

The following comments are from the National Senior Citizens Law Center and the National Committee to Preserve Social Security and Medicare on the Massachusetts Memorandum of Understanding (MOU) related to the state's dual eligible demonstration project. We tried to be comprehensive in our comments, noting both larger and smaller issues. The first section highlights positive elements, the second identifies broad concerns applicable to all MOUs, and the third notes specific issues/questions by section and page number. We hope this is useful to MMCO. Please let us know if you have questions, or would like us to walk through the document with you.

## 1. Positive Elements

There are several positive elements of the MOU that we hope will be incorporated in MOUs with other states. They include:

- Voluntary, opt-in enrollment in the first enrollment phase.
- An appeal structure that incorporates aid paid pending for both Medicare and Medicaid services through the first level of appeal; appeal decision deadlines that are consumer-friendly; access to both the Medicare and Medicaid appeal systems for services covered by both; and application of the more consumer-friendly decision where there is a conflict.
- A robust supplemental benefits package.
- Explicit commitments to *Olmstead* and to enforcing Title VI protections.
- Elimination of Part D cost sharing.
- Use of risk corridors.

## 2. Broad Concerns

Below are some larger concerns we have with the MOU—all closely intertwined—that we think are universally relevant when CMS negotiates future MOUs with other states.

**Specificity:** Throughout, the MOU is a very high level document. While it lays out some consumer protection principles that we appreciate, much more detail will be necessary to ensure those protections are realized. We counted 40 places where the MOU says that more details will be provided in the three way contract. There are many more places where detail is clearly needed to give meaning to general commitments. The level of specificity provided may be sufficient for a small, discreet demonstration, but more is needed for a demonstration that will impact so many lives.

**Omissions:** A closely related concern is the failure to include important protections such as an ombudsman program. MMCO has offered assurances that items missing from the MOU are not necessarily excluded from the demonstration. Yet with so many moving parts and players in each demonstration (typically multiple state agencies, state legislatures, and multiple parts of CMS, plans and

providers) all elements of the demonstration need to be clarified in writing. Without specific written commitments, there is no way to hold the many parties involved accountable and protect beneficiaries' access to services.

**Clarity:** It is unclear how information in the MOU relates to information in the Massachusetts proposal and the Request for Responses (RFR). We had thought that the MOU would provide more detail than the state's proposal while clearly identifying particular elements that CMS approved or rejected. The MOU did not meet these expectations. In some places, the state's proposal is more detailed than the MOU. In other places, the MOU seems to be inconsistent with, but not necessarily contrary to the proposal. Further, the state's RFR has additional details on issues like assessment requirements that are not found in the MOU. In a demonstration this size, it must be clear to CMS, the states, plans, providers and beneficiaries exactly what has been approved. Clarity is necessary to hold parties accountable and to ensure that beneficiaries are protected.

**Subject Areas Appropriate for the MOU:** Of particular concern is the fact that some areas left for further development in the three way contract are matters between the state and CMS, not the plans. Enrollment procedures and enrollment algorithms are examples.

**Compression of Decision-Making:** Massachusetts is proposing to begin sending out enrollment letters in January so plan contracts need to be negotiated quickly. Leaving so many critical details to the negotiation process does not facilitate a careful deliberation, with full stakeholder participation, about the multiple issues that need to be worked out if the demonstration is to launch successfully.

**Interaction with Medicaid Waiver Process:** Though the Medicaid waivers requested by Massachusetts are few, other states, particularly those seeking mandatory Medicaid managed care enrollment, will be requesting significant new authority. Since those waivers are critically important to program design (in many cases, these changes will impact beneficiaries outside of the demonstration) and also of great interest to stakeholders, we urge CMS to develop a more systematic way of coordinating the MOU and waiver processes and a more transparent timeline.

**Next Steps and Transparency:** It appears that the next step will be for CMS and the Commonwealth to select and enter into three-way contracts with plans. The three-way contract must be made public, posted, and subject to FOIA standards. We understand this is not the policy for Medicare Advantage, but it is for many Medicaid programs and for Center for Medicare and Medicaid Services (CMS), which just recently posted on its website Medicaid managed care contracts from several states. Given the legal protections to be negotiated in the three-way contracts (passive enrollment algorithm, standards for supplemental services, the role of the care coordinator), these agreements create legal standards for Medicare-Medicaid beneficiaries and must be publicly available. We appreciate CMS' commitment to making these documents public.

### 3. Specific Issues by Section and Page Number

#### **Memorandum of Understanding**

##### **Statement of Initiative**

p. 4. The MOU delays many important decisions about the demonstration to the three-way contract between the Integrated Care Organizations (the plans), the Commonwealth and CMS. In the statement of initiative, the MOU states that flexibilities will be coupled with beneficiary safeguards and included in the three-way contract. If CMS is going to grant the state and plans additional flexibilities, they should be detailed in the MOU, and not negotiated with the plans after the MOU.

##### **Specific Purpose of the MOU**

p. 4. The MOU states that the Commonwealth released an RFR for participating plans. As detailed throughout these comments, there are areas where the RFR and the MOU conflict, or the RFR provides additional information not included in the MOU. Additional clarity about the finality and authority of the MOU versus the RFR is necessary.

