ATTACHMENT 1 – SANDATA’S ELECTRONIC VISIT VERIFICATION – ADDITIONAL INFORMATION

Santrax® Payor Management ("SPM") addresses all of the major challenges in managing long-term care delivery including:

- Coordination of care across care settings;
- Quality management and outcomes;
- Visibility and actionable data;
- Provider networks and services;
- Beneficiary safety and satisfaction; and
- Fraud and abuse prevention.

COORDINATION OF CARE ACROSS CARE SETTINGS

A key focus of managing a care transition is to ensure appropriate timely care when a beneficiary is receiving care at home post discharge. The beneficiaries’ post discharge transition care plan can be loaded into their Plan of Care, which will allow the Managed Care Organization’s ("MCO’s") care coordination staff to closely monitor adherence to long-term services and supports’ visit schedule and additional transition care plan instruction. Recently discharged beneficiaries can also be specifically identified within the SPM system to allow care coordination teams to more closely monitor their home care services to minimize the risk for missed care and subsequent readmissions.

Transition Program Support

Figure 1: EVV supports care transition programs by ensuring compliance with plan of care, alerts for re-hospitalizations and collecting data to support continuous quality improvement within the Transitions and Home Care programs.
Effective care coordination across settings reduces administrative costs and ensures quality of care. SPM supports care coordination by:

- Supporting care management, care coordination activities and continuity of care between stakeholders through verification and coordination for care delivered in the home;
- Ensuring the delivery of the right services to the right beneficiary at the right time and by the right caregiver - improving quality of care for the beneficiary;
- Providing a beneficiary-centric view of home care services through jurisdictional oversight;
- Providing transparency and ongoing monitoring of the care plan to determine adherence to plan of care;
- Helping to identify barriers to care;
- Supporting transitions across settings through the monitoring of home-based transitions; and
- Reducing unnecessary service utilization by ensuring timely and accurate home care delivery thus reducing the likelihood of readmission.

QUALITY MANAGEMENT AND OUTCOMES

Measuring the quality of long-term supports and services is a key component of the SPM delivery model. One of the most exciting initiatives that will be underway this fall is a pilot program using the Electronic Visit Verification™ (EVV™) system to capture specific quality metrics. The pilot will capture assessment / screening metrics, early warning signs / indicators, and other metrics at the point-of-care. For example, key measures that are critical to the health of the beneficiary and their ability to remain in the home, such as whether or not a beneficiary has received their oxygen from the assigned DME vendor, can be collected by the caregiver/skilled nurse and reported back to the MCO and the State. These data indicators will then be reported to various stakeholders via alerts and/or customized reporting. The pilot will leverage the SPM suite of Plan of Care and point of care data collection capabilities (Figure 2) to provide key information to support quality measurement, benchmarking and program oversight and coordination. The current quality measure pilot design is outlined below:

- Key quality measures are determined and included in beneficiaries’ SPM Plan of Care; an example includes collecting the number of hours the beneficiary spent in a community setting or involved in community activities.

Figure 2: Santrax® Point-of-Care solutions support clinical assessment and data collection at the point of care.
- The quality measure question is input into the beneficiaries' chart and scheduled to be asked at the appropriate intervals, i.e. weekly.
- The quality measures can be configured to collect a variety of response options, ranging from Yes/No to additional data to support a specific response, i.e. 8 hours community involvement. Additional data elements can also be collected as required.
- When the caregiver arrives for that scheduled visit, they are prompted they need to ask the quality measures question upon their initial 'call in' visit verification.
- At the end of their visit, the caregiver can input the responses collected at their 'call out' visit verification.
- The collected response data will be stored within SPM's beneficiaries' chart and can be accessed via standard reporting as well as incorporated into BI analytical dashboards.
- Additional reporting can be used to better understand quality measurements at a visit, visit type, beneficiary, staff, provider, and programmatic level, including the ability to drill into any level required.

Sandata has recently met with national representatives from both the AARP policy group and NCQA to discuss the quality measures pilot design and activity, and both organizations have expressed their support in the use of the EVV technology to advance home and community based services quality measurement data collection. Both NCQA and AARP feel this technology could also be used once there are national standards for these quality metrics.

**VISIBILITY AND DATA**

SPM enables the Provider, Payor and other stakeholders to have a single, real time composite view of all authorized long-term supports and services and delivers it in an Electronic Health Record. The system provides a holistic view of beneficiaries' long-term services and supports activity for both Medicaid and Medicare benefits. Utilization data is available by program funding source, allowing for appropriate cost allocations and reporting.

SPM provides accurate, up-to-date business intelligence (BI) that enables all stakeholders to monitor, act on, and audit encounters, billing, care plan delivery and service benchmarks. The Jurisdictional View and BI capabilities will be used by MCOs to support varied Quality Management and Oversight activity ranging from a case coordinator monitoring their caseload in real time to program administrators using Sandata's advanced Business Intelligence dashboard to monitor quality of long-term services and supports delivery and focused opportunities for improvement. The Jurisdictional view and specific dashboards can be expanded to support additional long-
term services and supports stakeholders such as community coordinators, the State, or CMS, as appropriate.

SPM provides the foundation necessary for greater control and insight into clinical, financial and operational processes. With SPM, the Payor receives a single composite view of services, claims and data collected by all providers across a jurisdiction as shown in Figure 3.

Sandata’s business intelligence enhanced system reporting and analytics turns data into actionable information and knowledge and gives users a variety of Jurisdictional Analytical Dashboard templates to provide key information to specific users:

- Ability to measure performance against benchmarks
- Real time drill down into more detailed information
- Robust report library plus a report creation capability to allow users to meet unique report needs
- Sophisticated data warehouse is the foundation for BI system

![Figure 3: Jurisdictional configuration, showing stakeholder oversight, and each individual provider database.](image)

![Figure 4: Reporting filters allow users to narrow or expand the data queries quickly and easily.](image)
PROVIDER NETWORKS AND SERVICES

Sandata’s SPM system can assist the Dual Eligible Demonstration project as MCO’s can now effectively and efficiently coordinate, manage and monitor home care providers and caregivers to ensure quality home care service delivery. SPM enables the MCO to have a single, real time composite view of all authorized community based LTSS and care delivered within an Electronic Health Record. The system provides a holistic view of all community based LTSS activity for both Medicaid and Medicare benefits. Utilization data is available by program funding source, allowing for appropriate cost allocations and reporting.

Caregiver information is also captured within the SPM system and can be viewed in real time and via caregiver reports. The State and MCO can configure the SPM system to require key role-specific caregiver data to ensure they meet key compliance criteria, ranging from credentialing requirements to an updated CPR card. Caregivers that do not meet the specific compliance criteria cannot be scheduled for a home visit, nor can any of those caregiver claims be submitted until they are in compliance. Other SPM payor programs have found the caregiver information and compliance configuration to be beneficial in that it is often the only source they have about providing critical community based LTSS services, and allows them a single repository of data to confirm caregivers are properly registered, credentialed, and are able to match them against exclusion and sanction lists if required.

SPM also provides accurate, up-to-date business intelligence (BI) that enables all stakeholders to monitor, act on, and audit encounters, billing, care plan delivery and service benchmarks. The Jurisdictional View and BI capabilities can be used by the MCO to support varied Quality Management and Oversight activity ranging from an MCO Service Coordinator monitoring their caseload in real time, an MCO program administrators using Sandata’s advanced Business Intelligence dashboard to monitor quality of HCBS delivery with focused opportunities for improvement, to monitoring provider compliance around electronic visit verification usage and expectation rates.

BENEFICIARY SAFETY AND SATISFACTION

In order for beneficiaries to remain safely in the community, it is critical for care coordinators to have the necessary technology supports to ensure care is properly delivered. SPM includes a rich set of alert options that can be configured for each service to reduce the risk of services not being delivered or received late, affording all parties the opportunity to quickly react and protect beneficiaries. Alerts can be sent using any Windows-based method including:

1. Pop-up screen messages;
2. Email message; and
3. Text message to cell phones.

Alerts are conditional and can be established and setup to establish universal alert conditions.

