Medicare and Medicaid have requirements that specify the circumstances under which a beneficiary may be compelled to enroll in a managed care plan instead of obtaining services through the FFS program. How beneficiaries are enrolled in managed care, for example whether the enrollment is mandatory or voluntary, could have implications for dual-eligible beneficiaries who may have more serious health care needs and who, because of cognitive impairments, may require assistance in understanding their options or the implications of their choices.

### Continuity and Coordination of Care

In general, federal law and regulations do not specifically require MA plans or Medicaid managed care plans to cover services provided by a beneficiary's previous providers if that provider is not in the plan's network when a beneficiary first enrolls in a plan or switches plans. There are limited circumstances when managed care plans are required to cover such services during a transition period. Medicare and Medicaid also have certain federal requirements for managed care plans to ensure coordination of at least some services for beneficiaries. Dual-eligible beneficiaries often have complex health care needs and, therefore, may see several different providers. Accordingly, continuing relationships with providers, as well as ensuring coordination of care, is of particular importance to this population.<sup>23</sup>

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<sup>22</sup>As an illustration, federal regulations require that states have procedures in effect for monitoring the following: (1) recipient enrollment and disenrollment, (2) processing of grievances and appeals, (3) violations subject to intermediate sanctions, (4) violations of conditions of the receipt of federal funding, and (5) all other contractual provisions, as appropriate. 42 C.F.R. § 438.66.

<sup>23</sup>While our discussion of continuity of care focuses on the period of transition as a beneficiary changes managed care plans or payment systems, continuing relationships with providers and coordinating care are also important for dual-eligible beneficiaries in FFS given the complex array of services they may receive from several different providers.

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## Provider Networks

Medicare and Medicaid have requirements for managed care plans to maintain provider networks that ensure beneficiaries can access a range of health care providers and obtain services in a timely manner.<sup>24</sup> Within Medicaid managed care, provider participation problems have been specifically noted for specialty and dental care.<sup>25</sup>

## Marketing Materials

Medicare and Medicaid have requirements about the type and format of materials provided to beneficiaries to promote enrollment into a managed care plan or communicate information about coverage and costs. Inappropriate marketing practices have in the past led some Medicare beneficiaries to enroll in MA plans in which they had not intended to enroll or that did not meet their health care needs. Inappropriate marketing may include activities such as providing inaccurate information about covered benefits and conducting prohibited marketing practices, such as door-to-door marketing without appointments and providing potential beneficiaries with meals or gifts of more than nominal value to induce enrollment.

## Scope of Services

Medicare and Medicaid have requirements about how beneficiaries can qualify for certain services and the scope of coverage provided. According to CMS, two services where coverage differences between Medicare and Medicaid are particularly problematic for dual-eligible beneficiaries are nursing facility services and home health care. While both programs cover these benefits, they differ in terms of how a dual-eligible beneficiary can qualify for the benefit and the scope of the coverage provided. As a result, there can be cost-shifting between the programs.

*Nursing Facility Services.* Medicare and Medicaid both set requirements for the conditions a beneficiary must meet to become eligible for coverage of nursing facility services. Medicare's coverage of nursing facility care is limited to 100 days of posthospital skilled nursing facility (SNF) services.<sup>26</sup>

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<sup>24</sup>Although we focus on provider networks in relation to managed care plans, studies have found differences between provider participation in Medicare FFS and Medicaid FFS. See MACPAC, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: March 2011), and Sandra Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," *Health Affairs*, vol. 31, no. 8 (August 2012).

<sup>25</sup>Kathleen Gifford et al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, The Henry J. Kaiser Family Foundation (Washington, D.C.: September 2011).

<sup>26</sup>42 U.S.C. § 1395d(2).

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SNF services may only be provided in an inpatient setting and include skilled nursing (such as intravenous injections, administration of prescription medications, and administration and replacement of catheters); room and board; and physical, occupational, and speech language therapies. In contrast, Medicaid's coverage of nursing facility services includes skilled nursing, rehabilitation needed due to injury, disability or illness, and long-term care.<sup>27</sup> Under federal law, state Medicaid programs must cover nursing facility services for qualified individuals age 21 or over.<sup>28</sup> All states have chosen to also offer the optional benefit of nursing facility services for individuals under 21 years of age.

Medicare beneficiaries may continue to need nursing facility care after their Medicare benefit is exhausted. In such instances beneficiaries may pay privately or use any long-term care insurance they may have. In certain circumstances, the beneficiaries may also be eligible for Medicaid if, for example, they spend enough of their resources to meet Medicaid eligibility rules in their state. If the beneficiary does become dually eligible, the beneficiary may then qualify for Medicaid coverage of nursing facility services, beyond what Medicare covers.

Overlapping coverage of nursing facility care in Medicare and Medicaid provides nursing facilities with a financial incentive to transfer dual-eligible beneficiaries back to hospitals when nursing facility care is being paid for by Medicaid.<sup>29</sup> By transferring dual-eligible beneficiaries from a nursing facility to a hospital, the nursing facility will qualify for what is generally a higher payment under Medicare when beneficiaries are readmitted and require skilled nursing services. One study of hospitalizations among dually eligible nursing facility residents in 2005 found that approximately 45 percent of hospitalizations among beneficiaries receiving Medicare

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<sup>27</sup>Long-term care consists of health-related care and services above the level of room and board that are not available in the community and are needed regularly due to a mental or physical condition.

<sup>28</sup>42 U.S.C. § 1396a(a)(10)(A).

<sup>29</sup>CMS, *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents* (Mar. 15, 2012).



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SNF services or Medicaid nursing facility services were potentially avoidable.<sup>30</sup>

*Home Health Care.* Medicare and Medicaid both set requirements for how a beneficiary can qualify for home health services, and state Medicaid programs further refine these requirements for Medicaid coverage. Medicare's home health benefit covers skilled nursing services, physical therapy, speech-language pathology, occupational therapy, medical social services, and medical equipment.<sup>31</sup> State Medicaid programs are required to cover home health services for certain categories of beneficiaries, including those who are entitled to nursing facility services under the state plan.<sup>32</sup> Under Medicaid's home health benefit, states must cover nursing services, home health aide services, and medical supplies and equipment for use in the home. States may also choose to cover physical, occupational, or speech therapy under this benefit.<sup>33</sup> The Medicare Payment Advisory Commission reported that some states have tried to increase the proportion of home health services for dual-eligible beneficiaries covered by Medicare, rather than Medicaid. For instance, some states have required home health agencies to show proof of a Medicare denial for home health services for a dual-eligible beneficiary before covering the service under Medicaid.<sup>34</sup>

Additionally, states also have the option of covering home- and community-based services, including home health care and personal care services, for beneficiaries under different authorities. Personal care is designed to provide assistance inside or outside the home with activities

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<sup>30</sup>Edith Walsh et al., *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community Based Services Waiver Programs*, prepared for the Centers for Medicare & Medicaid Services (Washington, D.C.: August 2010).

<sup>31</sup>Medicare may also cover home health aide services on a part-time or intermittent basis if they are needed as support services for skilled nursing services.

<sup>32</sup>42 U.S.C. § 1396a(a)(10)(D).

<sup>33</sup>42 C.F.R. § 440.70.

<sup>34</sup>MEDPAC, *Report to the Congress: New Approaches in Medicare*, (Washington, D.C.: June 2004).

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of daily living (ADL), instrumental activities of daily living (IADL), supervision or guidance with ADLs, or a mix of those.<sup>35</sup>

## Appeals

Beneficiaries' ability to contest a determination that their benefits will be denied, reduced, or terminated is a basic right provided for both Medicare and Medicaid beneficiaries.<sup>36</sup> The appeals process that a beneficiary must follow depends on whether the benefit being contested is a Medicare or Medicaid benefit.

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## Programs to Integrate Medicare and Medicaid for Dual-Eligible Beneficiaries

For many years, efforts have been made to improve coordination of services for dual-eligible beneficiaries. One of these efforts is the Program of All-Inclusive Care for the Elderly (PACE), a provider-based program that serves frail, elderly individuals with the goal of keeping them in the community rather than in long-term care institutions as long as medically and socially feasible. PACE is covered under Medicare, and states may choose to cover the program as an optional benefit under Medicaid. According to CMS, nearly 94 percent of 2011 enrollees in PACE were dual-eligible beneficiaries. Dual-eligible beneficiaries may enroll in PACE if they are age 55 or older, are certified by their state as being eligible for coverage of nursing facility services, and live in a PACE program's service area. PACE providers receive separate capitation payments from Medicare and their state's Medicaid program, which represent total reimbursement for all the services they provide, including primary, acute, and long-term care; behavioral health services; prescription drugs; and end-of-life care planning.<sup>37</sup> The majority of PACE programs provide adult day care, where enrollees receive therapy, medical care, and social support from an interdisciplinary team. As of

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<sup>35</sup>ADLs generally refer to activities such as eating, bathing, using the toilet, dressing, walking across a small room, and getting into or out of a chair or bed. IADLs are necessary for an individual to live independently in the community and include activities such as preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone, doing laundry, getting around outside the home, and taking medications.

<sup>36</sup>Both Medicare and Medicaid have standard appeals processes and expedited appeals processes in cases of urgent need. In this report, we only describe the standard Medicare and Medicaid appeals processes.

<sup>37</sup>A PACE benefit program must include all Medicare covered items and services, Medicaid covered items and services as determined by the state, and other services determined necessary by an interdisciplinary team to improve the participant's overall health status.

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January 2012, 84 PACE sites in 29 states enrolled about 21,000 beneficiaries.<sup>38</sup>

Dual eligible special needs plans (D-SNP), first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),<sup>39</sup> are a more recent attempt to integrate care for dual-eligible beneficiaries.<sup>40</sup> D-SNPs are a type of MA plan exclusively for dual-eligible beneficiaries. As of 2011, about 9 percent of dual-eligible beneficiaries nationally were enrolled in a D-SNP, and another 10 percent were enrolled in other MA plans.<sup>41</sup> MA organizations seeking to offer D-SNPs must contract with the relevant state Medicaid agency.<sup>42</sup>

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## Medicare and Medicaid Consumer Protection Requirements Vary across Programs, Payment Systems, and States

There are key differences in enrollment choice requirements across the Medicare and Medicaid programs, the FFS and managed care payment systems and the selected states. Certain consumer protection requirements are unique to managed care plans in areas such as continuity and coordination of care and provider networks. Other consumer protection requirements also differ across the programs, payment systems, and selected states.

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<sup>38</sup>National PACE Association, "PACE in the States" (Alexandria, Va.: September 2012).

<sup>39</sup>The MMA authorized a type of MA plan referred to as a special needs plan to address the unique needs of certain categories of Medicare beneficiaries, including dual-eligibles. Pub. L. No. 108-173, § 231, 117 Stat. 2066, 2207 (2003) (codified, as amended, at 42 U.S.C. § 1395w-21(a)(2)(A)(ii)). SNPs, including D-SNPs, have been reauthorized several times since their establishment was first authorized in 2003.

<sup>40</sup>Dual-eligible beneficiaries may also choose to enroll in other types of special needs plans for which they are eligible, including institutional SNPs for individuals residing in nursing facilities or institutions, and chronic condition SNPs for individuals with severe or disabling chronic conditions.

<sup>41</sup>See GAO, *Medicare Special Needs Plans: CMS Should Improve Information Available about Dual Eligible Plans' Performance*, [GAO-12-864](#) (Washington, D.C.: Sept. 13, 2012)

<sup>42</sup>Effective January 1, 2010, all MA organizations offering a new D-SNP must have a contract with the state Medicaid agency to operate within a state. Existing D-SNPs that do not have a contract may continue to operate through the 2012 contract year but may not expand service areas during this period. 42 C.F.R. § 422.107(b)(d). If a D-SNP contracts with a state Medicaid agency, the D-SNP receives capitation payments from both Medicare and Medicaid.

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## Notable Differences Exist in Requirements for Enrollment Choice across the Programs, Payment Systems, and Selected States

Within Medicare, enrollment in managed care is always voluntary, whereas state Medicaid programs can require enrollment in managed care in certain situations. In Medicare, beneficiaries—including dual-eligible beneficiaries—are enrolled in FFS unless they select an MA plan. In general, beneficiaries may select an MA plan voluntarily when they first become eligible for Medicare, during an annual coordinated election period,<sup>43</sup> or during special election periods, such as when an MA plan's contract is terminated or discontinued in the area where a beneficiary lives or when CMS determines that beneficiaries meet exceptional conditions.<sup>44</sup> CMS has created a special election period for dual-eligible beneficiaries, and accordingly, they may opt into MA or FFS or change MA plans at any time. They generally may select any MA plan, including D-SNPs, that serves the area where they live, though the number of plans available varies by area. MA plans may limit the providers from whom Medicare beneficiaries, including dual-eligible beneficiaries, may receive covered services,<sup>45</sup> whereas beneficiaries in Medicare FFS may receive covered services from any provider enrolled in Medicare.<sup>46</sup>

In contrast, a Medicaid beneficiary's ability to choose to remain in FFS or enroll in managed care depends on how the state structures its Medicaid program. As an alternative to FFS, states can structure their Medicaid programs to require enrollment in managed care, or allow beneficiaries to choose between the two payment systems. Unlike in Medicare, states can mandatorily enroll beneficiaries, including dual-eligible beneficiaries, into Medicaid managed care with CMS approval of a section 1115

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<sup>43</sup>The annual coordinated election period extends from October 15 through December 7 of each year.

<sup>44</sup>During these times, beneficiaries may also switch between managed care plans. Beneficiaries may also disenroll from MA plans and enroll in FFS at any time from January 1 through February 14 of each year. 42 U.S.C. §§ 1395w-21(a), (e), 42 C.F.R. § 422.62.

<sup>45</sup>An MA organization may specify the network of providers from whom beneficiaries may obtain services if the organization meets certain criteria such as ensuring that covered services are available and accessible within the plan's service area. 42 U.S.C. § 1395w-22(d), 42 C.F.R. § 422.112(a). There are certain circumstances, however, when MA plans must provide coverage of out-of-network services such as for emergency or urgently needed services. 42 C.F.R. § 422.100(b).

<sup>46</sup>42 U.S.C. § 1395cc(a). A provider may be qualified to receive Medicare reimbursement for services rendered to a beneficiary if that provider enters into an agreement with CMS that meets applicable standards.

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demonstration waiver or section 1915(b) waiver.<sup>47</sup> States mandating enrollment into a managed care plan generally must provide beneficiaries a choice of at least two plans, except in specific circumstances, such as in rural areas.<sup>48</sup> Otherwise, similar to Medicare, the number of available Medicaid managed care plans varies, depending on how many plans are offered where the beneficiary lives. Subject to the terms and conditions of the waiver, Medicaid managed care plans can generally limit beneficiaries, including dual-eligible beneficiaries, to the plan's provider network,<sup>49</sup> whereas beneficiaries in Medicaid FFS may receive covered services from any qualified Medicaid provider.<sup>50</sup> CMS officials informed us, however, that for dual-eligible beneficiaries, the agency does not have the authority to allow states to limit the beneficiary's choice of provider for Medicare covered benefits when mandatorily enrolling them into Medicaid managed care plans.