##### **Participating Plan Selection**

p. 6. Please see comments on Appendix 7.

p. 7. MMCO has told advocates that any waivers needed for the purely Medicaid portion of the demo will need to go through the standard Medicaid waiver process. Although the Massachusetts proposal involves limited waivers, we have concerns about both the process and timing for waivers in other states, particularly around mandatory Medicaid managed care enrollment. We would appreciate more information about the approval process and timing.

##### **Readiness Review**

p. 7. The MOU includes a general statement that the Commonwealth and CMS will conduct a readiness review for participating plans to address network readiness and capacity. We do not understand the connection between the readiness review and the plan selection process as laid out in the MOU. It seems to us that some level of pre-readiness (which includes quality) should be required as part of plan selection and those criteria that deal with current capacity should be incorporated into RFPs. One concern, particularly in states where only two plans are chosen for a demonstration area, is that there will be significant pressure to find readiness since the demonstration cannot effectively move forward otherwise. Where does one process end and the next begin? We recommend that plans be required to clear a high bar to be selected for participation in the demonstration before moving on to the readiness review process.

We recommend a readiness review that verifies each plan has satisfactorily demonstrated readiness in the areas below. We would, of course, welcome the opportunity to review and provide feedback on a readiness tool.

#### Network

- Passing a rigorous network review that looks at:
  - the numbers of beneficiaries, geographic and disability access, and how many providers are actually accepting new patients,
  - the number of specialists and specialty facilities to meet the needs of the likely enrollee population,
  - the number of LTSS providers, broken down by type of LTSS provided, and
  - the ability and willingness of the network to engage in the care coordination process.
- The network review should also identify key providers within the community that are not part of the plan's network and ensure that steps have been taken to handle access issues for dual eligibles that rely on those providers.

#### Network staff

- The network has enough staff hired and trained on the assessment process/tool to conduct the number of assessments that will be required.
- The network has staff trained to answer questions about the new program in a culturally and linguistically appropriate manner.

#### Provider Authorizations

- Provider authorizations are received quickly and paid smoothly.
- Providers know how to get language help for limited English proficiency (LEP) enrollees.

#### Care continuity

- The plan's care continuity processes have been tested. There must be provisions to pay non-network providers and to answer questions and approve pre-approved procedures. The existence of processes is not enough; they must be tested to ensure they are operational.

#### Internal appeals

- The plan should have systems in place so paperwork flow meets deadlines and internal reviewers understand the appeal standards.

#### Systems

- Staff are authorized to fix problems particularly the inevitable unexpected problems during the start of a program.

- Culturally and linguistically appropriate customer services scripts are in place and staff are trained. Computer systems are in place and have been tested for communication between the enrollment broker's computer network, the state and the plans.

### **Eligible population**

p. 8. We believe that the exclusion of individuals with other comprehensive insurance from passive enrollment should be part of all MOUs.

p. 8. Are beneficiaries with a Share of Cost (SOC) included? We believe that all demonstrations should include people who routinely meet their SOC. Because so many individuals with a share of cost are nursing home residents or people with high HCBS costs, their exclusion would significantly hinder the goals of encouraging more HCBS and rebalancing care delivery.

### **Enrollment and Disenrollment Processes**

p. 9. We appreciate the MOU's inclusion of an initial voluntary, opt-in enrollment period, the option to opt-out at any time, and the inclusion of an independent third party to facilitate enrollment with plans. Please see the comments for Appendix 7 for more questions on the enrollment process.

### **Participating plan risk arrangements**

p. 11. We appreciate that risk arrangements with providers must be made available but ask that they be posted without a need for enrollees to make a request. MMCO has indicated that CMS does not involve itself in risk arrangements between plans and providers, wanting to allow for flexibility and experimentation, but that arrangements also must not incentivize limits to necessary services. Will the states be responsible for reviewing those arrangements? Will review be joint? Will there be any more specific criteria beyond the broad requirements in the MOU?

### **Enrollment assistance and options counseling**

p. 12. Since the process of enrollment counseling is a matter between the state and CMS and is critical to the success of the demonstration, we think it is an appropriate area for much more specific treatment in the MOU. How options counselors will interact with the enrollment broker, the extent and limits to their participation in the enrollment process, and their funding and training are all matters that need to be addressed with much more specificity and that are not appropriate for a three-way contract.

### **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964**

p. 12. We appreciate the strong and explicit statement that compliance with the ADA, *Olmstead*, and the Civil Rights Act will be required. We urge that similar language be included in all MOUs. We also

urge that these obligations be referenced and detailed in Appendix 7 when discussing person-centered care, assessments, and benefits. The statement alone does little to ensure that beneficiaries' rights are protected in application.

Note also that "interpreters" is the preferred term of individuals providing oral interpretation, rather than "translators." Also, interpretation services should be provided for those who speak English *less than very well*.