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Further, jurisdictional staff can monitor all service providers in real time and can receive alerts on demand, by service provider or consolidated (summary or detail), and generate alert and emergency back-up care reports.

Lastly, the solution supports for Consumer-directed models giving the beneficiary and/or his/her family members have control and autonomy in scheduling their own services at times that are convenient for them. Sandata offers specific functionality to support benefit management via tools such as authorization spend down indicators and plan of care prompting. This functionality promotes independence, improves quality of life and allows beneficiaries to remain in their homes longer.

These features help to improve compliance, verify the delivery of necessary care and increase beneficiary satisfaction.

**FRAUD AND ABUSE PREVENTION**

SPM prevents fraud and supports ongoing audit and management to ensure scarce dollars support only the actual services delivered to the beneficiary. SPM is tightly aligned with CMS' strategies for combating fraud, waste and abuse.

**Table 2: SPM addresses CMS' strategies for combating Medicaid fraud, waste, and abuse.**

<table>
<thead>
<tr>
<th>Fighting Fraud, Waste and Abuse in Medicaid</th>
<th>Sandata's SPM Solution</th>
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<tbody>
<tr>
<td><strong>1. Strengthening provider enrollment standards and procedures</strong></td>
<td>- SPM offers compliance tracking to ensure providers follow proper protocols for background checks, licensing and certifications of caregivers. SPM also validates caregiver compliance in real time through our Speaker Verification technology to ensure the right caregiver is providing services to the right beneficiary.</td>
</tr>
<tr>
<td><strong>2. Improving prepayment review of claims</strong></td>
<td>- By verifying that only authorized services are submitted for payment, SPM ensures Payors receive clean claims the first time.</td>
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<tr>
<td><strong>3. Focusing post payment claims review on the most vulnerable areas</strong></td>
<td>- SPM provides CMS, the State and MCOs with access to home health services data to effectively audit providers and conduct extensive post payment reviews on aberrant claims.</td>
</tr>
<tr>
<td><strong>4. Improving oversight of contractors</strong></td>
<td>- SPM provides CMS, the State and MCOs with jurisdictional oversight of all home care agency activities.</td>
</tr>
<tr>
<td><strong>5. Developing a robust process of addressing identified vulnerabilities</strong></td>
<td>- SPM gives CMS, the State and MCOs actionable data to support the development of corrective action processes and mechanisms to resolve vulnerabilities and thwart fraudulent practices.</td>
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With SPM, fraud, waste, and abuse are eliminated from the process proactively. SPM helps:
- Reduce fraudulent activity allowing for savings to be reallocated to providing improved care through ongoing innovative quality initiatives;
• Prevent fraud **BEFORE** claims are submitted and realize cost savings by removing the elements most closely associated with improper record keeping including paper time sheets and manual billing; and
• Ensure that the **ONLY** claims that are submitted for payment are claims where the service delivery matches the authorization.

In addition to proactively preventing fraudulent claims, SPM’s real time jurisdictional view dashboard allows the Payor to monitor and audit encounters, billing, and care plan delivery as the events occur. Should any edits be required, providers can make changes, assigning required reason codes for the change, and the system captures a complete audit trail showing what data was changed, who made the change, etc. All program audit activity can be aggregated and tracked to support the Payor's provider network management and compliance to the use of EVV to ensure quality care.

Sandata also provides key reporting and information to support program integrity and provider network management, including provider compliance and benchmarking. All of the data below has been blinded to ensure confidentiality for our existing clients.

**SUMMARY**

Sandata’s EVV technology suite, proven outcomes and ability to deliver complex State programs on time, every time, provides the State with a unique toolset that adds value and ensures that the goals of coordinating care, improving quality and managing utilization and costs by reducing the need for high cost facility care can be achieved. Ultimately, the program’s ability to maintain beneficiaries in a home and community based environment is key to its success. We offer the following advantages that will ensure the delivery of a successful program:

✓ **Focus:** 100% focused on the Home and Community based Service/Care Industry
✓ **Position:** Recognized Industry Leader – 100+ million visit verifications annually
✓ **Solution:** Comprehensive Santrax Payor Management solutions: *Electronic Visit Verification Advanced Provider Business and Scheduling Technology Jurisdictional View and Analytics*
✓ **Proven:** 1800+ customers and growing / Multiple State programs and Successes
✓ **Innovation:** Development of leading edge technology - $10m+ in infrastructure investments in less than 18 months
✓ **Adoption:** Progressive state partners tackling similar challenges such as TN, TX, FL, LA have chosen to partner with Sandata

We look forward to the next steps in the State’s Dual Eligible Demonstration process.
From: [Redacted]
Sent: Thursday, May 31, 2012 10:09 PM
To: CMS MN-MedicareMedicaidCoordination; Deborah Maruska; Pam Parker
Subject: MN Application for Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota

I am writing in support of the MN DHS final proposal "Re-designing Integrated Medicare and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota." This proposal builds nicely on Minnesota's experience with Managed Care for Seniors and for People with Disabilities.

I have been a member of the Stakeholder Advisory Group for Managed Care for People with Disabilities in the Special Needs Basic Care program since before the program began. It has been a joy to work with [Redacted] and the rest of the MN team as they built a product that incorporated extensive community comment. Important decisions about the SNBC product acknowledge stakeholder concerns and worked with stakeholders to find solutions. For example, the decision not to include long-term services and supports for people with intellectual disabilities was made in response to stakeholder concerns regarding the potential disruption an integrated product might cause to people who were receiving residential, employment, or other HCBS Waiver funded long-term support services from a provider who was in a different network than their medical providers, or who were not in any of the networks.

Another decision made in response to stakeholder feedback was to make the SNBC product an optional opt in program. When it was launched people remained by default in fee for service unless they opted in to SNBC. They were also allowed to return to fee for service, or to switch MCO's every month. Both features allowed people to try the product without worrying that terrible things would happen (for example they would not have a place to live) if provider network problems were not resolved. As it turned out, a substantial number of people tried and learned the liked the product and we learned a lot about specific barriers to participation that were not fully anticipated.

The original SNBC product had many features that supported substantial improvements in the quality of health care and quality of life for those who enrolled. A key feature of that original program was that it integrated care for people who were "dual eligibles" so that they would have only one medical identification card they had to carry that covered all of their medical needs including prescription drugs, Medicaid services and Medicare services. It was understandable but disappointing that several of the Managed Care Organizations participating in the initial roll...
out were unable to sustain their integrated programs for people with dual eligibility. As I understand it, a key issue was that they were not able to get an acuity of care adjustment in their rates for serving people with particularly expensive health care needs. The result was that some of the people most in need of an integrated product lost access to the integrated product. This new proposal includes an attempt to try again to find a method that is fiscally feasible for MCOS to provide services to people with dual eligibility.

Despite the challenges we have encountered along the way, the Minnesota SNBC program continues to be supported by a huge cast of stakeholders who have seen its potential benefit and hope that the Medicare reimbursement problems can be resolved so that people with dual eligibility can again participate in an integrated managed care plan. I encourage CMS to respond favorably to the specific requests in the proposal that will allow Minnesota to learn from and continue to improve our managed care products.
June 29, 2012

Melanie Bella

Dear Ms. Bella:

Paraquad appreciates the opportunity to comment on Missouri’s proposed managed fee for service demonstration for dual-eligible Missourians. Paraquad is a Center for Independent Living, and we see the barriers that people with disabilities on Medicaid and Medicare face in accessing timely, effective health care. The care coordination proposal is an opportunity to improve people’s health and integrate the range of health care and community supports important to independent living.

