COMMUNITY CATALYST

May 4, 2012

VIA ELECTRONIC MAIL

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: Ohio Capitated Financial Alignment Demonstration Proposal for Medicare-Medicaid Enrollees

Dear Ms. Bella:

Thank you for the opportunity to submit comments on Ohio's recently submitted Capitated Financial Alignment Demonstration Proposal for Medicare-Medicaid Enrollees.

Community Catalyst is a Boston-based national advocacy organization that has been giving consumers a voice in health care reform since 1997. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high quality, affordable health care for everyone. We focus our efforts on helping the most vulnerable consumers, including those that have low incomes, come from communities of color, and/or have difficulty speaking or understanding English.

As we have noted in previous comments, we believe CMS's duals demonstration projects offer unprecedented opportunities to address the numerous and complex problems faced by dual eligibles, and to reduce the costs associated with the medical and long-term supports and services they require. However, we believe they also present real and significant risks.

These new projects will represent a sea change in the way we deliver and pay for care for this vulnerable population, and require careful attention to ensure they meet the needs of the population they aim to serve, especially those of the most medically complex dual eligibles. Attached to this letter is a set of consumer advocate-oriented priorities for the duals demonstration projects (*Dual Eligible Demonstration Projects: Top Ten Priorities for Consumer Advocates*). These priorities guided our review of the Ohio proposal, and we hope they will also inform your office's review.

While the Ohio proposal meets a number of the attached priorities, there are many critical details missing as well as those that ought to be changed in order to meet the needs of the populations they intend to serve. We recommend that CMS require the state to fill in these missing details and make these changes before the demonstration project can move forward. Our comments on the specifics of the proposal follow.

Stakeholder Engagement Process

We commend the state's Department of Job and Family Services (ODJFS) and Office of Health Transformation (OHT) for placing high priority on integrating care for dually eligible Ohioans and for its vision of better care and lower costs. While the proposal contains an impressive-looking chart of all the stakeholder engagement activities, we are struck by how few of those activities occurred after the state committed itself to a formal draft. An earlier "strawman" proposal was so vague about the state's plans that it was utterly unhelpful to stakeholders attempting to understand the proposed changes in store for this most vulnerable population.

We are especially concerned about the quick turnaround between the close of the state's 30-day comment period on its full draft (March 30, 2012) and its submission to CMS (April 2, 2012). While a comparison of the state's draft with the proposal submitted to CMS demonstrates the influence of comments and suggestions from the advocacy community, we believe there is far more to be done before this proposal can be approved.

Praiseworthy Design Elements

There is much about the Ohio demonstration proposal to be commended. In particular, we believe the following design elements will preserve and enhance the well-being of people enrolled in Integrated Care Delivery Systems (ICDS plans):

- The **elimination of caps on home and community-based services (HCBS)** waiver participation
- The **expansion of covered services**, to include a wide variety of behavioral health services
- The requirement that ICDS plans **contract with Passport Administration Agencies (PAAs)** for LTSS screening, information and referral services
- The right of ICDS enrollees to choose an **LTSS coordinator**
- The expectation that ICDS plans are to provide a **robust set of care management services**
- The requirement that ICDS plans **include consumer representation on their governing boards and hold semi-annual member meetings**
- The requirement that ICDS plans offer enrollees the **option for self-directed services**
- The required **sharing of at least 50% of the CMS-required quality withhold with providers** who helped bring about quality improvements

Design Elements of Concern

Despite these commendable design elements, we have many issues of serious concern that we believe must be addressed before the Ohio demonstration project can permitted to move forward. Below is a quick summary of these concerns, which are briefed at length in our full comments:

- **Passive enrollment** with full lock-in for Medicaid services and partial lock-in for Medicare services
- **Inadequate requirements for a provider network** adequate to serve the more complex needs of a dually eligible population
- **Arbitrary limits on the use of out-of-network contracts or single-case agreements** in order to maintain existing beneficial provider relationships
- **No contract requirement for LTSS coordination and referral for enrollees under age 60**
- **Failure to include key benefits** such as personal care assistance or specific geriatric services
- No requirement of full compliance with the **Americans with Disabilities Act**
- **Insufficient attention paid to the steps needed to create proper ICDS financing** that will discourage the rationing of care
- **Absence of savings estimates with underlying evidence**
- **Inadequate commitment to cultural competence**
- **Insufficient track record among existing managed care plans** of caring for elders and people with disabilities who have complex medical and LTSS needs

Enrollment

Under the current proposal, Ohio would begin passively enrolling dually eligible beneficiaries into ICDS plans beginning February 2013. We appreciate the desire to reach a level of enrollment that would allow the ICDS plans to achieve scale and facilitate a strong evaluation. However, given the aggressive timeframe for start-up and the uncertainty about the entities that will serve as ICDS plans, we strongly recommend that the project employ a voluntary opt-in enrollment process in order to safeguard beneficiaries. This will allow ICDS plans to get their plans into place and then to attract enrollees by publicizing their strengths. The state – on its own and through respected community-based providers – can assist with this process.