### **Enrollee Communications**

p. 13. While we appreciate the requirement for the better Medicare or Medicaid standard for access to individuals with disabilities or limited English proficiency, we note that, for language access, those standards typically are derived from census data for the general population. The dual eligible population is disproportionately LEP and language access standards should, therefore, take into account those higher percentages.

### **Beneficiary Participation on Governing and Advisory Boards**

p. 14. We appreciate the requirement of consumer and community input, and the requirement of a consumer advisory committee for the Integrated Care Organization (ICO). The MOU states the plan may use a "range of approaches" to obtain beneficiary input, and gives inclusion on governing boards as an example. We have some skepticism about the ability of one consumer on a plan governing board to impact decisions of the organization. What other systems of consumer feedback fit within the "range of options" envisioned by CMS and the Commonwealth? We believe consumers supported by advocates are in a better position to have an impact in these committees and processes.

We are concerned that the MOU contains no explicit requirement for continuing stakeholder feedback at the state level. The governing board requirement applies to plans only. Future state MOUs should spell out the mechanisms that the state and CMS will use to ensure adequate consumer participation at the state level during program implementation. A state level structure is essential to identifying places where the state and CMS are failing to fulfill obligations of the MOU and for addressing systemic problems impacting beneficiaries across plans. A state structure also provides a forum for addressing problems that plans cannot or will not address.

### **Participating Plan Customer Service Representatives**

p. 14. The requirement that all three entities, the plan, the Commonwealth and CMS, have sufficient call center and customer services representatives (CRS) to address enrollee concerns should be modeled

in other states. We hope that the MOUs for other states provide additional detail on the CSRs and call centers. We realize that information on plan CSR requirements will be part of the three-way contracts. Where will further details be provided about state and CMS CSR requirements?

### **Limited Cost Sharing**

p. 14. We are very excited to see that the demo will experiment with the elimination of cost sharing for prescription drugs. This should provide valuable information on how best to encourage adherence to medication regimes. We hope that CMS will track this closely in its evaluation. We'd like to note that beyond medical outcomes, this change will likely have a tremendous impact on the lives of dual eligibles generally. This low-income population will now be spending less on their health care and have more money to spend on food and housing. This is a positive outcome in its own right. Thank you.

### **Administration and Oversight**

p. 16. We have serious concerns about the oversight system created in this MOU. The oversight system envisioned here is primarily focused on oversight of the individual plan, and lacks sufficient structure for oversight and monitoring of performance across plans, the state and CMS. As described in the MOU, oversight will be conducted on a plan by plan basis. This leaves many outstanding questions. How are system-wide problems spotted? How is a problem with a state responsibility spotted? How do stakeholders relay information to the contract management team? How do stakeholders inform the state and CMS of a systemic problem? Will the information the plans report be shared with anyone other than the contract management team?

### **Appendix 6**

p. 39. **Payments to Participating Plans.** Will CMS publish the factors that influence the rate-setting process? Will the factors be different in each state? Is there a standard formula for projecting savings?

p. 40. **Summary of Payment Methodology.** What kind of changes will warrant a reevaluation of the baseline?

p. 40. **Savings Percentages.** We remain concerned about the requirement for 1% savings in the first year. The first year savings requirement guarantees that the savings will come "off the top" of the baseline, rather than after the demonstration has proved it can effectively coordinate care to save money. How did CMS and the Commonwealth determine the 1, 2, 4% savings percentages? We are particularly interested in how the Commonwealth and plans plan to increase savings from 2% to 4% in second and third years.

We would also request more information about the underlying financial assumptions used to reach savings percentages. We expect that CMS and the Commonwealth analyzed data on preventable



hospitalizations, institutionalizations, and emergency room visits, along with estimates of what the state expects to invest upfront in increased primary care and community-based LTSS to meet the savings projections, prior to determining the savings targets. We request CMS and the Commonwealth to make this information, and any other underlying financial assumptions, public.

MMCO indicated that the percentages could vary from one state to the next. Is there a standard formula being used to set the savings percentage in each state? Will that formula be shared publicly? What factors are included in the formula?

p. 41. **Quality withhold.** How did CMS and the Commonwealth determine the withhold percentages?

p. 43. **Baseline spending-Medicaid.** We urge CMS to take into account the limits to the value of using historical data for the baseline. The ICO will be providing services, such as behavioral health services, that were previously unavailable to beneficiaries, or underutilized by beneficiaries who could not navigate the complexities of the system and access such services. On the Medicaid baseline, we'd like to know what other changes the state is making to its Medicaid program as part of the demonstration will be accounted for? For example, many states are implementing or expanding in some way a Medicaid managed LTSS system as part of the demonstration. Will the savings states expect from these changes to their Medicaid model be used to develop the baseline? Or will the expected savings be reflected in the savings percentages indicated in the MOU?

p. 44. **Baseline spending-Medicare Part A/B.** The general approach to setting the Medicare baseline is relatively straightforward and seems to make sense. We do have concerns, however, with Medicare's risk adjustment methodology and its ability to account for the unique needs of people with disabilities. Given that the Massachusetts proposal is targeted to this group we are concerned that the Medicare rate will be too low.

