

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 20, 2017

Submitted electronically to CMMI_New_Direction@cms.hhs.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

Re: Innovation Center New Direction—Request for Information

Justice in Aging appreciates the opportunity to provide a response to the above-referenced Request for Information (RFI).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Our comments primarily address guiding principles, both those articulated in the RFI, and additional principles that we believe are important as CMMI moves forward with any new demonstration. We also address the question of appropriate models for CMMI support, and urge continuing support of the Financial Alignment Initiative (FAI). The comments are informed by our work with low-income older adults and persons with disabilities, many of whom are dually eligible for both Medicare and Medicaid.

In our 45 years of advocacy, Justice in Aging has observed many demonstrations and seen the launch of significant program changes, including the introduction of the Medicare Part D benefit and the expansion of managed care in both Medicare and Medicaid. Most recently, for more than five years, our extensive involvement in the design and implementation of a current CMMI demonstration, the Financial Alignment Initiative (FAI), has helped shape our perspective on the elements necessary for a successful demonstration. The FAI demonstration, which in fact is 13 distinct state demonstrations, has broken much new ground in integrating Medicare and Medicaid services. Because of the complexity of that integration and because of the many unique state variations, the FAI provides a rich source of information on many of the elements discussed in the RFI. Our comments include many references to lessons learned from our involvement with that demonstration.

1. Guiding Principles

Guiding Principle 1. Choice and competition in the marketplace.

We support beneficiary empowerment so that individuals can make the best choices possible for their health care. Health care choices are among the most important decisions any individual can make and are among the most complex. For low-income individuals with no financial reserves, low health literacy, and often multiple chronic and serious conditions, the task is daunting and the stakes are high. They, like

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other Medicare or Medicaid beneficiaries, know their own needs and preferences and, like other beneficiaries, need assistance if they are to make meaningful choices. In this section, we discuss some basic components that should be in every demonstration to facilitate genuine informed choice, looking particularly through the lens of the low-income older adult.

Beneficiary Communications: All beneficiary communication about a demonstration, both at the start and throughout, should be in plain language and consumer-tested. Communication should be geared toward maximum comprehension as quickly as possible: well-organized, simple, active, and broken into understandable chunks. Care should be taken to tailor communications to the individual's particular circumstances and to narrow the content to what is necessary for the beneficiary to make the decision needed at the time. Letters and notices should not include extraneous materials that make communications long or complex. Focus group responses have shown that when materials are too long or too complex, consumers simply avoid taking any action and just hope for the best.¹

Materials should be accessible to individuals with disabilities and to those with limited proficiency in English. Statutes and regulations require it² and, as importantly, a demonstration simply cannot work for beneficiaries who do not understand what is happening to their care. Alternative formats—including large print, specialized fonts, color contrast, audio format, Braille, and more—can be an indispensable way to provide needed information to diverse populations. Because the Medicare program serves many individuals with age- or disability-related communication issues, alternative formats can mean the difference between effective communication and no communication. Similarly, individuals who do not speak English well need translated materials and oral interpretation so they have information that they can understand.

Beneficiary Tools: To exercise informed choice, beneficiaries need easy-to-use and accessible tools that allow them to compare options. We encourage CMMI to continue to work to improve choice tools for beneficiaries and for those who counsel them. Overly complex tools can overwhelm beneficiaries and bury them in too much information, particularly if the key items that beneficiaries want to know are hard to find. Testing of tool design with beneficiaries, their families, and counselors should be an essential part of the design process. Most importantly, tools must accurately reflect what is offered. For example, information about provider networks in a managed care network must be up to date and accurate. Limitations on access to listed services must be clear and prominent. It is very important in any demonstration that CMS hold participating entities responsible for providing accurate information and that the agency monitor their performance to ensure compliance.

One-on-one assistance: Beneficiaries need to have free, personalized assistance available both to understand their choices and to navigate a demonstration once they join. Personal assistance is something that is especially important for the many older adults and persons with disabilities who have difficulties using online resources. While they can use 1-800-Medicare, which is a valuable source of basic information, it is not a substitute for personalized assistance, such as SHIP counselors or local ombuds. It is our experience that 1-800-Medicare representatives cannot handle the level of state-specific advice that beneficiaries need effectively.

¹ See RTI International, *Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative* ("Beneficiary Experience"), pp. 10-11, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.

² See, e.g., Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794; Section 1557 of the Affordable Care Act, 42 U.S.C §18116; and 45 C.F.R. Part 92 et seq.

We urge that all beneficiary demonstrations include funding to support options counseling as was done in the FAI.³ Local, specific assistance in understanding a demonstration project is particularly necessary for low-income beneficiaries who need to be able to understand how any Medicare change relates to their state's Medicaid benefits. It also is important that a demonstration be explained to the wide range of counselors and advocates to whom beneficiaries are likely to turn, including SHIP counselors.⁴ Representatives at 1-800-Medicare also should have scripts and be trained on where to direct beneficiaries for more thorough assistance.

Voluntary beneficiary participation: Demonstrations are, by their very nature, trials of untested systems. No beneficiary should be required to participate in a trial. Beneficiary participation in any demonstration that impacts their receipt of services should also always be voluntary. If the demonstration has options within its design, those choices also should be the beneficiary's decision.