State requirements vary with respect to Medicaid enrollment into FFS or managed care and for choice between plans if beneficiaries enroll in managed care. For example:

- Arizona: The state requires Medicaid beneficiaries, including all dual-eligible beneficiaries, to enroll in either the Medicaid acute or long-term managed care programs under a section 1115 demonstration waiver. Beneficiaries in the state's acute care program have a choice among managed care plans. Beneficiaries enrolled in the long-term care program generally have a choice of plans if they live in or are moving to Pima or Maricopa counties, which are the state's two most

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<sup>47</sup>In addition to using waivers, states may also amend their Medicaid state plan to require certain Medicaid populations to enroll in managed care; however, federal law prohibits states from enrolling dual-eligible beneficiaries under this authority. If a state operates its Medicaid managed care program under this authority, enrollment of dual-eligible beneficiaries would need to be voluntary. See 42 U.S.C. § 1396u-2(a)(1).

<sup>48</sup>42 U.S.C. § 1396u-2(a)(3), 42 C.F.R. § 438.52. States may also limit beneficiaries to enrollment into a single health insuring organization, which is a certain type of plan operated by a county, as long as the beneficiaries have a choice of at least two primary care providers. This option only applies to the state of California.

<sup>49</sup>States must ensure that Medicaid managed care plans maintain a network of appropriate providers that is sufficient to provide adequate access to all covered services. In addition, there are certain circumstances when a Medicaid managed care plan must cover out-of-network services, such as when a beneficiary is unable to obtain necessary services within the plan's provider network. 42 C.F.R. § 438.206(b).

<sup>50</sup>42 U.S.C. § 1396a(a)(23)(A).

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populated counties and the only counties where more than one long-term care plan operates.

- California: Medicaid beneficiaries' choice of payment system varies depending on where they live among California's 58 counties. In 28 mostly rural counties all dual-eligible beneficiaries are in FFS.<sup>51</sup> In the remaining 30 counties, the state has three different Medicaid programs for enrolling beneficiaries in managed care. Dual-eligible beneficiaries in 14 California counties are mandatorily enrolled in managed care through a county-organized health system, which is a health plan operated by a county that contracts with the state to provide health care benefits to Medicaid beneficiaries. Because there is only one plan in each of these counties, beneficiaries enrolled in the county-organized health systems have no choice between plans. Dual-eligible beneficiaries in 14 counties may choose between FFS or the state's Two-Plan managed care program. Under the Two-Plan program, beneficiaries who enroll in managed care have a choice between the Local Initiative Health Plan—a public agency that is independent of the county—and a commercial plan. In the remaining two counties—Sacramento and San Diego—dual-eligible beneficiaries can choose between FFS or the Geographic Managed Care program.<sup>52</sup> Under the Geographic Managed Care program, dual-eligible beneficiaries who enroll in managed care can choose from several commercial managed care plans.
- Minnesota: Dually eligible seniors in Minnesota must enroll in one of two managed care programs, and dual-eligible beneficiaries who became eligible on the basis of their disabilities can choose whether to enroll in a managed care program. Minnesota has a 1915(b)(c) waiver to mandatorily enroll dually eligible seniors in a Medicaid managed care plan.<sup>53</sup> Alternatively, these seniors can choose to enroll

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<sup>51</sup>California is planning an expansion of Medicaid managed care in the state. By June 2013, all counties in the state will offer Medicaid managed care plans to beneficiaries.

<sup>52</sup>In the counties with the Two-Plan or Geographic Managed Care programs, most other Medicaid populations are mandatorily enrolled in managed care.

<sup>53</sup>A 1915(b)(c) waiver simultaneously implements a 1915(b) and a 1915(c) waiver. The combined waiver allows states to provide a continuum of services for the elderly and people with disabilities as long as the requirements of both waivers are met.

Minnesota's program for seniors is for all beneficiaries age 65 and over, whether or not they have a disability. Minnesota has a separate program for other Medicaid populations who are not dual-eligible beneficiaries.

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in a participating D-SNP that, under contract with the state, integrates Medicare and Medicaid financing and services. Dual-eligible beneficiaries age 18 to 64 who have disabilities may opt back into FFS. If they do not opt into FFS, they are enrolled in managed care and may opt into FFS at any time. Whether dual-eligible beneficiaries have a choice between plans varies depending on the county where they live.

- North Carolina: According to North Carolina Medicaid officials, all Medicaid beneficiaries, including dual-eligible beneficiaries, are in FFS, and the majority of dual-eligible beneficiaries are in a primary care case management program, where primary care providers are paid on a FFS basis, in addition to receiving a monthly fee to perform certain care coordination activities.

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## Certain Requirements for Continuity and Coordination of Care, Provider Networks, and Marketing Materials Are Unique to Managed Care

### Continuity and Coordination of Care

In general, federal law and regulations do not specifically require MA plans or Medicaid managed care plans to cover services provided by a beneficiary's previous providers if that provider is not in the plan's network when a beneficiary first enrolls in a plan or switches plans. There are limited circumstances when managed care plans are required to cover such services during a transition period. MA organizations must ensure that covered services are available and accessible to beneficiaries. In implementing this requirement, CMS officials informed us that MA organizations must ensure that there is no gap in coverage or problems with access to medically necessary services when a beneficiary must change to a plan-contracted provider. For example, a beneficiary receiving oxygen may need to switch to a new oxygen supplier when the beneficiary joins the MA plan or switches plans. As the beneficiary transitions to the new oxygen supplier, the MA plan may need to reimburse the beneficiary's previous provider to ensure that there is no gap in coverage, and that the beneficiary maintains access to medically necessary services. MA organizations also must ensure coordination of services through various arrangements with network providers, such as programs that coordinate plan services with community and social

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services in the area, such as services offered by an area agency on aging.<sup>54</sup> Additionally, D-SNPs or any other type of SNP must provide dual-eligible beneficiaries with access to appropriate staff to coordinate or deliver all services and benefits, and coordinate communication among plan personnel, providers, and the dual-eligible beneficiaries themselves.<sup>55</sup>

As with Medicare, Medicaid managed care plans are generally not required to cover services by a beneficiary's previous provider if that provider is not in the plan's network.<sup>56</sup> However, states determine to what extent Medicaid managed care plans must provide beneficiaries with access to a person or entity primarily responsible for coordinating health services on the basis of the services the plan must cover.<sup>57</sup> Individual states may have continuity of care requirements for their Medicaid managed care programs, as defined under an applicable waiver or state requirements. For example, in California, beneficiaries newly enrolled in managed care plans may request and receive coverage of the completion of treatments initiated by an out-of-network provider with whom they have an ongoing relationship in certain circumstances, such as for the treatment of a terminal illness or acute condition. The length of the coverage depends on the stability of the beneficiary and the nature of the medical condition.<sup>58</sup> Minnesota also has continuity of care requirements. For newly enrolled dually eligible seniors, managed care plans must

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<sup>54</sup>42 C.F.R. § 422.112(b).

<sup>55</sup>42 C.F.R. § 422.101(f).

<sup>56</sup>States that mandatorily enroll beneficiaries, including dual-eligibles, in rural areas into managed care without providing a choice of plans must cover out-of-network services and give the beneficiary's prior FFS provider an opportunity to become a network provider. If the provider does not join the network, the beneficiary must select or be transitioned to a participating provider within 60 days. 42 C.F.R. § 438.52(b).

<sup>57</sup>42 C.F.R. § 438.208(a)(3). For example, states determine whether plans must ensure that dual-eligible beneficiaries have a person or entity formally designated as primarily responsible for coordinating services. States also may determine that, on the basis of an assessment of special health care needs, plans must provide a treatment plan for these beneficiaries.

<sup>58</sup>In addition, during California's transition of non-dually eligible seniors and persons with disabilities into managed care, if beneficiaries were seeing a FFS provider before enrolling into a health plan, the beneficiaries may have been able to continue to see that doctor for 12 months while enrolled in the health plan, as long as the physician accepted payment from and agreed to work with the health plan and had no quality of care issues.



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cover medically necessary services that an out-of-network provider, a different plan, or the state agency authorized before the dual-eligible beneficiary enrolled with the managed care plan. However, the plan is allowed to require that the dual-eligible beneficiary receive the services from an in-network provider if that would not create an undue hardship on the dual-eligible beneficiary and the services are clinically appropriate. Arizona requires that managed care plans employ transition coordinators to ensure continuity of care, and beneficiaries in the state's long-term care program receive additional case management for help navigating their care options, including planning, coordinating and facilitating access to services.

## Provider networks

Medicare and state Medicaid programs require managed care plans to meet certain provider network standards. In order to limit beneficiaries to a network of providers, MA organizations must meet a number of requirements, including maintaining and monitoring a network of appropriate providers, under contract, that is sufficient to provide adequate access to covered services to meet the needs of enrolled beneficiaries.<sup>59</sup> Federal guidelines establish minimum network adequacy requirements that vary depending on a county's geographic designation, such as whether the county is urban or rural. MA organizations must contract with sufficient numbers of certain types of provider specialists per 1,000 Medicare beneficiaries in a county. For example, MA plans operating in rural counties must have at least one full-time equivalent (FTE) primary care provider per 1,000 beneficiaries.<sup>60</sup> Additionally, MA organizations must demonstrate that their network meets geographic requirements related to the time and distance it takes beneficiaries to travel to providers. For example, in rural counties, MA organizations must also ensure that 90 percent of beneficiaries can access primary care providers within 40 minutes and 30 miles of travel. MA organizations must also ensure that the networks include a minimum number of specialists and specialty facilities, such as at least one cardiologist and one skilled nursing facility per 1,000 beneficiaries.

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<sup>59</sup>See 42 U.S.C. § 1395w-22(d), 42 C.F.R. § 422.112(a)(1).

<sup>60</sup>For CMS's network adequacy calculations, the primary care provider category comprises physicians in general practice, family practice, internal medicine, and geriatrics, and primary care physician assistants and primary care nurse practitioners.

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States must ensure, through contracts, that Medicaid managed care plans demonstrate that they have the capacity to serve expected enrollment in the service area in accordance with state standards.<sup>61</sup> For example, plans must submit documentation to the state that they offer an appropriate range of preventive, primary care, and specialty services, and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the enrollees.

Unlike Medicare, however, federal Medicaid laws and regulations do not establish minimum provider network requirements and instead generally require states to set the standards for access to care. Accordingly, subject to the terms and conditions of a waiver, if applicable, states may establish requirements that define the minimum number and types of providers in a network, and time and distance requirements between beneficiaries and primary care providers, as well as other network adequacy requirements. For example, Medicaid managed care plans in California must maintain a provider to beneficiary ratio of one FTE primary care physician for every 2,000 beneficiaries and one FTE physician from any specialty for every 1,200 beneficiaries. In some counties, managed care plans must also ensure that primary care physicians are located within 30 minutes or 10 miles of beneficiaries' residences, unless the state approves an alternative time and distance standard. In addition to time and distance standards, Arizona requires managed care plans to contract with a specific number of providers, as determined by the state, which varies by each area that the plan serves. Arizona also defines time frames for beneficiaries to be able to access some services. For example, Arizona Medicaid managed care plans must provide beneficiaries with access to emergency primary care services within 24 hours, urgent primary care services within 2 days, and routine primary care services within 21 days. Plans must include a minimum number of other types of providers—such as dentists, pharmacists, home- and community-based services providers, and behavioral health facilities—in their networks as well.

## Marketing materials

Medicare and Medicaid each have requirements regarding the marketing materials managed care organizations send out to beneficiaries. MA organizations are required to comply with a variety of federal requirements for marketing materials that are intended to promote

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<sup>61</sup>42 U.S.C. § 1396u-2(b)(5), 42 C.F.R. § 438.207.

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enrollment in a specific health plan. For example, organizations generally must submit marketing materials to CMS for review prior to sending to beneficiaries.<sup>62</sup> Materials must provide an adequate written description of the plan's benefits and services and comply with formatting requirements, such as a minimum font size. In addition, MA organizations must translate materials into any non-English language that is the primary language of at least 5 percent of individuals in the plan's service area.<sup>63</sup>

Medicaid managed care plans are required to comply with both federal and state requirements for marketing materials. For example, Medicaid managed care plans must obtain state approval before distributing marketing materials.<sup>64</sup> Federal requirements also mandate that materials must be written in an easily understood language and format,<sup>65</sup> though requirements for format are not precisely defined. In addition, plans must make information, including Medicaid marketing materials, available in each prevalent language spoken by enrollees and potential enrollees in the plan's service area.<sup>66</sup> Subject to the terms and conditions of a waiver, if applicable, states may further define requirements for readability and material translation, while other states may prohibit marketing altogether. For example, marketing materials in California must be translated when a threshold number of beneficiaries whose primary language is not English live in a managed care plan's service area or in the same or adjacent zip codes, among other circumstances. Additionally, all Medicaid marketing materials in California must be written at no higher than the sixth-grade reading level and be approved by the state Medicaid agency. Arizona prohibits Medicaid managed care plans from conducting any marketing that is solely intended to promote enrollment; all marketing materials must include a health message.

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<sup>62</sup>42 U.S.C. § 1395w-21(h)(1), 42 C.F.R. § 422.2262(a).

<sup>63</sup>42 C.F.R. § 422.2264.

<sup>64</sup>42 U.S.C. § 1396u-2(d)(2)(A), 42 C.F.R. § 438.104(b).

<sup>65</sup>42 U.S.C. § 1396u-2(a)(5), 42 C.F.R. §§ 438.10(b), 438.104(b)(iii).

<sup>66</sup>42 C.F.R. §§ 438.104(b)(iii), 438.10(c). States must establish a methodology for identifying prevalent non-English languages spoken by enrollees and potential enrollees throughout the state.

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**Other Requirements Also Vary by Program, Payment System, and State**

Other requirements affecting dual-eligible beneficiaries, such as coverage for nursing facility and home health services and the appeals process, vary between Medicare and Medicaid, and between the FFS and managed care payment systems.

**Scope of Services: Nursing Facility Care**

Beneficiaries must meet different requirements to qualify for nursing facility care under Medicare and Medicaid. As required under federal law, to qualify for Medicare's 100 days of SNF coverage, beneficiaries must have a prior hospital stay.<sup>67</sup> Specifically, Medicare beneficiaries must have been hospitalized for medically necessary inpatient hospital care for at least 3 consecutive calendar days, not including the discharge date. In addition, Medicare beneficiaries must meet certain criteria, such as: (1) require skilled nursing or rehabilitative services on a daily basis, (2) services must only be rendered for a condition the beneficiary had during hospitalization, and (3) require daily skilled services that can only be provided in an SNF.<sup>68</sup>

Unlike Medicare, Medicaid does not limit coverage of nursing facility services to beneficiaries with prior hospital stays and states must cover services provided by qualified SNFs as well as other types of nursing facilities.<sup>69</sup> Instead, federal Medicaid law requires states to provide coverage of nursing facility services for adult Medicaid beneficiaries when medically necessary.<sup>70</sup> Within broad federal parameters, such as requiring that beneficiaries need daily, inpatient nursing facility services that are ordered by a physician, states may impose additional

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<sup>67</sup>42 U.S.C. § 1395d(2). MA plans generally must cover all services covered by Medicare FFS.