p. 45. **Part D.** While we understand that CMS wishes to leave relatively intact all aspects of Part D, we hope that the agency will monitor carefully the interaction of current incentives and disincentives of the rest of the demonstration with the incentives and disincentives in the Part D structure to identify areas where the two systems might interact in unexpected ways.

p. 46. **Aggregate Savings Percentages under the Demonstration.** We object to the requirement for demonstration savings in the first year. As noted by providers and consumer advocates throughout the proposal process, the creation of ICOs and provider networks will be complicated, and it is unlikely that savings can be achieved in the initial years.

p. 47. **Risk Adjustment Methodology.** We appreciate the recognition of the challenge in determining a risk adjustment formula that adequately accounts for the variety of factors, such as aggregate claims data, changes in year-to-year individual functional status, geographic proximity to services, and race and



ethnicity. We request that any functional data the Commonwealth collects to enhance the risk adjustment methodology be shared with the public.

p. 48. **Withhold Measures in Demonstration Year 1.** Beyond the “Access to an IL-LTSS Coordinator” measure, the withhold does not account for LTSS quality. How were these particular quality withhold measures selected?

We are concerned that the withholds are not LTSS specific or ambitious enough to actually mandate the ICO to deliver high quality care and maintain networks with high achieving LTSS providers.

p. 51. **Withhold Measures in Demonstration Years 2 and 3.** The measures do very little to address quality of long-term services and supports, beyond the “Quality of Life” measurement, which is left to be determined in the three-way contract. It is not appropriate for the plan to negotiate the various factors that will contribute to the quality of life measurement.

p. 51. **Evaluate and Pay Participating Plans.** Whether or not each plan has met the quality requirements in a given year will be made public, as will relevant quality results of participating plans in demonstration Years 2 and 3. We want to confirm our reading that results from all three years will be shared as they are collected, i.e., results from year 1 shared in year 2, year 2 shared in year 3, etc. We also recommend that all results, not just those deemed relevant, be shared publicly. Particularly because this is a demonstration, all stakeholders, researchers and others should have full access to data collected. Such access will facilitate the fullest review and evaluation of the success of the demonstration.

p. 52. **High Cost Risk Pools.** The inclusion of a high cost risk pool (HCRP) was not a part of the Massachusetts proposal, and not an area where there was an opportunity for stakeholder feedback. The MOU provides little information on the structure of the high risk pools, and leaves open to the three-way contract critical questions such as, what is the floor of spending that a beneficiary will hit for LTSS before being shifted into a HCRP? What is the portion of Medicaid capitation rate that will be withheld from the ICOs into the risk pool?

The MOU states that “HCRPs will be utilized until additional long-term care risk adjustment methodology is in place.” The description of risk adjustment methodology states that the Commonwealth will work on the development of enhanced risk adjustment methodology, but does not establish any time frame for when this will be completed. When will the use of HCRPs sunset and the enhanced risk adjustment methodology be complete? Are there benchmarks that will be set to ensure progress over the demonstration?

p. 52. **Risk Corridor.** Inclusion of a risk corridor was a high priority for advocates and we are pleased to see the inclusion of a risk corridor in the final MOU. We ask that CMS include a risk corridor for the initial years of other demonstrations as well. Given that the risk corridor proved successful for the

Massachusetts Senior Care Options (SCO) when it was utilized for a three year period, we question whether it is appropriate to limit the risk corridor to one year.

p. 53. **Risk Mitigation Process.** We appreciate the process for addressing unexpected outcomes related to payment and recommend keeping stakeholders informed about related developments.

p. 54. **Payments in Future Years and Mid-Year Rate Adjustments.** The MOU does not prohibit a state from changing policies to reduce benefits and services for dual eligibles. We recommend that all MOUs contain maintenance of effort provision that prohibits states from limiting the approved benefit package during the demonstration. If a maintenance of effort (MOE) provision is not included, the MOU should include explicit language that any change in state policy that reduces the benefits and services available under the demonstration will result in a reconsideration of the entire MOU, not just the rates.

### Appendix 7

p. 55.I. **Delegation of Administrative Authority.** Will CMS be conducting a readiness review to determine if state capacity to oversee the demonstration is adequate? If so, what will CMS use as its review criteria?

p. 55. II. **Plan or Qualified Entity Selection.** The selection process will take into account previous performance in Medicare and Medicaid, and ensure that bidders have met CMS' requirements, as specified in this MOU. As CMS is aware, we continue to have concerns about plan quality criteria and think that the MOU should not allow any plans to participate that have a Medicare star rating below three stars or a history of significant marketing and enrollment sanctions.

p. 56 b. **Enrollment and disenrollment processes.** Will enrollment transactions be submitted to the MAPRx enrollment system daily? Will individuals be able to disenroll from the demonstration by enrolling in another Medicare Part C or Part D plan? If so, how will this work? If not, what will happen if an individual tries to use that route?

p. 56 c. **Uniform enrollment and disenrollment letter and forms.** Some people who disenroll or who opt out will need to be auto-enrolled in a Part D plan. How will that work? What communications will they receive?

p. 56 d. **Enrollment effective date.** We are very pleased to see that enrollment will start as opt-in. This ensures that the first enrollees are individuals who have made an active choice to be part of the demonstration. It also allows for a break-in period during which plans, the state and CMS can determine how ready plans are to accept and serve additional enrollees. We greatly appreciate this modification to the Commonwealth's proposal and strongly urge CMS to include this element in other MOUs.