In the event, however, that the state pursues passive enrollment as outlined in its proposal, there are a number of outstanding issues that must be addressed prior to CMS allowing the project to proceed.

We recommend providing beneficiaries with at least 90 days to make a choice of ICDS plans. Additionally, as proposed, the state intends to communicate with enrollees solely through mailed notices. This is wholly insufficient, particularly because of the known age, disability and language barriers among this population. We recommend that written notices are supplemented by assistance from community-based organizations such as PAAs and

Independent Living Centers. The state should contract with these organizations as "navigators" to educate potential enrollees about their options and to assist them in selecting an ICDS that best serves their individual needs. By using these trusted organizations, the state will help to ensure that consumers make informed choices. Ultimately, we believe this process will increase the number of Ohio dual eligibles that enroll and, significantly, *remain* in ICDS plans.

Finally, but importantly, we recommend eliminating all lock-in periods for enrollees. As proposed, Ohio enrollees that choose to opt-out of the demonstration program may do so for only their Medicare benefits, and even then, only after a 90-day period. Enrollees would be locked in for their Medicaid benefits. And, those that choose to stay in the program may only change their ICDS plan during an annual enrollment period. Each of these provisions violates the principle of choice; that dually eligible beneficiaries must have the freedom to choose to participate or not and to decide the plan and provider that best meets their needs.

Provider networks

ICDS plans should be required to have robust provider networks that include a sufficient number of providers with experience working with the relevant enrollees. ICDS plans must ensure that all providers are trained on independent living and mental health recovery approaches. And, finally, ICDS plans should protect longstanding, beneficial provider relationships through the use of open networks as well as contracts or single-case agreements without arbitrary limits.

The Ohio proposal meets these criteria in some ways but falls short in others:

(1) According to the proposal, the state will require ICDS plans to "demonstrate adequate provider capacity to meet the CMS Panel Adequacy requirements for the region(s) for which they have applied. Plans will be required to maintain a network adequate to provide for those Medicaid benefits that exceed Medicare, such as dental and vision services providers. Plans will also be required to include providers whose physical locations and diagnostic equipment will accommodate individuals with disabilities." While CMS Panel Adequacy requirements may be sufficient for the average Medicaid managed care population, it is unclear to us that it is similarly adequate for a more complex set of dually eligible enrollees. Furthermore, stating that Plans have to "include" providers that can accommodate people with disabilities does not necessarily ensure adequate access. We recommend, instead, that ICDS plans and their providers be required to ensure full compliance with the Americans with Disabilities Act (ADA) (see below).

(2) The proposal is silent on the issue of training providers on independent living and mental health recovery approaches. We strongly recommend requiring this sort of training so that ICDS plans and providers are more attuned to the unique perspective that is the hallmark of the cross-disability community.

(3) While the proposal requires ICDS plans to have open networks, it allows "single-case agreements" to be used for certain services only for a transitional period (generally 90

days). A 90-day period is an insufficient amount of time for a person who has built a therapeutic relationship over years or even decades. We are concerned that an artificial limit of 90 days could be detrimental to the health and well-being of certain ICDS members, reversing progress that has been achieved through their years of work with a provider. Thus, we urge CMS to require Ohio to remove the 90-day limitation on single case agreements. We fully expect that if the ICDS builds a well-designed system with fair provider payment rates, it will be able to bring members' providers into the network. On the other hand, if the ICDS builds a robust and network of providers with the expertise and experience in caring for people with complex disabilities, it may eventually be able to shift members to in-network providers. Until those circumstances arise, however, we believe that single-case agreements represent important investments by the ICDS in the continued health of their members that will cost relatively little.

Long-Term Supports and Services

As noted above, the requirement that ICDS plans *must* contract with PAAs for those receiving HCBS is praiseworthy. However, it is striking that there is no parallel requirement to contract with other community-based organizations that serve people under age 60 with disabilities, e.g. Centers for Independent Living. We recommend that the state include this requirement.