This basic beneficiary protection is most important for the frail and vulnerable. For example, beneficiaries with multiple chronic conditions have often spent months or years developing provider networks that work well for them. They must always be given the option to keep their providers and not be required to disrupt their care to participate in a demonstration.

The best way to insure voluntary participation is through an opt-in process. We have seen in the FAI that passive enrollment processes—the process of defaulting a beneficiary into a plan if they do not make a decision to not participate—has significant negative consequences.⁵ Passive enrollment processes are difficult to explain to beneficiaries, are very complex to administer, cause significant disruptions in care, and can create mistrust of a demonstration among beneficiaries⁶.

Guiding Principle 3. Patient-centered care

Patient-centered care, or more precisely, person-centered care, needs to start with a demonstration design that works for and with beneficiaries. A design in which beneficiaries have input from the earliest stages, shared decision-making, and real beneficiary choice ensures that the demonstration reflects their priorities and values. Person-centered care means giving individuals the tools to manage their care, care coordination, navigation assistance, and culturally competent and accessible providers.⁷ Person-centered care means designing care that takes into account the unique circumstances and needs of each participating beneficiary, be it homelessness or housing insecurity, gender identity, dementia, language abilities, cultural preferences or other characteristics that are part of that individual's identity.

³ Funding support awards for FAI demonstration options counseling can be accessed at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOptionsCounselingforMedicare-MedicaidEnrollees-.html.

⁴ An example of advocate education material is the Justice in Aging Advocates Guide to California's Coordinated Care Initiative, available at http://dualsdemoadvocacy.org/wp-content/uploads/2015/06/CCI-Advocates-Guide_V4_06042015.pdf.

⁵ For more information about concerns with passive enrollment, see Justice in Aging's April 22, 2016 letter to California's Department of Health Care Services and the Medicare-Medicaid Coordination Office, available at <http://www.justiceinaging.org/wp-content/uploads/2016/04/CCI-Proposals-Comments-FINAL.pdf>.

⁶ See, Beneficiary Experience, *supra* note 1, pp. 9-12.

⁷ See, e.g., Justice in Aging, A Right to Person-Centered Care Planning, (April 2015), available at http://justiceinaging.org/wp-content/uploads/2015/04/FINAL_Person-Centered_Apr2015.pdf, for examples of effective person-centered care planning.

To do this effectively, it is critical to seek input from beneficiaries at every stage by asking beneficiaries for their views on developing the demonstration, asking for their input on the goals of the demonstration, and asking them how the demonstration is progressing through implementation. At the individual level, this means asking them what their goals are, what they are willing to do to meet them, and how much or little they want to direct their own care. Evaluations have shown that these approaches can be highly effective in engaging beneficiaries in their own care.⁸

In our experience, these are key elements in the concept of patient-centered care and “ownership,” not imposition of additional financial costs. As we discuss at more length in our response to Consumer Directed Care and Market-Based Innovation Models, even small premiums or co-pays can dissuade low-income Medicare beneficiaries from accessing needed care.

Guiding Principle 4. Transparent Model Design and Evaluation

In all demonstrations, we strongly support extensive and transparent work with all stakeholders at both the front end, designing a demonstration, and at the back end, evaluation. Experience has shown that any changes in Medicare and Medicaid systems have ripple effects that, if not anticipated and addressed, can harm beneficiaries. An open process with opportunities for meaningful and sustained stakeholder participation throughout the demonstration, from conception to evaluation, offers the best opportunity for prioritizing demonstrations that address the most urgent issues facing Medicare and Medicaid, for ensuring that the demonstrations work as designed, without adverse impact on beneficiaries, and for learning as much as possible from the demonstration. Our comments will address both design and evaluation elements.

Demonstration design process

Transparency in model design with early and continuing input from all affected stakeholders is critical. Demonstrations, particularly those that attempt to integrate systems in new ways, have many component parts. Ensuring that they work together requires shared action at every step from concept to through implementation. From our experience, we make the following observations:

Multiple opportunities: Transparency needs to include constructive participation by stakeholders at multiple points in the planning process. Early discussions with stakeholders at the concept stage can avert major problems down the line. However, these early discussions are not sufficient; design details also must be open for close review. For example, in the FAI, the three way contracts between CMS, the states and health plans benefitted in those states that opted to open review of drafts to additional stakeholders.

Structured forums for ongoing participation: Stakeholder participation must be sustained to be most effective. Ad hoc stakeholder participation is of limited value. Structures that facilitate ongoing substantive participation in planning and implementation by knowledgeable stakeholders committed to the process produce the most successful model designs.

⁸ See, e.g., Beneficiary Experience, *supra* note 1, p. 15.

Cross-stakeholder communications and collaboration: Although separate consultation with beneficiaries, advocates, providers, and other stakeholders are necessary and important, it also is important that there be structured opportunities for different stakeholders to work together. For example, in the Cal MediConnect demonstration, communications workgroups have developed, comprised primarily of health plan representatives and advocates. The workgroups have served as useful conduits for both sides to understand each other's challenges and constraints and to jointly develop responses and strategies. Similarly, the consumer-driven Implementation Council for the Massachusetts One Care demonstration has found value in routinely inviting health plan representatives to their meetings.