<sup>68</sup>42 C.F.R. §§ 409.30, 31. For beneficiaries in MA plans, however, the plans may determine that a direct admission to an SNF without a prior hospital stay is medically appropriate.

<sup>69</sup>SNFs provide skilled nursing care or rehabilitation services. In addition to these services, nursing facilities may also provide health-related care to beneficiaries who, because of their mental or physical condition, require institutional services (above the level of room and board).

<sup>70</sup>42 U.S.C. § 1396a(a)(10)(A). Medicaid managed care plans must cover the same benefits as covered by FFS under the state Medicaid plan.

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requirements when defining coverage for this benefit.<sup>71</sup> For example, beneficiaries in North Carolina, must show they meet the requirements to be in a nursing facility by demonstrating some qualifying conditions. Qualifying conditions may include, among other things, (1) the need for services that require a registered nurse a minimum of 8 hours a day and other personnel working under the supervision of a licensed nurse, (2) the need for restorative nursing to maintain or restore maximum function or prevent deterioration in individuals with progressive disabilities as much as possible, or (3) the need for a specialized therapeutic diet. In Arizona, the acute care program covers nursing facility services for a limited amount of time (90 days) if hospitalization will occur otherwise or the treatment cannot be administered safely in a less restrictive setting, such as at home. Medicaid beneficiaries in the long-term care program in Arizona have longer-term nursing facility benefits. Beneficiaries qualify for the long-term-care program when they have a functional or medical condition that impairs functioning to the extent that the individual would be deemed at immediate risk of institutionalization. Impairments may include, among other things, requiring nursing care, daily nurse supervision, regular medical monitoring, or presenting impairments with cognitive functioning or self-care with ADLs.

## Scope of Services: Home Health Care

Beneficiaries must meet different requirements to qualify for home health services under Medicare and Medicaid. Medicare beneficiaries may only qualify for home health coverage when they are confined to a home or an institution that is not a hospital, SNF, or nursing facility. Additionally, the beneficiary must be under the care of a physician, need intermittent skilled nursing care,<sup>72</sup> physical therapy, speech language pathology

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<sup>71</sup>42 C.F.R. § 440.50. Although coverage of services must be sufficient in amount, duration, and scope to achieve its purpose, states may place appropriate limits on services on the basis of criteria such as medical necessity or utilization control procedures. 42 C.F.R. § 440.230. While Medicaid managed care plans are required to cover services in the same manner as under the state Medicaid plan, in some cases states allow managed care plans to modify requirements so long as they are no more restrictive than the requirements under FFS. 44 C.F.R. § 438.210.

<sup>72</sup>Intermittent means that the skilled care is either provided or needed fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable.

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services, or have a continuing need for occupational therapy services, and receive services under a written plan of care.<sup>73</sup>

Unlike in Medicare, states may not require that Medicaid beneficiaries be confined to a home or institution in order to qualify for home health benefits. Instead, federal regulations require that in order to qualify for Medicaid coverage, home health services generally must be provided at the beneficiary's home and ordered by a physician as part of a written plan of care, which must be renewed every 60 days.<sup>74</sup> As with nursing facility services, state Medicaid programs have the authority to impose additional conditions on accessing home health benefits, and accordingly state programs vary with respect to when beneficiaries may qualify for home health benefits.<sup>75</sup> For example, to receive home health coverage in North Carolina, a physician must order the home health services and must have face-to-face contact with the beneficiary 90 days prior to care or 30 days after care, and the services must be medically necessary. Beneficiaries must have at least one reason, from a specific list of reasons set by the state, to receive home health services.<sup>76</sup> For example, beneficiaries might qualify if they require assistance leaving the home because of a physical impairment or medical condition, or if they are medically fragile.

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<sup>73</sup>42 C.F.R. §§ 409.42, 43. The written plan of care must be reviewed every 60 days or more frequently in some circumstances, such as when there is a change in the beneficiary's condition.

<sup>74</sup>42 C.F.R. § 440.70. As referenced earlier, states may also provide coverage for home health services under a 1915(c) waiver, or other authorities, under which there may be additional requirements to access home health benefits.

<sup>75</sup>Although coverage of services must be sufficient in amount, duration, and scope to achieve its purpose, states may place appropriate limits on services on the basis of criteria such as medical necessity or utilization control procedures. 42 C.F.R. § 440.230. In addition, while Medicaid managed care plans are required to cover services in the same manner as under the state Medicaid plan, in some cases states allow managed care plans to modify requirements so long as they are no more restrictive than the requirements under FFS. 44 C.F.R. § 438.210.

<sup>76</sup>North Carolina has several 1915(c) waivers to cover additional services for certain populations.

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## Appeals Processes

Medicare and Medicaid each have multiple levels of appeals, which vary further between each program's managed care and FFS delivery systems. Accordingly, the appeals processes that dual-eligible beneficiaries encounter differ depending on whether the benefit being denied, reduced, or terminated is a Medicare or Medicaid benefit, and whether the individual is enrolled in FFS or managed care.<sup>77</sup> Both programs require that beneficiaries in either managed care and FFS be notified of their right to appeal.<sup>78</sup>

Medicare has five levels of appeals for managed care and FFS.

1. Beneficiaries enrolled in an MA plan must first request review by the MA organization.<sup>79</sup> In FFS, beneficiaries first request review by the claims processing contractor that made the initial coverage decision.<sup>80</sup>

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<sup>77</sup>These appeals processes also apply when eligibility is denied or a claim is not acted upon with reasonable promptness. For this report, we are focusing on appeals for coverage that is denied, reduced, or terminated. There are other parties that may appeal a denial, reduction, or termination of a benefit. For purposes of this report, however, we only address the beneficiary's rights with respect to these appeal processes.

<sup>78</sup>For Medicare, beneficiaries must receive a notice of the initial coverage determination that includes information on the right to request review by the appropriate entity and subsequent appeals processes, when applicable. 42 U.S.C. §§ 1395w-22(g)(1), 1395ff(a)(4), 42 C.F.R. §§ 405.921(a), 422.568(e). Medicaid FFS beneficiaries must receive notice from the state informing them of their right to a state fair hearing when the state intends to terminate, suspend, or reduce covered services. 42 C.F.R. § 431.206. Medicaid managed care enrollees must receive a notice of the initial coverage determination from their managed care plan, which must include information on the right to file an appeal with the plan or request a state fair hearing, when applicable. 42 C.F.R. § 438.404.

<sup>79</sup>MA organizations must have a process in place to make organizational determinations as to whether a beneficiary is entitled to receive coverage for a health service. Beneficiaries have the right to request reconsideration by the MA organization of any adverse organizational determination. When a denial of coverage is based on the lack of medical necessity, the reconsidered determination must be made by a physician with the appropriate medical expertise. 42 U.S.C. §1395w-22(g)(1)-(2), 42 C.F.R. §§ 422.566, .578.

<sup>80</sup>42 U.S.C. § 1395ff(a), (b), 42 C.F.R. § 405.940. CMS contracts with Medicare Administrative Contractors to process claims in Medicare FFS. The contractors make initial determinations as to whether Medicare will cover services. Beneficiaries dissatisfied with this initial determination may request a redetermination from the contractor, regardless of the amount.

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2. For MA, if the adverse determination is affirmed, the issues must be automatically reviewed and resolved by an independent review entity, and for Medicare FFS, beneficiaries may request review by a qualified independent contractor.<sup>81</sup> For beneficiaries in either FFS or managed care, this is the earliest opportunity for their claim to be reviewed by a different entity than the one that made the original determination.
  3. If the independent entity affirms the adverse determination, MA and FFS beneficiaries have the right to request a hearing before an administrative law judge (ALJ) in the Department of Health and Human Services if the amount remaining in controversy—the projected value of denied services or a calculated amount based on charges for services provided—is above a specified level.<sup>82</sup>
  4. MA and FFS beneficiaries who are dissatisfied with the ALJ hearing decision may request review by the Medicare Appeals Council.<sup>83</sup>
  5. MA and FFS beneficiaries may request judicial review by a U.S. district court of a decision by the Medicare Appeals Council if the amount in controversy is above a specified level.<sup>84</sup>

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<sup>81</sup>42 U.S.C. §§ 1395w-22(g)(4), 1395ff(c), 42 C.F.R. §§ 405.960, 422.592.

<sup>82</sup>42 U.S.C. § 1395w-22(g)(5), 42 U.S.C. § 1395ff(b), (d), 42 C.F.R. §§ 405.1000, 405.1004, 422.600. Medicare FFS beneficiaries have the right to request an ALJ hearing if (1) they are dissatisfied with the qualified independent contractor's decision, (2) the qualified independent contractor has not rendered its decision within applicable time frames, or (3) the qualified independent contractor dismissed their request. ALJs are employed by the Department of Health and Human Services and are responsible for conducting formal proceedings such as hearings, among other things. CMS established a formula for annually calculating the minimum amount that must be in controversy for beneficiaries to appeal to an ALJ. That amount was \$130 for 2012.

<sup>83</sup>42 C.F.R. §§ 405.1100, 422.608. The Medicare Appeals Council undertakes a *de novo* review and may issue a final decision, dismiss the appeal, or remand the case to the ALJ with instructions for rehearing the case. Medicare FFS beneficiaries may also request this review if the ALJ dismissed their case or failed to issue a timely decision.

<sup>84</sup>42 U.S.C. § 1395w-22(g)(5), 42 U.S.C. § 1395ff(b), 42 C.F.R. §§ 405.1132, 422.612. The minimum amount that must be in controversy for beneficiaries to request judicial review is updated annually. The amount was \$1,350 for 2012. In addition to the threshold amount requirement, Medicare FFS beneficiaries may request judicial review if the Medicare Appeals Council has not issued a decision, dismissed the case or remanded the case back to an ALJ within the relevant period. MA beneficiaries may request judicial review if the council's decision is the final determination of CMS or the council denied the request for review.



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There are no federal Medicare requirements that benefits continue during the appeals processes for either managed care or FFS, nor do federal law and regulations require that FFS or MA beneficiaries receive personal assistance, including assistance from a care coordinator or other specialist, when navigating the appeals process. However, there are certain protections incorporated into the appeals process that are designed to assist Medicare beneficiaries. For example, Medicare beneficiaries may appoint a representative to assist them with an appeal. Beneficiaries also may seek assistance through the Office of the Medicare Beneficiary Ombudsman, which is responsible for resolving inquiries and complaints for all aspects of the Medicare program, through the 1-800-MEDICARE help line.

States can structure their Medicaid appeals processes within the parameters of federal requirements. Medicaid FFS beneficiaries must have access to a fair hearing before a state agency for certain actions, including when benefits are terminated, suspended, or reduced.<sup>85</sup> Once a final agency decision is made, Medicaid FFS beneficiaries may request a judicial review of the decision if permitted under state law. Beneficiaries in Medicaid managed care plans must have the ability to appeal a termination, suspension, or reduction of a benefit to the plan as well as have access to a state fair hearing.<sup>86</sup> States determine whether beneficiaries must first exhaust their appeal to their Medicaid managed care plans before they may request a state fair hearing. During these appeals, benefits generally must continue in certain circumstances. Benefits generally must continue until a final agency decision is made if the beneficiary is mailed a notice of action and files an appeal before the

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<sup>85</sup>42 U.S.C. § 1396a(a)(3), 42 C.F.R. §§ 431.205, .240(a)(3). State Medicaid agencies must provide for a hearing before the agency or an evidentiary hearing at the local level with the right to appeal to a state agency hearing. The state agency hearing must be conducted by one or more impartial officials. In providing a final agency decision to the beneficiary, state agencies may choose to accept or reverse the hearing officials' decision or request a rehearing.

<sup>86</sup>42 U.S.C. § 1396u-2(b)(4), 42 C.F.R. §§ 438.400, .402. Each Medicaid managed care plan must have an internal appeals process in place for beneficiaries to challenge certain actions, including termination, suspension, or reduction of a service, denial or limited authorization of a service, or a denial of payment for a service.

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date of the action.<sup>87</sup> As in Medicare, neither federal regulations nor law require that beneficiaries in Medicaid FFS have access to personal assistance in navigating the appeals process. States, however, have the option of providing this assistance to FFS beneficiaries.<sup>88</sup> For beneficiaries in Medicaid managed care, plans must give beneficiaries assistance with completing appeal forms and taking other procedural steps, including providing interpreter services and toll-free numbers for assistance.<sup>89</sup>

The appeals processes in the states that we reviewed varied, for instance as to whether a beneficiary in managed care has to appeal to his or her managed care plan first. For example, Arizona requires beneficiaries to first appeal to their managed care plan before requesting a state fair hearing. In contrast, Minnesota allows beneficiaries to request a state fair hearing without first appealing to their managed care plan. Dual-eligible beneficiaries in Minnesota may also request help from the state ombudsman, and county boards are required to designate a coordinator to assist the state Medicaid agency, including coordinating appeals with the ombudsman.

See appendix II for a more detailed summary of these consumer protection requirements across programs, payment systems, and selected states.

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<sup>87</sup>For Medicaid FFS beneficiaries, benefits must continue unless it is determined at the hearing that the sole issue is one of federal or state law or policy. 42 C.F.R. § 431.230. States may also reinstate benefits if the beneficiary requests a hearing within a certain time frame after the date of action. 42 C.F.R. § 431.231. For Medicaid managed care beneficiaries, benefits must continue if the beneficiary files a timely appeal, the appeal involves the termination, suspension, or reduction of a previously authorized service, the service was ordered by an authorized provider, the original period covered by the authorization has not expired, and the beneficiary requests the extension of benefits. 42 C.F.R. § 438.420.

<sup>88</sup>For example, states may assist beneficiaries with the submission and processing of their appeal requests. See 42 C.F.R. § 431.221(c).

<sup>89</sup>42 C.F.R. § 438.406.

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## CMS and States Used a Range of Actions to Help Ensure Organizations Comply with Medicare and Medicaid Consumer Protection Requirements

CMS and states used compliance and enforcement actions that ranged from informal written notices to contract terminations in order to help ensure MA organizations and Medicaid managed care plans complied with consumer protection requirements.