With respect to follow-on passive enrollment periods, we understand that Massachusetts views these enrollment periods as tentative and that final decisions on how many people will be enrolled and when will be determined after the first beneficiaries have been enrolled. However, to have a July 1 enrollment, notices would need to go out at least by May 1, only 30 days after the first enrollments and before even initial assessments are likely to be completed. It is important that criteria be developed—with stakeholder input—to determine when to move forward and at what pace.

Further, it is not clear whether newly eligible duals will be enrolled in 2013 and, if so, what the timetable will be for this group. How will new dual eligible individuals be enrolled in 2014 and thereafter?

The January 1, 2014 enrollment will include all individuals who were reassigned in 2013 and are eligible for reassignment in 2014. Will it include anyone else?

Enrollment is always prospective. How will this work for new duals who are Medicaid-first? For those who are Medicare-first? How will enrollment interact with LI-NET? A new dual who was Medicare -first presumably will not get a notice of passive enrollment until after becoming a dual. Can that individual opt for an earlier enrollment than 60 days from the notice?

p. 57.d.iii. **Enrollment packets.** Individuals will receive a packet with information about the plan into which they will be passively enrolled. How will they get access to information about other plans? Will there be a “plan compare” website or other consumer-friendly tool with which to compare plans?

p. 57 g. **Reassignment and new duals.** Passive enrollment will be coordinated with annual reassignment and daily auto-assignment. It would be helpful to spell out how this works, particularly with prospective enrollment. Will duals be reassigned into the demonstration? Will they receive information about other choices? Will they receive the ACA reassignment notice detailing formulary differences between their current Part D plan and the demonstration plan? For new duals, will they be auto-assigned into the demonstration? Will they also receive information about benchmark plans? How will they receive information about their Low Income Subsidy eligibility? Will the process be any different for those newly eligible duals who had Medicare first and therefore may already have a Prescription Drug Plan (PDP) or Medicare Advantage (MA) plan?

p. 57 h. **Intelligent assignment.** The algorithm for intelligent assignment is a critical element of the demonstration. It is not something to be negotiated in a three-way contract since it is fundamentally a matter between the state and CMS. Designing the algorithm should be a process with stakeholder input.

p. 57 i. **Beneficiary assistance.** We are disappointed that the general statement that counseling will be provided to beneficiaries offers no details about the mechanisms to be used. We hope that future MOUs will flesh out how this critical function will be handled. We also believe that it is important for Massachusetts and other states to make plans for providing broader beneficiary assistance, in addition

to enrollment counseling, throughout the demonstration. Beneficiaries will need people to help them navigate problems with demonstration plans even after they have made their initial enrollment decision.

The role of 1-800-MEDICARE also needs elaboration. We have asked that, at a minimum, 1-800-Medicare must provide a “warm handoff” meaning that the CSR identifies the proper organization to assist the individual, connects the individual with that organization, verifies with the organization that it is the appropriate place to handle the individual’s concern and only then disconnects from the call. If a call to an enrollment broker or counseling organization requires assistance from CMS, systems should be in place for similar handoffs from the broker or counselor to CMS. These systems should be in place and fully tested before the first enrollment notices are sent to beneficiaries.

p. 58 j. **Notices.** The MOU statement on notices is very general. First mailings are planned for January 1. We are concerned that much needs to be done to design notices that are integrated and include all the information required by beneficiaries yet written in plain language. Notices also need to be translated. We have serious concerns that the required notices with beneficiary input and consumer testing cannot be completed. We also are disappointed that the MOU does not provide any roadmap concerning planned notices.

p. 58 k. **Data reconciliation.** The lack of timely data transfers was and, in some states, continues to be a major access barrier in the transition to Medicare Part D coverage. More information should be provided in the MOU about what data CMS and the state will transfer and when. The role the enrollment broker and the plans will play in data transfers should also be mapped out for stakeholders. States that elect to participate in this demonstration should be required to transfer enrollment and eligibility data daily.

p. 58 a. **Provision of integrated services.** We appreciate the inclusion of an Independent Living and LTSS Coordinator. This is an innovation that was the result of stakeholder input and that is very appropriate for a demonstration project. We hope that CMS will encourage consumer-oriented innovations in other demonstrations. It is concerning that definitions of the roles of the Care Coordinator, clinical care manager and IL-LTSS coordinator are deferred to the three-way contract. These roles are critical to the design of the demonstration.

We note that the RFR states that Primary Care Providers will designate care coordinators for their patients yet the MOU does not speak to that. This is one of several areas referenced at the top of this document where we find the relationship between the RFR and the MOU to be unclear. If there are details in the RFR that are not found in the MOU, are we to assume that those details are approved by CMS or are they subject to change?