Inclusive preparation process: In planning for a demonstration, it is imperative to identify and include all affected entities in thinking through all operational aspects of the program. In the FAI, for example, many initial operational challenges could have been avoided if there had been prior in-depth discussions that included all provider groups that were affected by the demonstrations. At the start of the MyCare Ohio demonstration, billing processes between some long term service providers and health care plans did not mesh, resulting in long delays in payment and, in some cases, disruption in services to beneficiaries. The problems were ultimately resolved but the issue could have been identified before implementation if the consultation process had been more robust.⁹

Rigorous Systems Testing and Readiness Reviews: The start of any demonstration is the time when beneficiary access to care can be most at risk, and the issues often arise from systems errors: failure of data transfers to work correctly among participating entities, coding errors, unanticipated impact of demonstration changes on other systems or programs, etc. In the Cal MediConnect demonstration, for example, numerous issues arose with state and federal data systems. In some cases, issues with state data systems resulted in individuals who did not qualify for the demonstration being enrolled, and some who did qualify not receiving notices.¹⁰ In many states, Medicaid programs did not have current addresses for beneficiaries, which resulted in passive enrollment without any notice (because notices went to the wrong address) and, more importantly, plans not being able to locate and communicate with their new members. Computer "glitches" such as these have real consequences. Advocates reported that, because of the enrollment problems in the demonstrations, beneficiaries had to postpone the start of cancer treatments and reschedule surgeries and important doctor visits.

We strongly urge rigorous and extensive systems testing before the start of any demonstration. Robust readiness review procedures for participating providers and plans, states (if participating), and CMS itself also need to be developed for each demonstration. Early in the FAI, advocates in several states reported frustration in finding state Medicaid staff or plan staff who were designated and empowered to address implementation issues. Readiness review should address not just computer systems but personnel commitments to the demonstrations, provider understanding of the demonstration, and all other elements.

⁹ See WDTN, Stuck with the Bill, (Nov. 10, 2014), available at <http://wdtn.com/2014/11/10/payment-concerns-surrounding-mycare-ohio/>. See also Encarnacion Pyle, Trouble persists for health workers, The Columbus Dispatch (October 12, 2014), available at www.dispatch.com/content/stories/local/2014/10/12/trouble-persists-for-health-workers.html.

¹⁰ During enrollment in California, Justice in Aging compiled a "Fix List" of systems issues and the number of beneficiaries affected, available at www.justiceinaging.org/wp-content/uploads/2015/02/CCI-Fix-List-20150309.pdf.

Demonstration Evaluations

Rigorous evaluations should be a key element in every demonstration and are necessary to determine what is working well and what is not, as well to compare different initiatives to determine which is most effective. We urge the following considerations in evaluation design:

Rapid Cycle Evaluations: An evaluation design should include rapid cycle evaluations to facilitate mid-course corrections during the term of the demonstration, as well as longer term studies.

Inclusion of beneficiary experience: Beneficiary experience should be an important element in all evaluations. Collecting beneficiary response through focus groups, telephone surveys and other means can be especially valuable in early evaluation stages before more hard data becomes available. It also provides texture that cannot be captured from statistics alone and raises practical concerns that often can be addressed promptly. Both focus groups¹¹ and telephone surveys¹² have provided valuable insights into the FAI.

Realism about cost savings: Evaluations (and goals) should be realistic in recognizing that financial savings from improved care and outcomes may not be immediate. The Massachusetts OneCare demonstration, for example, required readjustment of savings goals because, in part, the demonstration uncovered unmet needs requiring provision of additional care that, in the longer run, could improve health outcomes and produce cost savings.

Prompt and complete release of evaluation data: As much as possible, underlying data should be publicly available to researchers and stakeholders. The FAI website has an evaluations page where evaluations are posted as soon as they are released.¹³ Data should be collected and compiled so that impact on sub-groups of beneficiaries can be fully analyzed. Stratifying data is key to identifying and addressing health disparities and promoting health equity. It also is helpful if researchers can have access to data in a form that they can easily use and analyze.

Inclusion of all relevant sources of information: Performance on well-designed quality measures as well as audit results and compliance actions are all important elements that need to be incorporated when evaluating any demonstration. To protect beneficiaries when models are being tested, it is important to only allow high performing providers and plans to participate. Further, during the course of the demonstration, CMS should ensure that the quality of service is maintained and, in addition to

¹¹ See Beneficiary Experience, *supra* note 1; RTI International, Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative (incorporating focus group participant responses throughout the report), available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CareCoordinationIssueBrief508032017.pdf.

¹² UC San Francisco & Berkeley, Evaluation of Cal MediConnect: The Beneficiary Perspective (including both telephone surveys and focus groups), available at www.thescanfoundation.org/sites/default/files/calmediconnect_2016_telephone_survey_results_051116.pdf.

¹³The webpage is www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html.

demonstration-specific evaluation tools, also incorporate all ongoing CMS review and oversight mechanisms and coordinate with other CMS oversight entities.¹⁴

Additional Guiding Principles

We urge CMMI to adopt two additional guiding principles.