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## CMS Took Compliance and Enforcement Actions against Medicare Advantage Organizations

CMS used both compliance and enforcement actions to bring noncompliant MA organizations into compliance with federal requirements. Compliance actions are intended to prompt managed care organizations to address issues of noncompliance, such as the timing of disenrollments, whereas enforcement actions impose a penalty on a managed care organization and are taken to address more significant violations. According to CMS, the nature of each violation is considered when determining the appropriate compliance or enforcement action and the actions generally proceed through the process in a step-by-step manner before enforcement actions are taken.<sup>90</sup>

## Compliance Actions

CMS takes compliance actions against MA organizations to address violations that are identified during the agency's monitoring and auditing activities. According to agency guidance, compliance actions are appropriate when the MA organization: (1) demonstrates sustained poor performance over a period of time; (2) has a noncompliance issue that involves a large number of beneficiaries; or (3) does not meet its contractual requirements. The lowest-level compliance action is a notice of noncompliance, which may be an e-mail from a CMS contract manager to a managed care plan stating that an aspect of the program is out of compliance. The notice of noncompliance requests the plan respond with how it will address the problem and may be followed by a warning letter from CMS that identifies a limited and quickly fixable issue of noncompliance that requires immediate remedy. If CMS determines that

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<sup>90</sup>For more serious violations, CMS may choose to immediately proceed to later-stage compliance or enforcement actions.

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the noncompliance affects multiple beneficiaries and represents an ongoing or systemic inability by the plan to adhere to Medicare requirements, CMS will send a formal letter to the MA's chief executive officer stating the concern and requiring the organization to develop and implement a corrective action plan (CAP). The CAP must address the deficiencies identified by CMS, provide an attainable time frame for implementing corrective actions, and devise a process for the managed care organization to validate and monitor that the corrective actions were taken and remain effective.

Between January 1, 2010, and June 30, 2012, CMS took 546 compliance actions generally related to consumer protection requirements of importance to dual-eligible beneficiaries.<sup>91</sup> (See table 1.) These issues of noncompliance that could potentially affect dual-eligible beneficiaries were identified during CMS's ongoing oversight activities, analysis of plan deliverables, and complaints made by beneficiaries or providers. Of these 546 actions, 386, or 70 percent, were due to marketing issues.<sup>92</sup> CMS sent notice of noncompliance or warning letters for marketing issues related to misrepresentation of requirements for enrollment and use of unapproved marketing materials.

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<sup>91</sup>CMS's Compliance Activity Module (CAM) includes 45 different compliance categories. In consultation with CMS staff, we determined the top eight issue categories most closely aligned with the consumer protections identified and detailed in our first finding. However, actions directly tied to dual-eligible beneficiaries could not be broken out from actions tied to the Medicare beneficiary population broadly.

<sup>92</sup>We have previously reported on marketing violations by MA organizations. See GAO, *Medicare Advantage: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue*, [GAO-10-36](#) (Washington, D.C.: Dec. 17, 2009).

**Table 1: Selected CMS Compliance Actions against Medicare Advantage (MA) Organizations, January 1, 2010–June 30, 2012**

Issue	Compliance actions			Total compliance actions
	Notice of noncompliance	Warning letters	Corrective action plans	
Marketing	314	72	0	<b>386</b>
Enrollment/disenrollment	94	23	1	<b>118</b>
Appeals/grievances <sup>a</sup>	12	2	2	<b>16</b>
Benefits administration	11	0	0	<b>11</b>
Complaint monitoring	5	1	0	<b>6</b>
Premium/copay Billing	4	0	2	<b>6</b>
Access to services/providers	3	0	0	<b>3</b>
Coordination of benefits	0	0	0	<b>0</b>
<b>Total actions</b>	<b>443</b>	<b>98</b>	<b>5</b>	<b>546</b>

Source: CMS.

Note: Data are from CMS’s Compliance Activity Module (CAM). The CAM includes 45 different compliance categories. In consultation with CMS staff, we determined the top eight issue categories most closely aligned with the consumer protections identified by researchers and detailed in our first finding. However, actions directly tied to dual-eligible beneficiaries could not be broken out from actions tied to the Medicare beneficiary population broadly. Data exclude compliance actions taken against Medicare prescription drug plans.

<sup>a</sup>A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested.

The second most common issue resulting in a compliance action was related to beneficiary enrollment/disenrollment in a MA plan. Twenty-two percent, or 118, of CMS’s compliance actions were due to issues such as delays in disenrollment processing, lack of monthly attestation of enrollment data, and failure to verify that beneficiaries were eligible to enroll in SNPs.

## Enforcement Actions

In addition to compliance actions, CMS may take enforcement actions against MA organizations for more serious violations. Enforcement actions can be taken when (1) all compliance actions have been exhausted, (2) the MA organization has a repeat deficiency, (3) the area of noncompliance could result in harm to one or more Medicare beneficiaries, or (4) the area of noncompliance is deemed a “substantial failure” of Medicare requirements. Enforcement actions include the imposition of intermediate sanctions defined as the imposition of civil money penalties (CMP), the suspension of enrollment of or marketing to Medicare beneficiaries, or the suspension of payment to a MA

organization.<sup>93</sup> CMS also has the authority to terminate the organization's MA contract.<sup>94</sup>

CMS took 22 enforcement actions related to consumer protection requirements against MA organizations between January 1, 2010, and June 30, 2012. (See table 2.) These enforcement actions were taken against MA organizations offering plans serving all beneficiaries, not just dual-eligible beneficiaries. Seventeen of the 22 enforcement actions were CMPs imposed because of marketing violations. According to CMS, these violations included incomplete, inaccurate, or late marketing communications about plan benefits or changes that prevented beneficiaries from having complete information to choose among competing MA plans. CMS levied a total of about \$3.4 million in CMPs against MA organizations during the period. The average CMP was about \$200,000.

**Table 2: CMS Enforcement Actions against Medicare Advantage (MA) Organizations, January 1, 2010–June 30, 2012**

Violation issue	CMS enforcement action		
	Suspension of enrollment or marketing	Civil monetary penalties	Termination
Access to services	0	0	0
Access to drugs	3	1	0
Marketing communications/broker	2	15	0
Patient billing/contract administration	0	1	0
<b>Total</b>	<b>5</b>	<b>17</b>	<b>0</b>

Source: CMS.

Note: Data are from CMS enforcement letters. These enforcement actions include those taken in response to issues affecting all MA beneficiaries, not just dual-eligible beneficiaries. Data exclude enforcement actions taken against Medicare prescription drug plans.

<sup>93</sup>42 U.S.C. 1395w-27(g). Intermediate sanctions may be imposed for certain categories of misconduct including (1) failing substantially to provide medically necessary services in a manner that has adversely affected beneficiaries, (2) imposing premiums or charges on enrollees that are in excess of those permitted under the program, (3) misrepresenting or falsifying information that is furnished to the Secretary or beneficiaries, and (4) failing to comply with marketing requirements.

<sup>94</sup>Prior to termination of a contract, CMS must provide the MA organization with the opportunity to develop and implement a corrective action plan (CAP) and the opportunity to appeal the termination.

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CMS suspended plan enrollment and marketing activities five times. Three plans were suspended because of deficiencies in the administration of their prescription drug benefit resulting in beneficiaries not receiving medications. The agency suspended two other MA plans because of the use of prohibited marketing practices affecting vulnerable populations. These practices included brokers using aggressive tactics,<sup>95</sup> misrepresenting plan information, and enrolling beneficiaries in plans without their knowledge. Once the five plans corrected these violations to CMS's satisfaction, the agency released them from sanctions and they were permitted to market to and enroll beneficiaries again. Four of the suspensions were for 14 months or longer. CMS did not terminate any MA plan during our reporting period.

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## States Took Actions against Medicaid Managed Care Plans

Oversight of Medicaid managed care plans is the primary responsibility of the states. The states we interviewed have systems in place to monitor ongoing activities and to take action when the need arises.<sup>96</sup> State officials said they communicate regularly with plans to anticipate and troubleshoot potential problems. They also provide plans with guidance and offer training and technical assistance resources. In addition, all three of the states we reviewed required monthly reports of plan activities, and conducted periodic audits of their managed care plans to identify and address issues of noncompliance.

The three states we reviewed used similar sequences of actions to identify and address issues of noncompliance by their Medicaid managed care plans. State officials reported that when noncompliance issues are suspected they first notify the plans and give them an opportunity to remedy the problem. Subsequent deficiencies may require a Medicaid managed care plan to initiate a corrective action plan that the state would monitor to assure the appropriate changes are made. Between January 1, 2010, and June 30, 2012, the three states reported they took a total of 157 compliance actions against their Medicaid managed care plans. These actions ranged from sending warning letters, issuing notices to

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<sup>95</sup>A broker is an individual who markets a specific MA plan and may receive compensation directly or indirectly from a managed care organization for marketing activities.

<sup>96</sup>North Carolina does not contract with managed care plans.

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cure, requiring CAPs, and imposing financial penalties.<sup>97</sup> The most common action taken by the states was to require a managed care plan to implement a CAP.

The reasons that states required Medicaid managed care plans to institute CAPs during the reporting period varied. California and Minnesota identified noncompliance with the appeals and grievance process that required corrective actions.<sup>98</sup> California required plans to take corrective actions to ensure beneficiaries were able to access appropriate translation services. The majority of the CAPs required by Minnesota's Medicaid office dealt with plan management of beneficiary appeals and grievances. Arizona required CAPs to address the use of unapproved marketing materials. After appeals, the next most frequent reason states requested CAPs on consumer protection requirements was to address problems regarding beneficiaries' access to providers, services, or drugs. Figure 2 illustrates the reasons why Medicaid managed care plans were required to implement a CAP for the 91 CAPs issued during the period.

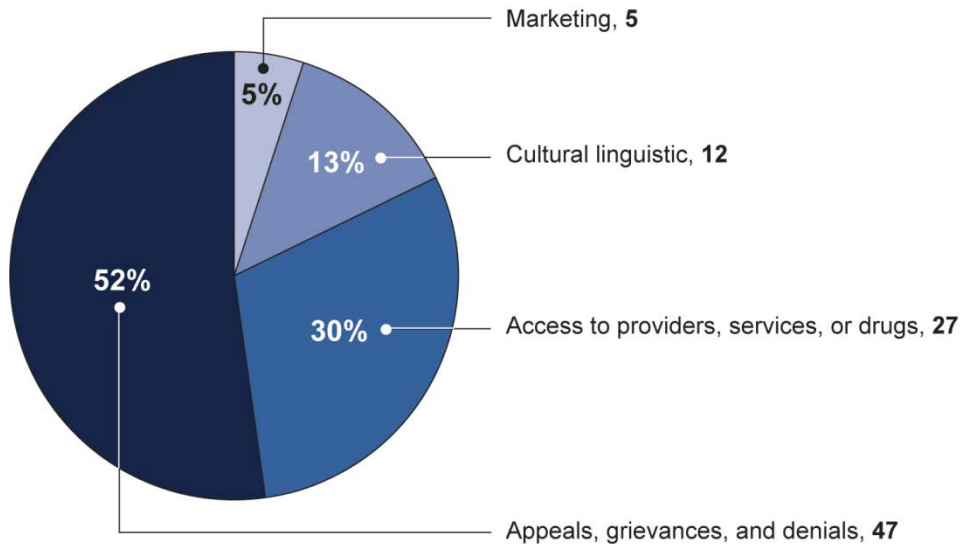
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<sup>97</sup>In California, two departments—the Department of Health Care Services and the Department of Managed Health Care—share responsibility for oversight of Medicaid managed care plans. We obtained compliance and enforcement data from the Department of Health Care Services, which operates the Medicaid managed care program in California. We were not able to obtain similar information from the Department of Managed Health Care, which oversees all managed care plans in the state, because its data do not separate Medicaid lines of business from other lines of business a managed care organization may operate. Officials from the Department of Managed Health Care told us that issues related specifically to Medicaid managed care plans represent a small percentage of total compliance and enforcement actions taken by that agency.

<sup>98</sup>A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the operations, activities, or behavior of a health plan, or its providers, regardless of whether remedial action is requested.



**Figure 1: Number of and Reasons for Corrective Action Plans (CAP) Required by Selected States, January 1, 2010–June 30, 2012**



Source: GAO analysis of information obtained from state Medicaid officials in Arizona, California, and Minnesota.

Note: Corrective action plans (CAP) may include actions to address multiple deficiencies.

In addition to termination of contracts, under federal law states must establish a series of intermediate sanctions that may be imposed on Medicaid managed care plans for failing to comply with certain federal requirements.<sup>99</sup> An intermediate sanction may be imposed when a managed care plan (1) fails substantially to provide medically necessary services under its contract with the state, (2) imposes premiums or charges on enrollees that are in excess of those permitted under the program, (3) discriminates among enrollees on the basis of their health status, and (4) misrepresents or falsifies information that it furnishes to CMS or the state. Under these circumstances, states may impose a CMP, appoint temporary management for the health plan, grant enrollees the right to terminate enrollment without cause, suspend new enrollment in the plan, or suspend payment to the plan. If a state takes an intermediate sanction against a managed care plan it must report it to CMS. According

<sup>99</sup>42 U.S.C. § 1396u-2(e). While the intermediate sanction authority pertains to statutorily defined categories of noncompliance, states also have authority to take action for other types of noncompliance such as defined under the terms of their contracts with Medicaid managed care plans.

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to CMS, none of the three states we reviewed imposed an intermediate sanction against a managed care plan because of violations of consumer protection requirements during our reporting period.

While CMS does not directly oversee the operation of Medicaid managed care plans, CMS has the authority to disallow or withhold federal matching funds to states for certain reasons, including if states fail to obtain prior approval of contracts with Medicaid managed care plans or if the contracts fail to meet applicable federal requirements.<sup>100</sup> Between January 1, 2010, and June 30, 2012, CMS did not stop or defer federal Medicaid payments to any state Medicaid program because of contractual issues related to consumer protections, according to agency officials.<sup>101</sup>

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## Agency Comments

We received written comments on a draft of this report from the Department of Health and Human Services, which are reprinted in appendix III, and technical comments, which we incorporated as appropriate. The department noted that the report was an accurate assessment of the programs we reviewed, and added that the Medicare-Medicaid Coordination Office has already made some progress aligning the requirements between the two programs in the area of appeals. CMS has developed a revised Notice of Medicare Denial of Coverage (or Payment) that includes optional language to be used in cases where a Medicare health plan enrollee also receives full Medicaid benefits that are being managed by the Medicare health plan. The revised Notice of Medicare Denial of Coverage (or Payment) is under review as part of the approval process.

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We will send copies of this report to the Administrator of CMS and interested congressional committees. We will also make copies available at no charge on GAO's website at <http://www.gao.gov>.

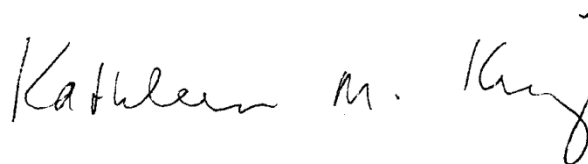
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<sup>100</sup>As a condition of federal matching funds for Medicaid managed care programs, CMS must review and approve comprehensive risk contracts between states and Medicaid managed care plans.

<sup>101</sup>CMS did defer four payments to two states for reasons unrelated to the consumer protections we reviewed for this report. The four deferred payments were for \$6,477, \$64,227, \$65,732, and \$4,203,782, totaling about \$4.34 million.

