

June 19, 2013

Ms. Melanie Bella
Director, Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 315H-01
200 Independence Ave, SW
Washington, D.C. 20201

Dear Ms. Bella:

In July 2012, advocates from 33 national and state organizations representing dual eligible individuals sent you a letter outlining recommendations regarding consumer protections for the state dual eligible demonstrations. Since then, much progress has been made on the demonstrations, and we appreciate the Medicare-Medicaid Coordination Office's (MMCO) efforts to develop high-quality programs aimed at improving the care provided to individuals dually eligible for Medicare and Medicaid benefits.

We especially appreciate your efforts to address many of our concerns, including no Medicare lock-ins, and in most states: delaying the launch date, establishing a voluntary enrollment period, and promoting the development of ombuds programs. However, since our last letter, there have been Memoranda of Understanding (MOU) released from several states, and we have been disappointed in many respects. While we appreciate the need for state flexibility, the demonstrations must include baseline consumer protections and not the amount of inconsistency that we are seeing across states.

Listed below is a summary of 10 outstanding concerns and specific recommendations and/or questions for your office, followed by detailed descriptions. Moving forward, we hope to see these elements included in future MOUs and three-way contracts.

Thank you for your assistance and continued leadership in serving dual eligible individuals.

Sincerely,

1. Alliance for Retired Americans
2. American Association on Health and Disability
3. American Network of Community Options and Resources
4. Association of University Centers on Disabilities
5. B'nai B'rith International
6. Center for Medicare Advocacy, Inc.
7. Community Catalyst
8. Direct Care Alliance
9. Disability Rights Education and Defense Fund
10. Easter Seals

11. Families USA
12. Leading Age
13. Lutheran Services in America Disability Network
14. Medicare Rights Center
15. Mental Health America
16. National Academy of Elder Law Attorneys
17. National Alliance on Mental Illness
18. National Association of Area Agencies on Aging
19. National Association for Home Care and Hospice
20. National Association of Nutrition and Aging Services Programs
21. National Association of Professional Geriatric Care Managers
22. National Association of State Long-Term Care Ombudsman Programs
23. National Caucus and Center on Black Aged, Inc.
24. National Committee to Preserve Social Security and Medicare
25. National Consumer Voice for Quality Long-Term Care
26. National Council for Behavioral Health
27. National Council on Aging
28. National Council on Medicaid Home Care
29. National Health Law Program
30. National Senior Citizens Law Center
31. PHI-Quality Care Through Quality Jobs
32. OWL – The Voice of Midlife and Older Women
33. Services and Advocacy for GLBT Elders (SAGE)
34. The Arc of the United States
35. United Spinal Association

cc: Marilyn Tavenner
Jonathan Blum
Cindy Mann
Kathy Greenlee
Becky Kurtz
James Toews
Marisa Scala-Foley

