



October 17, 2018

Tim Engelhardt, Director
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

Submitted via: MMCOcomments@cms.hhs.gov

Re: Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0

Dear Mr. Engelhardt:

Community Catalyst respectfully submits the following comments in response to the invitation for public comment on the Massachusetts Medicare-Medicaid Integration Demonstration: Duals Demonstration 2.0.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. Our Center for Consumer Engagement in Health Innovation (Center) focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those that are most vulnerable.

The Center has been working to improve care for Medicaid-Medicare beneficiaries for more than a decade, producing tools for consumer advocates to use in state-based advocacy as well as tools for use by other stakeholders. Our work is also informed by the experience of our state advocacy partners, including those in Massachusetts such as the Disability Advocates Advancing our Healthcare Rights (DAAHR) Coalition and Health Care for All.

Demonstration Goals

The Commonwealth's stated purpose of the Duals Demonstration 2.0 proposal is to "grow its integrated care capacity and expand the participation of dual eligibles in the One Care and SCO programs" and it seeks new flexibilities from CMS that would support this goal. The Center is not opposed to scaling up and strengthening the One Care and SCO programs, but we believe the Commonwealth should first work to address existing issues in the programs such as:

- Limited knowledge among members and family caregivers of the Ombudsman office
- Variability in member knowledge and use of care coordination and care planning
- Difficulty accessing adequate and reliable transportation services

At a minimum, we recommend that CMS require the Commonwealth to explain how each of the provisions of the Duals Demonstration 2.0 would:

- Improve members' care, outcomes and quality of life
- Address the social determinants of health that prevent members from meeting their goals for health and quality of life
- Reduce health disparities
- Promote independence and autonomy, in the least restrictive setting (frequently in the home and community)
- Help members meet their own self-identified goals.

Enrollment (p. 5-9)

Passive enrollment

Our longtime concerns about the passive enrollment of dual eligible beneficiaries remain. As your office will no doubt recall, passively enrolling large numbers of beneficiaries into the One Care program proved extremely challenging not merely because the program was new but because of the complex needs of the members themselves. The dangers of passive enrollment are only exacerbated by the proposed use of fixed enrollment periods. Furthermore, the Commonwealth's request to passively enroll beneficiaries who had previously opted out of One Care is particularly offensive. Involuntarily re-enrolling people who made a conscious decision against enrollment is an assault on their freedom of choice.

Rather than resorting to the use of the blunt tool of passive enrollment, we believe the Commonwealth's goals of expanding enrollment in SCO and One Care could be achieved through the use of a voluntary, opt-in process paired with a comprehensive outreach and education plan about the robust benefits of each program.

Fixed enrollment periods

We strongly oppose applying fixed enrollment periods to dually eligible beneficiaries enrolled in One Care or SCO. Beneficiaries must be allowed to opt-out of the demonstration at any time, without being subject to a lock-in period, especially when paired with passive enrollment. Beneficiary choice is a hallmark of the Medicare program and is all the more important for dual eligible beneficiaries who have particularly complex needs and often have spent years piecing together systems of care with providers they trust. Getting stuck in a plan that does not work for them could cause a major disruption in these systems resulting in adverse health outcomes. We note that both California and New York have sought waivers to new Medicare enrollment regulations that would limit Special Election Periods for their states' dual eligible demonstration projects.¹ It is also notable that the Commonwealth's proposal to use fixed enrollment periods for dual eligible beneficiaries is even more restrictive than the enrollment policy currently under consideration for the Medicare Advantage program.

Continuity of care

While we support the inclusion of a continuity of care provision, 90 days is far too short for beneficiaries with complex health and social needs. Instead, to prevent disruptions in care, we recommend a continuity of care provision of at least 180 days. We also support the use of "single-case agreements" that would allow members to continue seeing their existing provider. We recommend, however, that the Commonwealth improve the effectiveness of single case agreements as a tool to promote enrollee access to care by working with stakeholders to create a set of guidelines for single case agreement requests, creating a plan for educating members and providers about these guidelines, and reporting on members' awareness of the

¹ See, e.g., Department of Health Care Services announcement. Available at <http://calduals.org/2018/06/21/cal-medicconnect-enrollment-updates/>.

availability of this option, the number of requests made, and the number of single case agreements executed. Creating these guidelines should begin with a review of data from both One Care and SCO of the number and outcomes of single case agreements to date.