A) Consumer Protections and Robust Oversight

In order to successfully implement the guiding principles discussed in the RFI, we urge CMS to prioritize the inclusion of consumer protections, along with oversight, so that those protections are effective. All demonstrations should ensure that beneficiaries are not harmed by changes. Strong consumer protections must be in place. These include:

Appeals: Beneficiaries need access to a fair, easy-to-access appeals system with timely decision making. For dual eligibles, the innovations developed in the New York FIDA demonstration present a model that, though still being tested, offers promise. In all models, it is important that both decisions and effectuation deadlines are met. It also is important that beneficiaries have timely access to independent decision-makers without unreasonable delays in internal plan appeal processes, so that beneficiaries can access the health care they need in a timely manner. Demonstrations that involve health or drug plans should also include monitoring of plan handling of appeals. CMS audits of plans over several years have shown continuing problems with both the timeliness and quality of plan appeals processes.¹⁵

Quality and safety standards: Flexibility and innovation in demonstrations must always be accompanied by standards to ensure that beneficiaries receive high quality services and that they are safe. Beneficiaries participating in a demonstration should never be put at greater risk because of their participation. Developing appropriate quality measures is a critical part of any demonstration. We urge CMS to continue to find ways to include consumer experiences as part of those quality measures.

Care continuity: Demonstrations should ensure that individuals entering new systems do not experience disruptions in their care. Even with notices, many beneficiaries are caught unaware when elements of their care delivery change. Having care continuity protections in place is essential so beneficiary health is not endangered. For protections to work, providers must be well educated on their mechanics. Further provider authorization, billing and payment must be easy for the provider to navigate.¹⁶ Experience with the FAI has shown that for care continuity to be effective, there needs to be significant provider education about how to use the system.

¹⁴ When coordination of oversight within CMS is incomplete, problems can arise. For example, a health plan that passed Cal MediConnect readiness review was found during an audit to have such serious violations that its enrollment was suspended, creating significant complications for the demonstration.

¹⁵ CMS Intermediate Sanctions and Civil Monetary Penalties are reported at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html. Almost all of the significant monetary penalties and the suspensions included appeals violations.

¹⁶ See the fact sheet on continuity of physician care in Cal MediConnect as an example of provider education about care continuity, available at http://calduals.org/wp-content/uploads/2016/08/PhysToolkit_ContOfCare-R8.pdf. The care continuity procedures in that fact sheet represent improvements from those originally used, which had resulted in numerous problems in accessing care.

Ombuds program. Having a robust ombuds program that can assist beneficiaries in navigating a demonstration and that also can identify and address systemic issues has proved to be an effective consumer protection. We urge that an ombuds function, adequately funded, be part of every demonstration. Ombuds programs can have different designs, and different types of entities can be appropriate to act as ombuds, depending on the program and local strengths. What is important is that consumers have good direct and indirect channels to the ombuds, that they know about the services of the ombuds, and that participating entities in an demonstration, whether a state, a provider entity or health plan, or CMS itself, are committed to working closely with the ombuds to identify and address both individual and systemic issues. The ACL-organized collaborative of ombuds in the FAI demonstrations can be a rich source of learning about ombuds best practices and varying organizational options.

Language and disability access: Services and providers must be accessible, both for persons with disabilities and for those with limited English proficiency. Services must be delivered without discrimination. Training, oversight, and safeguards must ensure non-discriminatory access. There also needs to be careful attention when the demonstration is being designed and extensive consultation with stakeholders to ensure that the demonstration design does not, directly or indirectly, discriminate against categories of beneficiaries.

Vigorous oversight: To be effective, all of these protections must be accompanied by oversight and enforcement. CMS has an overarching obligation to beneficiaries to provide robust oversight of providers and plans, an obligation that is even more important when new models are being tried and unexpected issues arise that could harm beneficiaries.

b) Prioritize Addressing Health Disparities

Models should foster health equity, particularly among populations with significant and unmet needs, aiming to address, reduce, and eradicate discrimination and disparities in health care. Models should aim to deliver culturally competent health care services and should take into account a person's language, race, values, culture or ethnicity, socioeconomic status, abilities and disabilities, sexual orientation, gender, and age when designing and implementing new programs. Further, cultural competency should be clearly defined within each model.

While many health disparities are known, models should also work with individuals and communities to identify disparities that may otherwise go undetected. Further, advocates and other experts should be involved in the design of care models in order to ensure that these models do not reinforce existing disparities but instead work toward health equity.

CMMI should explicitly recognize and commit to eliminating health disparities caused or impacted by race, ethnicity, sex, immigration status, and language. Any change to CMMI's direction and priorities should be consistent with and build upon existing federal initiatives, like CMS's Healthy Equity Plan to Improve Quality in Medicare and Healthy People 2020.

2. Potential Models

Our comments address three model types discussed in the RFI. In addition, we urge continuing support of the FAI and propose two additional areas where demonstrations could have significant impact.