Summary of Recommendations

- 1. Transparency.** Oversee a transparent three-way contract development process by sharing for comment drafts of three-way contracts with consumer advocates.
- 2. Ombuds programs.** Put into place additional designated funding, staffing, and appropriate training before individuals enroll in the demonstrations.
- 3. Financing Structure.** Provide clear information about how Medicaid rates are calculated and about underlying assumptions for Medicaid and Medicare savings targets. Use individual prior cost information to risk adjust payments for dual eligibles enrolled in the demonstrations until more data are collected on beneficiaries' functional status. Shield plans from large losses for individuals whose annual costs exceed an appropriate threshold, e.g., \$100,000. Implement tighter risk corridors all three years of the demonstration to protect the most complex and costliest beneficiaries. Total risk to each health plan should be strongly limited, so that none will lose or profit by more than roughly three percent. Forgo the requirement that demonstrations show savings in the first year. Any savings amounts required in future years should be justified by publicly shared data.
- 4. Quality measures.** Develop consistent long-term services and supports (LTSS) quality measures, including consumer-level measures. Include consumer experience, direct workforce (i.e., employee turnover, training, and availability of the direct care workforce), and quality-of-life outcomes in the MOUs. Use existing measures while continuing to develop other new measures. Ensure that all MOUs include rebalancing measures. Require that health plan performance on quality measures is collected and reported in a star rating system that is available to the public.
- 5. Passive enrollment.** Require states to utilize at least a four-month voluntary enrollment period before beginning capped (similar to Illinois process), phased passive enrollment, beginning with those who have less complex needs. Allow passive enrollment only to plans deemed ready to accept certain populations, and numbers, of dual eligibles. Require states to employ a hybrid approach that uses only voluntary enrollment in some geographic areas while using passive enrollment in others. This approach would permit a valid comparison between the two groups.
- 6. Size and speed.** Approve only real demonstrations, comprising fewer than one million beneficiaries nationwide. Programs should be phased in gradually and only be expanded across a whole state or population when they have proven to be successful in terms of enhanced quality of care and not just savings.
- 7. State and plan readiness.** Review and approve states, not just plans, for their readiness to manage and oversee the demonstrations prior to enrolling individuals into the demonstration. The results of state and plan readiness review should be public. Provide details about the state readiness review process and ensure that states have the infrastructure and oversight mechanisms in place before people are enrolled in the demonstration. Slow down the readiness review process. The timeline for the process should not be set by arbitrary implementation dates. Include more on site review and testing of systems as part of the readiness process to ensure that new plan policies and procedures have been operationalized.
- 8. Continuity of care and transitions.** Establish strong minimum care continuity standards that are applicable across all demonstrations. Extend care continuity protections for access to services and treatment regimes, not just providers. Offer meaningful opportunities to provide a beneficiary perspective on drafts of beneficiary communications about care continuity rights to ensure that they understand their rights during the transitions.

9. Enrollment broker. Clarify CMS position on the inclusion of independent, conflict-free enrollment brokers in future MOUs and state demonstrations.

10. Supplemental services. Ensure that states require managed care plans participating in the demonstrations to include supplemental services. Also, ensure that provisions for plan flexibility to deliver services do not erode consumer rights to services.

Detailed Descriptions of Recommendations

1. Transparency

A year ago, stakeholders asked the MMCO for a transparent and open MOU development process. However, much of the process was, and continues to be, far from transparent and based on closed-door negotiations between the states and the MMCO. As a result, the MOUs include surprising elements, such as California's county and birthday enrollment schedule that were not introduced in the proposals and would have benefited greatly by additional stakeholder review and input.

We are very concerned that the development of the three-way contracts will be equally private, which is an alarming prospect considering the MOUs defer critical decisions about beneficiary protections to the contracts. We recognize that states have all engaged on some level of stakeholder process for the demonstrations and that the MMCO has met routinely with advocates. However, going through the motions of a stakeholder process while failing to share key documents or lay out core methodologies under consideration until after a policy is finalized significantly diminishes the value of that process and the ability of stakeholders to provide meaningful input.

Publishing a draft of the three-way contract will not compromise the negotiating process with plans and the states. Rather, it will allow stakeholders to provide feedback on the elements of the contract before problems unfold during implementation. Washington is an example of a state that published its draft three-way contract for comment, and this should be mirrored in other states. In the Medicaid context, some states share draft managed care contract templates with stakeholders for comment and value the feedback they received from a transparent process.

Moving forward, stakeholder feedback will be as critical for implementation as it was for development. Enrollment is scheduled to begin soon in some states, and implementation decisions will happen quickly. An ongoing structured stakeholder process is needed with genuine opportunities for beneficiaries and their advocates to provide feedback on implementation issues as they arise.

Recommendation: Oversee a transparent three-way contract development process by sharing for comment drafts of three-way contracts with consumer advocates.

2. Ombuds Programs

We appreciate the MMCO's receptivity to the advocates' recommendation for ombuds programs and for encouraging states to include ombuds programs in their demonstrations. We are pleased that California, Illinois, Virginia, and Ohio included ombuds programs in their MOUs, and we understand that Massachusetts is working with your office to develop a program for their demonstration. While this is a good start, we are concerned that the ombuds programs will not succeed unless they have designated funding, adequate staffing, and appropriate training. While states have the flexibility to design their ombuds programs, they should each include the specific core functions of individual advocacy, systemic monitoring, and consumer education.