There is a great need in Missouri for improved care coordination to prevent unnecessary hospitalization and nursing home placement. One woman we know who has multiple disabilities, including asthma and anxiety, would frequently go to the emergency room in a panic because she was not feeling well. She knew that was not the best option. She tried to do the “right thing” and call her doctor rather than follow her instinct to head to the hospital. The doctor couldn’t see her and his office told her to just go to the emergency room.

Missouri’s health home program can make sure this woman gets information and assistance to control her asthma and can offer her supports and health advice when she needs it. We believe the goals of Missouri’s program are important and that Missouri’s demonstration will be less disruptive to individuals’ care compared to other financing and delivery models. We also like the changes the state made to clarify the individual’s rights and choices in the planning process: the right to a second opinion, to refuse treatment, to call the team together when needed, etc.

We also are glad that the state has identified the goal of integrating long term services and supports and preventing unnecessary placement in nursing homes. Referrals to community supports and the inclusion of options counselors on the team when will help more people make informed choices. It also will benefit the state by helping them meet the most integrated setting mandate under the Americans with Disabilities Act.

We believe the program should be designed based on the principles of consumer choice and control, transparency, consumer protections, appropriate shared savings formulas,
accessibility and consumer involvement. The following comments provide our concerns and recommendations to make sure the demonstration is as successful as possible.

Performance Measures:
- While health outcomes are an important goal of the health homes, evaluation should take a holistic view of the individual. We believe that care coordination will be most successful if attention is paid to the community supports that people need to stay healthy and independent and performance measures should be developed to measure those outcomes. For example, was the individual discharged from the hospital to the setting of their choice (home, rehab facility, etc.)?
- The measures do not include participant experience. People may find it easier to just answer “always satisfied” but if you ask them “Were you in charge of your treatment?” “Did you understand the information presented to you?”, etc. people may give more informative answers.
- On page 23, the state says additional metrics may be developed related to “access and utilization of services that are specific to the dually eligible population enrolled in the Health Home programs.” People who are dually eligible have multiple chronic conditions and need to use a high level of health care services. Metrics should be developed so as to not create incentives to deny care. We recommend a working group that includes consumers and consumer advocates so that the measures are not developed without their input.

Sharing cost-savings:
- The provider share of cost-savings should not be made on an individual provider’s savings. These could create incentives to cut costs.
- Are the cost-savings specific to duals or based on the health home model overall?
- One option might be to have shared cost savings that rewarded providers solely based on good performance measures in the first year and a higher reward for combined good performance measures and cost savings in the following years.

Consumer protections:
- There needs to be more detail provided on how individuals are informed of their right to opt out of the health home. Can you just tell your provider? Does it have to be done in writing? Can you opt-out over the phone? How will this information be given to participants? Participants must have ample time to opt out and multiple ways.
could also be an “enrollment broker” to inform folks when they were enrolled and help them make an informed decision if they were to opt out.

- There should be more information on a grievance process for this program. We recommend an ombudsman program for individuals and/or their designee to use if they do not feel their choices or rights are being observed.

Consumer Involvement:

- More detail on the survey of consumers is important. When will the survey be done? How often? Will the results be made public?
- The plan to include one person who is dually-eligible on the steering committee is not enough. Who else is on the steering committee? How many people? Are there other consumer advocates? If there is one consumer on a large committee, the voice of the consumer is not as strong.
- Consumer input and feedback is critical on both the individual health home level and the oversight level.

Transparency:

- There should be maximum transparency of survey results. We recommend the state clarify how the results will be shared.
- Transparency of evaluation and outcomes of the program is very important. Information on how the program is operated, program data, outcome measures, etc. should be available.

Health Care Teams

- It is not clear how specialists are included or involved. Can the consumer choose their specialist to lead the health home team? Many people with disabilities use a specialist more frequently. That specialist may understand the person’s disability and have developed a relationship with the person. It may more effective if the consumer can choose the specialist to lead the team.

Long Term Services and Supports

- On page 13 the state says “These services will improve the overall provision of care to the member and will provide greater ongoing beneficiary support, reducing the need for long-term care services and supports”. This is not a realistic expectation for everyone. There is a need for on-going services and supports. The long term services and supports
can have a positive impact on health and prevent hospitalizations (for example, reducing incidence of pressure sores), but it is not reasonable to expect reduction in LTSS needs.

Peer Support and Independent Living

This program can be more successful and help address the range of health care and independent living goals of people with disabilities and seniors. Adding Peer support and Independent Living LTSS coordinators to the team at the request of the participant can provide greater supports to participants. Many people with disabilities may have traumatic past experiences with the medical system that could make it harder to interact effectively with medical professionals. Also, it is difficult to find providers who understand disability. Being able to talk with a peer who has personal experience and understanding of the disability is more beneficial for many people. Peers can provide support and information on how to manage one’s health, useful assistive technology, tips on living with a disability, etc. IL LTSS coordinators can provide information and connect people to community service options and resources to support participants’ choices and goals in the community. Missouri’s Balancing Incentives Payment Program initiative will address single entry point, assessments and conflict free case management. Both the health homes and BIP initiatives share the goal of reducing unnecessary hospital or nursing home placements, and coordination of the two programs can increase the effectiveness and help more people with disabilities and seniors stay in their own homes and communities.

Again, we believe there are great opportunities for Missouri’s proposal. We hope that CMS will work with the state to assure consumer protections, choice and control as well as cost-savings formulas that do not create incentives to deny care. We also urge CMS to have strong requirements for consumer involvement in this and all initiatives.

Thank you.

Sincerely,

Megan Burke, LCSW
Senior Policy Analyst
To whom it may concern:

Please find attached a letter from ten (10) national, nonprofit organizations, which advocate on behalf of persons who depend upon Medicare and Medicaid to receive healthcare services. This letter was sent to the attention of Melanie Bella, the CMS Director, to convey our increasing concern about the impact this change, that will allow states to automatically enroll dual eligible beneficiaries into a range of new, state-run manage care programs, may have on continuity of service.

Our members are patients, seniors, veterans, caregivers, family members, and professionals who work to serve them. We are writing to express our urgent concern over proposed changes which will affect the dual eligible population. Though we are deeply concerned about other aspects the proposed changes may have on this at-risk population, we are relieved to hear that CMS plans to extend patient protections provided in Part D prescription drug coverage to state-run programs.

RetireSafe, a 400,000 strong nationwide advocacy organization for older Americans (39,626 in Missouri), is focused on protecting the health and security of dual eligibles, some of which represent the most vulnerable of the senior population. We urge Missouri’s Department of Health and Senior Services to give close consideration to our comments.

Thank you,

Yana Jurovitzki, MPH
Director, Communications and Advocacy
RetireSafe
1616 H Street NW, suite 902
Washington D.C. 20006
www.retiresafe.org
801-209-7994
Ms. Melanie Bella
Director of the Medicare-Medicaid Coordination Office
Center for Medicare and Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Dear Ms. Bella,

We are organizations representing stakeholders who depend upon Medicare and Medicaid for healthcare services. Our members are patients, seniors, veterans, caregivers, family members and professionals who work to serve them. We are writing to express our urgent concern over proposed changes which will affect the dual eligible population.

Dual eligibles, individuals who fully qualify for both Medicare and Medicaid services, are among the most vulnerable of our population. Approximately 9 million in number, this group encompasses the frailest, the poorest, the sickest and the costliest segments of the Medicare population. Moreover, dual eligibles face many other challenges in accessing care. They are more likely to be minorities, have disabilities, suffer from cognitive disabilities, be socially isolated, have educational disadvantage, or live in rural areas where care providers are scarcer. Consequently, any discontinuity in the process through which these individuals receive care, or which diminishes the safeguards that protect them, is particularly burdensome and carries with it the potential for disruptions which could have serious consequences for their health and stability.

The Centers for Medicare and Medicaid Services (CMS) has recently published guidance for the implementation of new programs affecting the dual population. They allow states to automatically enroll these beneficiaries into a variety of newly created, state-run managed care programs. One goal of this initiative is to improve care coordination for this population. All who work with this population support that goal. In addition, we are relieved to hear that CMS has promised that the critical patient protections provided in Part D prescription drug coverage will be extended to state-run programs.