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If you or your staff have any questions about this report, please contact me at (202) 512-7114 or KingK@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

A handwritten signature in black ink that reads "Kathleen M. King". The signature is written in a cursive style with a small mark above the letter 'i' in "King".

Kathleen M. King  
Director, Health Care

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*List of Requesters*

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate

The Honorable John D. Rockefeller IV  
Chairman  
Subcommittee on Health Care  
Committee on Finance  
United States Senate

The Honorable Sander M. Levin  
Ranking Member  
Committee on Ways and Means  
House of Representatives

The Honorable Henry A. Waxman  
Ranking Member  
Committee on Energy & Commerce  
House of Representatives

The Honorable Pete Stark  
Ranking Member  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

The Honorable Frank Pallone Jr.  
Ranking Member  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

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# Appendix I: Information on Selected States' Medicaid Programs

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## Arizona

In Arizona's Medicaid program, called the Arizona Health Care Cost Containment System, nearly all Medicaid beneficiaries, including dual-eligible beneficiaries, are enrolled in the acute care managed care program for Medicaid benefits. Individuals requiring long-term supports and services are enrolled in a separate long-term care managed care program. Both managed care programs operate under a section 1115 demonstration waiver. As of January 2012, Arizona had about 110,000 dual-eligible beneficiaries enrolled in Medicaid managed care, and over 1.3 million total Medicaid beneficiaries.

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## California

California's Medicaid system, called Medi-Cal, includes 28 counties with only a fee-for-service (FFS) system and 30 counties with one of three different managed care programs. Of the managed care options, the first is a county-operated health system, which requires nearly all Medicaid beneficiaries in participating counties, including dual-eligible beneficiaries, to enroll in a plan operated by the county. The second is the Two-Plan model, which has a commercial plan and a Local Initiative Health Plan—a public agency that is independent of the county. In the third program, called Geographic Managed Care, several commercial plans are offered as choice for beneficiaries. In both the Two-Plan and Geographic Managed Care programs, most Medicaid beneficiaries in the county are mandatorily enrolled in a managed care plan, but dual-eligible beneficiaries are in FFS unless they enroll voluntarily into one of the health plans. California officials reported that, as of June 2012, 26 percent of California's approximately 1 million dual-eligible beneficiaries are enrolled in managed care, while the remaining 74 percent of dual-eligible beneficiaries are in FFS.

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## Minnesota

In Minnesota, dual-eligible beneficiaries who are 65 years old and older are required to enroll in a managed care program called Minnesota Senior Care Plus (MSC+). As of June 2012, about 10,500 dually eligible beneficiaries 65 and older in Minnesota are enrolled in MSC+. Alternatively, dual-eligible beneficiaries 65 and older may choose to enroll in the Minnesota Senior Health Options (MSHO) program. Unlike MSC+ plans, MSHO plans are Medicare special needs plans that also have contracts with the state for the Medicaid benefits package, which enables the plans to integrate Medicare and Medicaid financing and services for dual-eligible beneficiaries. About 35,700 dually eligible beneficiaries 65 and older in Minnesota are enrolled in a MSHO plan. Dual-eligible beneficiaries age 18 to 64 who have a disability are enrolled in the state's Special Needs Basic Care managed care program if they do not opt into

Medicaid FFS. As of July 2012, about 39,000 of the state's disabled population (both dual-eligible beneficiaries and non-dual-eligible beneficiaries) are enrolled in Special Needs Basic Care. More than 21,000 of these disabled beneficiaries were dual-eligible beneficiaries. According to Minnesota Medicaid officials, as of June 2012, almost 14 percent, or about 114,500, of Minnesota's Medicaid population are dual-eligible beneficiaries, and 59 percent of the state's dual-eligible beneficiaries are enrolled in managed care.

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## North Carolina

According to North Carolina Medicaid officials, North Carolina primarily operates its Medicaid program through a primary care case management (PCCM) program, called Carolina Access. Under the PCCM program, primary care providers are paid on a FFS basis, in addition to receiving a monthly fee for certain care coordination activities. The state's enhanced PCCM program, called Community Care of North Carolina, includes 14 networks of primary care providers that are responsible for an enhanced set of care coordination activities. According to North Carolina Medicaid officials, dual-eligible beneficiaries are assigned a primary care provider in one of the 14 networks, but they may opt out of the program if they choose a healthcare provider outside of the state's Medicaid program. As of June 2012, according to state officials, about 13 percent of the state's Medicaid population was dually eligible for Medicare and Medicaid and almost 68 percent of dual-eligible beneficiaries in the state were enrolled in the state's PCCM program.

# Appendix II: Description of Selected Federal and State Requirements

Table 3 describes selected consumer protection requirements for Medicare and Medicaid fee-for-service (FFS), and table 4 describes selected consumer protection requirements for Medicare Advantage (MA) and Medicaid managed care.

**Table 3: Selected Requirements in Medicare and Medicaid FFS**

Requirement	Payment system	
	Medicare FFS	Medicaid FFS
<b>Enrollment and choice</b>		
How are beneficiaries enrolled (e.g., mandatory or voluntary enrollment)?	<p><i>Federal requirements</i></p> <p>Beneficiaries are enrolled in FFS if they do not enroll in managed care voluntarily.</p>	<p><i>Federal requirements</i></p> <p>Beneficiaries may enroll voluntarily in a managed care plan or are mandatorily enrolled if the state has the Centers for Medicare and Medicaid Services (CMS) approval. They are in FFS if they are not enrolled in managed care.</p> <p><i>Examples of state requirements</i></p> <p>Arizona has a section 1115 demonstration waiver to mandatorily enroll beneficiaries in managed care.</p> <p>In California, all beneficiaries in 28 counties are in FFS. Dual-eligible beneficiaries in another 16 counties are in FFS unless they enroll voluntarily in a managed care plan. Dual-eligible beneficiaries in the 14 remaining counties are mandatorily enrolled in managed care.</p> <p>Minnesota has a section 1915(b)(c) waiver to mandatorily enroll dually eligible seniors in managed care. A 1915(b)(c) waiver simultaneously implements a 1915(b) and a 1915(c) waiver. The combined waiver allows states to provide a continuum of services for the elderly and people with disabilities as long as the requirements of both waivers are met. Dual-eligible beneficiaries age 18 to 64 who have disabilities may opt into FFS. If they do not opt into FFS, they are enrolled in managed care and may opt into FFS at any time.</p> <p>All North Carolina beneficiaries are in FFS.</p>
To what extent can beneficiaries select their primary care provider?	<p><i>Federal requirements</i></p> <p>Beneficiaries may generally select any provider who is enrolled as a Medicare provider.<sup>a</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries may generally select any provider who is enrolled as a Medicaid provider.<sup>b</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare FFS</b>	<b>Medicaid FFS</b>
Can beneficiaries enrolled in managed care switch to FFS?	<p><i>Federal requirements</i></p> <p>Dual-eligible beneficiaries may switch to FFS at any time, while most other beneficiaries may only switch during certain periods.<sup>c</sup></p>	<p><i>Federal requirements</i></p> <p>Requirements depend on whether dual-eligible beneficiaries are voluntarily or mandatorily enrolled into plans.<sup>d</sup></p> <p><i>Examples of state requirements</i></p> <p>Beneficiaries in Arizona generally may not switch to FFS.</p> <p>In California, dual-eligible beneficiaries in 16 counties are enrolled voluntarily in managed care and may switch to FFS at any time. Dual-eligible beneficiaries in 14 counties are mandatorily enrolled in managed care and may not switch to FFS.</p> <p>In Minnesota, dually eligible beneficiaries with a disability who are enrolled voluntarily in managed care may switch to FFS in any month. Dually eligible seniors may not switch to FFS.</p>
How are beneficiaries informed of and counseled on enrollment options?	<p><i>Federal requirements</i></p> <p>Beneficiaries receive information about Medicare coverage from CMS. Beneficiaries may also receive CMS-reviewed marketing materials sent by MA organizations.<sup>d</sup></p>	<p><i>Federal requirements</i></p> <p>In states that also have managed care programs, states must ensure that beneficiaries receive a summary of the state's Medicaid managed care program from the state or its contracted representatives. The summary must include, among other things, information about the program requirements, covered benefits, and cost for each plan operating in the service area.<sup>e</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, beneficiaries in the long-term care program have access to an eligibility case worker who determines eligibility and helps them navigate their enrollment options.</p> <p>Beneficiaries in Minnesota may call a help line specifically for senior citizens or people with disabilities for information about enrollment options. The state or county agency is responsible for describing the available managed care plans for dually eligible seniors through presentations or written materials.</p> <p>In North Carolina, county Departments of Social Services are responsible for notifying beneficiaries about their provider options.</p>



**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare FFS	Medicaid FFS
<b>Scope of services</b>		
Under what circumstances can beneficiaries obtain coverage for nursing facility services?	<p><i>Federal requirements</i></p> <p>Medicare covers posthospital extended care services for up to 100 days for any spell of illness.<sup>f</sup></p> <p>In order to access posthospital skilled nursing facility (SNF) care, beneficiaries must have been hospitalized for medically necessary inpatient hospital care for at least 3 consecutive calendar days, not including the discharge date and be eligible for Medicare on the date of discharge. The beneficiary also generally must be admitted to the facility within 30 days after the date of discharge from the hospital.<sup>g</sup></p> <p>In addition, (1) the beneficiary must require skilled nursing or rehabilitative services on a daily basis, (2) the services must be furnished for a condition the beneficiary had during hospitalization, and (3) the daily skilled services required are those that can only be provided in an SNF.<sup>h</sup></p>	<p><i>Federal requirements</i></p> <p>State Medicaid programs must cover nursing facility care for adult Medicaid beneficiaries and may cover this benefit for children as an optional benefit.<sup>i</sup></p> <p>Beneficiaries must need daily, inpatient nursing facility services ordered by a physician in order to qualify for nursing facility services.<sup>j</sup> States must cover services provided by qualified SNFs as well as nursing facility services.<sup>k</sup> States, however, may place appropriate limits on services on the basis of criteria such as medical necessity and utilization control procedures.<sup>l</sup></p> <p><i>Examples of state requirements</i></p> <p>In Minnesota, beneficiaries must meet one of several criteria for nursing facility care, as determined by the state. The criteria include, among other things: requiring assistance with activities of daily living; exhibiting impaired cognition, such as short term memory loss; or experiencing frailty or vulnerability, such as frequent falls.</p> <p>Beneficiaries in North Carolina must show they meet the requirements to be in nursing facility care by demonstrating some qualifying conditions. Qualifying conditions may include, among other things, the need for services that require a registered nurse a minimum of 8 hours daily and other personnel working under the supervision of a licensed nurse, the need for restorative nursing to maintain or restore maximum function or prevent deterioration in individuals with progressive disabilities as much as possible, or the need for a specialized therapeutic diet. The services must be medically necessary.</p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare FFS</b>	<b>Medicaid FFS</b>
Under what circumstances can beneficiaries obtain coverage for home health services?	<p><i>Federal requirements</i></p> <p>Beneficiaries must: be confined to a home or an institution that is not a hospital, SNF, or nursing facility, need intermittent skilled nursing care,<sup>m</sup> physical therapy, speech language pathology services, or have a continuing need for occupational therapy services; and receive services under a written plan of care.</p> <p>Home health services must be ordered by a physician as part of a written plan of care, which must be reviewed every 60 days, or more frequently in some circumstances, such as when there is a significant change in the beneficiary's condition.<sup>n</sup></p>	<p><i>Federal requirements</i></p> <p>State Medicaid programs must cover home health services for categories of beneficiaries, including those who are entitled to nursing facility benefits under the state's Medicaid plan.<sup>o</sup></p> <p>Home health services must be ordered by a physician as part of a written plan of care, which must be renewed every 60 days.<sup>p</sup></p> <p>States are not allowed to require that beneficiaries be homebound in order to access home health services. States, however, may place appropriate limits on services on the basis of criteria such as medical necessity and utilization control procedures.<sup>q</sup> Additionally, states also have the option of covering home- and community-based services, including home health care and personal care services, for beneficiaries under different authorities.</p> <p><i>Examples of state requirements</i></p> <p>In California, beneficiaries have multiple paths to obtain home health services. For example, to qualify for home health services through the 1915(c) HCBS waiver for nursing facilities and acute health, the beneficiary must be medically fragile or technology dependent. Specifically, the beneficiary must have a medical need for at least 90 days of care in an acute hospital setting or an inpatient nursing facility. Qualifying criteria may include, among other things, the need for constantly available skilled nursing services for conditions such as those that require therapeutic procedures, like dressing postsurgical wounds.</p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare FFS	Medicaid FFS
		<p>In Minnesota, home health services must be medically necessary, ordered by a physician, documented in a care plan that is reviewed every 60 days, and generally provided at the beneficiary's residence other than a hospital or long-term care facility. Home health services including skilled nurse visits and home health aide visits must be authorized by the commissioner or the commissioner's designee. They base their authorization on medical necessity and cost-effectiveness when compared with other care options, among other things. The commissioner must receive the request for authorization of skilled nurse visits and home health aide visits within 20 working days of the start of service. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services is considered for cost-effectiveness. Authorization may be valid for up to 1 year. Dually eligible beneficiaries may also access home health services under Minnesota's 1915(c) waivers.</p> <p>In North Carolina, a physician must order home health services and have face-to-face contact with the beneficiary within 90 days prior to care or within 30 days after care, and the services must be medically necessary. Beneficiaries must have at least one reason, from a specific list of reasons created by North Carolina Medicaid officials, to receive home health services.<sup>f</sup> For example, beneficiaries might qualify if they require assistance leaving the home because of a physical impairment or medical condition, or if they are medically fragile. Dually eligible beneficiaries may also access home health services under North Carolina's 1915(c) waivers.</p>
<b>Appeals</b>		
How are beneficiaries notified of their right to appeal a denial, reduction, or termination of benefits?	<p><i>Federal requirements</i></p> <p>Beneficiaries must receive a notice of the initial coverage determination that services are denied, which must include information on the right to an appeal.<sup>s</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must receive notice from the state when it intends to terminate, suspend or reduce services. The notice must include information about the right to an appeal.<sup>t</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare FFS</b>	<b>Medicaid FFS</b>
What is the appeals process for beneficiaries that have a benefit denied, reduced, or terminated?	<p><i>Federal requirements</i></p> <p>Medicare has five levels of appeals. Beneficiaries first appeal to the Medicare contractor that made the initial coverage decision and is responsible for processing claims.<sup>u</sup> In the second level, beneficiaries may request review by a qualified independent contractor (QIC).<sup>v</sup> In the third level, beneficiaries may file an appeal to an administrative law judge (ALJ) if the amount remaining in controversy—the projected value of denied services or a calculated amount based on charges for services provided—is above a specified level.<sup>w</sup> In the fourth level, they may request review by the Medicare Appeals Council.<sup>x</sup> Finally, beneficiaries may request judicial review of the decision by the Medicare Appeals Council by a U.S. district court if the amount in controversy is above a specified level.<sup>y</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must have access to a fair hearing before the state agency. Beyond this federal requirement, states may define other levels of appeals, which can include a request for a hearing prior to a state fair hearing and an appeal to state court.<sup>z</sup></p> <p><i>Examples of state requirements</i></p> <p>In California, beneficiaries may request a state fair hearing conducted by an ALJ employed by the state Medicaid agency. The state Medicaid agency may adopt the ALJ's decision, decide the matter for himself or herself, or order a further hearing. After receiving a final decision from the state Medicaid agency, beneficiaries may request a rehearing or may file a petition for judicial review in state court.</p> <p>In Minnesota, beneficiaries may request a state fair hearing, during which a hearing officer recommends an order to the commissioner of human services, who either accepts, rejects, or modifies the order. Beneficiaries who disagree with the commissioner can request reconsideration by the commissioner, who may either amend or affirm the original order. A beneficiary may then request judicial review in state court.</p> <p>In North Carolina, beneficiaries may request a state fair hearing. The state Medicaid agency then accepts or reverses the ALJ determination. After receiving a final decision, beneficiaries may request judicial review in state court. Beneficiaries may opt for mediation instead of a state fair hearing. If they do not accept the terms of the mediation, they receive a fair hearing.</p>
Are there provisions to ensure continuity of access to benefits throughout the duration of the appeal process?	<p><i>Federal requirements</i></p> <p>There are no federal requirements that benefits continue during the appeals.</p>	<p><i>Federal requirements</i></p> <p>Benefits generally must continue if the beneficiary is mailed a notice of action and filed an appeal before the date of action.<sup>aa</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare FFS	Medicaid FFS
To what extent are beneficiaries required to have personal assistance, including from a care coordinator or other specialist, in navigating their appeal options?	<p><i>Federal requirements</i></p> <p>Although federal law and regulations do not require that beneficiaries receive personal assistance when navigating the appeals process, there are certain protections. For example, Medicare beneficiaries may appoint a representative to assist them with an appeal.<sup>bb</sup> Beneficiaries also may seek assistance through the office of the Medicare Beneficiary Ombudsman, which is responsible for resolving inquiries and complaints for all aspects of the Medicare program, through the 1-800-MEDICARE help line.</p>	<p><i>Federal requirements</i></p> <p>Although federal law and regulations do not require that beneficiaries receive personal assistance when navigating the appeals process, Medicaid beneficiaries may appoint a representative for the state fair hearing.<sup>cc</sup> Federal regulations provide states with the option of providing assistance.<sup>dd</sup></p> <p><i>Examples of state requirements</i></p> <p>Beneficiaries in California may request help from the county when filing a state fair hearing request.</p> <p>In North Carolina, notice that service(s) will be denied, terminated, suspended, or reduced must inform beneficiaries that they may contact Legal Aid, which provides free legal services to low income individuals.</p>