We cannot emphasize enough how important it is have ombuds programs fully operational before enrollment begins. Given the minimal experience managed care organizations have with serving the LTSS population, and strained state capacity for oversight, it is critical that ombuds programs are conflict-free and have sufficient resources. Current programs serving other needs should not be expected to take on the added responsibilities of the dual demonstrations without additional funding and training, as many are already understaffed and underfunded.

Recommendation: Put into place additional designated funding, staffing, and appropriate training before individuals enroll in the demonstrations.

3. Financing Structure

We have significant and longstanding concerns about the financing structure underlying the capitated model. The approaches used by the capitated financing states with MOUs in place are different, yet none provides adequate protection for beneficiaries, especially those with the most complex needs. First, there has been an absolute lack of transparency about the underlying data states used to calculate base Medicaid rates. Second, the methods for risk adjusting these Medicaid rates are insufficient to account for the frailty and functional status among the highly heterogeneous dually eligible population. Third, while two of the states – Massachusetts and California – attempt to mitigate the risk that plans will suffer massive losses or reap windfall profits, these strategies are inadequate thereby increasing the dangers of underservice. Neither Illinois nor Ohio has any mitigation provisions. Fourth, some states expressed a reticence to utilize tools, such as rate cells, that would financially encourage community-based care over institutionalization. All states should utilize rate structure tools to encourage community-based alternatives to institutionalization. Finally, the requirement that Medicare and Medicaid spending be reduced by what appear to be arbitrary amounts only multiplies the risk to beneficiaries. No information has been shared about how CMS and states determined these spending reductions to be reasonable or achievable. We believe CMS and each of the states should take the following steps:

Recommendation:

- ***Provide clear information about how Medicaid rates are calculated and about underlying assumptions for Medicare and Medicaid savings targets.***
- ***Use individual prior cost information to risk adjust payments for dual eligibles enrolled in the demonstrations until more data are collected on beneficiaries' functional status.***
- ***Shield plans from large losses for individuals whose annual costs exceed an appropriate threshold, e.g., \$100,000.***
- ***Implement tighter risk corridors all three years of the demonstration to protect the most complex and costliest beneficiaries. Total risk to each health plan should be strongly limited, so that none will lose or profit by more than roughly three percent.***
- ***Forgo the requirement that demonstrations show savings in the first year. Any savings amounts required in future years should be justified by publicly shared data.***

4. Quality Measures

We continue to have concerns about the lack of core quality measures for LTSS in the MOUs and the absence of a coordinated CMS strategy to develop LTSS measures. Some states have included promising state-specific measures, however, we are troubled by the lack of consistency across the MOUs in key areas as rebalancing and self-direction. The number of care coordinators trained in self-direction appears to be emerging as a CMS core measure. Unfortunately, that is not a consumer-level measure. Many important areas of LTSS quality have received no attention in the MOUs, such as measures related to the direct care workforce (i.e., employee turnover, training, and availability of the direct care workforce). The majority of measures focus on structure

and process. Nearly all MOUs also are silent on critical areas like consumer experience, rebalancing progress, and quality-of-life outcomes.

Recommendation:

- ***Develop consistent LTSS quality measures, including consumer-level measures.***
- ***Include consumer experience, direct workforce (i.e., employee turnover, training, and availability of the direct care workforce), and quality-of-life outcomes in the MOUs.***
- ***Use existing measures while continuing to develop other new measures.***
- ***Ensure that all MOUs include rebalancing measures.***
- ***Require that health plan performance on quality measures is collected and reported in a star rating system that is available to the public.***

5. Passive Enrollment

We continue to believe that the goals of the Financial Alignment Initiative could be achieved with a voluntary, opt-in process that would allow the demonstrations to grow at a rate that matches the capacities and competencies of the plans. The best way to ensure robust enrollment in the demonstrations is to offer robust benefits and high quality health plans that are attractive to consumers because they meet consumer needs in ways the current system does not. Dual eligible individuals are known to suffer from greater-than-average cognitive or mental impairments. Passively enrolling this population into a plan that may not meet their needs jeopardizes their care and is likely to result in poor health outcomes. It also necessitates substantial beneficiary education on complex health care choices in a very compressed timeframe.