However, we remain deeply concerned about other aspects of these new programs and their potential to adversely affect this at-risk population. These issues include:

1) The loss of Medicare protections - Some states have proposed to substitute their state Medicaid formularies for Part D plan formularies meeting Medicare's extensive requirements. These states are seeking to have important provisions of Part D standards waived, in contrast to CMS guidance.

2) Passive enrollment / continuity of care - Some states are planning to passively enroll beneficiaries into a managed care plan, giving beneficiaries no other plan in their area from which to choose. Removing dual eligibles from their current health and prescription drug plans could cause disruption particularly if they have established provider relationships or their new drug plan has a different formulary. Moreover, even
though an opt-out exists, it would require that this group to navigate an appeals process. This can be particularly problematic for dual eligibles.

3) Access to care - State budgets are already severely constrained. It is essential that the focus remain on achieving savings through better coordinated care and not be centered upon techniques which historically have been used to restrain spending such as cuts to providers, or limits on the number of prescriptions filled per month. Access to existing providers, specialty care, and other needed health services are critical to this special needs population.

4) Oversight - Dozens of states have said that they intend to develop managed care programs for the dual population. Given the number of plans and their diversity, CMS will face a complex task in monitoring them for quality. Moreover, many state Medicaid programs do not have extensive experience in working with the needs of dual eligibles as the majority of their service population has been children and families. All issues regarding the sharing of essential information between the states and CMS should be resolved before plan implementation.

5) Equity – One of the hallmarks of the Medicare system has been its universality. This principle is forever changed by transferring responsibility for Medicare beneficiaries to the individual states. Such an approach opens the door to different standards for these lowest income beneficiaries—potentially leading to lower provider payment rates and reduced access to care on the basis of income.

We ask that these issues and the risks they raise be fully addressed and resolved before the dual eligible population is subjected to disruption in their health care coverage.

Signed

RetireSafe
The Men’s Health Network
National Grange
American Autoimmune Related Diseases Association
Veterans Health Council
National Council for Community Behavioral Healthcare
Mental Health America
National Psoriasis Foundation
National Alliance on Mental Illness
Women Against Prostate Cancer
In order to have consistency between Federal and State programs, consistent network adequacy standards should be used across the programs, taking advantage of vetted time and distance requirements and county designations that have been completed and used by CMS.

Best Regards

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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: Missouri Financial Alignment Demonstration Proposal

Dear Ms. Bella:

Thank you for the opportunity to submit comments on Missouri’s Financial Alignment Demonstration Proposal aimed at providing integrated care management and support services to individuals who are dually eligible for Medicare and Medicaid and served by the state’s Health Home programs.

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. The Missouri proposal offers a great opportunity to share savings from the state’s recently-launched Health Home programs created pursuant to Section 2703 of the Affordable Care Act.

As proposed, however, the Missouri demonstration project presents risks for dually eligible beneficiaries. Our consumer advocate-oriented priorities for the duals demonstration projects (Dual Eligible Demonstration Projects: Top Ten Priorities for Consumer Advocates) guided our review of the Missouri proposal, and we hope they will also inform your office’s review.

Acknowledging that CMS has already approved Missouri’s State Plan Amendments for its Health Home programs, we believe the state’s proposal meets a number of these priorities. However, we believe the state should make additional design changes specific to the needs of
the target duals population before this demonstration project can move forward. Our comments on the specifics of the proposal follow.

Praiseworthy Design Elements
The Missouri demonstration proposal is based upon a commendable Health Home program design. The following are a few of its praiseworthy design elements:

- The use of **multidisciplinary care teams** at each Health Home practice site that can include optional members identified by the beneficiary or his/her caregiver
- The participation of each health home in a **learning collaborative**
- The use of **evidence-based practices** such as the Chronic Care Model and the Screening, Brief Intervention and Referral to Treatment (SBIRT)
- The use of **electronic health records** that allows all MO HealthNet providers and enrollees to access their records and that assists with care transitions

Design Elements of Concern
Despite these commendable design elements, we have a number of serious concerns that we believe should be addressed before the Missouri demonstration project can permitted to move forward. Below is a quick summary of these concerns, which are briefed at length in our full comments:

- A stated expectation that Health Homes will result in a **reduction of long term services and supports** (LTSS)
- **Performance measures are medically-oriented** and fail to incorporate measures related to LTSS and participant experience
- **Lack of clarity** around
  - **opt-out procedures**
  - **grievance processes**
- Insufficient mechanisms for **ongoing participant feedback**
- **Lack of transparency on program results**
- Insufficient assurances about **maintaining long-standing relationships with specialists**

Enrollment

While we acknowledge that the state has already passively enrolled the majority of its target population into it health homes, we recommend the state and CMS use a voluntary opt-in enrollment process for new participants. In the event, however, that the state continues passive enrollment as outlined in its proposal, the state should provide greater detail on its procedures for people to opt out of the program at any time.
Provider networks/Coordination/LTSS

We applaud the state’s use of multidisciplinary care teams for which the beneficiary or his/her caregiver may also request additional team members. While this model has the potential to promote a holistic approach to meeting a beneficiary’s needs -- and, in fact, there is a stated expectation that the Health Homes will “coordinate with HCBS providers” -- there is insufficient detail about how this will occur. In order to ensure that LTSS needs are adequately met, we recommend that an LTSS coordinator be part of the team. The coordinator’s role would be to:

- ensure all LTSS needs of the beneficiary are efficiently addressed and communicated to the entire care team, and
- communicate, as needed, with the beneficiary about his/her LTSS needs on an ongoing basis.

In addition, we remain concerned about the coordination with existing specialists, who in many instances, serve as dually eligible participant’s primary provider. The state acknowledges this in its proposal, but downplays the importance of specialists. We recommend the state require the inclusion of an existing specialist on the care team, and if requested by the beneficiary, that the specialist be permitted to lead the team.

Benefits

We applaud the state for offering and/or coordinating a wide array of benefits through its Health Homes programs. We are troubled, however, by the expectation stated on page 13 that the provision of services such as case management, care coordination and health promotion would “improve the overall provision of care to the member and will provide greater ongoing beneficiary support, reducing the need for long-term care services and supports.” (emphasis added). While this may be true for some, it is critical that the state understand that this reduction is not a realistic expectation for every beneficiary. For those with ongoing needs -- e.g. people with quadriplegia -- LTSS must be maintained at current levels or, in some cases, expanded.

Consumer Engagement

While we acknowledge that the state responded to advocates’ comments about providing consumers with mechanisms for ongoing input into the Health Home program, its response is simply insufficient. According to the proposal, “the state will work to ensure that at least one beneficiary who is dually-eligible for Medicare and Medicaid is included on the Steering Committee” which meets every six months. Without more information about the composition of the Steering Committee, it is difficult to evaluate the sufficiency of this requirement. However, we are concerned that a single beneficiary on the committee will be marginalized.

We recommend the state create a separate advisory council comprised of participants (including those that are dually eligible), family members and representatives of advocacy organizations that serve the Health Home population. Finally, each Health Home should have
a mechanism to regularly and meaningfully engage enrollees, their families and caregivers, and consumer advocacy groups.

**Beneficiary Protections**

The state proposes to use the existing grievance and appeals processes for Medicaid and Medicare and to require Health Home staff to help beneficiaries determine which process is appropriate. We recommend the state provide additional protections, such as:

- Developing materials and a customer service system that serves beneficiaries with disabilities, speech and vision limitations and limited English proficiency
- Requiring Health Homes to be in full compliance with state and federal non-discrimination laws including the American with Disabilities Act. As it stands, the state has committed only to providing “effective communication and auxiliary aids for people with disabilities.”
- Contracting with an independent ombudsman to field beneficiary complaints and questions.