Ombudsman

We enthusiastically support the Commonwealth's request for continued financial support, expanded to match the increase in program enrollment, of the *My Ombudsman* program as an important tool to assist dually eligible beneficiaries with questions and problems, as well as to identify emerging systemic issues.

Administrative Alignment (pp. 9-10)

Member-facing communications and materials

We support, in concept, the alignment of member-facing communications and materials for One Care and SCO. We recommend, however, that the Commonwealth engage stakeholders from the disability and older adult communities to review all draft materials to ensure that they are easy to understand and at an appropriate reading level but also that they are clear about the unique aspects of each program.

Appeals and grievances

The Center supports, in concept, the alignment of the appeals and grievances processes for One Care and SCO. However, we strongly encourage the Commonwealth to convene a group of stakeholders to develop this approach and by gathering and sharing data on the number and outcome of appeals in One Care and SCO to date.

Contracting

The Commonwealth fails to provide a rationale for its proposal to administer the One Care and SCO programs through a combination of three-way and two-way contracts. We request a more complete explanation and, should this proposal be approved, public review and input into the development of both types of contracts.

Financing (pp. 10-14)

We are supportive of efforts to strengthen the financial infrastructure of both the SCO and One Care programs. We know that the right financing infrastructure – together with strong oversight – can motivate Medicare-Medicaid plans to pursue innovative approaches to care, resulting in better outcomes without higher cost. Conversely, poorly designed financing arrangements can create the wrong incentives: plans may skimp on services for their members, or pull out of the demonstration altogether, leaving consumers vulnerable to harmful interruptions in their care.

We start with the premise that while alignment of the SCO and One Care financing methodologies is an admirable objective, it must combine the best elements from both programs in order to create a solid foundation that promotes the overarching goals. In addition, the methodologies should be transparent, subject to consumer oversight and equitable in their allocation of costs between Medicare and Medicaid.

In its Duals 2.0 proposal, the Commonwealth seeks approval of a complex array of financial arrangements it views as necessary to achieving fiscal sustainability for the SCO and One Care programs. We find several of these provisions potentially beneficial in achieving the above-stated goals while others are either vague or troubling.

For instance, we support the following proposed changes to the financial methodologies for SCO and One Care:

- The Commonwealth receiving authority to pay the Medicare Part B premiums for **Full Benefit Dual Eligibles** (FBDE) members
- CMS including a county-level adjustment for **bad debt** load in the Medicare capitation for both One Care and SCO plans
- CMS making the **low-income cost-sharing subsidy** available to both SCO and One Care plans
- SCO and One Care plans becoming eligible for the **frailty adjuster**

On the other hand, we have concerns about the following proposed changes:

- **Experience-based capitation rates:** The Commonwealth's proposal to implement risk-adjusted, experience-based Medicaid capitation rates in both SCO and One Care raises significant questions about how care that is not captured through traditional claims, the hallmark of integrated care, will be recognized. One Care and SCO allow for more flexibility in care arrangements in order to achieve timely, person-centered and coordinated care. This includes a strong focus on care management and other services (such as intensive assistance with social needs, telephonic assistance, coordination of care with other providers, use of technology to improve care, and use of mobile integrated health) as well as provision of supplies which have not traditionally been billed for through claims. How will these important services and, more importantly, these innovative approaches be incentivized and accounted for in the capitated rates if the rates are experience-based?
- **Medicare Stars ratings:** We believe that the Medicare Stars rating system should be modified to better suit both the SCO and One Care populations. Developing a modified approach for both programs is important given that plans serving dual eligibles have traditionally tended to receive lower star ratings.² We are concerned, however, about the Commonwealth's quality measurement approach in general (see below) and believe that the measures selected need to be important to consumers and closely tied to program quality.
- **Quality measures:** We commend the Commonwealth's desire to refine the slate of quality measures for Medicaid services given the unique needs of the SCO and One Care populations. We disagree, however, with the proposal to align the measures with those in the Medicaid ACO program. Given that the Medicaid ACO program is a mere seven months old, it is highly premature to rely on these measures. Furthermore, because these measures were not selected with dual eligible populations in mind, we question their adequacy and applicability. A measure slate needs to be identified with strong input from beneficiaries. As part of this slate, we agree with the suggestion of our colleagues from the Disability Advocates Advancing our Healthcare Rights (DAAHR) coalition encouraging the Commonwealth to include some of the recently-released MLTSS quality measures developed by Mathematica and NCQA.³
- **Quality withhold:** While we agree that a quality withhold can serve as an incentive for plans to focus on improved quality of care and outcomes for dual eligible members, we encourage CMS to provide oversight to ensure that the Commonwealth uses the withhold for quality improvement rather than merely a financial management tool.
- **Risk corridors:** The application of the type of two-sided risk corridor structure used in One Care to the SCO program would be a positive development, but because the Commonwealth's proposal fails