Some features in the approved MOUs represent steps in the right direction. We appreciate that all the MOUs mention the development of an “intelligent assignment” process and urge the MMCO to incorporate this feature in all future MOUs. If implemented successfully, this should improve continuity of care for the beneficiary. We also appreciate that all MOUs to date employ initial voluntary enrollment to some degree. However, we remain concerned that not enough consumer protections are built into the process. For example, California is using initial voluntary opt-in enrollment for Los Angeles County only, but not in other demonstration counties. From a beneficiary perspective, the Illinois approach to passive enrollment is preferable. It includes a four-month voluntary period for all beneficiaries. In order to prevent plans from taking on more beneficiaries than they can handle, the Illinois MOU limits the number of people who can be passively enrolled into each plan in a month.

Recommendation:

- ***Require states to utilize a minimum four-month voluntary enrollment period before beginning capped (similar to Illinois process), phased passive enrollment beginning with those who have less complex needs.***
- ***Allow passive enrollment only to plans deemed ready to accept certain populations, and numbers, of dual eligibles.***
- ***Require states to employ a hybrid approach that uses only voluntary enrollment in some geographic areas while using passive enrollment in others. This approach would permit a valid comparison between the two groups.***

6. Size and speed

A major concern since the start of demonstration is launching a demonstration of this size in a short time period. We recognize and appreciate that there has been some reduction in the size of the overall demonstration due to the fact that many state proposals remain pending. The size of the demonstrations within particular states, however, remains significant and concerning. In California, for example, while the size was significantly reduced from the original proposal, the demonstration will still impact over 450,000 people, and an estimated 200,000 or more will be passively enrolled on the first day of implementation (January 1, 2014).

Proceeding with such a large population under a demonstration raises several concerns. Our primary concern is that beneficiaries will lose access to needed services and providers. In addition to the immediate risks to beneficiaries by such a huge change in a relatively short window, the magnitude of the demonstrations makes it very difficult for states to roll back or adjust the demonstrations in the event that they do not achieve intended goals. Our unease is heightened by the statements made by state officials who clearly view the demonstrations as a permanent system redesign.

Recommendation:

- ***Approve only real demonstrations, comprising fewer than one million beneficiaries nationwide.***
- ***Programs should be phased in gradually and only be expanded across a whole state or population when they have proven to be successful in terms of enhanced quality of care and not just savings.***

7. State and Plan Readiness

State readiness. We are concerned that states will not have the infrastructure and oversight mechanisms in place in time for the launch of the project. Managing these contracts is a new challenge for states and CMS, and will require new systems and additional expertise. We have yet to see any guidance from MMCO on how state readiness will be tested. We suggest CMS evaluate states based on the following criteria:

- Sufficient staff with adequate training to manage the project
- Financial sustainability to carry out the demonstration
- Fully developed rates and payment systems
- Appropriate IT systems
- Infrastructure for outreach and enrollment
- Detailed plan for an ongoing system of oversight with meaningful consumer representation

Recommendation:

- ***Provide details about the state readiness review process.***
- ***Ensure that states have the infrastructure and oversight mechanisms in place before people are enrolled in the demonstration.***
- ***The results of state readiness reviews should be public.***

Plan readiness. Health plan readiness continues to be a concern. It remains unclear to us that plans are adequately prepared to serve the medical and nonmedical needs of dual eligible individuals, particularly the 20 percent with the most complex needs. People who fall into this category are often involved with providers who are not in any typical networks that managed care companies operate. These networks take time to build, and we are concerned that it cannot be done in the relatively short timeframe available before the start of the 2013 demonstration projects. These challenges are exacerbated by the fact that most states seek to passively enroll large numbers of duals in short timeframes.