Similarly, the Massachusetts proposal includes some limited detail on the role of the care coordinator, while the MOU says instead that the role will be set out in the three-way contract. Advocates had expected that the MOU would be a more detailed document than the state proposal but we find that in several respects, such as here, it is less so, making it difficult for stakeholders to understand what is settled and what is still up for negotiation.

p. 59. We appreciate the express commitment to person-centered care and hope that commitment will appear in all MOUs. Similarly, we appreciate the requirement for training in the specific elements identified in the MOU. We hope that CMS and the states will enlist consumers and advocates to help provide such training. Consumers providing their own experience on issues such as accessibility and cultural competence can be powerful trainers.

p. 59 iv.1. **Assessments.** The MOU is silent about whether the initial assessment must be an in-person assessment. The Massachusetts Proposal (p. 9) seems to assume that it is in-person. We think that even an initial assessment, particularly for the disability population covered by the Massachusetts demonstration, should be in-person absent very special circumstances (such as the person electing a different format).

The question of what assessment tools will be used for the comprehensive assessment is left open. We think that an MOU, even if it does not identify the exact tools to be used, should be further along in narrowing the universe.

The comprehensive assessment is to be done by “the care team,” but the MOU does not contain a specific requirement for participation by assessors who can address psycho-social and other non-medical needs of the enrollee. We appreciate what we understand is CMS and the Commonwealth’s intent to include these needs, and a caregiver assessment, into the comprehensive assessment, and request that this intent be clarified in writing in future MOUs.

The Massachusetts proposal had required that the “initial comprehensive assessment” be conducted by the care coordinator and the LTSS coordinator (Proposal, p. 9). This is another case where the MOU seems to be a step backwards in specificity and we cannot tell if it is rejecting the requirement in the Massachusetts proposal, approving it, or neither.

This section should include a statement that the individual must be given a copy of his individualized care plan along with a statement of rights to appeal any elements of the plan.

There is no discussion of when the ICP must be updated and under what circumstances.

p. 59.iv.2. **Clinical Care Management.** The description of clinical care management is summary, which seems inappropriate since the value of the demonstration is how well it delivers care management. Of particular concern is the lack of any discussion about or emphasis on care management during

transitions. Also, the MOU states that care management will be provided to individuals identified as high risk. The Proposal, however, also plans to make clinical care management available to individuals with many prescription medications or one or more chronic health conditions (Proposal, p. 10). Again it is not clear if this is a step backward in what will be available to beneficiaries or just an alteration in wording.

p. 60 b. **Network adequacy.** We find the network adequacy standards to be insufficient for the demonstration population. Plans must have networks that meet the very specific and very diverse needs of this high-need population. The absence of any reference to specialists is particularly concerning, as is the LTSS standard of just two LTSS providers per covered service. We think that network adequacy requirements should start with an assessment of the needs of the anticipated enrollee population. The network adequacy requirements should be built around that assessment. Further, there is no discussion of patient load, open panels, accessibility (although accessibility is discussed generally at p. 12), language competence, etc. The MOU also lacks any provision discussing periodic reassessments of networks.

p. 61 d. **Credentialing and Practitioner Licensure Authorities and Application.** We echo the concern of other advocates regarding the lack of CMS and Commonwealth oversight of the ICO credentialing process. We agree that this should be part of the readiness review process, but also suggest that monitoring plan credentialing should be a part of the Commonwealth and CMS oversight process.

p. 68. **Benefits.** We are concerned that use of the medical necessity definitions alone does not adequately account for beneficiary rights under *Olmstead*. While *Olmstead* rights are mentioned elsewhere in the MOU, the failure to include an *Olmstead* analysis as a necessary part of a determination of rights to benefits in this section should be corrected. This is a particular concern in light of the Massachusetts Medicaid medical necessity definition which excludes services if there are other services that are “more conservative or less costly.”

Another area of concern is the standard to apply where there is overlap between Medicare and Medicaid coverage. This should not be a matter of negotiation in the three-party contract. These standards are a matter of beneficiary rights and we echo the concern of other advocates regarding confusion caused by the current MOU language.

Further, we appreciate what we understand as CMS’ and the Commonwealth’s intent to provide protection that is the most generous to the beneficiary, and recommend including an affirmative statement that this is CMS and the state’s policy. For example, “in the event of an overlap between a Medicare and Medicaid standard/protection/test, the most rigorous beneficiary protection standard applies.”