In addition, we recommend the state:

- Provide more detail on the assessment of enrollees' LTSS needs. Specifically, ICDS plans should be required to conduct a comprehensive and conflict-free assessment of each beneficiary's LTSS needs that includes an evaluation of functional status, social and vocational needs, socioeconomic factors, personal preferences, and the ability to obtain accessible services
- Require that ICDS plans maintain current levels and breadth of LTSS until the comprehensive assessment is conducted
- Require plans to contract with LTSS providers who have the capacity and expertise to meet member needs
- Clarify that the beneficiary must play the central role in the LTSS assessment and in the development of an LTSS plan
- Support family caregiving by allowing the designation of family members as paid aides where appropriate and where consumers request this, as well as through respite services

Furthermore, the state must ensure that there are no financial incentives for an ICDS to provide services in an institutional setting. To prevent this from happening, the state and CMS must set capitation rates for enrollees in nursing homes or other institutions no higher than those for enrollees with the same level of medical and LTSS needs living in the community. Rather, we recommend that to the extent financial incentives are created for ICDS plans, they focus largely on maintaining dually eligible beneficiaries in community settings and moving people in institutional settings to the community to the extent possible

and desired by the consumer. Performance incentive payments should be awarded for progress in this direction.

Coordination

Tight coordination of medical care and LTSS is one of the hallmarks of a successful integrated care program for dual eligibles. And, as noted above, the robust set expectations for care management services and the required LTSS coordinator are two of the critical and praiseworthy elements of the Ohio demonstration proposal that will help to ensure this type of coordination.

We believe the required contract with PAAs for LTSS coordination services will offer enormous benefit to ICDS enrollees over age 60. It is critical, however, that the state includes a parallel LTSS coordinator requirement for those *under* age 60. This coordinator should be contracted from an independent community-based organization with expertise in working with people with disabilities and would serve the following roles:

- Conduct an initial assessment to determine the beneficiary's level of need and to develop an appropriate LTSS plan in partnership with the beneficiary or to participate on the consumer's behalf with their consent in the initial assessment
- Ensure all LTSS needs of the beneficiary are efficiently addressed and communicated to the entire care team
- Communicate, as needed, with the beneficiary about his/her LTSS needs on an ongoing basis

Benefits

We applaud the state for expanding the array of benefits available to ICDS enrollees, particularly those related to behavioral health services. In addition to these benefits, however, we recommend several more that are critical to the health and well-being of enrollees.

- Personal assistance services
- Geriatric pharmacologic medication therapy management
- Evidence-based care transitions programs, such as the Coleman model
- Evidence-based self-management programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP)
- Palliative care services

Consumer Engagement

As noted above, we commend the state for requiring ICDS plans to have local governance bodies in each geographic region and to require that at least 20% of the members be ICDS plan members. We recommend, however, that plans consult community-based advocacy groups to select and support consumer members. We also commend the state for requiring ICDS plans to hold semi-annual meetings among their members, though we suggest that they be held more frequently given the demonstration nature of the program.

In addition to these requirements, however, we also recommend that each ICDS create a separate advisory council comprised of ICDS members, family members and representatives of advocacy organizations that serve the dually eligible population.

Beneficiary Protections

While we are pleased that the state intends to guarantee that enrollee protections "will be no less than the protections provided to members of [Medicare Advantage]plans, Medicaid-only plans, and individuals enrolled in 1915(c) home- and community-based waiver services or in any other affected setting," we believe additional assurances should be made. For instance:

- More guidance must be provided on the ICDS plan's grievance and first-level appeals systems to ensure that these systems are easy for enrollees to navigate
- Program materials be written not only for people with limited English proficiency, but also for those with disabilities or speech and vision limitations
- Emphasis on the right to home and community-based services and supports

We are surprised and dismayed that the proposal contains no mention at all of the Americans with Disabilities Act (ADA). It is essential that ICDS enrollees have access to facilities, providers, equipment and scheduling that is compliant with the ADA. The state's proposal should explicitly require this compliance and specify how it will provide oversight and enforcement. We also recommend that the payment rates developed take into account the significant upfront investments required to achieve compliance. This payment would also account for the enhanced role that ICDS care coordinators will need to take in assuring that the services they prescribe can be offered in accessible facilities and with accessible providers.

Finally, to ensure that beneficiary rights are protected, we recommend that the state contracts with an independent ombudsman to field complaints and questions.

Financing and Payment

The Ohio proposal offers few details about the payments that will be made to ICDS plans, stating only that it will use rate cells and "may include" risk adjustment, risk-sharing and pay-for-performance.