Advanced Alternative Payment Models (APMs)

The RFI requests comments on ways stakeholders can capture appropriate data to design APMs. With respect to data and monitoring the progress and adoption of APMs, data must be sufficiently robust to monitor the impact of population-based payment systems on patient outcomes, health care costs, and other measures of significance to patients and other stakeholders. Data is only as valuable as the degree to which it can be stratified. In particular, we recommend that, where practicable, data be collected, analyzed and reported by race, ethnicity, primary language and other sociodemographic factors. APMs must also collect data to identify and redress disparities in health, health outcomes, care experience, access, and affordability. Such data is critical to examining the long-term adoption of APMs and ensuring APMs are actually providing quality care.

Consumer Directed Care & Market-Based Innovation Models

We look forward to working with CMMI to increase consumer-directed care and empower beneficiaries within models that provide positive incentives for beneficiaries. We believe that any demonstration should first and foremost promote the principles of Medicare and Medicaid to make medical assistance available and meet the health care needs of all beneficiaries. These programs entitle all eligible beneficiaries to specified benefits and do not distinguish between those who can afford to pay more and those who cannot. Accordingly, CMMI should carefully examine all models to ensure that new models do not have the unintended consequences of reducing access to health care for beneficiaries.

In designing any program for Medicare and Medicaid beneficiaries, the limited income and resource available to most Medicare beneficiaries and all Medicaid beneficiaries must set the context. In 2016, half of Medicare beneficiaries had income below \$26,200 and savings below \$74,450.¹⁷ Medicaid beneficiaries, who must meet very stringent financial eligibility requirements to qualify for the program, have very limited income available for health care and services.

While we strongly support empowering consumers to make the best decisions they can about their own health and care, we are concerned about any models that increase costs for beneficiaries. If “Consumer-Directed Care” models focus on increasing “skin in the game” for consumers, rather than providing them with information and tools to navigate their care options, then they will not be furthering the purpose of the Medicare and Medicaid programs. In particular, we urge CMMI not to implement models that impose additional cost-sharing on or provide potentially negative financial incentives to beneficiaries as these can encourage people to choose a treatment option that may not be optimal for their health or even forgo treatment altogether. Market-based models should not penalize low-income enrollees based on their employment status, premium payment histories, or inability to keep up with cost-sharing requirements.

Demonstrations that impose additional cost burden on struggling Medicaid beneficiaries through higher premiums or copayments or shrink their access to needed services through restricted provider networks do not advance the purposes of the Medicaid statute. We strongly urge CMMI not to pursue such models. There is little evidence that these methods accomplish their aims and ample evidence that they harm consumers’ access to care. Studies have shown that even small out-of-pocket costs reduce access

¹⁷ Income and Assets of Medicare Beneficiaries, 2016-2035, Kaiser Family Foundation (April 21, 2017) available at www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

to care, especially for those with low incomes or chronic illnesses.¹⁸ Going down this route would increase existing health disparities by their disproportionate effect on low-income beneficiaries.

We have related concerns about models that would remove beneficiary cost protections that prohibit providers from charging patients more than the Medicare rate. Such demonstrations would not advance the goals of the Medicare statute and would erode the universality of Medicare coverage by segmenting beneficiaries into those who can afford to pay additional amounts to providers and those who cannot. Many Medicare beneficiaries already spend large portions of their disposable income on out-of-pocket health expenses,¹⁹ would not be able to afford increased costs for health services, and would have limited negotiating power. A private contract system would largely benefit those with more expendable resources who would be in a position to negotiate, thereby creating a 2-tiered system where those who can afford greater costs have access to more providers, and eroding support for the Medicare program overall. In addition, if providers can privately contract, those beneficiaries who need less common specialty services, but can't afford to pay more, may not have a choice of a Medicare participating providers and may take on unaffordable financial risk. At a time when health disparities are recognized as one of the most significant challenges facing our health care system, a move in this direction is only likely to widen existing gaps and hinder efforts to achieve health equity.

Finally, we do support increasing transparency in prices to empower beneficiaries, especially in the context of Medicare non-participating providers, so that beneficiaries have a better sense of their out-of-pocket costs. It is important to recognize, however, that price transparency can have limited value if an individual has rare or complex conditions with limited provider choice or lives in an underserved area where getting access to any provider can be challenging. Nor is it any help in emergency or urgent situations where comparison shopping simply is not an option. Price transparency is valuable as an adjunct to, but not a substitute for Medicare cost sharing limits and billing protections.

Support for the Dual Eligible Financial Alignment Demonstration

In addition to its consideration of new models, we urge CMMI to continue its support of current valuable demonstrations that are testing new delivery models and providing important information to guide future policy. The Financial Alignment Initiative (FAI) is an ongoing demonstration that is yielding significant learning about effective ways to integrate services to dual eligible beneficiaries. Dual eligible beneficiaries are the most vulnerable and medically fragile of those served by the Medicare and Medicaid programs. More than 40% of dual eligibles require long-term services and supports, a much

¹⁸ For example, a Wisconsin study found that adding a \$10 premium for Medicaid beneficiaries made them more likely to exit the program. This study also found that it was the premium itself and not the amount of the premium that caused people to leave the program, showing that even small out-of-pocket costs can significantly reduce access to care. Laura Dague, The effect of Medicaid premiums on enrollment: A regression discontinuity approach, *Journal of Health Economics*, (2014), available at <https://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf>.