The MOU is silent on the standard to be applied to the provision of supplemental benefits and flexible benefits. Will medical necessity definitions apply or some other standard? Will the standard differ for flexible benefits? Even though these services are “flexible,” they cannot be offered arbitrarily. Beneficiaries need to know the criteria for access to these services and understand the standards on which they could base an appeal of denial of services. Since standards create beneficiary rights, it is not appropriate to negotiate the standards for receipt of these services with the ICOs in the three-way contract.

p. 69-81. **Services.** We greatly appreciate the array of services under the demonstration. Access to additional services will be a key advantage of membership in the demonstration in Massachusetts; we urge that CMS require that all MOUs contain meaningful supplemental benefit packages. We note particular items such as peer support and community health workers, which incorporate non-medical responses to enrollee needs.

p. 82c. **Flexible benefits.** We appreciate that plans should have flexibility to meet enrollee needs. Nevertheless, there needs to be a system whereby individuals can understand what services potentially are available, how to request them if not offered, how to appeal a denial, and the basis on which an appeal will be considered. There must also be an avenue to appeal the denial of any service, including a supplemental or flexible service, to an independent third party and standards that party can use to adjudicate an appeal.

p. 82 e. **Hospice.** We do not have a position on the carve out of hospice services but believe that careful monitoring is needed to ensure that it does not distort incentives or negatively affect care. We also wonder whether people enrolled in hospice should be excluded from passive enrollment into the demonstration, both because they already receive a high level of care coordination and because, as hospice participants, they have a less than six-month life expectancy. Moving them into a new system for a short time may do little to improve their care and cause unnecessary disruption.

p. 82 f. **Continuity of Care.** MMCO has informed advocates that the intent of the MOU is to require care continuity until a care plan is in place but, as currently written, the MOU does not offer that protection. Care continuity only extends for 90 days or until the initial assessment is complete. As set out in the MOU, the initial assessment determines a person’s rating category but does not establish a care plan. The individualized care plan is a product of the comprehensive assessment, which has no time limit for completion. We note that the Massachusetts Proposal (p. 12) recognized this and had much more beneficiary-friendly language that should be substituted for what is now in the MOU: “. . . when members enroll with an ICO they will have access to the same services and providers, at the same levels and rates of payment, that they were accessing in FFS prior to their enrollment for the longer of 90 days or until their initial assessment, any necessary additional assessments, and all noticing for their new care plan are complete.”



We are also concerned about instances in which the ICO completes the assessment so near the end of the 90 day period that there is no time to implement required transitions to new services or providers. We recommend that care continuity apply for at least 30 days after the completion of the individual care plan to account for this.

Also there is a reference to Appendix 7, Section V.d.ii. The reference should be to Section V.f.ii.

We also ask that in all MOUs, the care continuity provisions be more explicit in stating that care continuity rights extend to services from all categories of providers. No category, such as DME suppliers or non-emergency medical transportation, should be excluded.

p. 83 f.iv. **Notice and appeal rights.** We ask that the MOU clarify that the right to notice, appeal, and aid paid pending applies to all prior LTSS services, even if a prior authorization period has ended. This is a particular concern for LTSS since these services are by their nature long-term. Any change in LTSS authorization should trigger appeal rights, regardless of arbitrary authorization periods.

We also request clarification that any reduction or elimination of services at any time, not just at an initial assessment, triggers a requirement for written notice and to full appeal rights.

p. 83 g. **Out of Network Reimbursement.** Consistent with our comments on (f), out-of-network reimbursement must continue until a care plan has been established and properly noticed.

Further, the reference to single case agreements should be more explicit with respect to nursing home residents. The MOU should clearly require that, absent special circumstances, individuals should be able to remain in a non-network nursing home through use of a single case out of network agreement.

p. 83 iv. **Model of Care.** As we have expressed earlier to CMS, we think that the scoring methodology for the SNP models of care is overly reliant on giving points for ticking off required elements (e.g., points for including an example of x) rather than on an evaluation of the quality and efficacy of the model. Further the Model of Care (MOC) requirements, since they were developed for SNPs and not for fully integrated plans, are overwhelmingly geared to Medicare services and do not meaningfully and fully incorporate LTSS. MMCO has informed advocates that the MOC is only the beginning and that states will add Medicaid and especially LTSS elements to plan requirements. However, it is concerning that the MOU only covers the Medicare elements and leaves the critically important Medicaid/LTSS elements of design to the three-way contract. As a result, it appears that beneficiaries and their advocates will only have minimal opportunity to contribute to the design of these key components of the model.

p. 85 VII. **Grievances.** There are no deadlines for responding to grievances and no required procedures. Grievance requirements should be at least as strong as those for Medicaid managed care plans and Medicare Advantage grievances, which include specific timelines and procedures for requesting expedited grievances. See Medicare Advantage Manual, Ch. 13 <http://www.cms.gov/Regulations-and->

[Guidance/Guidance/Manuals/Downloads/mc86c13.pdf](#). Though plans are required to track and resolve grievances, there does not appear to be a reporting requirement or any specific oversight noted in the MOU regarding the handling of grievances.

p. 85 XI. **Appeals.** We very much appreciate several positive elements of the appeals process, and hope MMCO will continue with this good start and include the following provisions in other MOUs: the 60 day appeal timeframe, the deadlines for resolution of appeals, the provision for aid paid pending for both Medicare and Medicaid services, and the integrated notice. We also thank you for including the right of an individual to go to both the ICO and the Board of Hearings, with the ruling most favorable to the enrollee prevailing. This is an important protection of rights.

We object to forcing an individual to go through an internal appeal before being allowed to go to fair hearing. This is an erosion of existing rights and contrary to the “best of both worlds” promise of the demonstrations.