**Financing and Payment**

Missouri seeks to share in any Medicare savings it achieves through its Health Homes program with respect to its dual eligible target population. It also proposes to share savings with providers to “incentivize and reward improvements in service delivery and quality of care.” We agree with this approach and are pleased that the state intends to determine the payment based individual Health Home’s performance on clinical process outcome indicators, rather than upon individual providers’ savings.

In addition, we recommend the state:

- Make all shared savings information transparent
- As noted below (Quality Measures), base payments on quality metrics specific to the duals population prior to the start of the demonstration.
- Ensure that there are protections in place so that neither physicians nor case managers are compensated or otherwise encouraged to steer enrollees into care that will produce short-term savings but hurt quality, particularly without providing due process rights to challenge what effectively amounts to a verbal denial of services.

**Savings estimates**

The proposal offers details about estimated Medicaid savings for all beneficiaries enrolled in the Health Home programs, but does not yet offer specifics about anticipated savings with respect to the dual eligible population. We recommend that CMS approve the project only after the state provides both savings estimates and its underlying financial assumptions for the target dual eligible population. For example, the public should understand what the state knows about the rates of preventable hospitalizations, institutionalizations, and emergency
room visits for the population prior to the start of the Health Home programs 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

The state's proposal provides a robust list of quality measures it has begun using for its Health Home programs. We note, however, that the measures are primarily medical in nature, which addresses only a portion of the needs of the target dual eligible population. And, we are concerned that the state says only that it “will consider including metrics such as measures of the access and utilization of services that are specific to the dually eligible population enrolled in the Health Home programs.” (emphasis added). Employing these types of metrics should not be optional. They are essential to serving the dual eligibles in the program and to creating incentives to provide, rather than deny, care.

While we acknowledge the state’s plans to use tools that measure participants’ “satisfaction” on an annual basis, this is simply insufficient to measure participants’ experience. Among the additional measures we recommend are those that evaluate participants’:

- 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)

Ultimately, however, we recommend the state create a working group that includes consumers and their advocates so that the measures are developed with their input.

Finally, we strongly recommend that the state publicly report its quality outcomes from the Health Homes program, including specific data on dual eligibles.

Cultural Competence

Any duals demonstration project should be respectful of the beneficiary’s culture and seek to minimize barriers to care because of any lack in cultural competency. While the proposal states that “[a]ll members of the team will be responsible for ensuring that the care provided is person-centered, culturally competent and linguistically capable,” it offers few details on how its Health Homes will promote cultural competence. We recommend the state ensure 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.

***

In summary, Community Catalyst commends the state of Missouri for working to build on its existing Health Home programs, which show promise for improving the health and well-being of so many Missourians with chronic conditions. We believe this proposal is moving in the right direction, but it does not yet adequately address the unique needs of dually eligible seniors and people with disabilities.

We urge CMS to require that the state address the key issues identified above before CMS approves this demonstration project.

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
Good Afternoon,

We reviewed the Financial Alignment Initiative Proposals to specifically look at three areas:

1. Will participant-directed long term services and supports be covered through a capitated arrangement?
   a. If so, does the proposal identify how the state will assure the plans have the competency and skills to administer participant-directed service options?
   b. What outcome measures will be collected to assure participant direction

2. Do the care planning/coordination strategies specifically reference or describe a person-centered approach?, and

3. Was there meaningful and comprehensive participant/advocacy engagement?

The Missouri proposal does not specify options for participant-direction, although appears to offer other home and community based services through a couple of approaches. We strongly recommend that Missouri consider expanding these options to include participant-direction.

Thank you for the opportunity to comment.

Best,
Dianne

Dianne Kayala, MS
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National Resource Center for Participant-Directed Services
Boston College Graduate School of Social Work
401-294-3472
401-338-0864 (Tuesday Only)
kayala@bc.edu
www.participantdirection.org

Interested in becoming a member? Find out more about joining the NRCPDS!
Checklist for
Managed Care Organizations
Implementing Participant-Directed
Service Options

May 2012
INTRODUCTION

Participant direction is a service delivery system that has been growing in popularity over the last decade, and is currently available in at least one publicly-funded program in every state. As of November 2011, over 250 programs offer participant direction. In rigorous research of the Cash & Counseling program, a cutting edge participant direction program researched in 2007, members enrolled in participant direction proved to be more likely to have health needs met, to be more satisfied with life and have lower acute care costs than members using traditional services.

The essential premise of participant direction is that the member can choose who he/she hires to perform personal care services, including family and friends. The participant manages the workers and can terminate them if needed. Many programs also support participants in individual budgeting, i.e., managing and controlling how funds allocated to them are spent across approved services. The member’s allocated fund amount is developed using an established methodology and should be roughly equivalent to what would be spent for personal care services in a traditional model. Once an amount is determined, the individual can decide how much to spend on each of his or her approved services within the budget.

Participant direction programs have supports in place to help participants direct and control their services. These include options counseling, to help participants get services and supports in place, and financial management services, to handle administrative duties and compliance, including paying workers and managing associated taxes.

The following checklist outlines the key infrastructure and components of a participant-directed program that should be in place prior to program inception. Many of these checklist items will be common sense to Managed Care Organization (MCO) providers, and may relate to existing policies and procedures already in place for other programs. In our experience, they are all important to assure compliance with legal requirements, and to facilitate the balance of participant control and risk mitigation. For MCO providers seeking more detailed guidance or support, contact us at info@participantdirection.org for further information.
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<tr>
<th>Item</th>
<th>In Place?</th>
<th>Notes</th>
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<tr>
<td>1. Procedures and protocols are in place to ensure the member maintains full control and decision-making capacity, especially in regard to workers</td>
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<td>2. All information is provided in a range of formats to be accessible to individuals with a variety of disabilities</td>
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<td>3. All members who may be eligible have the opportunity to make informed consent or refusal of the participant-directed option</td>
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<td>4. The following supports are available to MCO members who self-direct:</td>
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<td>a. Counseling supports: may include assessment, service planning support, training to self-direct, risk negotiation, or other supports</td>
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<td>b. Financial management supports: operate in compliance with IRS, business, and employment regulations locally and nationally, supports for hiring workers and processing payroll</td>
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<td>5. Self-direction support and MCO staff are trained in participant direction philosophy, components, and evidence-based advantages</td>
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<td>6. A customer service system is in place that supports participants and any other authorized stakeholders to obtain information regarding participant direction in a timely manner</td>
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<td>7. Program and member manuals are complete and include policies, procedures and reference materials for members and staff.</td>
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<td>8. A designated staff holds overall responsibility that participant direction components operate in compliance with policies and assures continuous quality management</td>
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<td>9. A system is in place to collect, analyze, and report process and outcome measures applicable to the goals of members that self-direct</td>
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## PROGRAM COMPONENTS

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<tr>
<th>Item</th>
<th>In Place?</th>
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<tr>
<td>1. The intake process meets the following criteria:</td>
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<td>a. Allows for the informed choice of all members</td>
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<td>b. Is goal-oriented, person-centered and comprehensive</td>
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<td>c. Includes written materials to describe policies, rights and responsibilities</td>
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<td>d. Includes an option to have a representative</td>
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<td>2. The needs assessment process meets the following criteria:</td>
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<td>a. Includes identification of barriers to meeting goals</td>
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<td>b. Includes personal preferences for how tasks are performed</td>
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<td>c. Includes assistive technology and addresses any home/community accessibility needs</td>
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<td>3. There is an established methodology to determine each member’s self-directed budget amount (if applicable) or number of authorized hours of employee services</td>
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<td>4. Assistance with PD Service Planning features the following:</td>
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<td>a. Reference materials and worksheets</td>
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<td>b. Tools to help the participant identify potential workers and items to purchase for the plan (if applicable) including problem solving strategies to identify creative solutions to needs</td>
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<td>c. Risk identification and mitigation policies in place</td>
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<td>d. Emergency back-up plans are required of each member</td>
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<tr>
<td>e. Community resource guide/directory is available</td>
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<td>5. Implementation of Participant-Directed plans feature the following:</td>
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<td>a. Curriculum and process for member training on how to be an effective employer is developed</td>
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<td>b. Assistance and written guidance (ex. Member Manual) is in place for employment paperwork flow, including time sheet submissions</td>
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<td>c. Process for purchase of non-employee goods and services (if applicable) is established</td>
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<tr>
<td>d. Timelines and process for reassessments and changes to an established plan are in place, including identification of changes in a member’s level of need</td>
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June 29, 2012