¹⁹ See Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status, The Commonwealth Fund (May 12, 2017), available at www.commonwealthfund.org/publications/issue-briefs/2017/may/medicare-out-of-pocket-cost-burdens.

higher percentage than other Medicare or Medicaid beneficiaries.²⁰ Many innovations are coming out of the FAI and it has proved to be a rich source of learning about ways to address the challenges in coordinating the care of dual eligibles and aligning financial incentives. We strongly support the goals of the FAI and urge CMMI to continue to fully support the demonstration through its projected completion date of 2020.

Justice in Aging has been deeply engaged in the FAI demonstrations from the early planning stage. Our efforts have ranged from educating stakeholders, including consumer advocates, community-based organizations, providers and health plans, to developing issue briefs to highlight the most critical issues facing dual eligibles, to providing recommendations on how to address these pressing issues. For example, our early issue briefs on ensuring consumer protections,²¹ care continuity,²² and alignment challenges²³ in the FAI, provided legal analysis and detailed recommendations on these issues from a beneficiary-focused perspective. We have engaged with the Medicare-Medicaid Coordination Office (MMCO) and state officials throughout the demonstrations and have trained hundreds of state advocates on the intricacies of the demonstrations.²⁴ Having been involved in the development of the FAI demonstrations from the very beginning and having observed them closely with a critical eye, we believe that they are producing much valuable information and insight on how to effectively meet the needs of dual eligibles and that the much additional learning will come. Independent evaluation using multiple lenses²⁵ has been an important aspect of the FAI, and those evaluations promise to bring a wealth of analysis as the demonstrations mature.

Value of the FAI demonstrations: The FAI is really a collection of state-based demonstrations, each with particular characteristics. In total, about 400,000 dual eligible beneficiaries are enrolled. These demonstrations test systems to improve and integrate service delivery and financing for the dual eligible population, the most medically complex and most costly segment of both Medicare and Medicaid enrollees. The FAI demonstrations are testing two overarching designs: a managed fee-for-service model and a fully integrated capitated model. Although early evaluations are providing important insights, they are still preliminary and based on only one or two years of data.²⁶ More time and additional data will provide a much fuller picture of outcomes and financial results.

The demonstrations also are important because each is unique and they all involve many moving pieces. The specific designs in each state reflect state priorities and are adapted to mesh with other Medicaid

²⁰ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, Congressional Budget Office (June 6, 2013), available at www.cbo.gov/publication/44308.

²¹ Justice in Aging, Ensuring Consumer Protections for Dual Eligibles in Integrated Models, available at www.justiceinaging.org/wp-content/uploads/2015/04/RE_DualsNSCLC_issue_brief_1_3.pdf

²² Justice in Aging, Continuity of Care in the Dual Eligible Demonstrations: A Tool for Advocates, available at http://dualsdemoadvocacy.org/wp-content/uploads/2015/03/RE_Care-Continuity-Final-052913.pdf.

²³ Justice in Aging, Medicare and Medicaid Alignment: Challenges and Opportunities for Serving Dual Eligibles, available at www.acgov.org/board/district3/documents/DualsAlignmentBrief-NSCLC.pdf.

²⁴ See, e.g., Justice in Aging, Advocates Guide to California's Coordinated Care Initiative, available at http://dualsdemoadvocacy.org/wp-content/uploads/2015/06/CCI-Advocates-Guide_V4_06042015.pdf

²⁵ For information on evaluation design, see the Integrated Care Resource Center evaluation webpage at www.integratedcareresourcecenter.com/integrationResourceLib/dataAndEvaluation/evaluation.aspx

²⁶ For evaluations that have been completed to date, see the MMCO evaluations page at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html

initiatives and with the existing managed care environment in the state. With different designs and many different sub-characteristics, the FAI demonstrations are providing a wealth of information about all the moving pieces and on-going learning as plans and states identify implementation challenges and develop responses. Already best practices have been shared on issues such as effective consumer communications,²⁷ culturally competent outreach,²⁸ provider engagement, locating and engaging beneficiaries, and many other topics. Much of the learning that is taking place has applicability throughout managed care systems in both Medicare and Medicaid, as well as to other fee-for-service models.

The most important issues in these demonstrations—including how to create genuinely person-centered care plans, how to manage care teams that work effectively, and how to calibrate capitation payments to accurately capture needs and acuity, to name just a few-- are only now being explored fully as implementation takes hold, although preliminary evaluations have found that new care coordination approaches are being implemented with a high level of consumer satisfaction among those using services, and that progress is being made in addressing the needs of beneficiaries with high and complex needs.²⁹ There will be much value to continued evaluation as care coordination and delivery implementation approaches mature during the course of the FAI.

Capitalizing on stakeholder investment: The investment in the FAI by all stakeholders has been enormous. Advocates and consumers have spent and continue to spend countless hours on advisory committees, in formal and informal meetings with Medicare-Medicaid managed care plans, reviewing draft consumer communications and draft guidance documents, and educating consumers on the program. States, CMS, plans, and providers, particularly providers of long-term services and supports, have negotiated contractual language, implemented agreements, amended and re-amended contracts, and developed working protocols. A whole web of formal and informal working relationships has developed that simply did not exist before the demonstrations began.³⁰ Now that the demonstrations have moved from planning and enrollment into implementation, there are real opportunities to leverage those relationships to identify implementation challenges and improve execution.