Source: GAO analysis of federal and state statutes, regulations, and guidance.

Notes: Information on state laws was confirmed by state Medicaid agency officials. We use “beneficiaries” to refer to statements or requirements that apply to all individuals receiving Medicare or Medicaid benefits, and “dual-eligible beneficiaries” to refer to statements or requirements that apply only to the dual-eligible beneficiaries.

<sup>a</sup>42 U.S.C. § 1395cc. Any provider of service may be qualified to receive Medicare reimbursement for services rendered to a beneficiary if that provider enters into an agreement with CMS that meets applicable requirements.

<sup>b</sup>42 U.S.C. § 1396a(a)(23)(A).

<sup>c</sup>42 U.S.C. § 1395w-21(a), (e), 42 C.F.R. § 422.62.

<sup>d</sup>42 C.F.R. § 422.2262(b).

<sup>e</sup>42 C.F.R. § 438.10(e).

<sup>f</sup>42 U.S.C. § 1395(d)(2).

<sup>g</sup>42 C.F.R. §§ 409.30, .31. For beneficiaries enrolled in MA plans, however, the plans may determine that a direct admission to an SNF without a hospital stay is medically appropriate.

<sup>h</sup>42 C.F.R. § 409.31.

<sup>i</sup>42 U.S.C. §§ 1396a(a)(10)(A), .1396d(a).

<sup>j</sup>42 C.F.R. § 440.50.

<sup>k</sup>SNFs provide skilled nursing care or rehabilitation services. In addition to these services, nursing facilities may also provide health-related care to beneficiaries who because of their mental or physical condition require institutional services (above the level of room and board).

<sup>l</sup>42 C.F.R. § 440.230.

<sup>m</sup>Intermittent means that the skilled care is either provided or needed fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable.

<sup>n</sup>42 C.F.R. §§ 409.42., .43.

<sup>o</sup>42 U.S.C. § 1396a(a)(10)(D).

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**Appendix II: Description of Selected Federal  
and State Requirements**

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<sup>p</sup>42 C.F.R. § 440.70.

<sup>q</sup>42 C.F.R. § 440.230.

<sup>r</sup>North Carolina has several 1915(c) waivers to cover additional services for certain populations.

<sup>s</sup>42 U.S.C. § 1395ff(a)(4), 42 C.F.R. § 405.921(a).

<sup>t</sup>42 C.F.R. § 431.206.

<sup>u</sup>42 U.S.C. § 1395ff(a), (b), 42 C.F.R. § 405.940.

<sup>v</sup>42 U.S.C. § 1395ff(c), 42 C.F.R. § 405.960.

<sup>w</sup>42 U.S.C. § 1395ff(b), 42 C.F.R. § 405.1000. ALJs are employed by the Department of Health and Human Services and are responsible for conducting formal proceedings such as hearings, among other things. CMS established a formula for annually calculating the minimum amount that must be in controversy for beneficiaries to appeal to an ALJ. That amount was \$130 for 2012. Beneficiaries may request an ALJ hearing if (1) they are dissatisfied with the QIC's decision, (2) the QIC did not render its decision within applicable timeframes, or (3) the QIC dismissed the request.

<sup>x</sup>42 C.F.R. § 405.1100. The Medicare Appeals Council undertakes a de novo review and may issue a final decision, dismiss the appeal, or remand the case to the ALJ with instructions for rehearing the case. Beneficiaries may also request this review if the ALJ dismissed their case or failed to issue a timely decision.

<sup>y</sup>The minimum amount that must be in controversy for beneficiaries to request judicial review is updated annually. The amount was \$1,350 for 2012. In addition to the threshold amount, beneficiaries may also request judicial review if the Medicare Appeals Council does not issue a decision, dismisses the case, or remands the case back to an ALJ within relevant time frames. 42 U.S.C. § 1395ff(b), 42 C.F.R. § 405.1132.

<sup>z</sup>42 U.S.C. § 1396a(a)(3), 42 C.F.R. §§ 431.205, .240(a)(3). State Medicaid agencies must provide for a hearing before the agency or an evidentiary hearing at the local level with the right to appeal to a state agency hearing. The state agency hearing must be conducted by one or more impartial officials. In providing a final agency decision to the beneficiary, state agencies may choose to accept or reverse the officials' determination or request a rehearing.

<sup>aa</sup>Benefits generally must continue unless it is determined at the hearing that the sole issue is one of federal or state law or policy. 42 C.F.R. § 431.230. States may also reinstate benefits if the beneficiary requests a hearing within a certain time frame after the date of action. 42 C.F.R. § 431.231.

<sup>bb</sup>42 C.F.R. § 405.910.

<sup>cc</sup>42 C.F.R. § 431.206(b).

<sup>dd</sup>42 C.F.R. § 431.221(c). States may assist beneficiaries with the submission and processing of their fair hearing requests.

**Appendix II: Description of Selected Federal and State Requirements**

**Table 4: Selected Requirements in Medicare Advantage (MA) and Medicaid Managed Care**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
<b>Enrollment and choice</b>		
How are beneficiaries enrolled in managed care (e.g., mandatory or voluntary enrollment)?	<p><i>Federal requirements</i></p> <p>Beneficiaries may enroll voluntarily in an MA plan.</p>	<p><i>Federal requirements</i></p> <p>Beneficiaries may enroll voluntarily in a Medicaid managed care plan, or they are enrolled mandatorily if the state has CMS approval of a State Plan Amendment, 1115 demonstration waiver, or 1915(b) waiver.<sup>a</sup></p> <p><i>Examples of state requirements</i></p> <p>Arizona has a section 1115 demonstration waiver to mandatorily enroll beneficiaries in managed care.</p> <p>In California, all dual-eligible beneficiaries in 28 counties are in FFS. Thirty counties have one of three different managed care programs. The first program is a county-operated health system, which requires nearly all Medicaid beneficiaries, including dual-eligible beneficiaries, in the 14 participating counties to enroll in a health system operated by the county. The second program is the Two-Plan program, which has a Local Initiative Health Plan—a public agency that is independent of the county—and a commercial plan in 14 counties. The third program, called Geographic Managed Care, has several commercial health plans in 2 counties. In the Two-Plan and Geographic Managed Care programs, dual-eligible beneficiaries are in FFS unless they enroll voluntarily in managed care.</p> <p>Minnesota has a section 1915(b)(c) waiver to mandatorily enroll dually eligible seniors in managed care. A 1915(b)(c) waiver simultaneously implements a 1915(b) and a 1915(c) waiver. The combined waiver allows states to provide a continuum of services for the elderly and people with disabilities as long as the requirements of both waivers are met. Dual-eligible beneficiaries age 18 to 64 who have disabilities may opt into FFS. If they do not opt into FFS, they are enrolled in managed care and may opt into FFS at any time.</p> <p>Not applicable in North Carolina where all beneficiaries are enrolled in FFS.</p>
To what extent can beneficiaries select their primary care provider?	<p><i>Federal requirements</i></p> <p>Beneficiaries in MA may be limited to the plan's provider network.<sup>b</sup></p>	<p><i>Federal requirements</i></p> <p>Subject to terms and conditions of a waiver, if applicable, beneficiaries in managed care may be limited to the plan's provider network.<sup>c</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
To what extent can beneficiaries select their managed care plan?	<p><i>Federal requirements</i></p> <p>The number of plan options varies by county. Beneficiaries may select any plan for which they are eligible that serves the area where they live.<sup>d</sup></p>	<p><i>Federal requirements</i></p> <p>Whether beneficiaries may select among plans varies by state. For example, states that mandate enrollment in a managed care plan must provide beneficiaries a choice of at least two plans, except in specific circumstances, such as in rural areas.<sup>e</sup></p> <p><i>Examples of state requirements</i></p> <p>Beneficiaries in Arizona’s acute care program have a choice among managed care plans, and have choice in the long-term care program in some circumstances, including if they live in or are moving to one of the state’s two most populated counties—Pima or Maricopa counties.</p> <p>Dual-eligible beneficiaries’ choice of managed care plans in California varies, depending on the county where they live. Dual-eligible beneficiaries living in the counties that have the Geographic Managed Care program may choose from several plans. Dual-eligible beneficiaries living in counties that have the Two-Plan program may choose between one of two plans. In the other counties that have the county-operated health system, dual-eligible beneficiaries have no choice because there is only one plan operating in the county.</p> <p>Dual-eligible beneficiaries’ choice of managed care plans in Minnesota varies, depending on the county where they live.</p>
When can beneficiaries switch between managed care and FFS or change managed care plans?	<p><i>Federal requirements</i></p> <p>Dual-eligible beneficiaries may switch between MA and FFS or change MA plans at any time. Most other beneficiaries may only switch to FFS or between plans during certain periods.<sup>f</sup></p>	<p><i>Federal requirements</i></p> <p>Requirements depend on whether dual-eligible beneficiaries are voluntarily or mandatorily enrolled in plans. For mandatory enrollment, subject to the terms and conditions of the waiver, if applicable, states may limit disenrollment to 90 days following initial enrollment and at least once a year or at other times with cause.<sup>g</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, beneficiaries may generally enroll in or switch plans within 30 days of the date of notice of enrollment, during an annual election period, or in special circumstances, such as when a notification of the annual enrollment period was not sent. For beneficiaries in the long-term care program, in limited circumstances generally involving preexisting conditions and continuity of care issues, beneficiaries may request to change plans on a case-by-case basis if they live in a county with more than one plan.</p>