VIA ELECTRONIC MAIL (MO-MedicareMedicaidCoordination@cms.hhs.gov)

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: Missouri’s Integrated Care Proposal

Dear Ms. Bella:

We appreciate the opportunity to provide comments on the integrated care (“shared shavings”) proposal submitted by the MO HealthNet Division (“MHD” or “the State”) to the Centers for Medicare and Medicaid Services (“CMS”). Legal Services of Eastern Missouri (hereinafter “LSEM”) is a nonprofit organization that provides free legal assistance to low-income clients in 21 Missouri counties in the areas of consumer law, housing, health, public benefits, family law, immigration and education. Assisting our clients in obtaining access to health care through Medicare and Medicaid (MO HealthNet) is one of our key priorities.

We appreciate that MHD proposes to implement an integrated care system for dual eligible Missourians and we support the decision to use a fee-for-service (FFS) approach in doing so. Such an approach, if implemented correctly, could improve health care for these individuals while resulting in long-term savings for the State. We also appreciate that MHD has revised its proposal in response to our comments submitted on May 25, 2012.1 We offer the following comments regarding the proposal for your review and consideration.

A. Financial Incentives for Health Home Providers

MHD’s revised proposal, in relevant part, states, “The programs’ calculations of savings will not be based on individualized provider savings but rather on the total savings created by all of the providers within each Health Home program (CMHC and Primary Care).” Revised Integrated Care Proposal at p.14 and at Appendix F. The revised proposal appears to address the concern we raised in our comments of May 25 in that the State has clarified that incentive payments will not be based on individualized provider savings.

However, a remaining concern is the reference to basing the size of the incentive payment, in part, on the individual provider’s relative size. See Appendix F of the Revised Integrated Care Proposal. Paragraph 14 of Appendix F, in relevant part, states: “If the Health Home program generates savings, then the size of the incentive payment will be determined by the individual provider’s relative size and its performance on the quality measures described in the proposal.” It is unclear how the provider’s relative size factors into determining the size or amount of the incentive payment.

Recommendations: We support the revisions that the State has made in moving towards a system where incentive payments are based on improvements in (or maintenance of) care outcomes. We recommend that CMS require the State to clarify how the provider’s size factors into determining the size and amount of the incentive payment. We respectfully request that CMS require that this clarification be made public, with an additional 30 day comment period, to allow consumers and consumer advocates to provide comments on these future modifications.

B. Passive Enrollment

The State initially proposed to implement an “opt-out” (or “passive enrollment” model for the integrated care project consistent with its “Health Care Home” program. Draft Integrated Care Proposal at pp. 13-14. We believe that an “opt-in” model is preferable and communicated this preference to MHD in our May 25th comments. While MHD is still continuing its “opt-out” model, it appears that MHD has revised its proposal to indicate that [going forward, beneficiaries who were not auto-enrolled in Health Homes may be referred to the program by their providers.]

It is, however, unclear whether, in this situation, MHD is continuing the opt-out approach, implementing a referral process where the beneficiary has the ability to choose to complete the referral by directly

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2 The original version had limited this referral process to providers who were already Home Health providers. Draft Integrated Care Proposal at 14. It appears the referral process is being expanded to any provider. Revised Integrated Care Proposal at 12.
contacting the Health Home program, or implementing a mixed approach where a referral is made but the enrollment is completed automatically.

**Recommendation:** We recommend that CMS request that the State clarify how the passive enrollment process will work when providers that are not within a Health Home refer an individual for participation in the project and that the State make this clarification available to the public.

We note that the opt-out procedures appear to be the same ones used in the Health Homes project administered by the Missouri Department of Mental Health. We strongly support the State’s decision to allow participants to opt-out at any time without penalty and to choose or change health care home providers without adverse consequences. Integrated Care Proposal at p.18. We further support the State’s decision to limit the project to a subset of dually eligible Missourians, namely those that meet the criteria of the project. Id. at 3, 7-8.

Because the Health Care Homes State Plan Amendment is the basis for the integrated care project, we reviewed the Health Care Homes notices which are currently available on the Missouri Department Mental Health’s website (http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm) and noted several apparent shortcomings that need to be corrected in order to ensure that passive enrollment does not adversely affect low-income individuals dually eligible for Medicare and Medicaid. We raised these concerns in our May 25th comments regarding the Draft Integrated Care Proposal.

For example, we noted that the CMHC Participant offer letter designed by the State (available at: http://dmh.mo.gov/docs/medicaldirector/CMHCparticipantofferletter.pdf) does not contain information on how a participant may opt-out of the Health Care Homes project (e.g.: does the participant have to opt-out in writing or does a telephone call suffice? Can a participant opt-out online? Can a participant simply inform his/her provider that he/she wants to opt out?) In our comments regarding Missouri’s draft proposal, we stated that it would be helpful to incorporate such information into the offer letter, or as an attachment to that letter. We further stated that it also would be helpful to have opt-out procedures written into the integrated care proposal to ensure that consumer advocates, in addition to CMS, are able to determine whether these opt-out procedures are sufficiently and adequately informing low-income Missourians eligible for Medicare and Medicaid of their opt-out rights.

Additionally, we previously noted that the CMHC Participant Opt-out letter sample (available at: http://dmh.mo.gov/docs/medicaldirector/CMHCHCHClientOpt-OutLetter82511.pdf) also does not contain information regarding how the participant can ensure continuity of care once he or she has opted out (e.g.: can a participant request that medical records be transferred from the health care home provider to his or her healthcare provider of choice? Does that request have to be in writing or can it simply be done via a telephone call? Can the participant simply continue with the health care home provider
but not participate in the health care homes project?) Continuity of care is important to low-income Missourians who are dually eligible because it ensures that they will get the health care that they need without unnecessary interruption if they decide to opt out.

In response, the State has revised the proposal to state that the "notice will describe beneficiary choice in selecting a Health Home and clearly describe the process for changing Health Home providers and for opting out of the Health Home program at any time without jeopardizing eligibility and coverage of existing Medicaid and Medicare services." Revised Integrated Care Proposal at p.17. Moreover, the State has stated that the "beneficiaries will be meaningfully informed about their care options, including their decision to participate in or opt out of a Health Home program." Id. at p.17. Finally, the State "will add additional information about the process for opting-out of the Health Home to the enrollment letters sent to beneficiaries when they are enrolled in a Health Home Program." Id. at Appendix F.

However, the revisions made by the State do not contain information about how beneficiary choice will be described, how the opt-out process will be described or how consumers can ensure continuity of care after opting out. Without such information, it is impossible for CMS, let alone consumers and consumer advocates, to determine whether beneficiaries will be meaningfully informed regarding beneficiary choice of providers and the opt-out process.

**Recommendations:** We recommend that CMS require MHD to submit additional information that indicates what specific information will be added to these notices and to make that additional information public, with a 30 day comment period, so that consumers and consumer advocates can determine whether such information translates to meaningful notice. Additionally, we would like to bring to CMS’ attention the draft “General Enrollment Strategy for Currently Eligible Dual Beneficiaries” that California is currently considering as a notification scheme for dual eligibles for that State’s demonstration project. The strategy under consideration there includes a layered notification strategy. Such a layered notification strategy may be of great benefit to dual eligibles in Missouri and, therefore, we recommend that CMS bring this to the attention of Missouri for the State’s consideration.