² See, e.g., Inovalon, *An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures*, Available at [http://www.inovalon.com/sites/default/files/documents/INV_Duals_Study_Report_\(3%2026%2015\)_v1%200%201.pdf](http://www.inovalon.com/sites/default/files/documents/INV_Duals_Study_Report_(3%2026%2015)_v1%200%201.pdf)

³ Centers for Medicare and Medicaid Services, *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*. August 2018. Available at https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

to provide detail about the proposed risk corridors—e.g., who shares in what level of risk and what savings assumptions are built into the structure—it is difficult to evaluate their adequacy.

- **Savings:** The Commonwealth fails to provide information about the expected annual savings percentages. This information is critically important to assessing the impact of the Commonwealth’s proposal on these highly vulnerable populations.
- **Stop-loss mechanism:** We agree that One Care plans should be protected from large losses for individuals whose annual costs exceed an appropriate threshold. As the Commonwealth and CMS explore this mechanism, we urge public transparency on how it will be established, funded and operationalized.
- **Transparency:** Transparency in rate setting will be critical, and we would like the Commonwealth to commit to making its rate setting methodology publicly available, including with the One Care Implementation Council and the SCO Consumer Advisory Committee, with an appropriate comment period. In particular, we would like to better understand the assumptions around long-term services and supports (LTSS) the Commonwealth is building into its rates, particularly its assumptions around wages for home care workers. In addition, given the predominance of LTSS needs of the SCO and One Care population, and the well-known scarcity of home care workers, it would be important to carefully track the impact of these changes on care, and specifically, to report the percentage of approved LTSS hours that are actually filled and measure unmet needs for LTSS.

Value-Based Purchasing (VBP) (p. 14)

We are troubled by the Commonwealth’s proposal to align the value-based purchasing initiatives in One Care and SCO with those used in MassHealth’s MCOs and ACOs, as well as Medicare ACOs. It is unclear whether using the ACO system adequately accounts for the more complex needs of the dually eligible population. And, similar to our aforementioned comment with respect to quality measures, the MassHealth ACO program is so new, that it seems premature to use their VBP initiatives as a benchmark.

Transparency and Data Sharing (pp. 14-15)

We support the Commonwealth’s request for increased transparency and data sharing, but urge the state and CMS to increase public access to relevant, de-identified data such as risk scores, beneficiary-level plan payments, appeals and grievances.

Medical Loss Ratio (MLR) Requirements (pp. 15-16)

We do not oppose the Commonwealth’s proposed use of a Medical Loss Ratio (MLR) construct that blends Medicare and Medicaid data expenditures, but we request clarification about what kinds of services are included in calculating the MLR. In particular, how will critical services such as care management and flexible spending to address members’ social determinants of health be included in the MLR?

Crossover Payments (p. 17)

We are concerned about the Commonwealth’s proposal to place limits on the Medicaid crossover portion of provider payments for both One Care and SCO. The Commonwealth indicates that some plans are paying providers above the Medicare FFS rate, and it would be important to understand more about why these payments are being made. For example, these rates may be paid in order to ensure critically important access to care for this vulnerable population. We do not know if these rates are being paid to secure access to primary care, behavioral health, or subspecialty care that is important for this population. Given the potential risk to access to care for this population, before moving forward with this proposal, the Commonwealth must clearly demonstrate that there will be no negative impact on access to care if this proposal were implemented. Moreover, we request that should CMS approve this provision, it establish oversight mechanisms to monitor any impact on member access.

Shared Savings Agreement (p. 19)

Conceptually, we support the creation of a shared savings agreement between the Commonwealth and CMS. That said, the track record on these types of agreements is quite limited. However, in the negotiation of such an agreement, we urge CMS to require the Commonwealth to reinvest its portion of the savings to benefit this population, such as through expanded member benefits, services and supports and to ensure a livable wage is paid to direct service workers rather than simply being placed into the General Fund. And, as mentioned above, we request more information about the savings targets in these programs as an inappropriately aggressive savings target could result in harm to members.

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Please do not hesitate to contact me at ahwang@communitycatalyst.org should you have any questions or if you would like additional information.

Sincerely,



Ann Hwang, M.D.
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