We also are concerned that there is no mention of how appeal procedures will be structured for supplemental and flexible benefits. Will an appeal of supplemental benefits be subject to the same procedures as the appeal of any Medicaid benefit? Because most supplemental benefits are LTSS-related, it makes sense that those appeals go through the state system. What about flexible benefits? Individuals who want such benefits and are denied them need an appeal route that includes the right of review outside the plan.

Finally, future MOUs should address the problem of plans limiting aid paid pending to the previous prior authorization period. Aid paid pending should continue at the previous benefit level until the current appeal is resolved -- regardless of when a treatment authorization ends.

p. 87. **Marketing.** Though perhaps outside the scope of the MOU, we continue to be concerned that, to date, there has been no discussion about rules or restrictions for non-demonstration plans, brokers and agents who are marketing to duals that are eligible for the demonstration.

p. 88. **LIS Rider.** We are unclear why the Low Income Subsidy (LIS) rider will not be required. Is it because all materials will be integrated? That may work in Massachusetts because the demonstration will remove prescription drug co-payment responsibility from all enrollees. But if demonstrations in other states include prescription drug co-payments, there will be a need for correspondence that informs beneficiaries of their co-payment levels, since those levels will change depending, for example, on whether a plan member is receiving HCBS. Beneficiaries should also receive information about their LIS eligibility so they know what their co-pay liability will be if they leave the demonstration to join a PDP or MA plan.

p. 89. **Administration and Oversight. Contract Management Team.** Although the main text of the MOU says that details will be provided in this appendix, it appears, instead that the appendix language is

boilerplate, saying that the makeup of the team “will vary by state.” MOUs should provide more specific information.

Missing from the MOU: **Ombudsman.** We strongly urge that the MOU explicitly provide for a conflict-free independent ombudsman’s office, adequately funded. A state commitment to this important consumer protection should be part of every MOU.

p. 89. **Administration and Oversight.** This section lacks specificity and appears to limit information that will be available to consumers. Overall, the monitoring process, as described in the MOU, will largely be accessible only to CMS, the state and the plans. We recommend that future MOUs provide more detail, and that the oversight processes be made more transparent to consumers.

We also note that the structure seems entirely focused on ensuring plans are following requirements. There does not seem to be any structure for ensuring the state is performing its functions, especially in the area of enrollment, or for identifying system-wide problems that may not be the result of a plan or plans not following the rules. For example, the problems in the transition to Part D were largely the result of data transfer issues between states and CMS, not plans acting inappropriately. Systems should be in place for monitoring the performance of the state and the demonstration across plans.

p. 89. **Oversight Framework.** The discussion states that “many Medicare Advantage requirements regarding oversight, monitoring and program integrity will be applied to Demonstration Plans by CMS.” The MOU instead should list which of the requirements will apply — a reference to “many” requirements is insufficient

p. 89. **Contract Management Team.** The MOU provides that the CMS-State Contract Management Team has broad responsibilities: it is tasked with “ensur[ing] access, quality, program integrity and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action.” (MOU, p. 89). The MOU, however, provides little detail about the range of corrective actions that would be available to the Team.

Under the MOU, the Team “will be responsible for the day-to-day monitoring of each contractor,” which includes “[r]eceipt and response to complaints” and “issuance of joint notices of non-compliance/enforcement.” This is a huge and important task, deserving of a much more specific discussion. For a monitoring system to work properly, the Team must be in a position to receive complaints from enrollees and others. The Team must develop an infrastructure that makes the process accessible to consumers, along with the capacity to investigate complaints, initiate necessary enforcement actions, and monitor remedial activities. The entire process should be appropriately transparent to consumers and other stakeholders.

p. 90. **Reporting.** The MOU provides only an outline of these important functions. More detail is necessary.

p. 92. **Data Systems, Reporting and Interoperability.** This section of the MOU appears to have been left unfinished. Information on how data will be transmitted between the state, different part of CMS, the enrollment contractor, the plans, providers, pharmacies and more is essential to ensuring the smooth operation of the demonstration. Information about how encounters are reported is also key to understanding how the demonstration will incentivize and monitor the provision of quality care. When will these elements be filled in? What is the plan for ensuring the security of data?

p. 93-105. **Quality Metrics.** The MOU lists a “preliminary combined set of core metrics” that includes 104 separate quality measures. Subsets of these quality measures will be used for evaluation of quality and for determining the refund (if any) of the quality withhold payment. Since CMS has not specified at this point which of the measures actually will be used, it is difficult for stakeholders to fully evaluate the merits of the proposed quality metrics system. Future MOUs should offer much greater specificity on this point.

We appreciate that the MOU builds on existing program measures, but are disappointed by the lack of LTSS specific measures. Beneficiaries and their advocates are excited and concerned about the ability of the demonstration to increase access to and quality of these services. Measures must be developed to track whether plans are effective at doing so.

Thank you for the opportunity to share our comments. We look forward to continuing to work with MMCO on this important initiative in Massachusetts and other demonstration states.