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3 California Department of Health Care Services, California Duals Demonstration Notification Strategy, Draft Planning Document, revised as of June 21, 2012 (available at: http://caltduals.org/wp-content/uploads/2012/06/Duals-Notification-Types-and-Timelines-062012_950pm.doc). Dual eligibles would be notified about the demonstration project and how to opt-out of the project at various stages. Initially, dual eligibles would get a short notification letter 90 days before enrollment, a notification packet that includes detailed information on how to choose their provider, a list of providers, and a detailed description of the opt-out procedures 60 days before enrollment, and a final notification 30 days before enrollment.

4 This is a notification strategy that the State of California has not yet agreed to implement but is currently considering as one of many possible notification options for their dual eligible demonstration project.
C. Data Collection and Quality Assurance

With respect to collection of data related to performance and outcome measures, we noted that there is not much information or research regarding appropriate quality assurance measures for dually eligible individuals, and it is not clear whether all of the measures listed in the proposal are applicable to duals, or whether any of them are specifically targeted to duals. Since the dual-eligible population encompasses individuals with physical impairments or cognitive impairments or a combination of such impairments as well as individuals of varying ages, the data collected should be categorized in a manner that will capture the diversity of the dual-eligible population.

We suggested that the State work with consumer advocates, disability groups and CMS to identify measures that are in fact targeted to this population. The State has revised the proposal to include the fact that it “will consider including metrics such as measures of the access and utilization of services that are specific to the dually eligible population enrolled in the Health Home programs. For example, the programs may measure the percentage of health home beneficiaries that access long-term support services, different HCBS waiver services, home health, and nursing homes and skilled nursing facilities.” Revised Integrated Care Proposal at p. 23 and Appendix F.

It is important to ensure that the demonstration project use metrics that are tailored for the dual eligible population because dual eligibles, as noted above, have such widely varying impairments. Given such diversity in the population, it stands to reason that a “one size fits all” approach will not adequately capture whether the demonstration project is improving or maintaining quality of health care for dual eligibles at less cost.

Recommendation: We recommend that CMS require MHD to consult with consumers and consumer advocates to identify these metrics within a defined time frame and that CMS should seek a commitment from the State to include these identified metrics in the demonstration project as soon as practicable.

D. Consumer Protection

We strongly support the proposal’s inclusion of information regarding a participant’s right to a fair hearing if he/she applies for participation in the integrated care project and is denied such participation or if the participant’s MO HealthNet services have been denied, reduced or terminated. Revised Integrated Care Proposal at p. 18.

In our May 25th comments to the State, we asserted that quality assurance monitoring should also include monitoring of complaints and grievances, a mechanism for addressing those complaints and grievances and a mechanism for making complaint and grievance data publicly available, along with data about the resolution of those
complaints and grievances. We further noted that MHD could designate an ombudsman with knowledge of Medicare and Medicaid issues to help resolve any disputes that arise.

MHD has not explicitly responded to that suggestion in its revised proposal yet it agreed to make public "an update of all Health Home activities, the program outcomes and summary information about the volume and types of complaints, appeals and grievances received regarding the Health Home programs. Further, the Committee meetings will include as a standing item on the agenda a request for consumer and dually eligible beneficiary feedback and suggestions for the Health Home programs and the financial alignment demonstration." Revised Integrated Care Proposal at p.18 (emphasis added). Such an agreement to make complaint, appeal and grievance information public indicates that MHD is establishing such a monitoring system but there is no information in the revised proposal about how the monitoring system will operate, e.g. how the participant can file a grievance or complaint; who will address such grievances and complaints; or whether there is a specific timeframe for resolution of the grievance or complaint.

**Recommendation:** We, therefore, urge CMS to require the State to include specific information within the proposal that details the grievance or complaint process, along with a 30 day comment period, to ensure that consumers and consumer advocates can adequately determine whether the consumer protections provided are sufficient.

We also concur with the State’s use of a survey mechanism to gauge consumer satisfaction with the services provided under the integrated care proposal. While the State revised the proposal to indicate annual surveying (Revised Integrated Care Proposal at Appendix F), it is unclear from the proposal when the surveys will be administered. There also is no specific discussion of with whom and how the data from these surveys will be shared. Additionally, compiling data from the surveys (as well as the grievance system discussed above) and making that information available to the public would provide transparency to the administration of the program and ensure protection of consumers’ interests.

**Recommendation:** We recommend that CMS require public disclosure regarding the timeframe for administration of the surveys as well as with the results of the survey are shared.

**E. Consumer Involvement**

The revised proposal lacks sufficient mechanisms for ensuring meaningful ongoing consumer (and consumer advocate) involvement in the demonstration project. The section on Stakeholder engagement mentions past consultations with provider organizations and other stakeholders (with very limited consumer involvement) through
the Missouri Medical Home Collaborative Council. Yet there is no description of a mechanism by which the State will ensure meaningful consumer involvement, other than including "at least one beneficiary who is dually eligible for Medicare and Medicaid as a member of the Steering Committee." Revised Integrated Care Proposal at p.1 and Appendix F. To ensure a breadth of consumer input and involvement, the State should have a consumer advisory council or committee that represents the interests of dually eligible individuals whom the "shared savings"/integrated care project is intended to benefit.

**Recommendation:** We recommend that CMS require MHD to work with consumers and their representatives to develop an effective mechanism for regular, ongoing consumer input into the dual demonstration project.

**F. Composition of the Health Home**

Both the draft and the revised proposals are not clear about the membership of the Health Home team and how the State will ensure continuity of care for dually eligible individuals covered by the project. Draft Integrated Care Proposal at p.13; Revised Integrated Care Proposal at p.12. While the revised proposal at page 12 discusses auto-assigning individuals to "existing providers," our May 23rd comments questioned how the State would ensure that dually eligible individuals' existing providers -- both primary care providers and specialists -- are incorporated into the health care home. For a dually eligible individual with a significant disability, the specialists may be just as important, if not more critical, than the primary care provider.

Missouri has revised the proposal to clarify that the specialists "may serve as [the individual's] primary point of contact with the medical system. However, the Health Home programs believe that it is important for that individual to have a team that will look at the patient’s needs holistically and not just through the lens of the specialist and will work to coordinate the care of the specialist and the other members of the Health Home care team." Revised Integrated Care Proposal at p.11 and Appendix F. Despite the clarification regarding the composition of the health home, there are still remaining questions about how Missouri will prioritize among the range of different providers when assigning a disabled individual to a health care home, whether Missouri will allow individuals to choose the specialist as the leader of the health home team (which would be in line with the person-centered care planning process envisioned by the proposal), and how Missouri will ensure that the specialists are involved in the care planning process.

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5 The draft proposal indicated that the Steering Committee of the Missouri Medical Home Collaborative Council will meet "to review practice data submissions and analysis by the Missouri Foundation for Health as well as the status of practice transformation activities" (Draft Integrated Care Proposal at 19). While the proposal was expanded to include the invitation of consumer advocates and beneficiaries to the steering committee, the proposal does not contain information as to how Missouri will solicit and maintain consumer involvement about all the important aspects of health care home performance, including issues that have nothing to do with practice data submissions, MPF analyses, or practice transformation activities.
In addition, the proposal fails to address potential Health Home members and how they can be included in the Health Home team. For example, adding Peer Support and Independent Living LTSS coordinators to the team at the request of the participant can provide critical support to participants in improving or maintaining quality of care. Many people with disabilities may have traumatic past experiences with the medical system and it is difficult to find providers who understand the effects of disability upon participants. Peer Support and/or IL LTSS coordinators can provide support, resources and information that may not be available to participants through other Health Home team members.

**Recommendation:** We recommend that CMS require MHD to consider the inclusion of other potential Health Home members to ensure that dually eligible individuals have access to the full range of primary care providers and specialists within the health care home proposal.