We have seen the readiness review tools released by the MMCO for Massachusetts, Illinois and California, and are concerned about the timeframe of when all readiness review components will take place; from desk reviews, site visits to a separate network validation review and an enrollment functions and systems assessment. With Massachusetts, Illinois, and Ohio slated to start in 2013 or early 2014, it seems unrealistic that all the components of readiness will be completed and plans will be ready on day one. In addition, we are concerned that much of what is in the readiness tool is not placing enough accountability on the plans. Simply asking for plans to have policies and procedures in place is not sufficient to protect beneficiaries.¹

Recommendation:

- ***Slow down the readiness review process. The timeline for the process should not be set by arbitrary implementation dates.***
- ***Include more on site review and testing of systems as part of the readiness process to ensure that new plan policies and procedures have been operationalized.***

8. Continuity of Care

While we have been pleased to see continuity of care addressed in all of the MOUs, the level of protections varies greatly and there are significant gaps in each MOU. We think that a uniform high level of beneficiary protection, including a 12-month transition period, is essential to the success of the demonstrations. We also are disappointed to see, for example, that California has excluded “ancillary services” from care continuity and the lack of special protections for nursing home residents in all MOUs except Ohio’s.

We also note the critical importance of good communication with beneficiaries so that they understand their care continuity rights and how to exercise those rights. Designing effective communication is a significant challenge. In a recent evaluation of the move of non-dual seniors and persons with disabilities in California into Medicaid managed care, fully 83 percent of respondents reported that they did not know about continuity of care rights.²

Recommendation:

- ***Establish strong minimum care continuity standards that are applicable across all demonstrations.***
- ***Extend care continuity protections for access to services and treatment regimes, not just providers.***
- ***Offer meaningful opportunities to provide a beneficiary perspective on drafts of beneficiary communications about care continuity rights to ensure that they understand their rights during the transitions.***

9. Enrollment Broker

We appreciate the inclusion of an independent enrollment broker in the MOUs. Independent enrollment brokers are key to limiting the abusive marketing practices that Medicare Advantage plans have used to induce

¹ For detailed suggestions on consumer perspectives for state and health plan readiness see Community Catalyst paper: http://www.communitycatalyst.org/doc_store/publications/State-and-health-readinessFINAL.pdf. Also see the comments of the National Senior Citizens Law Center to the draft Massachusetts readiness tool for a more detailed discussion of these concerns.

² See Briefing—Transitioning the SPD Population to Medi-Cal Managed Care, Slide 17, available at www.chcf.org/events/2013/briefing-spd-transition-managed-care. The evaluation was conducted by California HealthCare Foundation at the recommendation of the California Department Health Care Services.

enrollment in the past and are likely to continue to use in the context of the demonstrations. We ask that future MOUs and other documents provide more clarity about the role of the enrollment broker.

As we envision it, an independent enrollment broker must at least provide an unbiased and conflict-free entity to provide information about enrollment options and to processes beneficiary choices. In some states, enrollment brokers may also be capable of providing options counseling, though we believe in most cases, this role will be best left to properly funded SHIPs and other community based organizations. More detail is needed about the role of the enrollment broker in helping beneficiaries who elect not to participate in the demonstration and, therefore, need assistance making Medicare Advantage or Medicare Part D enrollment decisions. It is unclear from the MOUs how state-based enrollment brokers will work with Medicare to ensure a smooth process for these beneficiaries. It also remains unclear to us where this additional detail will be provided. It does not seem like an area that the three-way contract would address since enrollment broker duties are not a plan responsibility.

Recommendation: Clarify CMS position on the inclusion of an independent, conflict free enrollment brokers in future MOUs and state demonstrations.

10. Supplemental Services

We appreciate that some of the state MOUs, such as Massachusetts, California, and Ohio, are requiring the demonstrations to provide supplemental services in addition to providing all traditional Medicare and Medicaid benefits, but would like to see standards in place for determining when these services must be provided. As new services and providers are included in demonstration plans, CMS and states must also establish minimum performance standards for providers and medical coverage criteria for services. Without this, there is a risk that beneficiaries will not receive these services or will not know what they are eligible to receive.

In addition, we are concerned that some MOUs allow the plans to have significant discretion in terms of offering supplemental benefits. In Illinois, the MOU does not require that plans provide any new supplemental services. The MOU states that plans will have discretion to use the capitated payment to offer flexible benefits appropriate to address the enrollee's needs, but does not require them to do so and does not establish any right for beneficiaries to receive services other than those currently available to them. In California, plans also have great flexibility to offer home and community based services benefits without specific consumer protections.

Recommendation:

- ***Ensure that states require managed care plans participating in the demonstrations to include supplemental services.***
- ***Ensure that provisions for plan flexibility to deliver services do not erode consumer rights to services.***