Getting the financing and payment right is critical to assuring ICDS plans have the necessary resources to provide the medical care and the LTSS needed by their members, especially those of the most complex members. Without paying close attention to these issues, ICDS plans are likely to receive either windfall profits or devastating losses, results that would undermine the goals of the demonstration program. To avoid these results, Ohio should:

- Make financing and payment structures transparent
- Ensure that payments do not give providers an incentive for denying or minimizing services and care needed by beneficiaries

- Use payments to incentivize care provided in community-based settings rather than institutional settings
- Use a risk adjustment system that includes validated measures of functional status, diagnosis and other relevant socioeconomic and cultural factors such as race, ethnicity, language and gender as well as other social determinants of health such as access to housing, transportation and education.

Each of these steps is critical. In addition, we recommend that CMS and the state use risk sharing mechanisms, particularly in the first one to three years of the demonstration project. While progress is being made in developing risk adjustment methodologies that adequately account for the complex needs of individual beneficiaries, they are still at a nascent stage. This elevates the importance of using strategies such as risk-sharing. While we recognize that Medicare has not traditionally used risk-sharing mechanisms, there is precedent in other states for sharing, at the end of each contact year, percentages of gains or losses. For instance, we understand this has been a successful approach for the Massachusetts Senior Care Options program and urge CMS to adopt this structure for this demonstration program.

Finally, we believe that the state should set a minimum medical loss ratio requirement for ICDS plans that is at least equal to the benchmark set for large-group insurance companies by the Affordable Care Act. By limiting administrative expenses to a maximum of 15%, the state can assure that as much of the capitated payment as possible will be dedicated to serving members' medical and LTSS needs. This benchmark makes sense particularly in light of the lighter administrative burden placed on ICDS plans under a passive enrollment scenario.

Savings estimates

We note the absence of any savings estimates in the Ohio proposal. We would expect that the state would be able to provide an estimate of those savings, along with its underlying financial assumptions, prior to CMS approving the project. For example, the public should understand what the state knows about current rates of preventable hospitalizations, institutionalizations, and emergency room visits and how much the state believes it will need to invest upfront in increased primary care and community-based LTSS in order to not only meet quality metrics, but also to achieve the long-term projected savings.

Quality assessment

Comprehensively assessing the quality of care provided by ICDS plans and the outcomes achieved for beneficiaries through this demonstration project will be essential to evaluating how successful it has been at improving the lives of the people it seeks to serve. Ohio is to be commended for the priorities and goals of its Medicaid Quality Strategy, but the ICDS plans taking part in this program must be evaluated based upon a core set of measures that is specific to the more complex population they will be serving.

Among the measures we recommend are those that evaluate data on beneficiaries' experience, including their:

- level of confidence in taking care of themselves, managing problems and getting better health care
- level of involvement in their community
- ability to maintain meaningful relationships
- ability to choose among LTSS options (including home care services, personal care attendants and peer supports)

Finally, we wonder whether, in addition to the CMS-required quality withholds, the state will assess penalties against an ICDS for a failure to meet quality targets. For instance, will such a plan be disallowed from retaining a share of savings? Or, will it be barred from further participation in the demonstration? And, how the state will make information about these penalties public?

Cultural Competence

While the state is to be commended for its stated intention to choose ICDS plans that use culturally sensitive care management models and that recruit providers capable of communicating with individuals in their primary language, we believe the state must provide additional specificity, such as requiring that:

- Beneficiaries are guaranteed a choice of providers who speak and understand their culture and language, including those who use American Sign Language or who are blind
- Written materials for beneficiaries are culturally sensitive and available in languages other than English
- Customer service departments have oral interpretation services available to beneficiaries free-of-charge.

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In summary, Community Catalyst commends the state of Ohio for placing such a high priority on improving the lives of dually eligible beneficiaries in the state. While it is evident that the state has taken to heart some of the recommendations from consumer advocates, beneficiaries and community-based service organizations, there is much left to be done before this proposal can be approved.

Finally, we must underscore our overall concerns about the aggressive timeline for enrolling dual eligibles beginning in February 2013. We appreciate the need to show savings as quickly as possible, but strongly caution your office against allowing any state to enroll people – many of whom are the most frail Americans in our country today – before it can assure CMS that it will have integrated care entities with the experience and expertise to care for the complex needs of the members they will serve. Existing managed care plans in Ohio have an insufficient track record of serving these populations. They may, indeed, be able to

assume these roles, but it will take time to put into place the systems and provider networks necessary to achieve the laudable goals of the program. **We urge CMS to delay the start of this program until consumer concerns are addressed and the program is truly ready to launch.**

Again, we appreciate the opportunity to provide these comments and would be happy to talk with you further as your office continues its review.

Sincerely,

Renée Markus Hodin
Director, Integrated Care Advocacy Project
Community Catalyst

Enclosure