G. Long-term services and supports (LTSS)

We recognize and appreciate the limited nature of the project but CMS should ensure that Missouri’s proposal addresses the issue of long term services and supports and how the Health Home will ensure that dual eligible individuals will access necessary and appropriate LTSS. Dual eligibles should have information about and access to home and community based services that provide them with an opportunity to live within the least restrictive setting. An important goal of the project should be ensuring that dual eligible individuals receive services in the most integrated setting appropriate to their needs and the health home should be structured to make that happen, for example, by including “options counselors” as part of the care coordination team. Such counselors would advise participants about available home and community based services and other long term services and supports. CMS should require Missouri’s proposal to make clear how the health home will ensure that people with disabilities receive necessary assessments for LTSS, and/or the referrals to the appropriate agencies that make those assessments.

We are concerned about the language on page 13 of the Revised Integrated Care Proposal which states that the “[supplemental and/or ancillary/supportive] services will improve the overall provision of care to the member and will provide greater ongoing beneficiary support, reducing the need for long-term care services and supports”. This is not a realistic expectation for every participant. For some participants there will be a need for on-going long-term services and supports. The long-term services and supports can have a positive impact on health and prevent hospitalizations.

**Recommendation:** We recommend that CMS request MHD to clarify the statement referenced at Page 13 of the proposal to ensure that the demonstration project provides participants, as appropriate, with access to on-going long-term services and supports.
Conclusion

In sum, we are greatly encouraged by Missouri’s revisions to the Integrated Care Proposal, and hope that you will address our concerns and suggestions as the proposal moves forward. Thank you for considering these comments.

Sincerely,

Karen C. Warren
Attorney at Law

Joel D. Ferber
Attorney at Law

James Frost
Attorney at Law
COMMISSION FOR CASE MANAGER CERTIFICATION (CCMC)
POSITION REGARDING
CMS-STATE DUAL ELIGIBLE DEMONSTRATION PROPOSALS

The Commission for Case Manager Certification ("the Commission") is pleased to offer its recommendations for coordinating health care services provided to dual eligible individuals. Since 1992, the Commission has led efforts to elevate the practice of case management to better manage health care for patients with complex care needs. We are the foremost nationally-accredited organization offering licensed professionals the opportunity to be board certified as case managers.

Recommendation

We recommend that board certified case managers lead care coordination teams and case management teams for dual eligible individuals.

We recommend that all non-licensed case managers working on the care coordination team be trained in an appropriate manner for the patient population being served.

Rationale

The Commission urges States and the Centers for Medicare and Medicaid Services (CMS) to adopt these requirements for case managers as part of the CMS-State dual eligible financial alignment demonstrations.

Board certified case managers are licensed professionals who have demonstrated that they have met the highest standards for their profession.

Board certified case managers must pass a rigorous examination, hold a current licensure or certification in a health or human services discipline, and possess professional experience in case management.

Board certified case managers are uniquely qualified to lead care coordination teams that will be responsible for designing care plans, performing assessments, monitoring patient progress, and tracking patient outcomes for dual eligibles.

Given workforce shortages and an expected increase in demand for case management and care coordination services, the Commission recognizes that individuals with different backgrounds will serve on case management and care coordination teams.

The Commission has over 30,000 case managers that are currently board certified by CCMC. Other organizations also provide certification programs for case managers. In some instances, case managers will hold a professional licensure in fields such as nursing or social work, but may not be board certified. Other individuals may have unique education and experiences in care coordination or case management, but may not be licensed professionals.

Regardless of their background, individuals serving on care coordination teams must have access to appropriate training to ensure they can meet the complex needs of vulnerable dual eligible individuals. Such training would include opportunities to become licensed and board certified.
Dear CMS Medicare-Medicaid Coordination Office:

Attached is a letter from the National Minority Quality Forum and seven co-signers which was written to express our apprehensions about the proposed changes to the manner in which benefits for some Medicare enrollees are financed and provided. Our specific reference is to the state-based demonstrations of financial models to integrate care for Medicare and Medicaid dually-eligible enrollees. We are aware of, and share, the concerns that have been communicated to you by patient advocacy groups and other organizations. As you will note when you read the letter, however, our issue with these demonstration projects is more fundamental.

We look forward to future opportunities to discuss this issue with you. In the interim, if you have any questions, please don't hesitate to contact me.

Sincerely,

Gretchen C. Wartman  
Vice President for Policy and Program  
National Minority Quality Forum  
202-223-7560, x5944
April 25, 2012

Richard J. Gilfillan, M.D.
Acting Director
Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD  21244

Dear Dr. Gilfillan:

The National Minority Quality Forum, and the co-signing organizations listed below, are writing to join with other concerned citizens groups to express our apprehensions about the proposed changes to the manner in which benefits for some Medicare enrollees are financed and provided. Our specific reference is to the state-based demonstrations of financial models to integrate care for Medicare and Medicaid dually eligible enrollees. We are aware of, and share, the concerns that have been communicated to you by patient advocacy groups and other organizations, but our issue with these demonstration projects is more fundamental.

According to CMS data, there are approximately 9 million dual eligibles. They encompass some of the poorest, the sickest and the costliest of the Medicare population. Moreover, dual eligibles face many other challenges in accessing care. They are more likely to be minorities, have disabilities, suffer from mental conditions, have educational disadvantage, or live in rural areas where care providers are more scarce.

As others, we are concerned that these demonstration projects could:

- Cause disruptions to continuity of care and the resulting risk for poor or compromised outcomes of the care, and thus increased financial risk for the system;

- Compromise access to essential health and medical services;

- Create a third-class of beneficiary that will no longer have the protections associated with the Medicare social insurance safety net;

- Lead to the abrogation of the rights of these dual eligible, who will be mass-enrolled into programs that are economic experiments at best, and low-income healthcare gulags at the worst; and

- Employ metrics to measure the failure or success of these demonstrations that prioritize economic efficiencies over quality of care and outcomes of care.

We have a more fundamental concern, however. We have been watching with ever-increasing dismay the endless promulgation of regulations, rule-making, and
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Letter to Richard J. Gilfillan, M.D.
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Implementation of demonstration projects which threaten to overwhelm our healthcare market. The proposed demonstration projects that this letter references are just another example of a CMS-sponsored activity that is not driven by or responsive to beneficiary demand, but is based on what, in our view, is a complete misread of how the Medicare and Medicaid programs can provide real value to the American people in shaping our future.

This avalanche of regulations and demonstration projects seems to be emanating from the idea that consumer demand for healthcare in general, and in the Medicare and Medicaid programs more specifically, will necessarily have undesirable consequences. To thwart these rising consumer expectations, there is a belief that government intervention is needed to suppress them by instituting price controls, shifting costs to beneficiaries, reducing the availability of new therapies while promoting older, less expensive treatments, and micro-regulating the practice of medicine.

Government should not be alarmed by a rise in consumer demand for healthcare. The American population is both aging and becoming more ethnically diverse. For each group there will be increased demand for quality healthcare. Rather than an undesirable factor, this is the type of consumer demand that can power our economy, ushering in a new era of American prosperity — an age in which we have a healthier, more productive, and more competitive workforce and business sector. Historically our economy has thrived on this kind of market opportunity. Government should play an active role in encouraging it to build capacity for the emerging healthcare market.

We look forward to discussing these issues with you.

Sincerely,

Gary A. Puckrin, PhD
President and CEO

Co-signers:
Mervyn M. Dymally, PhD, President, Central Neighborhood Health Foundation
Bambi W. Gaddist, DrPH, Executive Director, South Carolina HIV/AIDS Council
Loretta Jones, Founder & Executive Director, Healthy African American Families, Phase II
Randall Maxey, MD, PhD, Executive Director, Community Life Improvement Program
Curren D. Price, Jr., JD, State Senator (District 26), California State Assembly
Anubry Stone, President/CEO, California Black Chamber of Commerce
Andre Williams, Executive Director/CEO, Association of Black Cardiologists, Inc.