**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
		<p>In California, dual-eligible beneficiaries living in counties that have either the Two-Plan or Geographic Managed Care programs may enroll in a plan, switch plans, or opt out of managed care into FFS at any time. Dual-eligible beneficiaries living in counties that have the county-operated health system may not switch plans or change into FFS.</p> <p>In Minnesota, dual-eligible beneficiaries with a disability may change plans or enroll in managed care in any month. Dually eligible seniors enrolled in a special needs plan for duals (D-SNP)—a type of Medicare managed care plan exclusively for dual-eligible beneficiaries—may change plans once per month and during an annual open enrollment period. Dually eligible seniors who are not enrolled in a D-SNP may change plans during an annual open enrollment period, once during the first year of enrolling in the program, and in limited circumstances, such as within 60 days of moving to a new county or at any time for good cause (e.g., poor quality of care).</p> <p>Not applicable in North Carolina where all beneficiaries are enrolled in FFS.</p>
How are beneficiaries informed of and counseled on enrollment options?	<p><i>Federal requirements</i></p> <p>Beneficiaries receive information about Medicare coverage from CMS, which distributes material that MA organizations submit. Beneficiaries may also receive CMS-reviewed marketing materials sent by MA organizations.<sup>h</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must receive a summary of the state's Medicaid managed care program from the state or its contracted representatives. The summary must include, among other things, information about the program requirements, covered benefits, and cost for each plan operating in the service area.<sup>i</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, beneficiaries in the long-term care program have access to an eligibility case worker who determines eligibility and helps them navigate their enrollment options.</p> <p>In California's counties where managed care enrollment is voluntary, enrollment brokers—who provide plan information to beneficiaries and help them choose a plan—must provide a presentation on plan options and enrollment to beneficiaries.</p> <p>In Minnesota, dual-eligible beneficiaries may call a help line specifically for seniors or people with disabilities for information about enrollment options. The state or county agency is also responsible for providing presentations or written materials to dually eligible seniors.</p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
<b>Continuity and coordination of care</b>		
Can beneficiaries continue to see historical providers not in the managed care plan's network when transitioning into managed care or between plans?	<p><i>Federal requirements</i></p> <p>MA organizations generally are not required to cover services by a beneficiary's previous provider who is not part of the MA network when a beneficiary first enrolls in a plan or switches plans. There are limited circumstances when MA organizations are required to cover such services during a transition period. MA organizations must ensure that covered services are available and accessible to beneficiaries. In implementing this requirement, CMS officials informed us that MA organizations must ensure that there is no gap in coverage or problems with access to medically necessary services when a beneficiary must change to a plan-contracted provider.</p>	<p><i>Federal requirements</i></p> <p>Medicaid managed care plans generally are not required to cover services by a beneficiary's previous provider who is not part of the managed care network.<sup>j</sup> Individual states, however, may have continuity of care requirements as defined under the terms and conditions of their waiver or state requirements.</p> <p><i>Examples of state requirements</i></p> <p>In California, beneficiaries newly enrolled in managed care plans may request and receive coverage of the completion of treatments initiated by an out-of-network provider with whom they have an ongoing relationship in certain circumstances, such as for treatment of a terminal illness or acute condition. The length of the coverage depends on the stability of the beneficiary's health and the nature of the medical condition. For coverage to continue, the provider must accept either the health plan rate or Medicaid FFS rate, whichever is higher. Health plans must ensure, to the maximum extent possible, existing provider-beneficiary relationships are not disrupted for certain providers. These providers include traditional providers, which are physicians who have delivered services to Medicaid beneficiaries in the prior 6 months, and safety-net providers, which are any providers of comprehensive primary care or acute hospital inpatient services that provide these services to a significant number of Medicaid, charity, or medically indigent patients.<sup>k</sup></p> <p>In Minnesota, for newly enrolled dually eligible seniors, managed care plans must cover medically necessary services that an out-of-network provider, a different plan, or the state agency authorized before the dual-eligible beneficiary enrolled with the managed care plan. However, the plan may require the dual-eligible beneficiary to receive the authorized services from an in-network provider and the services be clinically appropriate.</p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
To what extent do beneficiaries have access to assistance with coordination of care?	<p><i>Federal requirements</i></p> <p>MA plans must ensure coordination of services through various arrangements with network providers such as programs that coordinate plan services with community and social services in the service area.<sup>l</sup> Beneficiaries who enroll in an SNP—which can be a D-SNP or other type of SNP—must have access to appropriate staff to coordinate or deliver all services and benefits and coordinate communication among plan personnel, providers, and beneficiaries to ensure continuity of care.<sup>m</sup></p>	<p><i>Federal requirements</i></p> <p>States determine whether plans must ensure that dual-eligible beneficiaries have a person or entity formally designated as primarily responsible for coordinating services. States also may determine that, on the basis of an assessment of special health care needs, plans must provide a treatment plan for these beneficiaries.<sup>n</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, managed care plans are required to employ a transition coordinator who advocates for beneficiaries who are leaving or joining the plan and coordinates the transition between plans to ensure continuity of care. Beneficiaries in the long-term care program must receive case management from a case manager who helps them navigate their care options, including service planning and coordination and facilitating access to services.</p> <p>In California, beneficiaries enrolled in managed care have access to a state ombudsman office to provide assistance. Some beneficiaries, including those deemed medically fragile or those who have multiple diagnoses and require services from multiple providers, may receive targeted case management including help navigating care options. Managed care plans must also identify beneficiaries who are receiving services from out-of-network providers and ensure coordination of care. Additionally, managed care plans must have a call center and a 24-hour nurse advice line to assist beneficiaries with care options.</p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
		In Minnesota, for dually eligible seniors, access to a patient advocate or ombudsman to help navigate care options depends on the program. Dually eligible seniors enrolled in the program where the health plan is a Medicare D-SNP contracted to provide Medicaid benefits receive additional care coordination and case management. This is intended to ensure access and integration of covered services, which includes an assigned case manager to arrange and coordinate the necessary provision of supports and services. Dually eligible seniors who are in a non-D-SNP managed care plan have a case manager to coordinate plan services, but do not receive the additional care coordination. Managed care plans for dual-eligible beneficiaries with disabilities must have a range of case management services available, from telephone consultation to intensive ongoing intervention depending on the dual-eligible beneficiary's health status. Dual-eligible beneficiaries have access to a 24-hour nurse line for consultations.
<b>Provider network</b>		
Are there requirements addressing whether the provider network has an adequate number of providers?	<p><i>Federal requirements</i></p> <p>In order to limit beneficiaries to a network of providers, MA organizations must meet a number of requirements, including maintaining and monitoring a network of appropriate providers, under contract, that is sufficient to provide adequate access to covered services to meet the needs of enrolled beneficiaries.<sup>o</sup></p>	<p><i>Federal requirements</i></p> <p>States must ensure, through contracts, that Medicaid managed care plans demonstrate that they have the capacity to serve expected enrollment in the service area in accordance with state standards.<sup>q</sup> For example, plans must submit documentation to the state that they offer an appropriate range of preventive, primary care, and specialty services, and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees. Federal regulations do not establish a minimum number of providers that must be in the network, though states may be subject to requirements under the terms and conditions of their waiver, if applicable.</p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
	<p>Federal guidelines establish minimum requirements that vary, depending on a county's geographic designation, such as whether the county is urban or rural. MA organizations must contract with sufficient numbers of certain types of provider specialists per 1,000 beneficiaries in a county. For example, the networks of managed care plans operating in rural counties must have at least one full-time equivalent (FTE) primary care provider per 1,000 beneficiaries in a county.<sup>p</sup> Additionally, MA organizations must demonstrate that their network meets geographic requirements related to the time and distance it takes beneficiaries to travel to their providers. For example, in rural counties, MA organizations must also ensure that 90 percent of beneficiaries can access primary care providers within 40 minutes and 30 miles of travel.</p>	<p><i>Examples of state requirements</i></p> <p>In Arizona, managed care plans must ensure that their network of primary care providers is sufficient to provide beneficiaries with available and accessible services within specified time frames. Managed care plans also must contract with a specific number of providers established by the state, which varies depending on the area covered by the plan. For example, beneficiaries must be able to access emergency primary care services within 24 hours, urgent primary care services within 2 days, and routine primary care services within 21 days. The network must also be sufficient to provide covered services within designated distance limits. For example, for the acute program, in Arizona's two most populated counties, at least 95 percent of the beneficiaries living in a metropolitan area must be within 5 miles of a primary care physician, dentist, or pharmacy.</p> <p>In California, plans ensure their provider network is adequate to provide the covered services for beneficiaries in the service area. For example, plans must maintain a provider to beneficiary ratio of one FTE primary care physician for every 2,000 beneficiaries, and one total FTE physician in the network for every 1,200 beneficiaries. Primary care physicians must be located within 30 minutes or 10 miles of a beneficiary's residence, unless the state has approved an alternative time and distance standard.</p> <p>In Minnesota, the maximum travel distance or time must be the lesser of 30 miles or 30 minutes from the beneficiary to the nearest provider for each of the following services: primary care, mental health, and general hospital services. For primary care, the plan must arrange services on a timely basis; appointment times are not to exceed 45 days from the date of a beneficiary's request for routine and preventive care and 24 hours for urgent care. Managed care plans may receive an exception by demonstrating this requirement is not feasible in a service area, or if the beneficiary has full knowledge when choosing a plan that contracts with no providers meeting these requirements.</p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
Are there requirements addressing whether the provider network has the appropriate types of providers?	<p><i>Federal requirements</i></p> <p>Federal guidelines establish the minimum number of each provider and facility specialty type for each MA network. For example, the networks of MA plans must have at least one general surgeon and one cardiologist per 1,000 beneficiaries in a county. These networks must also include at least one occupational therapy and skilled nursing facility per 1,000 beneficiaries. MA organizations may need to contract with more than the minimum number of providers and facility specialty types to meet the time and distance requirements.</p>	<p><i>Federal requirements</i></p> <p>States must ensure, through contracts, that Medicaid managed care plans demonstrate that they have the capacity to serve expected enrollment in the service area in accordance with state standards.<sup>q</sup> For example, plans must submit documentation to the state that they offer an appropriate range of preventive, primary care, and specialty services, and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees. Federal regulations do not establish minimum numbers for specialty providers and facility specialty types that must be in the network, though states may be subject to requirements under the terms and conditions of their waiver, if applicable.</p> <p><i>Examples of state requirements</i></p> <p>In Arizona, managed care plans must contract with specific types of providers, which varies by geographic service area and is determined by the state. The state has contracting requirements for a variety of types of providers, including dentists, pharmacists, and primary care providers. For long-term care plans, providers include nursing facilities, assisted living facilities, home- and community-based care providers, and behavioral health facilities.</p> <p>In Minnesota, generally, the maximum distance or time must be the lesser of 60 miles or 60 minutes from the beneficiary to the nearest provider of each of the following services: specialty physician, ancillary, specialized hospital, and all other health services not included in the 30 miles or 30 minutes requirement. Managed care plans may receive an exception by demonstrating this requirement is not feasible in a service area.</p>
Under what circumstances can beneficiaries access out-of-network services?	<p><i>Federal requirements</i></p> <p>MA organizations must cover out-of-network benefits in some circumstances, such as ambulance services dispatched through 911 or for emergency or urgently needed services.<sup>r</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must receive out-of-network coverage if the network is unable to provide necessary services that are covered under the state plan. The cost to the beneficiary may be no greater than if the services were provided in network.<sup>s</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
		<p><i>Examples of state requirements</i></p> <p>In Arizona, out-of-network services are covered if: the beneficiary is referred by a primary care provider for specialty care outside the service area (the plan is required to provide all other medically necessary covered services); there is a net savings in costs without undue travel time or hardship for the beneficiary; the plan authorizes placement in a nursing facility outside the service area; or the services were provided during a prior period of coverage.</p> <p>In California, in addition to the federal requirement described above, Medicaid managed care plans in certain counties must arrange for rarely used medically necessary services to be provided by specialists outside the network if unavailable within the network.</p>
<b>Marketing materials<sup>†</sup></b>		
Are marketing materials permitted to promote enrollment in a specific health plan?	<p><i>Federal requirements</i></p> <p>Yes, marketing materials are permitted to promote enrollment in a specific health plan if MA organizations send the materials to CMS for review prior to distribution.<sup>u</sup></p>	<p><i>Federal requirements</i></p> <p>Yes, marketing materials are permitted to promote enrollment in a specific health plan.<sup>v</sup> However, in some circumstances states have prohibited such materials.</p> <p><i>Examples of state requirements</i></p> <p>Arizona does not permit Medicaid managed care plans to send marketing materials that are intended solely to promote enrollment in a specific health plan. All marketing materials must include a health message.</p> <p>California permits marketing materials to promote enrollment in a specific health plan through means such as billboards and flyers.</p> <p>Minnesota permits marketing materials to promote enrollment for some beneficiaries, including dual-eligible beneficiaries with disabilities, dually eligible seniors who are in a D-SNP, and Medicaid beneficiaries who will be eligible for Medicare within 6 months. Marketing is not permitted to dually eligible seniors who are not in a D-SNP.</p>
What requirements, if any, exist for the readability of marketing materials?	<p><i>Federal requirements</i></p> <p>Marketing materials must provide an adequate written description of the plan's benefits and services and comply with formatting requirements, such as using a minimum font size.</p>	<p><i>Federal requirements</i></p> <p>Marketing materials must be written in easily understood language and format.<sup>w</sup></p>

**Appendix II: Description of Selected Federal  
and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
At what reading level do managed care organizations have to write marketing materials?	<p><i>Federal requirements</i></p> <p>There are no federal requirements that marketing materials be written at a certain reading level.</p>	<p><i>Federal requirements</i></p> <p>There are no federal requirements that marketing materials be written at a certain reading level, however materials must be available in a format that considers those who have limited reading proficiency.<sup>w</sup></p> <p><i>Examples of state requirements</i></p> <p>All correspondence sent to managed care beneficiaries, including marketing materials, in California must be written at or below the sixth-grade reading level.</p> <p>Marketing materials in Minnesota must be written at or below the seventh-grade reading level.</p>
When do marketing materials have to be translated for beneficiaries who do not speak English?	<p><i>Federal requirements</i></p> <p>Medicare marketing material must be translated into any non-English language that is the primary language of at least 5 percent of individuals in the plan's service area.<sup>x</sup></p>	<p><i>Federal requirements</i></p> <p>Medicaid marketing materials must be translated into each prevalent language spoken by enrollees and potential enrollees in the plan's service area.<sup>y</sup></p> <p><i>Examples of state requirements</i></p> <p>In California, marketing materials must be translated when: 3,000 mandatorily enrolled managed care beneficiaries live in the plan's service area and indicate their primary language as other than English; or 1,000 mandatorily enrolled managed care beneficiaries in a single zip code or 1,500 mandatory managed care beneficiaries in adjacent zip codes live in the service area and indicate their primary language as other than English.</p> <p>In Minnesota, vital documents must be translated into 10 languages specified by the state. Additionally, vital documents must be translated when the lesser of either 5 percent or 1,000 beneficiaries eligible to be served or likely to be affected in the service area speak a non-English language. Plans that enroll dually eligible seniors must provide oral translation or translation by other means to any potential or current beneficiary who does not speak English.</p>



**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
<b>Scope of services</b>		
Under what circumstances can beneficiaries obtain coverage for nursing facility services?	<p><i>Federal requirements</i></p> <p>MA plans must provide coverage using the same criteria as FFS, which are described in table 3.</p> <p>For beneficiaries in MA plans, the plans may determine that a direct admission to an SNF without a prior hospital stay is medically appropriate.</p>	<p><i>Federal requirements</i></p> <p>Coverage of nursing facility services by managed care plans must be no more restrictive than Medicaid FFS coverage.<sup>2</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, nursing facility services are covered when beneficiaries qualify for the state's long-term care program. Beneficiaries qualify for the long-term care program when they have a functional or medical condition that impairs functioning to the extent that the individual would be deemed at immediate risk of institutionalization. Impairments may include, among other things, requiring nursing care, daily nurse supervision, regular medical monitoring, or presenting impairments with cognitive functioning or self-care with activities of daily living. General requirements also include that nursing facility services are medically necessary, cost-effective, federally reimbursable, coordinated by a case manager, have prior authorization, provided in licensed or certified facilities, provided by registered providers, and the appropriate type of care as determined by the case manager or primary care provider. The acute care program covers nursing facility services for a limited amount of time if hospitalization will occur otherwise or the treatment cannot be administered safely in a less restrictive setting, such as at home.</p> <p>In California, county-organized health system plans must cover nursing facility services as covered under FFS. In the Two-Plan and Geographic Managed Care programs, health plans only cover the first month of admission and 1 additional month. At that point, the beneficiary is disenrolled into FFS.</p> <p>In Minnesota, managed care plans must cover nursing facility services under the same circumstances as when beneficiaries receive coverage in FFS.</p>