Most importantly, the 400,000 beneficiaries who are enrolled in FAI models are invested in the demonstrations. Because of their enrollment, many have changed at least some of their providers and all are still learning about systems that are in certain aspects new to them. Their experience and their health outcomes over the course of the demonstrations will be the most important product.

²⁷ See, e.g., Justice in Aging, Outreach and Enrollment Materials in States Implementing a Dual Eligible Demonstration, available at www.justiceinaging.org/wp-content/uploads/2015/07/Outreach-and-Enrollment-Materials-in-State-Implementing-a-Dual-Eligible-Demonstration.pdf.

^{28,28} See, e.g., Justice in Aging, Thinking Outside the Box: Creative and Culturally Competent Outreach Strategies in Health Care Transitions, discussing innovative outreach used in connection with the California Coordinated Care Initiative, available at www.justiceinaging.org/wp-content/uploads/2015/03/AAAE_Cultural_CompetencyFINAL.pdf.

²⁹ See Special Populations Issue Brief, *supra*.

³⁰ See, e.g., discussion in RTI International, Report on Early Implementation of Demonstrations under the Financial Alignment Initiative, p. 21, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.

We strongly urge continued support of the FAI. It is testing ways to integrate care and bring more coherent approaches to the needs of the most challenging population in the Medicare and Medicaid systems. Its design includes rigorous evaluation and, though evaluation is still at a preliminary stage, it is already clear that the demonstration is producing much valuable learning on many fronts.

Oral Health Integration and Models

Besides the potential models discussed in the RFI, we recommend CMMI test and promote models of care that provide comprehensive, integrated health care that includes integrated oral health services. For far too long, oral health has been seen as separate from overall health and not given adequate attention in the development of new payment and delivery models. However, addressing a person's oral health needs is essential in ensuring improved health outcomes and is a necessary component of patient centered care. We urge CMMI to place an emphasis on developing models that focus on treating the whole person and improving integration of oral health services into all aspects of health care.

Oral health integration requires recognizing that oral health is an integral part of overall health and wellness. It necessitates that primary care and other medical providers take responsibility for the oral health of their patients by providing education, and appropriate services and referrals, and that payment and technology support quality and integration.³¹ To that end, we recommend CMMI promote the following strategies:

- Integrate referral systems, where all providers, including dentists, screen for general health needs and refer to an appropriate provider, creating no wrong door for entry into the health care system.
- Develop and enable shared electronic health records (EHR) systems that enable both dental and medical providers to easily view each other's entries and communicate directly. A recent study showed that lack of access to integrated information technology is one of the leading barriers to oral health integration.³²
- Co-locate services, better enabling integrated care delivery. Especially promising are new models where a dental hygienist, dentist, or dental therapist works in a primary care office or clinic; or a nurse practitioner or physician assistant works in a dental office.³³
- Embed oral health education in health sciences curricula, to prepare new workforce for integrated care delivery.

We also recommend that CMMI develop a demonstration that would offer oral health benefits through Medicare coverage. Currently Medicare covers very limited oral health care, with no preventive or routine dental care coverage. Consequently, Medicare recipients' oral health is neglected, which results

³¹ See, Justice in Aging, Oral Health in California: What About Older Adults, available at www.justiceinaging.org/wp-content/uploads/2016/07/Oral-Health-in-CA_What-About-Older-Adults.pdf.

³² The Commonwealth Fund, In Focus: Integration Oral Health into Primary Care, available at <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2015/february-march/in-focus>; American Dental Association, Health Policy Institute, Dental Care Within Accountable Care Organizations: Challenges and Opportunities, available at https://oralhealth.hsds.harvard.edu/files/oralhealth/files/ada_hpi_aco_brief.pdf.

³³ Center for Health Care Strategies, Oral Health Integration in Statewide Delivery System and Payment Reform, available at <https://www.chcs.org/resource/oral-health-integration-statewide-delivery-system-payment-reform/>.

preventable tooth loss, increased emergency room use, and a decline in overall health and quality of life. One quarter of individuals age 60 and over no longer have their natural teeth, and twenty-three percent of older adults have severe gum disease, which increases their risk for aspiration pneumonia and other infections.³⁴

Developing a model that adds dental care to Medicare's Part B benefit would advance the goal of integrating oral health into total health care by incorporating the benefit administratively into the Medicare program that covers other health care providers. The demonstration would also be able to test the scope of benefits that should be included and the impact the provision of dental benefits has on overall health and on health care spending and savings.