**Appendix II: Description of Selected Federal and State Requirements**

<b>Requirement</b>	<b>Payment system</b>	
	<b>Medicare Advantage</b>	<b>Medicaid managed care</b>
Under what circumstances can beneficiaries obtain coverage for home health services?	<p><i>Federal requirements</i></p> <p>MA plans must provide coverage using the same criteria as FFS, which are described in table 3.</p>	<p><i>Federal requirements</i></p> <p>Coverage of home health services by managed care plans must be no more restrictive than Medicaid FFS coverage.<sup>z</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, one way that beneficiaries can qualify for coverage of home health services is by qualifying for the state's long-term care program, which may occur when they have a functional or medical condition that impairs functioning to the extent that the individual would be deemed at immediate risk of institutionalization. Impairments may include, among other things, requiring nursing care, daily nurse supervision, regular medical monitoring, or presenting impairments with cognitive functioning or self-care with activities of daily living. General requirements for coverage also include that home health services are medically necessary, cost-effective, federally reimbursable, coordinated by a case manager, with prior authorization, provided in licensed or certified facilities, provided by registered providers, and the appropriate type of care as determined by the case manager or primary care provider. Reassessments must be conducted within 62-day periods after the initial assessment or more often if necessary.</p> <p>In California, home health coverage is not covered by managed care plans, and is provided under FFS.</p> <p>In Minnesota, managed care plans must provide coverage using the same criteria as FFS.</p>
<b>Appeals</b>		
How are beneficiaries notified of their right to appeal a denial, reduction, or termination of benefits?	<p><i>Federal requirements</i></p> <p>Beneficiaries receive a notice of the initial coverage determination from their managed care plan, which must include information on the right to request another review by the MA organization and a subsequent appeal.<sup>aa</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must receive a notice of the initial coverage determination from their managed care plan, which must include information on the right to file an appeal with the plan. If the state does not require beneficiaries to exhaust the managed care plan's appeals process, the notice must also inform the beneficiaries of their right to request a state fair hearing.<sup>bb</sup></p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
What is the appeals process for beneficiaries that have a benefit denied, reduced, or terminated?	<p><i>Federal requirements</i></p> <p>Beneficiaries enrolled in an MA plan must first request the MA organization that made the initial determination to review the decision.<sup>cc</sup> For MA, if the adverse determination is affirmed, the issues must be reviewed and resolved by an independent review entity.<sup>dd</sup> If the independent entity affirms the adverse determination and the amount remaining in controversy is above a specified level, MA beneficiaries have the right to request a hearing before an administrative law judge (ALJ) in the Department of Health and Human Services.<sup>ee</sup> MA beneficiaries who are dissatisfied with the ALJ hearing decision may request review by the Medicare Appeals Council.<sup>ff</sup> MA beneficiaries may request judicial review by a U.S. district court if the amount in controversy is above a specified level and the Medicare Appeals Council's decision is the final determination of CMS or the Council denied the request for review.<sup>gg</sup></p>	<p><i>Federal requirements</i></p> <p>Beneficiaries must have the ability to file an appeal with their Medicaid managed care plan as well as request a fair hearing before the state agency. States determine whether beneficiaries must first exhaust their plan-level appeal before they can request a state fair hearing. Once a final agency decision is made following a fair hearing, beneficiaries may request judicial review of the decision if permitted under state law.<sup>hh</sup></p> <p><i>Examples of state requirements</i></p> <p>Arizona requires beneficiaries to appeal first to their managed care plan before requesting a state fair hearing with a state ALJ. The state Medicaid agency must accept, modify, or reject the ALJ decision. After receiving the agency decision, beneficiaries can request another review. The state Medicaid agency will grant a rehearing or review if the beneficiary's rights have been materially affected, such as misconduct by a party or newly discovered evidence. Beneficiaries may then appeal to state court.</p> <p>In California, beneficiaries may submit an appeal to the plan, or may request a state fair hearing before exhausting the plan's appeals process. After appealing to the plan, if the service is denied, reduced, or terminated, or the plan fails to satisfactorily resolve the dispute, the beneficiary may request a review by the Independent Medical Review System, where an independent contractor reviews the appeal and makes a determination as to whether the service was medically necessary. The Department of Managed Health Care must adopt this determination. Beneficiaries may also request a state fair hearing prior to, during, or at the conclusion of the plan's appeal process. If the hearing is conducted by an ALJ, the Director of the Department of Health Services may adopt the ALJ's decision, decide the matter for himself or herself, or order a further hearing. After receiving a final decision from the state Medicaid agency, beneficiaries may request a rehearing or may file a petition for judicial review in state court.</p>

**Appendix II: Description of Selected Federal and State Requirements**

Requirement	Payment system	
	Medicare Advantage	Medicaid managed care
		In Minnesota, beneficiaries may submit an appeal to their managed care plan, or may request a state fair hearing without first appealing to their plan. During the state fair hearing, a hearing officer recommends an order to the Commissioner of Human Services, who either accepts, rejects, or modifies the order. Beneficiaries who disagree with the commissioner may request reconsideration by the commissioner, who may either issue an amended order or affirm the original order. A beneficiary may then request judicial review in state court.
Are there provisions to ensure continuity of access to benefits throughout the duration of the appeal process?	<p><i>Federal requirements</i></p> <p>There are no federal requirements that benefits must continue during the appeals.</p>	<p><i>Federal requirements</i></p> <p>Benefits must continue during the appeal if: the beneficiary is mailed a notice of action and files an appeal prior to the effective date of action, the appeal involves services that are being reduced, terminated or denied; the course of treatment was previously authorized; the services were ordered by an authorized provider; the original period covered by the authorization has not expired; and the beneficiary requests an extension of benefits.<sup>ii</sup> If the beneficiary also requests a state fair hearing, benefits must continue during that process in the circumstances as described above.</p>
To what extent are beneficiaries required to receive personal assistance, including from a care coordinator or other specialist, in navigating the appeals process?	<p><i>Federal requirements</i></p> <p>Although federal law and regulations do not require that beneficiaries receive personal assistance when navigating the appeals process, there are certain protections. For example, Medicare beneficiaries may appoint a representative to assist them with an appeal.<sup>jj</sup> Beneficiaries may also seek assistance from the Medicare Beneficiary Ombudsman through the 1-800-MEDICARE help line.</p>	<p><i>Federal requirements</i></p> <p>Federal regulations require that Medicaid managed care plans provide beneficiaries assistance with completing appeal forms and take other procedural steps, including providing interpreter services and toll-free numbers for assistance for plan-level appeals.<sup>kk</sup> Medicaid beneficiaries may appoint a representative for the state fair hearing.<sup>ll</sup> Federal regulations provide states with the option of providing assistance during the state fair hearing process.<sup>mmm</sup></p> <p><i>Examples of state requirements</i></p> <p>In Arizona, managed care plans are required to provide reasonable assistance to beneficiaries when completing forms and taking other procedural steps during the appeals process, including, for example, providing interpreter services.</p>

Source: GAO analysis of federal and state statutes, regulations and guidance.

Note: Information on state laws was confirmed by state Medicaid agency officials. We use “beneficiaries” when referring to statements or requirements that apply to all individuals receiving Medicare or Medicaid benefits, and “dual-eligible beneficiaries” when referring to statements or requirements that apply only to the dual-eligible beneficiaries.

<sup>a</sup>Dual-eligible beneficiaries can only be mandatorily enrolled in managed care under an 1115 demonstration waiver or 1915(b) waiver.

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**Appendix II: Description of Selected Federal and State Requirements**

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<sup>b</sup>42 U.S.C. § 1395w-22(d), 42 C.F.R. § 422.112(a). In order to limit beneficiaries to a network, MA organizations must meet certain federal requirements, such as ensuring that covered services are available and accessible within the plan's service area.

<sup>c</sup>42 U.S.C. § 1396u-2(b)(5), 42 C.F.R. § 438.207. In establishing provider networks, plans must demonstrate that they have the capacity to serve expected enrollment in the service area in accordance with state standards.

<sup>d</sup>42 U.S.C. § 1395w-21(a)(1), (b)(1).

<sup>e</sup>42 U.S.C. § 1396u-2(a)(3), 42 C.F.R. § 438.52. States may also limit beneficiaries to enrollment in a single health insuring organization, which is a certain type of plan operated by a county, as long as the beneficiaries have a choice of at least two primary care providers. This option only applies in the state of California.

<sup>f</sup>42 U.S.C. § 1395w-21(a), (e), 42 C.F.R. § 422.62.

<sup>g</sup>42 C.F.R. § 438.56(c).

<sup>h</sup>42 C.F.R. § 422.2262(b).

<sup>i</sup>42 C.F.R. § 438.10(e).

<sup>j</sup>There are certain exceptions. States that mandatorily enroll beneficiaries into plans in rural areas without providing a choice of plans must cover out-of-network services and give the beneficiary's prior provider an opportunity to join the network. If the provider does not join, the beneficiary must select or be transitioned to a participating provider within 60 days. 42 C.F.R. § 438.52. In addition, states that mandatorily enroll Medicaid beneficiaries under a state plan amendment must meet certain federal requirements. Specifically, if beneficiaries do not select a plan, the state must ensure there is an enrollment process to assign them to a plan. This process must seek to preserve existing provider-beneficiary relationships in which the provider was the main source of Medicaid services for the beneficiary during the previous year. 42 C.F.R. § 438.50(f). However, these federal requirements do not apply to dual-eligible beneficiaries, who cannot be mandatorily enrolled in managed care under a state plan amendment.

<sup>k</sup>In 2011, California began mandatorily enrolling seniors and persons with disabilities—excluding dual-eligibles—into Medicaid managed care. Beneficiaries who are mandatorily enrolled in managed care may see their prior FFS provider for the first 12 months if the provider works with and accepts payment from the managed care plan and had no quality of care issues.

<sup>l</sup>42 C.F.R. § 422.112(b).

<sup>m</sup>42 C.F.R. § 422.101(f).

<sup>n</sup>42 C.F.R. § 438.208(a)(3).

<sup>o</sup>42 U.S.C. § 1395w-22(d), 42 C.F.R. § 422.112(a)(1).

<sup>p</sup>For CMS's network adequacy calculations, the primary care provider category comprises physicians in general practice, family practice, internal medicine, and geriatrics, and primary care physician assistants and primary care nurse practitioners.

<sup>q</sup>42 U.S.C. § 1396u-2(b)(5), 42 C.F.R. § 438.207.

<sup>r</sup>42 C.F.R. § 422.100(b).

<sup>s</sup>42 C.F.R. § 438.207(b).

<sup>t</sup>We refer to marketing communications in the context of materials intended to promote enrollment in a specific health plan.

<sup>u</sup>42 C.F.R. § 422.2262.

<sup>v</sup>42 C.F.R. § 438.104.

<sup>w</sup>42 U.S.C. § 1396u-2(a)(5), 42 C.F.R. §§ 438.10(b), 438.104(b)(iii).

<sup>x</sup>42 C.F.R. § 422.2264.

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**Appendix II: Description of Selected Federal  
and State Requirements**

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<sup>y</sup>42 C.F.R. § 438.10(c). States must establish a methodology for identifying prevalent non-English languages spoken by enrollees and potential enrollees throughout the state.

<sup>z</sup>42 C.F.R. § 438.210.

<sup>aa</sup>42 U.S.C. § 1395w-22(g)(1), 42 C.F.R. § 422.568(e).

<sup>bb</sup>42 C.F.R. § 438.404.

<sup>cc</sup>42 U.S.C. § 1395w-22(g)(1)-(2), 42 C.F.R. §§ 422.566, .578. MA organizations must have a process in place to make organizational determinations as to whether a beneficiary is entitled to receive coverage for a health service. Beneficiaries have the right to request the MA organization that made the initial determination to review any adverse determination. When a denial of coverage is based on the lack of medical necessity, the reconsidered determination must be made by a physician with the appropriate medical expertise.

<sup>dd</sup>42 U.S.C. § 1395w-22(g)(4), 42 C.F.R. § 422.592.

<sup>ee</sup>42 U.S.C. § 1395w-22(g)(5), 42 C.F.R. § 422.600. ALJs are employed by the Department of Health and Human Services and are responsible for conducting formal proceedings such as hearings, among other things. CMS has established a formula for annually calculating the minimum amount that must be in controversy for beneficiaries to appeal to an ALJ. That amount was \$130 for 2012.

<sup>ff</sup>42 C.F.R. § 422.608. The Medicare Appeals Council undertakes a de novo review and may issue a final decision, dismiss the appeal, or remand the case to the ALJ with instructions for re-hearing the case.

<sup>gg</sup>The minimum amount that must be in controversy for beneficiaries to request judicial review is updated annually. The amount was \$1,350 for 2012.

<sup>hh</sup>42 U.S.C. § 1396a(a)(3), 42 U.S.C. § 1396u-2(b)(4), 42 C.F.R. §§ 431.205, .240(a)(3), 438.400, .402. Each Medicaid managed care plan must have an internal appeals process in place for beneficiaries to challenge certain actions, including termination, suspension, or reduction of a service, denial or limited authorization of a service, or a denial of payment for a service. State Medicaid agencies must provide for a hearing before the agency or an evidentiary hearing at the local level with the right to appeal to a state agency hearing. State agency hearings must be conducted by one or more impartial officials. In providing a final agency decision to the beneficiary, state agencies may choose to accept or reverse the officials' determination or request a rehearing.

<sup>ii</sup>42 C.F.R. § 438.420.

<sup>jj</sup>42 C.F.R. §§ 422.672.

<sup>kk</sup>42 C.F.R. § 438.206.

<sup>ll</sup>42 C.F.R. § 431.206(b).

<sup>mm</sup>42 C.F.R. § 431.221(c). States may assist beneficiaries with the submission and processing of their fair hearing requests.

# Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

NOV 21 2012

Kathleen King  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare and Medicaid: Consumer Protection Requirements Affecting Dual-Eligible Beneficiaries Vary Across Programs, Payment Systems, and States" (GAO-13-100).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE AND MEDICAID: CONSUMER PROTECTION REQUIREMENTS AFFECTING DUAL-ELIGIBLE BENEFICIARIES VARY ACROSS PROGRAMS, PAYMENT SYSTEMS, AND STATES" (GAO-13-100)**

The Department appreciates the opportunity to review and comment on this draft report. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who are enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees, also known as dual eligible beneficiaries. Our goal is to make sure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible. We also strive to provide consumer protections for dual eligible beneficiaries.

While this report provides no recommendations for the Centers for Medicare & Medicaid Services (CMS), HHS agrees that the report is an accurate assessment of the programs overviewed.

We would also like to note that, as mentioned in GAO's report, one of the goals of our Medicare-Medicaid Coordination Office is to align the regulations between the two programs, and in support of these and other efforts, we are working with states to develop demonstrations to integrate Medicare and Medicaid for dual eligible beneficiaries. We identified a number of specific opportunities through our Alignment Initiative and have used the Initiative as a starting point for streamlining Medicare and Medicaid Program rules, requirements and policies and to inform the development of our state Demonstrations to Integrate Care for Dual-Eligible Individuals.

Through the Alignment Initiative, we have already made some progress in the area of appeals, one of the consumer protections described in the report. CMS has developed a revised Notice of Medicare Denial of Coverage (or Payment) (CMS-10003). This notice combines the existing Notice of Denial of Medicare Coverage with the Notice of Denial of Payment and includes *optional* language to be used in cases where a Medicare health plan enrollee also receives full Medicaid benefits that are being managed by the Medicare health plan. We believe that the combined notice, currently in the Paperwork Reduction Act approval process, will greatly increase flexibility for health plans administering benefits to the dual-eligible population and enhance enrollee understanding of and access to all of their appeal rights.



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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathleen M. King, (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Randy DiRosa (Assistant Director), Lori Achman, Anne Hopewell, Lisa Motley, Laurie Pachter, Pauline Seretakis, Lillian Shields, and Hemi Tewarson made key contributions to this report.

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