Mental and Behavioral Health Models

We also encourage CMMI to develop models that focus on treating the whole person and improve coverage and integration of mental health and substance use disorders services into primary care. Mental health is a critical issue for older Americans, as one in five older adults has a mental health issue, and older men have the highest suicide rate of any group, according to the CDC.³⁵ For dual eligibles, the issue is even more urgent. About 44% of older adults and persons with disabilities who are dually eligible for Medicare and Medicaid have at least one mental or cognitive condition, while more than half of all Medicare inpatient psychiatric facility patients are dual eligibles.³⁶ The mental health needs of persons who are dually eligible are often overlooked in traditional medical settings, ramping up costs and leading to inadequate care. Stigma and inadequate screening mechanisms prevent beneficiaries from accessing behavioral health services.

We believe CMMI can address these barriers and disparities through existing and future demonstrations. We strongly urge CMMI to promote integration of mental health and substance use disorder services in all models and build upon the existing efforts in the dual eligible demonstrations. The means for doing this can be drawn from existing models and best practices. For example, the Administration for Community Living has identified best practices among states and community-based organizations with respect to outreach and education strategies regarding individuals with severe mental illness.³⁷ Other ideas include ensuring care coordinators at managed care plans are trained in how dementia and Alzheimer's disease affect this population, promoting prevention and early intervention strategies such as SBIRT (for substance use disorders and for depression) as universal practice at primary care visits, and incorporating the Collaborative Care model.

³⁴ Centers for Disease Control and Prevention, Adult Oral Health, available at www.cdc.gov/oralhealth/publications/factsheets/adult_oral_health/adult_older.htm.

³⁵ Centers for Disease Control and Prevention, The State of Mental Health and Aging in America: What Do the Data Tell Disease Directors, (2008), available at www.cdc.gov/aging/pdf/mental_health.pdf.

³⁶ Center for Health Care Strategies, Extending Lessons from a Medicaid Pilot to Improve Care for Medicare and Dual Eligible Beneficiaries (Feb. 2013), available at www.chcs.org/resource/extending-lessons-from-a-medicaid-pilot-to-improve-care-for-medicare-and-dual-eligible-beneficiaries/.

³⁷ Administration for Community Living, Expanding Home- and Community-based Behavioral Health Services for Older Adults (2013) available at www.acl.gov/sites/default/files/programs/2016-11/Issue%20Brief%2010%20Expanding-Grantee.pdf.

Question 5. How can CMS further engage beneficiaries in development of these models and/or participate in new models?

Our final comment responds to Question 5 in the RFI which asks an open-ended question about suggestions for further engagement of beneficiaries in development and participation in new models. We very much appreciate this question since direct participation by beneficiaries can greatly improve the success of any demonstration. Based on our experience and analysis of different states in the FAI, we see a number of lessons learned:

Format: There is no one vehicle for beneficiary participation. There must be many different opportunities for consumers to participate: open meetings, ongoing advisory councils, inclusion of consumers in cross-stakeholder workgroups, to name a few.

An example of an innovative way to use technology to include consumers who have difficulty leaving home is the tele-town hall format used by the Personal Assistance Services Council, an In-home Supportive Services (IHSS) coalition in Los Angeles County. Coalition members, who are consumers of Medi-Cal personal care services (called IHSS in California), are contacted by phone and can opt to participate in the call by phone or over the computer in a format that is similar to a radio talk show. Thousands of IHSS consumers and their providers have participated in calls, which include an opportunity to ask questions about the call topic.³⁸

A model for consumer advisory group participation is the Implementation Council that is part of the Massachusetts One Care FAI demonstration. The Council, which meets at least six times a year, is composed of consumers, who must always be in the majority, and also includes representatives from community-based organizations, providers, trade organizations and unions. To facilitate the participation of consumer representatives, accommodations such as sign language interpreters, are provided. Further, transportation and travel stipends are available for consumers whose work with the Council is not supported by other organizations.³⁹

Diversity: To ensure that a representative participation of consumers can participate, it is important that outreach efforts particularly seek out participants from all affected populations. Accommodations for disabilities and transportation are key to enabling robust participation. Recruiting participation from individuals in different language and cultural communities and providing language assistance also ensure that varying perspectives will be heard.

Consumer testing and focus groups: Consumer testing of communications and outreach materials, both at the concept stage and when drafts have been developed, should be a bedrock procedure. Both the California and New York FAI demonstrations ran into serious problems when untested beneficiary communications about the demonstrations both confused and alarmed recipients. Holding beneficiary

³⁸ More information on these tele-town halls can be found at www.pascla.org/our-first-teletown-hall/.

³⁹ For a detailed discussion of the design and functioning of the Implementation Council, see RTI International, Financial Alignment Initiative Annual Report: One Care: MassHealth plus Medicare, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MASSFirstAnnualEvalReport.pdf

focus groups periodically throughout a demonstration also provides information and texture about how the demonstration is proceeding in a way that data alone cannot.⁴⁰

Thank you for the opportunity to submit comments. We appreciate CMMI's continued commitment to demonstrations that will improve quality, reduce costs, and improve outcomes. Justice in Aging looks forward to working with CMMI in the future in designing demonstrations that give beneficiaries the tools to actively participate in their health care, are person-centered, ensure strong beneficiary protections, and promote health equity.

If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Directing Attorney

⁴⁰ See, e.g., RTI International, Beneficiary Experience, Early Finding from Focus Groups with Enrollees Participating in the Financial Alignment Initiative, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf.