

Medicare-Medicaid Alignment Proposal

Public Comment

March / April 2012

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Liz Baxter, MPH – We Can Do Better – 3/10/12

- First, as an organization that endorsed the Triple Aim in 2008, we ask that the reference to better health care be replaced with Berwick's language of a 'better experience of care.' There is a significant difference between the two - a better experience of care is an outcome; providing better care is one of the strategies to get there. The experience of care is a measurement of the user's perspective, better care is from the system's perspective. You can use both, but one cannot replace the other.
- p.11 - a key component has to be pre-emptive risk assessment/evaluation. Of the 37,459 duals not receiving LTC services I will guarantee you that there are many who are at-risk and could be prevented from needing LTC services with appropriate intervention and care coordination. (based on 25 years working with at-risk seniors in Oregon.) The flaw, that keeps us in the medical model, is the belief that a primary care/medical home is the center of the universe for all beings. Many at-risk seniors and people with disabilities are not seen as 'at-risk' when they viewed from within the health system lens.
- p.14, add to the set of bullets mid-page, something like "decimation of community based services that assess and intervene with at-risk community members, keeping them from entering the medical or LTC systems."
- add to promising coordination models bullets - better linkages with community based senior centers, home delivered meals programs, parish and faith-based supportive programs. Again, the things that are listed are great, but it leaves out the majority of people who are dually eligible - those who haven't hit the medical door yet.
- Rather than outlining all the references, we refer to the chart on page 10 which outlines the numbers of Oregonians who are eligible for Medicare and Medicaid, and yet, the models being described do not adequately describe how things will change for those who are not currently receiving LTC services. The summary does a superb job of describing models for duals who are in LTC, but there are many opportunities for community based interventions that should be a part of this proposal.

Liz Baxter, MPH – We Can Do Better – 3/10/12

General comment:

This applies for CCOs as well. There is a need for education in terms of partnering on care decisions and one place that is clear is in the use of advance directives and the POLST. There should be a place where partnership with Oregon Health Decisions and its guide for conversations around the advance directive is included in the plan. The POLST always gets more prominence because it is in the medical model and is signed by the provider, but the Guide developed by Oregon Health Decisions is the individual's opportunity to make their wishes known.

Liz

Mauro Hernandez, Ph.D., CEO, Concepts in Community Living – 3/12/12

The proposed pilot projects for PACE innovations and Congregate Housing with Services look very promising.

Given the lack of rural PACE sites and service-enriched housing options in Oregon's rural communities, the proposal should be more explicit about how each of the programs will be designed to address the unique challenges faced by rural elders. For example, the 3 proposed Congregate Housing with Services pilot sites should include locations along the rural-urban continuum (see <http://www.ers.usda.gov/briefing/rurality/ruralurbcon/priordescription.htm>).

Mauro Hernandez, Ph.D., Chief Executive Officer
Concepts in Community Living

Eddie Perse, Medicare Director, FamilyCare Health Plans – 3/12/12

1. Agent Commissions and Renewals—If all Full Duals are passively enrolled in a CCO on 1/1/2013, we need specific CMS guidance on how plans are to pay renewal commissions for duals enrolled in the demonstration? Currently, we are contractually obligated to pay renewal commission on MA members (including duals) for 6 years when they continue to stay enrolled in our MA plan each calendar year.
2. We would also like to make sure there is detailed guidance on the opt out process, marketing to dual members and enrollment of members into a dual SNP who choose to opt out. Will CMS still allow agents to market to dual members who are not enrolled in a COO?
3. There are many unknown factors and details regarding the dual integration and the enrollment of the population into CCO's. There is urgent, real-time financial considerations plans have to account for regarding revenue and reimbursement of the dual members in 2013. The fact that the MOU between the State and CMS will not be available for at least another month, we will be moving forward with the Medicare Bid SNP bid for 2013 and will continue to provide services to dual members (who opt out) in our Medicare Advantage Dual DSNP within our current 6-county Service Area.

With the issues and concerns considered, what if a plan does not believe the reimbursement for the dual population in the CCO demonstration will be adequate? Is a CCO required to participate in the dual demonstration project or can a CCO have a SNP plan instead and enroll all of its duals in the SNP plan?

Eddie Perse
Medicare Director
FamilyCare Health Plans

Bob Joondeph, Disability Rights Oregon - 3/30/12



March 30, 2012

TO: Oregon Health Authority
FR: Bob Joondeph, Executive Director
RE: Comments on Proposal to CMS to Integrate Medicare & Medicaid Services

Thank you very much for this opportunity to comment on OHP's Proposal to CMS, State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid. Disability Rights Oregon (DRO) has supported and participated in the state's efforts to transform its Medicaid system. Similarly, we generally support Oregon's desire to serve individuals who are dual eligible in a more effective and efficient manner.

Our comments recognize that the Proposal is inextricably intertwined with the creation and roll-out of CCOs. Providing a thorough critique of the Proposal would necessarily require a much broader analysis of the entire health transformation process which is highly complex and fluid. Since that is beyond the scope of this document, please accept these questions and concerns with our recognition that the Proposal is one aspect of a broader effort.

1. Optional Participation by CCOs

DRO received the recent memorandum regarding optional participation. It states that OHA "hopes to secure terms that will be beneficial to individuals who are dually eligible and will also be a fit for CCOs." This statement naturally raises the question of what OHA and/or potential CCOs see as the disconnect between the interests of recipients and CCOs.

The entire CCO enterprise promotes local control, coordination and planning. While this approach has many strengths, it has the potential of allowing a wide disparity of access and quality of services in different regions of the state. Permitting optional participation in the Dual Proposal would seem to increase that possibility. DRO is concerned that individuals across the state may not share an expectation of quality services and that there may be an incentive for consumers to relocate to areas where quality services are more accessible.

2. Mental Health Drugs

On page 12, second paragraph under "Benefit design and accountability for providing services," the draft states that: For drug coverage, Medicare Part D will continue to be the primary drug coverage for dually eligible individuals under the demonstration; Oregon plans to require to require CCOs to use the statewide evidence-based preferred drug list (PDL) as their Part D formulary for this demonstration starting in 2014, and will seek CMS approval of the PDL as meeting Part D requirements.

On page 13 under "Excluded services" the draft states:

For dually eligible individuals, the exclusion of mental health drugs on the Medicaid side will not be as significant, since these drugs will largely be provided through Part D and thus will be included in the CCO.

We understand this to say that an individual who uses mental health drugs will be able to access drugs that are not on the PDL through fee-for-service Medicaid coverage. If that is not true, we think it should be and we think it should be stated clearly in the proposal.

3. Durable Medical Equipment

On page 12, last paragraph, the draft states that the need for "specialized services or other types of supports that would be uniquely beneficial" to health, improve the quality of care or ensure affordable delivery of services will be "individually determined by the CCO in the best interests of the member."

While we applaud the flexibility and creativity that this provision encourages, we wonder how a member will be aware that such services and supports may be available, how to request them and how to appeal if a request is denied. As noted above, we are also concerned about the uniformity of access across the state. Encouraging and carrying out individualized supports and access to equipment need not set state-wide precedents that apply for other recipients, but radical differences in equipment availability should be avoided.

4. Behavioral Health Services

On page 13, the draft says that the CCO delivery system network "is expected" to employ intensive care coordination or care management practices consistent with best practices. Does this constitute a requirement or a suggestion?

5. Beneficiary Protections

We understand that a workgroup has been scheduled to work on due process and other member protections but the mere promise to work with CMS to develop integrated grievance and appeals processes is vague and unassuring. We intend to participate in the workgroup and will be making the following points:

- Notice must be provided prior to the termination, suspension or denial of a service.
- There should be only one level of internal appeal before getting to an external review entity.
- The process must allow for speedy resolutions, including expedited review.
- Benefits should continue pending an appeal.
- Medicare's amount in controversy should not apply.
- Enrollees should not be required to file simultaneous review requests but should have a single appeal process that applies the broadest coverage criteria available under both Medicaid and Medicare.

On page 30, the draft states that for Medicare, areas where it is anticipated that there may be a need for flexibility around current rules including "enrollment requirements, particularly around timing." What kind of flexibility is desired in this regard and why?

On page 34, we are pleased to see that "disability status" is included in the groups to be assessed and reported on to measure minority health and health disparities. In various transformation-related documents, including this proposal, there seems, however, to be much less attention paid to individuals with disabilities than to ethnic minorities. Data available from OHSU shows enormous disparity in secondary disabling conditions among the disability population than the general population. This disparity must be addressed in a dual eligible integration due to the large number of affected enrollees who have significant disabilities. There must be collection and maintenance of data on the disability status of all members so that quality measures may be tracked by this factor.

6. Community Advisory Councils

We agree that the participation of enrollees through community advisory councils is vital to the success of health care transformation. This Proposal, however, makes no mention of how council members will receive training and technical assistance in order to be as effective as possible. Without adequate training and support, the councils will not fulfill their purpose.

7. Long Term Care

While the definitions in the Proposal are improved over early documents, we believe that the draft could provide a clearer and more consistent definition of "long term care."

DRO appreciates all the work that has gone into devising means of coordination between LTC and CCO given the legislature's decision to carve out LTC. We continue to be concerned, however, that individual's ADA rights under Olmstead to not be unduly institutionalized may not be honored without adequate fiscal incentives and monitoring. We would appreciate more clarity about what OHA will consider an adequate arrangement in a CCO proposal. Oregon's strong record of utilizing home and community based services must not be eroded in the transformation process.

8. ADA

We find nothing in the Proposal that mentions the obligations of CCOs and providers to comply with the Americans with Disabilities Act and that requires applicants to demonstrate that all of their services are accessible to individuals with disabilities. The web site where we obtained a copy of the Proposal makes no mention of accessibility, does not offer alternative formats for important documents and shows no sign of certification as ADA accessible. We believe that OHA should model ADA compliance, lead by example and make no assumptions that CCOs or providers understand their ADA obligations.

9. Enrollment

Nationally, many advocates are opposing "passive enrollment" in integration projects. DRO is not opposing this approach, but is concerned that the Proposal makes no mention of how enrollees will receive information and assistance about their enrollment options including their right to opt out initially and at any time during the enrollment year. The most effective way to assure person-centered care and rights protection is the use of independent enrollment brokers who can assist enrollees in making informed decisions.

10. Estate Recovery

We did not find discussion in the Proposal of how estate-recovery features of these federal programs will be affected by integration. This should be addressed.

Thank you again for this opportunity to comment. We look forward to seeing more specifics of how services are to be delivered to this most vulnerable population.

Tom Eversole - 3/24/12

Will Oregon's Public Meeting Law apply to CCOs and especially CCO board meetings? It seems to me that they should, because these are public dollars being spent for public services.

M E M O

From: Oregon Public Health Division

Date: April 2, 2012

Re: Public Comment Period for Draft Medicare-Medicaid Alignment Proposal to CMS

Attachment and Language Inconsistencies

- The current Appendix D does not currently reflect the same layout and listing of metrics as the proposed accountability metrics included in the CCO Request for Applications issued on March 19, 2012.
- In Appendix E, page 44, the “Peer-Delivered Services” line references “Living well” alongside “AMH peer services”. If this refers to the evidence-based Stanford Chronic Disease Self-Management Program, which is called Living Well with Chronic Conditions in Oregon, please change the term to “Living Well with Chronic Conditions” or the “Stanford Chronic Disease Self-Management Program” so it is clear this means a particular program. The Living Well with Chronic Conditions program is not only suitable as a peer-delivered service for people with mental health conditions, but is beneficial for people with one or more physical health conditions. It may be possible to capture these types of services (appropriate for both physical and mental health conditions) as “health promotion services and programs” rather than “peer-delivered services”, which typically denotes services provided specifically for mental health consumers.

Health Promotion Services

- On page 12, under “Benefit design and accountability for providing services”, second paragraph, it is stated that CCOs will be expected to provide health promotion and preventive services such as smoking cessation programs, weight watchers (or similar) and lactation services. The corresponding Appendix E does not indicate at what coverage level weight watchers will be provided for each subset of the Medicaid population. In order to promote client engagement in weight watchers, a little or no premium to participate is suggested.

The Public Health Division suggests that the smoking cessation programs provided also cover forms of smokeless tobacco use, and thereby should be referred to as tobacco cessation. Both the tobacco cessation and weight management programs other than weight watchers should be evidence-based in order to ensure reliable outcomes. Inclusion of these benefits will address the two leading risk factors for chronic disease, an approach strongly supported by the Public Health Division.

- On page 13, the bulleted list at the top of the page indicates potential optional benefits provided to individuals or a portion of the member population using the CCO global budget. The Public Health Division supports these types of services, particularly when services offered are evidence-based, and suggests that CCOs also consider employing methods to reduce barriers to clients accessing these services, such as transportation and child care.
- On page 22, the third paragraph references that through the Congregate Housing with Services pilot, Oregon hopes to “create a culture of wellness”. It is unclear based on this description what a “culture of wellness” means and to whom it specifically applies. Based on findings from a recent communications project, the Public Health Division would define a “culture of wellness” as making sure healthy options are available for everyone where they live, work, play and learn. The Public Health Division strongly supports this effort to support healthy environments where people live, as the environment in which people live impacts their ability to manage their health effectively. As CCOs are established, this concept of a “culture of wellness” should apply not only to individuals participating in the Congregate Housing with Services pilot, but to all CCO members, employees and the community at large.
- On page 34, the Public Health Division supports OHA and CCOs in their participation in the Million Hearts Initiative and can be a resource in the implementation of evidence-based approaches to support the national goals of Million Hearts.

**Catherine K. Anderson, MPA –United Healthcare (Sent by Rick Knickerbocker) –
4/3/12**



Catherine K. Anderson, MPA
National Vice President
Medicare-Medicaid Enrollees
37 West 2000 South Driggs, ID 83422

April 3, 2012
Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301

Regarding: Comments on Draft Proposal to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

To whom it may concern:

UnitedHealthcare Community & State appreciates the opportunity to provide the Oregon Health Authority (OHA) comments on the Centers for Medicare and Medicaid Services (CMS) draft proposal to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid. As one of the nation's leading providers of Medicare and Medicaid services and as a current Medicare Advantage plan that serves dual eligible individuals in Oregon, our response to the State's request for comments is based on our direct experience and the best practices that we have implemented and operate in several capitated integrated Medicare and Medicaid programs across the country.

We applaud Oregon's goal to incorporate the CMS Financial Alignment demonstration into its overall Health System Transformation reform efforts, which combined will:

Transform Oregon's delivery system to focus on prevention, integration, and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve;

Promote the Triple Aim of better health, better health care, and lower per capita costs; and

Establish supportive partnerships with CMS to implement innovative strategies for providing high-quality, cost-effective, person-centered health care under Medicare and Medicaid.

We recognize that Medicare Medicaid Enrollees (MMEs) are some of the most complex individuals served by the two programs; however, we believe the proposed demonstration holds great promise to improve quality, increase access to preventive and proactive care, enhance the use of community-based supports and services and decrease the reliance on costly services.

Care Model Overview

Proposed Delivery System Model

We believe effective primary care is a foundational element to an effective integrated model of care for populations with complex needs. As such, we agree that every member should have a primary care provider that supports regular, preventive care and proactive treatment of chronic conditions.

Establishing a model that encourages primary care is quite different from establishing a patient-centered medical home for each MME. Our experience has shown that many practices lack the resources and/or desire to develop a more progressive model that would result in their recognition as a person-centered medical home. Particularly for complex populations such as MMEs, practices are not universally inclined to manage the full range of services and supports.

We recommend OHA consider adopting the standard that every MME be assigned a primary care provider rather than a Patient-Centered Primary Care Home (PCPCH). This allows CCOs the opportunity to identify, work with, and foster the development of more progressive primary care models for practices interested in expanding their capabilities. This coupled with a comprehensive approach to integrate physical and behavioral benefits as outlined in the proposal will result in a more effective approach to primary care and ensure that expanded primary care is supported for those practices best prepared to embrace a more expansive role in managing MMEs.

Benefit Design and Accountability for Providing Services

Creating a benefit structure for the demonstration that ensures flexibility and coordination is fundamental to integrated care delivery models for complex populations such as MMEs. The inclusion of the broadest set of Medicare and Medicaid benefits and services enables coordination in a single system focused on the holistic delivery of services while avoiding redundancies, fragmentation of services, duplicative administrative costs, cost shifting, and poor outcomes. In order to maintain the foundation of person-centeredness, benefits should be combined into a seamless delivery system focused on ensuring alignment of benefits and services to an individual's needs and the flexibility to modify plans of care as individual needs change.

Although we understand and appreciate the success that Oregon has experienced in creating a balanced long term care (LTC) system, it is our experience that carving out LTC benefits leads to fragmentation, which is one of the fundamental weaknesses of a non-integrated model. To that end, we recommend that Medicaid LTC services and the home- and community-based waiver services for people with disabilities be carved-in to the demonstration. We recognize that Medicaid-funded LTC services are legislatively excluded for the CCO global budgets; therefore, we advocate that the State's design proposal to be submitted to CMS allow for the flexibility and option to carve-in Medicaid LTC benefits in year two or three of the proposed demonstration. Given the robust and mature delivery models in Oregon, CCOs should be encouraged to create innovative relationships with existing LTC providers. This enables the State to test the merits of a fully integrated, person-centered system of care with CCOs that have forged collaborative partnerships with the LTC delivery system.

Second, we have concerns regarding Oregon's proposal to require CCOs to use the statewide evidence-based preferred drug list (PDL) as their Part D formulary for the demonstration beginning in 2014. Requiring health plans to use the State's PDL has the potential to reduce the CCO's ability to leverage pharmacy rebates and proven authorization lists and processes for MMEs. This mandate will also impede a CCO's ability to effectively link its medication therapy management program (MTMP) in a

comprehensive manner with the care planning and complex care management activities that are an integral component of the proposed model of care.

Integrated Care Pilots

We applaud OHA's interest in leveraging and expanding the role of PACE in its integrated proposal. PACE effectiveness and scalability have been limited by the regulatory limitations of the program. We believe many components of the PACE program are the very foundation on which to build a truly holistic and comprehensively integrated program for MMEs. While we support the concept of expanded opportunities for PACE within Oregon, we suggest that PACE organizations be considered alongside CCO plans to ensure consistent regulatory structure and minimize any competitive disadvantages to CCOs. Further, we recommend that OHA not place any limitations on the development of innovative relationships between CCOs and PACE providers.

Evidence-based practices

Enrollment

We support the State's proposed facilitated voluntary enrollment approach for the demonstration that includes a unified passive enrollment process for MMEs eligible to participate in the demonstration. UnitedHealthcare believes that a passive enrollment process with an opt-out option and appropriate beneficiary protections is an essential program design requirement to ensure sufficient enrollment of all enrollees that can benefit from this demonstration. Based on our direct experience operating other similar voluntary integrated programs for duals nationally, a passive enrollment process for the demonstration is needed to ensure viability. Second, UnitedHealthcare supports OHA's approach to ensuring continuity of care by taking into consideration an individual's Medicare and Medicaid health plan enrollment when assigning MMEs to CCOs under the proposed demonstration.

Additionally, in order to establish meaningful relationships with MMEs, we suggest OHA consider adopting a lock-in period of at least six months for the demonstration, following an initial opt-out period. A six-month, lock-in provision for both Medicaid and Medicare allows participating CCOs to appropriately identify individuals in the greatest need of support; conduct a comprehensive assessment of their clinical, functional, and social needs; and apply effective chronic condition management with the goal of positively impacting quality and outcomes. Further, we believe a longer enrollment period with the option to disenroll from the health plan only after six months enables the State and CMS to more effectively evaluate the merits of the demonstration and avoid potential adverse risk selection issues that can arise under a monthly disenrollment option. To ensure appropriate beneficiary protections, OHA can develop certain requirements for changing CCOs that may include provider participation or demonstrated quality concerns by the MME.

We also support the State's intent to implement the demonstration on a statewide basis with the flexibility to add additional CCOs to the demonstration at a later date (after January 1, 2013) as these partnerships form. We believe this approach allows for maximum consumer choice and options under the proposed demonstration.

Stakeholder Engagement and Beneficiary Protections

Beneficiary Protections

We support the State's goal to ensure appropriate beneficiary protections are in place under the proposed demonstration. In particular we appreciate OHA's intent to provide CCOs with necessary information on MME utilization and authorization information to ensure continuity of care and minimize any disruption of services.

Financing and Payment

Financial Alignment Model and Payments to Plans and Providers

UnitedHealthcare believes that one of the most important elements of the proposed demonstration is the development of an actuarially sound integrated financing and payment model to ensure long-term program viability and sustainability. Appropriately structured rates will result in savings for Medicare and Medicaid as well as increased early detection of individual needs and appropriate alignment of benefits and services. We support OHA's financing principles as outlined in the demonstration proposal to "provide each CCO with a global budget that combines funding streams in a manner that allows this flexibility and creates a single point of accountability for members' health and their access to and experience of care." We also support the State's commitment to explore the use of risk mitigation strategies such as risk-corridors and re-insurance. This is important particularly in the early years of the demonstration. Finally, we also strongly support the State's intent to fund the cost of providing care coordination and management activities that CCOs will be expected to provide as part of the blended rate to be developed by CMS and OHA.

We offer the following additional key principles we believe should also be taken into consideration as the State moves forward with the further development of the financing model for the demonstration:

The blended capitation payment should be based on member-level historic experience with appropriate risk adjustments to ensure appropriate plan-level funding for the population served by the demonstration.

When calculating Medicaid utilization and, therefore, savings targets, Oregon should include increased costs associated with historic limited collection of cost share amounts.

Savings assumptions should be based on aggregate Medicare and Medicaid utilization and should be phased in over the course of the three-year contract to allow for appropriate recognition of savings impacts over time. As noted in the demonstration proposal, this will be particularly important given Oregon's mature managed care delivery system.

Medicare funding should be established in such a way as to ensure adequate funding and appropriate savings for program sustainability.

Medicare funding should be structured in such a way as to minimize underfunding as compared to Medicare Advantage.

Supplemental benefits that are appropriately aligned to the needs of MMEs, such as dental and vision benefits, should be allowed and funded to encourage appropriate competitive positioning against Medicare Advantage products.

In addition, quality withholds should be based upon appropriate criteria to ensure alignment of incentives and should be sensitive to shifts in membership absent extended facilitated enrollment timelines. For year one of the demonstration, we believe that financial incentive structures and quality standards and performance targets should largely be focused on administrative processes and access to services to appropriately account for the ramp up of membership/enrollment under the three-year demonstration.

Quality Measures

Establishing quality criteria that supports program success and alignment with the population to be served in the integrated demonstration will positively position the program for broader adoption and success. Given the proposed carve out of Medicaid LTC services, the development of appropriate quality and outcome measures related to shared accountability with the LTC system is critical to ensure the proposed model meets the State's policy and program goals. We support the State's proposed approach that performance metrics and financial accountability for year one of the demonstration be focused on process measures while work is underway to finalize appropriate utilization and cost metrics. Subsequent years should phase in member quality impact criteria, but should be tempered based upon facilitated enrollment timeframes.

In addition, we believe member quality criteria should use appropriate STAR criteria and include additional metrics to ensure measurements of quality such as person-centeredness, community placement and repatriation, and comprehensive alignment of care planning for clinical, behavioral, social, and functional needs.

In closing, UnitedHealthcare Community & State appreciates the opportunity to comment on this important demonstration proposal. We look forward to continued participation in the stakeholder process and partnering with OHA, CMS, local providers and consumers and other key stakeholders in the community to improve the experience for MMEs while systematically improving costs associated with managing their care.

Sincerely,

A handwritten signature in blue ink, appearing to read "Catherine K. Anderson".

Catherine K. Anderson, MPA
National Vice President, Complex Care Products
UnitedHealthcare Community & State

Rick Bennett, American Association of Retired Persons-Oregon – 4/3/12

Date: April 3, 2012

To: Oregon Health Authority

From: Rick Bennett, AARP Oregon

Re: Oregon Proposal

AARP is a national non-profit membership organization for persons age 50+ dedicated to enhancing quality of life for all as we age. We lead positive social change and deliver value to members through advocacy, service, and information and providing value and best practices through the marketplace.

In Oregon, we have over one-half million members; about half are under age 65.

AARP is an active supporter of initiatives to make health and health care more coordinated, integrated, and consumer- and outcome-oriented. We also support efforts to control health care costs through greater efficiency and systems that foster better care.

With that in mind, AARP Oregon is submitting comments regarding the Oregon Proposal: Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid (Proposal) that identify a small number of major issues of concern and articulates viable resolutions for each issue.

Major issues:

1. Network Adequacy and Health Care Provider Selection Criteria

While the Proposal emphasizes Oregon's extensive experience and reliance on evidence-based practices as a successful tool to attaining improved quality and outcomes, it fails to incorporate this approach in the selection of health care providers and facilities for networks and in the utilization of long-term care providers. The Proposal focuses on the capacity of the network to serve the dual population, but not on the quality of the providers within the network.

Proposed Modification

Care Coordination Organizations (CCOs) should be required to select only National Committee for Quality Assurance (NCQA) accredited providers. Oregon should develop minimum quality standards for network inclusion and retention for each type of health care provider and facility. These standards should be based on available objective quality information and updated as new data becomes available. Each CCO should be required to provide current and prospective enrollees with information on the objective quality standards and minimum standard selection criteria used in constructing its network and with comparative ratings of its network providers when such ratings are available.

In coordinating with long-term providers, CCOs should be required to provide consumers with objective quality data on Long Term Services & Supports (LTSS) providers and to encourage consumers to use highly rated LTSS providers. If placement with a low-rated LTSS provider is necessary, CCOs should be required to notify consumers when placement with a higher rated provider becomes available. Part of the coordination process should include periodic review of consumers already in the LTSS system to determine if higher quality placement options are possible. (Note: In keeping with HB 3650 (2011) and the exclusion of Medicaid LTSS, comments are related to LTSS providers and Medicare-covered services.)

2. Enrollment and Transitions

The Proposal provides scant detail on the enrollment and opt-out process. While the Proposal indicates that current managed care enrollment would be used in assigning individuals to a CCO, it does not address how assignments will be made for those not now in managed care. The Proposal does not clarify the circumstances under which enrollees would be able to continue with ongoing care and treatment being provided by health care providers outside of their CCO network.

Proposed Modification

The passive enrollment system should provide prospective enrollees with advance notice and a reasonable election period to select a CCO. Advance notice should include information on CCO options, details on provider networks, and objective quality and credential data on the CCO and their provider networks. This notice should also list the health care providers the prospective enrollee has used during the preceding 12 months and indicate whether each provider is part of each CCO's network. If any current and recent health care providers are not part of a CCO's network, the notice should state that the enrollee in that CCO will not be able to use that provider after a date certain. The notice should also state which CCO the prospective enrollee will be assigned to if they do not select an alternative CCO. The assigned CCO should be the CCO with the provider network that best matches the prospective enrollee's current and recent medical care providers. The notice should also state that enrollees might change CCOs or opt-out and delineate the transfer and opt-out procedures and process. CCOs should also be required to provide consumers with the option to continue any ongoing course of treatment and to develop systems to prevent any gaps in care and treatment. This is highly important for the duals population given the prevalence of multiple, chronic conditions.

3. Retention and Disenrollment

It is especially important in the first few years of this project to monitor consumer experience and satisfaction with this new system, but the Proposal lacks specific monitoring standards and practices.

Proposed Modification

Disenrollment is a clear indicator of consumer dissatisfaction that warrants robust oversight. The Oregon Health Authority (OHA) and Centers for Medicare & Medicaid Services (CMS) will want to guard against any CCO that might attempt to encourage disenrollment by consumers who are medically challenging and expensive to care for. The Authority or an independent entity should conduct exit interviews of those who disenroll and CCOs should be required to take corrective action when appropriate. Enhanced oversight and a system of prior authorization for potentially adverse changes in care would help identify incidences of network inadequacy, poor customer service, or "lemon dropping." The Authority should also develop incentives for CCOs with high retention rates and should consider disincentives or financial sanctions for those with low retention rates. Data on CCO retention rates should be supplied to prospective enrollees and current enrollees at renewal time.

The responsibility of the CCO and the health care professionals within its network should not end with disenrollment. They should be required to develop and implement a transition plan to ensure continuity of care.

4. Expected Outcomes —Quality

The Proposal provides a good system of retrospective monitoring for quality indicators, but does not include a system of targeted, proactive monitoring during the critical initial years of this program. The Proposal mentions the need for protections against underutilizations and inappropriate denials and for access to qualified advocates, but provides no details.

Proposed Modification

For this population and their often complex medical needs in the largely uncharted waters of a merged Medicare and Medicaid managed care system, the interests of consumers, CMS and the State warrant a prompt, proactive system of oversight. It will be advantageous for all to rapidly identify and address problem areas and to uncover promising, replicable practices that result in improved quality and contain costs.

Given the high rate of behavioral health conditions and mental impairments with this population and the inherent incentive to limit per enrollee expenditures of a capitated payment system, strong consumer protections are called for and will help ensure that the state and HHS receive good value for their dollars.

It would be appropriate to prospectively examine CCO-proposed changes in a plan of care that would result in significantly reduced benefits or lower CCO expenditures, and, when appropriate, to reject such changes if they are not in the best interests of the consumer. From this review, changes in care that maintain or improve patient care and outcomes and quality of life could be distinguished from those that have adverse impacts.

The dually eligible will also need ready access to assistance in advocacy. Accordingly, the proposal should include an adequately funded, independent system that provides no-cost advocacy services to ensure that enrollees receive access to the full range of benefits and rights afforded by both Medicare and Medicaid. Advocacy in both programs will be complicated by the significant differences, as well overlaps, in benefits and by disparate appeals processes, with differing coverage standards set by federal and state law, regulation and policy; different administrative and judicial forums, procedures and timetables, and different governing state and federal case law. Ensuring that benefits and rights are maintained and protected under both programs will require professional staff with sophisticated knowledge, legal expertise and experience.

Rick Bennett
Director of Government Relations
AARP Oregon
9200 Sunnybrook Blvd., Ste 410
Clackamas, OR 97015

AARP: The Power to Make it Better!



Bruce Goldberg, MD, Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Submitted electronically

April 4, 2012

Dear Dr. Goldberg,

On behalf of Oregon's 58 hospitals, I want to thank you for the opportunity to comment on the *State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid*. This proposal represents an exciting opportunity to improve patient care and care coordination for a high-need, high-cost population, potentially prompting delivery system changes that could benefit all Oregonians. Oregon hospitals are generally supportive of this proposal, but would like to offer a few suggestions for improvements.

Flexibility needed for dual eligible enrollment

One of our primary concerns about this program is that the Oregon Health Authority (OHA) Coordinated Care Organization timeline does not align well with the Centers for Medicare and Medicaid Services (CMS) timeline for inclusion of the dual eligible population. Entities that form Coordinated Care Organizations after 2012 could miss the opportunity to integrate the dual eligible population into their patient mix. We ask OHA to elevate this concern to CMS and seek flexibility for additional enrollment dates in 2013 and beyond.

Support for expansion of access to PACE

We support language in the proposal that would pursue flexibility and innovation in the areas of PACE and congregate housing services (pages 21-22). PACE programs have shown strong outcomes, and we are supportive of encouraging expansion and greater access to them. In this spirit, we encourage the state to seek CMS approval to open PACE eligibility to individuals younger than 55 years old. We know that a large subset of the dual eligible population is younger than 55, entering the program with significant physical or developmental disabilities. We believe these individuals could also benefit from access to PACE. In addition, we encourage the state to seek ways, with CMS approval, to work with partners to expand the PACE program for patients beyond Multnomah County.

Clarity needed regarding acute mental health care provisions

It is unclear which services within the mental health system will be the responsibility of a Coordinated Care Organization and which remain within the county/state system for the Medicaid population. This must be clarified, especially with regard to placements between hospital emergency departments, in-patient acute psychiatric facilities, community placements and the Oregon State Hospital. The time and staff work to find and make arrangements for transfer and placement is significant, and responsibility for these duties needs to be clarified.

In numerous places in the demonstration proposal and in Appendix F there are references to "acute care placements," "care settings" and "inpatient care." These references exclude "in-patient acute psychiatric facilities," or terms are not being used appropriately. The coordination that it takes to place clients leaving these facilities or coming into them is not mentioned. On page 13 under "Excluded Services" it says that "certain mental health services...will continue to be provided externally..." Then on page 20 this is contradicted by the wording at the end of the first paragraph.

Rate setting requires flexibility, clarity

Many dual eligible individuals, particularly those currently enrolled in the fee for service, are likely receiving few preventive services. Their rate of utilization in an integrated system is difficult to predict. For this reason, it would be wise to build into the system an opportunity for periodic rate adjustment.

We are concerned about vague rate setting and global budget language in this document. On page 25, under "Financial alignment model," the last sentence of the paragraph says "CCOs will be required to participate in the three-way contracts, contingent on OHA and CMS reaching mutually agreeable terms, after OHA consultation with Oregon's health plans." We are adamant that providers should know the details of those agreements prior to signing up for the three-way contracts.

Additional comments

- OAHHS applauds OHA's request to waive the three day prior hospital stay for the skilled nursing benefit. (Page 30)
- We asked that CCO members be fully educated about choices (including for PACE) rather than, or in addition to, using passive enrollment. (Page 19)
- We ask that providers using proven formularies within integrated delivery systems be given the option to keep using them, and not be forced to adopt the Medicare Part D preferred drug list. (Page. 12)
- We will look forward to additional clarity about how state-funded case worker roles may change, and about what they will be responsible for in light of the CCO's extensive provisions encouraging the use of non-traditional health care workers.

Thank you again for the opportunity to comment about this important proposal. We ask that you give serious consideration to our proposed improvements. Do not hesitate to contact me if you want to discuss the content of this letter, or if you have questions.

Sincerely,



Robin J. Moody
OAHHS Director of Public Policy

Jan Faiks, VP – Pharmaceutical Research & Manufacturers of America (Sent by Leslie Wood) – 4/4/12

Jan Faiks
Vice President Government
Affairs and Law



April 4, 2012

Bruce Goldberg, M.D., Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

VIA ELECTRONIC SUBMISSION

Re: State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

Dear Dr. Goldberg:

The Pharmaceutical Research and Manufacturers of America (“PhRMA”) appreciates the opportunity to submit comments regarding the Oregon Demonstration to Integrate Care for Medicare-Medicaid Enrollees.¹ PhRMA is a voluntary nonprofit organization representing the country’s leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports efforts to improve care coordination for dual eligible beneficiaries and to provide more person-centered care by developing a better integrated and less fragmented system of care for this population. However, we oppose the approach proposed by Oregon for providing pharmacy coverage in this demonstration. We believe that if the draft proposal is implemented as described it will seriously disrupt beneficiaries’ prescription drug coverage and undermine the success of the Medicare Part D program (“Part D”).

Specifically, Oregon’s proposal that pharmacy coverage be uniform across plans and determined by the State in a unilateral way eliminates crucial Part D benefits and protections and would reduce beneficiary access to medicines. Such a proposal is wholly inconsistent with the CMS guidance, violates the statutory prohibition on a direct government role in determining the formulary, and is inconsistent with providing beneficiaries choice and the competitive approach that has made Part D successful.

¹ State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid: Draft for Public Comment. (March 5, 2012), (hereinafter “Oregon Proposal”) available at: <https://cco.health.oregon.gov/DraftDocuments/Documents/Duals%20Demonstration%20Proposal%20-%20Final%20Public%20Comment%20Draft%203-2-12.pdf>

Pharmaceutical Research and Manufacturers of America

950 F Street, NW, Suite 300, Washington, DC 20004 • Tel: 202-835-3466 • FAX: 202-715-6993 • E-Mail: jfaiks@phrma.org

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Additionally, it could result in insufficient payment to demonstration plans for pharmacy benefits.

As a consequence of our grave concerns about the proposed approach, we strongly recommend that Oregon revise its proposal as follows:

- Eliminate the proposal that demonstration plans be required to use the state-wide preferred drug list (PDL), as this approach is inconsistent with the Social Security Act, CMS guidance, and with the principles that underlie the success of Part D and would extend beyond CMS authority;
- Either require all participating plans to fully comply with all Medicare Part D requirements, as laid out in the CMS guidance, or exclude pharmacy coverage from the demonstration in order to assure that Oregon residents continue to have the full range of benefits and protections currently available through Part D; and
- Limit enrollment in the demonstration consistent with the experimental nature of this initiative, to avoid destabilizing Part D for non-dual beneficiaries and risking significant disruptions of care for beneficiaries in Oregon.

In the absence of such revisions to Oregon's proposal, we cannot support the demonstration going forward and will recommend to CMS that the proposal be denied.

The Imposition of a State-wide Formulary Is Contrary to Law and Denies Patients the Protections of Part D

CMS has indicated multiple times that all plans participating in the demonstration should meet all Part D requirements regarding formularies. It stated this first in its *Letter to Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in Interested States* issued to plans on January 25, 2012 (the "January CMS Duals Guidance"). CMS reiterated in its *Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013* issued to plans on March 29, 2012 (the "March CMS Duals Guidance") that sponsoring organizations must seek CMS approval of a formulary consistent with Part D requirements....²

Nevertheless, Oregon proposes an approach clearly incompatible with the principles outlined by CMS. According to its proposal, "Oregon plans to require Coordinated Care Organizations ("CCOs") to use the statewide evidence-based preferred drug list (PDL) as their Part D formulary for this demonstration starting in 2014,"³ and notes that it will seek a waiver of the Part D formulary requirements.⁴ The proposal's statement that it will seek CMS approval of the PDL as meeting Part D requirements does not change the fact that the unilateral imposition of a uniform formulary determined by the state is at odds with the fundamental underpinnings of the Medicare Part D program, which is based on robust market competition between health plans in

² March CMS Duals Guidance at 1.

³ Oregon Proposal at 12.

⁴ Id. at 30.

order to balance broad access with cost savings. Oregon's proposed approach both eliminates all competition between health plans for pharmacy coverage – undermining the very aspects of Part D which have helped to assure its success – and violates the explicit statutory prohibition on government establishment of the Part D formulary.

The Oregon Statewide PDL applies to the state's Medicaid prescription drug program, which serves a wholly different patient population than dual eligibles. In marked contrast to the Medicaid PDL, Part D requirements were developed taking the needs of duals and the entire Medicare population into account. Indeed, at the time of Part D's enactment, beneficiary advocates campaigned to let dual eligibles receive drug benefits in Part D rather than Medicaid.⁵ Oregon's proposal, in effect, substitutes Medicaid drug coverage for Medicare drug coverage. This substitution of Medicaid benefits for Medicare benefits is unrelated to the purpose of the demonstration, which is to better integrate Medicare and Medicaid benefits. Worse, this approach would result in reduced benefits and protections for dual eligible beneficiaries and create a dangerous precedent for differentiating among Medicare beneficiaries for coverage purposes based on an individual's income or disability status.

While there are significant opportunities to improve care coordination for the dual eligible population, Oregon presents no evidence that eliminating a health plan's ability to set its own formulary will improve the plans' ability to manage care patterns for enrollees. Furthermore, we note that the Oregon Medicaid PDL differs in important ways from formularies typically used in Part D, which typically make more medicines available without prior authorization. As a result, use of the Medicaid PDL would likely require many more Oregon beneficiaries and their providers to go through a prior authorization process to continue on their current medications. For example, PhRMA compared Oregon's PDL to the Part D formularies of the two Part D plans with the highest dual eligible enrollment in Oregon for specific drug classes.⁶ For common chronic conditions, Oregon's PDL includes 59 drugs as "preferred" with no restrictions on access; whereas, the two Part D plans cover 77 and 82 drugs with no restrictions.

Dual eligible beneficiaries have been well-served by Medicare Part D and should have access to the same breadth of coverage available to higher income Medicare beneficiaries. Shifting pharmacy coverage for dual eligibles back to a state-administered Medicaid program runs the unacceptable risk of establishing a different standard of care for dual eligibles. Oregon must revise its proposed approach to comply with the principles in the CMS guidance and not attempt to impose the statewide Medicaid PDL on participating plans in these demonstrations.

⁵ See "The Six Million Medicare Beneficiaries Excluded From Prescription Drug Benefits Under the Senate Bill are Disproportionately Minority," Leighton Ku and Matthew Broaddus, Center on Budget and Policy Priorities, September 9, 2003; and AARP News Release, "Letter by AARP CEO Bill Novelli to Congress Concerning Prescription Drug Benefit in Medicare," July 14, 2003.

⁶ The two plans were CVS Caremark Value (PDP) and CareOregon Advantage Plus (HMO-POS SNP). Drug classes examined were: Antidiabetic Agents, Antiglycemic Agents, Anticoagulants, Anti-inflammatories, Inhaled Corticosteroids, Bronchodilators, Phosphodiesterase Inhibitors (Xanthines), Antileukotrienes, Bronchodilators, and Sympathomimetics. These classes were selected based because they are used to treat the three most prevalent chronic conditions among dual eligible individuals: diabetes, pulmonary and stroke (<http://www.kff.org/medicaid/upload/8081.pdf>).

Oregon's Approach to Prescription Drug Coverage Also Undermines Part D's Success in Controlling Spending

Since 2006, the Medicare Part D prescription drug program has effectively provided access to robust prescription drug coverage for Medicare beneficiaries, with high levels of beneficiary satisfaction, and at far lower costs than initially projected.⁷ It has also resulted in substantial savings for other parts of the Medicare program; a recent study published by the Journal of the American Medical Association ("JAMA") found annual savings of \$1,200 on other, non-drug Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.⁸

Yet Oregon's approach, which would impose a single uniform formulary statewide, may put these savings at risk. A statewide formulary will undermine the ability of CCOs to negotiate with manufacturers and obtain the lowest possible prices for prescription drugs. By dictating which drugs a plan may or may not cover, the state would effectively tie the hands of the CCOs to negotiate lower prices and formulary placement for the drugs they prefer. GAO, the Medicare Trustees and the HHS Office of Inspector General have all reported on the importance of plan negotiations in determining prescription drug prices (including rebates negotiated directly with manufacturers), and the impact of such negotiations in lowering plan premiums for beneficiaries.⁹

As a result, Oregon's approach would be likely to increase costs for plans. Further, if the capitated payment to plans for pharmacy coverage in the Oregon demonstration were based on the Part D national benchmark, as proposed by CMS, payment to plans may be too low and may impede their ability to provide full coverage. This result would occur because the national average Part D payment is based on the experience of plans that are able to negotiate with manufacturers directly, and directly apply manufacturer rebates to lower their premium bids. Thus, if the State proceeds as proposed, the plans may be underpaid, which could reduce access to medicines and reduce the number of plans that participate.

⁷ See e.g., CBO, "Updated budget Projections: Fiscal Years 2012 to 2022" March 2012. P. 9. See also, CMS Press Release, "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in Donut Hole." August 4, 2011.

⁸ J.M. McWilliams, et al., Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage, Journal of the American Medical Association (July 27, 2011).

⁹ Government Accountability Office. "Overview of Approaches to Control Prescription Drug Spending in Federal Programs." Statement of John E. Dicken Director, Health Care, before the Subcommittee on Federal Workforce, Postal Service, and the District of Columbia, Committee on Oversight and Government Reform, House of Representatives, June 24, 2009; The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." August 5, 2010; Department of Health and Human Services Office of the Inspector General. "Concerns with Rebates in the Medicare Part D Program." March 2011.

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Moreover, it is not clear how rebates would be negotiated by plans or imposed by the State for drugs dispensed as part of the demonstration as Oregon may not impose a rebate on the drugs dispensed to dual eligible beneficiaries. Outpatient prescription drugs are a Medicare-covered benefit for dual eligible beneficiaries and may not be paid for by Medicaid.¹⁰ The demonstration may not change, or waive, that prohibition.

Additionally, it is critical that Medicare beneficiaries in Oregon continue to receive pharmacy benefits through Part D plans so that negotiated rebates and discounts between drug manufacturers and plans are exempted from the Best Price provisions of the Medicaid drug rebate statute.¹¹ Under federal law, the rebates between manufacturers and Part D plans and MA-PD plans are exempted from the best price calculation and the policy of that exemption should be continued.¹²

Oregon's Approach to Prescription Drug Coverage Also Undermines Part D's Success for Those Not Even in the Demonstration

Beyond the issue of imposing the Medicaid formulary, the scale of the proposed Oregon initiative raises significant risks to continuity of care and to the stability of Part D coverage available not only to the dual eligibles, but also to beneficiaries who remain enrolled in traditional fee-for-service Medicare. Oregon has proposed removing as many as 68,000 duals from their current Medicare coverage. Such large-scale changes in coverage create the potential for significant disruptions in patient care and could significantly alter the market dynamics in Part D. Furthermore, enrollment of the overwhelming majority of dual eligibles in the state is not consistent with the experimental nature of such a demonstration.

If all of Oregon's dual eligibles are removed from their current Part D coverage and from the competitive bidding system, PhRMA is concerned that the Part D program may be fundamentally altered for other non-dual eligible Medicare beneficiaries in the State. It is critical that the demonstrations do not undermine and destabilize prescription drug coverage that is working for non-dual beneficiaries. Medicare beneficiaries in Oregon must continue to have access to robust and affordable prescription drug benefits through Part D. Oregon should revise its proposal to limit enrollment to a small share of dual eligibles in the state. This is critical to assure continuity of care, assure that beneficiaries have access to the full range of Part D benefits and its protections, and to allow the demonstration to operate as truly a demonstration that can provide meaningful insight into the best ways to integrate care for dual eligibles.

* * * * *

We thank you for your consideration of these comments on the Oregon State Demonstration to Integrate Care for Medicare-Medicaid Enrollees. We urge Oregon to revise its proposal in a

¹⁰ Social Security Act §1935(d).

¹¹ Social Security Act, Section 1927 (c)(1)(C)(i)(VI).

¹² See, e.g., H. Rep. 107-539, page 110; H.Rep 108-178 (11), pp. 145-146; H.R. Rep 108-178(ii), pp. 154-155.

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manner that enhances coordinated care without either unnecessarily disrupting care for Oregon's most vulnerable beneficiaries, or compromising Medicare prescription drug benefits for all Medicare beneficiaries in the State. We look forward to the opportunity to continue working with Oregon in its development of this demonstration. Please contact me if you have any questions regarding these comments. Thank you again for your attention to these important issues.

Respectfully submitted,



Jan Faiks
Vice President, Government Affairs and Law

O R E G O N L A W C E N T E R

KAREN BERKOWITZ

April 4, 2012

To: Oregon Health Authority

Re: Comments on Proposal to the Centers for Medicare and Medicaid Services – State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

Thank you for allowing us the opportunity to comment on the Medicare/Medicaid integration proposal. I am submitting these comments on behalf of the Administrative Law Taskforce, a group of Oregon advocates from the Legal Aid community who routinely represent low income individuals in public benefits cases, including Medicare and Medicaid.

Benefit Design and accountability for providing services: We applaud the proposal to create optional benefits that are unique to the individual and would allow coverage of equipment and supplies that are likely to maintain health and functionality. It will be important to include a specific right to receive these benefits in rules that may be relied on by clients. In addition, clients must be informed about these, and other benefits listed on page 13 of the proposal, so that they can request the benefits and services. We suggest that you require specific reporting to measure whether the CCOs are providing these new benefits and services, and to evaluate their success. The proposal should clarify that the equipment and supplies mentioned on page 13 are something more than just the traditional durable medical equipment.

The proposal will require CCOs to coordinate all services, including services that are not part of the CCO, such as long term care. Clients must be informed of this obligation and must be given the right, through rules, to receive coordinated care outside of the CCO.

We have significant concerns about the use of community health workers and other paraprofessional staff as a way of cutting costs, rather than as a way to enhance services. We are already hearing that there are proposals to reduce costs by eliminating community health nurses, and substituting less expensive community health workers. This should not be a cost containment issue. Appropriate expertise is needed up and down the system. Peer counselors, for example, are a good idea, but can't take the place of a mental health counselor. We had hoped and expected that health care reform in Oregon would result in enhanced services, using community health care workers and other paraprofessionals, rather than using health care reform to eliminate professional health care workers.

How much control will a client have over this coordinated team approach? Clients should be assured that they will be able to continue to get second opinions, and choose to change members of the care team.

We have concerns about providing adequate and appropriate services to clients with serious mental health and chemical dependency conditions. Under our current system, these clients have been disenrolled from managed care, and providers have refused to treat them. We have seen a pattern of violations of the Americans With Disabilities Act. The proposal should address how this will change under the CCO system of care. All CCOs should be required to have a plan for providing care to these clients, including education of providers and staff, and monitoring the effectiveness of the plan. The education must include ADA training for all CCOs and providers.

Long term care coordination: In order to have effective coordination of long term care and physical and mental health care, the current model needs to be changed to have joint decision making, including eligibility decision making, between DHS and the medical providers.

There are inconsistencies between eligibility for Medicare nursing care benefits and Medicaid long term care that could result in clients having to choose care in a more institutional setting to access Medicare benefits, upon discharge from a hospital stay, rather than waiting for an eligibility determination for Medicaid that would allow payment for care in the community. Coordination of long term care with CCOs must include a mechanism for a fast Medicaid long term care eligibility determination for individuals who are about to be discharged from the hospital so that they can receive services in the community rather than in a nursing facility.

We have concerns about delivering services in congregate settings. While this can be cost effective, it must be done in a way that will not create a conflict of interest. The entity providing the services should not also be the “landlord”. We have seen cases where mental health providers who also provide housing have evicted clients who have decompensated, rather than providing enhanced treatment to keep the client housed and stable.

LTC and CCO coordination should involve meaningful client input to measure how successful coordination is from a client perspective. We believe that there should be a stakeholder group, including clients, to address LTC and CCO coordination issues as they arise.

The proposal should include a list of the required elements for the memorandum of understanding between CCOs and LTC partners.

Beneficiary protections: Clients should be able to make an informed choice about receiving services through a CCO. We believe that an opt in system would be preferable to the opt out system. Clients should have the greatest freedom of choice possible.

Regardless of which system is used in Oregon, we believe the proposal must include client education about CCOs so that clients may make an informed decision about whether to opt out or be served by a CCO. Clients should be guaranteed continuity of care during this transition.

Clients should be permitted to go out of network for continuity of care, or if access to specialized care is limited or not available within a reasonable time. These clients have unique needs and must have access to providers who are best able to serve them, even if it means going outside of the CCO for appropriate services.

It is unclear whether the opt out provision applies to Medicare services only, or to both Medicare and Medicaid. Clients should be able to opt out of CCOs for both benefits.

The proposal does not provide sufficient detail about the grievance and appeal process. We believe the process should be uniform and simple to use. Where Medicare and Medicaid procedures differ, the more client-friendly procedures should be used.

- There should be one notice for both programs.
- We suggest adopting the longer Medicare timeframes for appeals (60 days) and the shorter Oregon timeframes for making decisions on coverage.
- We oppose using the IRE, which is an extra step that Medicaid clients do not currently use, and which prolongs the process.
- Oregon should only require the client to file one appeal to begin the process, and there should only be one internal appeal before external review. If the decision is not fully favorable to the client, the appeal should process automatically to the next step, external review at a state contested case hearing, without the need to file an additional document. This is similar to the IRE process, where the appeal is automatic.
- There should be a process for expedited review.
- There should be a right to continuing benefits through the contested case hearing stage.

The proposal does not address the grievance procedure, which is also very different for Medicare and Medicaid. We support the use of the Medicare grievance procedure, which has some important client protections not found in the current Oregon procedure. For example, the Medicare grievance procedure places the burden on the entity receiving the grievance to determine whether it is a grievance, quality of care complaint, or appeal, and treat it appropriately. This avoids placing the potential harm arising from procedural errors on the client. The Medicare process also has a Quality Improvement Organization review of quality of care complaints, which is a benefit not found in the Medicaid program. In addition, the Medicare program requires annual notice of the grievance procedure, and also allows a client to request grievance data from a plan. The stronger protections are important for clients, particularly as Oregon transitions to a new system for delivery of health care.

Infrastructure and Implementation: We have some concerns about DHS' ability to implement and coordinate activities related to LTC. With the current DHS budget pressures and staffing issues, we question whether there is a sufficient infrastructure to make this proposal successful. There should be a significant investment in the infrastructure to make the implementation of this proposal successful.

Need for waivers: We oppose any "flexibility" that would involve relaxing network adequacy requirements.

Thank you again for this opportunity to comment.

Very truly yours,

Karen A. Berkowitz
Attorney at Law



5/15/2012

TO: Oregon Health Authority
FR: Kathleen Cody, Executive Director, Alzheimer's Association – Oregon Chapter
RE: Comments on Medicare/Medicaid alignment proposal to CMS

Thank you for the opportunity to provide feedback on the proposal to CMS to integrate care for the dual-eligible population in Oregon. As you know, thousands of the people who are dually-eligible for Medicaid and Medicare are people living with Alzheimer's disease or other forms of dementia. This population also needs long term care (LTC) at a higher rate than many other "duals". The Alzheimer's Association Oregon Chapter advocates on behalf of all Oregonians living with dementia and their families, therefore how service is provided to them is of concern to us.

The goals of this proposal meet needs we have also identified. Service delivery for people with dementia is fragmented, confusing, and expensive. During seven town hall meetings we held last year in Oregon, we heard these complaints many times, particularly from the family members of people who are dual-eligible. We fully support the three key policy objectives of this proposal.

Our organization reviewed the proposal to CMS through our lens as an advocate for people with dementia. We noted several elements that we feel are important to our population.

- We feel it is critically important to ensure there is a sufficient provider network. The proposal explicitly and effectively addresses that issue.
- Even though we'd prefer an opt-in system, people can opt out any time and they have something to opt out to.
- We want enrollees to have a substantial benefit package. While that can be a judgment call as to what "substantial" entails, it appears to us that this is acceptable to us.
- It is absolutely clear in the proposal that "person-centered, evidence-based" care will be the basis for the delivery of services.
- There has been a great amount of thought given to meaningful and uniform quality measures and evaluation. We will be interested to see how this develops, especially as it relates to enrollees with dementia, as their capacity to provide feedback is different from people who do not have dementia.
- Family members are to be included as integral to the care of the enrollees. This is particularly important to the population we serve, as family members are critical to the success of any health outcomes for people with dementia.

While we are encouraged by how many issues are addressed in this proposal, there are some issues consider important, but are not made clear in the draft.

- How will communication be handled with enrollees? People living with dementia need to be communicated with differently than other people in the plan. Family members or other guardians will need to be included in the process for all communication.
- How will beneficiaries be informed about these changes? It was not clear in the proposal how the thousands of dual-eligible Oregonians will learn about the move to CCO's and what it means to them.
- How frequently will enrollees receive a comprehensive, holistic assessment of needs, and will it include screening for cognitive impairment? We encourage you to be explicit about the need for cognitive impairment screening as part of any assessment. The earlier dementia is identified and diagnosed, the more effective symptom treatments are, the more useful caregiver training will be, and families will have an easier time addressing legal issues.
- It was not clear in the proposal what consumer protections will exist in the CCO model. How are complaints handled? What is the appeals process? How will enrollees know about these processes?
- While there was a great deal of thought that went into how standards will be created and analyzed, it was unclear what the ramifications would be for failing to meet the standards.

Naturally, one key area to us is coordination between the CCO's and the LTC system. Our inclination is to want to see LTC integrated with the health care system, but this proposal has put a lot of thought into how to coordinate effectively and efficiently between the two systems. We will also be interested to see how coordinating between the CCO's and LTC works compared to the PACE program, as that is a pilot of a fully integrated system.

Another element of the proposal we will follow is how well family members are involved in care delivery for people with cognitive impairment. There is mention in the proposal of involving family members, but that goes to another level with people with dementia. A person with Alzheimer's cannot remember doctor's instructions or when their appointments are.

Overall, we are encouraged by this proposal as a way to improve the delivery of needed services to dually-eligible Oregonians with dementia, and to improve health outcomes for them while reducing costs. We ask that you consider our comments regarding issues we deem important but the plan was unclear about how they would be addressed. If you have questions about our comments, feel welcome to contact our Public Policy Director, Jon Bartholomew.

We intend to be a partner with OHA moving forward in ensuring that Oregonians with dementia and are dually-eligible have the care and support they require.

Michael Becker, Providence Health (Sent by Kristen Downey) - 4/13/12

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Comments on draft for public comment
State of Oregon, Oregon Health Authority
State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid

From: Michael Becker, Director of Government Affairs, Providence Health & Services – Oregon
Date: April 11, 2012

Providence Health & Services is committed to the success of Oregon's health care transformation and the implementation of coordinated care organizations to facilitate change. We commend the Oregon Health Authority for developing a structure able to recognize and meet the unique needs of Oregon's dual eligible population.

Providence has emphasized the need for flexibility for the Program of All-Inclusive Care for the Elderly and for Housing with Services to allow for collaboration with coordinated care organizations and opportunities to develop innovative and fully integrated care. This proposal meets those needs by including a flexible model for PACE and a "Pathway to PACE" program (page 21), which creates a foundation to further develop PACE for broader populations and to expand the program in other regions of the state. We'd like to acknowledge the great support our PACE program has received from the State of Oregon through the Aging and Persons with Disabilities Department.

As an organization currently providing integrated care to the dually eligible populations in Oregon, we have carefully reviewed the demonstration proposal and have a few specific observations:

Overall timing of waiver

We submitted comments on April 5 supporting a 2014 launch for the demonstration. We believe a later start date would not only benefit CCO applicants, but also the vulnerable dual eligible population in that more definitive information will be available. This allows more CCOs to be ready to serve Oregonians who are dually eligible with stronger, well planned programs.

Benefit design and accountability for providing services (page 12)

We were concerned about the statement that, in relation to drug coverage, "Oregon plans to require CCOs to use the statewide evidence-based preferred drug list as their Part D formulary for this demonstration starting in 2014." However, we understand that this language is to be deleted, which we support. We would have commented that this type of significant policy decision should only be made after a full opportunity for feedback by those who would be affected. Providence has a proven formulary that is integrated into our patient care and is part of our success in holding down costs. If this every is considered in the future, providers using proven formularies within integrated delivery systems should be given the option to keep using them.

The benefit design section states that, "CCOs will be expected to provide health promotion and preventive services such as including smoking cessation programs, weight watchers® (or similar), and lactation services." We would prefer to see a term used such as "weight management program" rather than the name of a particular provider. This would ensure full flexibility for the CCO to determine the best treatment plan for their member.

Other elements of delivery system –service area and enrollment (page 19)

This section states that, “OHA proposes to enroll beneficiaries in the demonstration using passive enrollment with an option to opt-out.” We recognize that CMS requirements for beneficiary notices will be used but this method may not fully address the scope of member concerns. Providence would prefer a transition that fully informs members and their families about available choices, allowing them to be active participants in their health care choices.

Counseling and referral to PACE program (related to pages 19 and 21)

Also on the subject of educating members and their families, based on our lengthy experience with the needs of the frail elderly, we recommend that when dual eligible members reach the point of needing long-term services and support, they be offered information through “options” or “choice” counseling that includes information about PACE. To ensure that CCOs are aware of and educated about this option for appropriate referrals, it could be addressed in the long-term care MOUs. We submitted similar comments on April 6 in relation to the long-term care/CCO memorandum of understanding.

Thank you for the opportunity to provide this feedback and we look forward to an ongoing partnership with the Oregon Health Authority as we continue transformation efforts.



NorthWest Senior & Disability Services

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To: Oregon Health Policy Board
From: NWSDS Senior Advisory Council and
Disability Services Advisory Council
Date: April 13, 2012

Re: Proposal to the Centers for Medicare and Medicaid Services
State Demonstration to Integrate Care for Individuals Dually Eligible for
Medicare and Medicaid

The two volunteer advisory councils of NorthWest Senior and Disability Services would like to present comments and questions addressing certain representations made in the proposal to CMS:

- A chart, on page 5, indicates an increase to the average monthly caseload of 9,000 enrollees, between 2010 and 2013. We could not find an explanation for the cause of this 15% increase, and feel that an explanation for the increase would help clarify the proposal.
- We could not find an explanation for how future anticipated savings will be used. What will become of these savings?
- There is no direction as to what will happen if there is more than one PCPCH in the same area. Will enrollees have a choice? If so, how will that be offered?
- Some Oregon enrollees access medical services in other states abutting Oregon's borders. Does the proposal make provisions for this? We could find no reference in the proposal regarding this issue.
- On page 13 is a list of flexible alternative services that the CCOs can offer. We can find nothing specific about accommodating accessibility and safety concerns, e.g., handrails in bathrooms, ramps to get indoors, retrofitting for wheelchairs.

- Throughout the proposal, numerous references are made to LTC. Since Oregon has two LTC systems - one medical, and one home and community-based care - it is difficult at times to know which LTC system is being discussed. We recommend that the two systems be defined and differentiated early in the proposal, using something such as Medical LTC for medical, and Oregon's LTC system for the home and community-based care as it has been referred to since it was created.
- Medicare/CMS language for the level of care issue is "skilled nursing facility" (not custodial or LTC). Should the definition in the glossary include/use Medicare's definitions?
- On page 53 there are directions for AAA/APD to refer a complaint about a CCO on to the CCOs, but there are no directions for CCOs to refer complaints about the AAA/APD to the AAA/APD offices. This would make better lines of communications between the two agencies.
- There is nothing said about CCOs taking all prospective enrollees in their area. This could be a means of avoiding "cherry picking."
- Under congregate housing, there is no indication if an enrollee will be able to choose to live in the congregate housing. The Principle of Choice is stated elsewhere in the proposal. Will it follow through here? What will happen if an enrollee chooses to live elsewhere?
- The heading on Appendix G the initials "LTC" are used without indicating which LTC system is being defined.
- In Appendix F: Global Budget, page 46, the term "**clients**" is used throughout the chart. This is a concern, because part of the Triple Aim is to get enrollees to take responsibility for their own care. We understood that, through public input, a concerted effort was to be made that people-first language would be used.
- There is no mention of what will be done if a CCO decides to withdraw from the program. What will happen to the enrollees? Who will work with them to get the medical care they need?

Thank you for allowing us this opportunity to comment.

Freddy Sennhauser, Mid Rogue Independent Physician Association - 4/13/12

Compared to other states, Oregon has high health outcomes with regard to care delivered to Medicare beneficiaries – despite receiving some of the nation’s lowest reimbursements. We strongly believe CMS’s demonstration proposal will fill a void in many states with low health outcomes and will be helpful to Oregon with respect to the dually eligibles currently on Fee-For-Service (FFS) Medicare.

The proposal, however, fails to recognize successful Medicare Advantage programs already operational in the State for more than seven years. Why fix what is not broken? Why not enhance these successful programs rather than degrade or eliminate them?

By statute, Medicare Advantage Special Needs Plans are already following NCQA approved Models of Care and thus, are practicing care coordination etc. at a very high level. Even before we implemented our Model of Care program, we had been practicing intensive care coordination between OHP and Medicare for more than seven years.

While we do not deny the need for comprehensive care coordination and integration (tearing down the delivery silos), we do not believe the overhaul necessitates the elimination of an already successful program, the Medicare Advantage program.

The initial discussion about funding the demonstration program fails to mention any risk of adjusting the caps – an omission we find troubling, to say the least. The demonstration program resembles the Medicare + Choice program, which failed because of the lack of risk adjusting. We are truly concerned that the proposed blended rate combined with the unleashing of the pent-up demand for health care of the dually eligibles currently in FFS Medicare will not fully pay for the care of this highly needy population.

Our recommendation is to integrate the Medicare Advantage Plans into the CCO concept alongside the demonstration program– as long as MA plans meet clearly defined quality and performance benchmarks. Since federal law allows Medicare beneficiaries to enroll in any program of their choice, the State ought not to limit that freedom by restricting membership in CCOs.

Please consider the following when finalizing your proposal:

Section B. Background

Page 7, Integration, and coordination: ...The current payment system provides little incentive for the prevention or disease management services that can improve health and stabilize chronic conditions, and thus lower costs. Furthermore, navigation of several different plans to receive services would be confusing and difficult for the individuals served.

Our response:

1. We disagree with these findings. From a Medicare Advantage (MA) plan’s perspective, the current payment system provides quality bonuses for

effectuating prevention and disease management services leading to positive results. Furthermore, the payment structure adjusts to better health outcomes by reducing the bid amount vs. the MA benchmark, resulting in savings for CMS. Because MA contractors are at risk, MA plans have an interest – financial as well as philosophical – in maximizing disease management, care coordination, and integration.

2. Over the past seven years, the members of our MCO and MA plan have not expressed feelings of confusion about the plan. The feedback we have received indicates the opposite is true. The integration of all three programs – OHP, Medicare, and Part D – is working just fine. We have received five stars, the highest performance rating, from Medicare with respect to Member Satisfaction.

Section C. Care Model Overview

Page 12, Benefit design: ...The initial integration of Medicare and Medicaid benefits will be a combination of the two current benefit structures, with Medicare Parts A, B & D...

Our response:

It should read: ...benefit structures, with Medicare Parts A, B & D for dually eligibles receiving Medicare under the Fee-For-Service structure and Medicare Parts A, B, C & D for dually eligibles receiving Medicare under the MA structure.

Page 19, Other elements of the delivery system:

OHA proposes to enroll beneficiaries in the demonstration using passive enrollment with an option to opt-out...Newly dually eligible individuals will be enrolled in CCOs with the option to opt-out.

Beneficiaries will continue to have the right to change their Medicare plan throughout the plan year... Individuals who opt-out of CCOs for Medicare will be considered to have also opted out of the CCO for their Medicaid coverage.

Our response:

This language is too harsh and disadvantages dually eligibles who currently enjoy many benefits FFS Medicare does not offer for free such as: Routine vision benefits (including eye ware), health club membership, additional transportation, alternative medicine benefits (chiropractic and acupuncture), OTC medication benefits, counseling support services, unlimited worldwide coverage, and weight management programs. Individuals who opt-out of receiving Medicare coverage through the demonstration program should be allowed to remain members of the CCO as long as the CCO or an affiliated organization retains the member in its MA program and as long as that MA plan is following and maintaining its NCQA approved Model of Care program.

New dually eligible beneficiaries ought to have the right to choose between the demonstration program, Medicare Advantage, and FFS Medicare and not be passively enrolled into the demonstration program without receiving adequate and objective counseling.

Section E. Financing and Payment

Page 26, Initially, the proposed demonstration envisions CCOs ... As mentioned above, OHA has some concerns about the ability to create a blended rate that works for Oregon.

Our response:

We appreciate and share your concerns. The blended rate needs to account for the loss of the quality bonuses and be fully risk adjusted.

Section H. Feasibility and Sustainability

As stated in the above referenced paragraph, the FFS population has had limited access to care and thus, any historical spending for this group is not reflecting a true picture and should not be used to determine future exposure and compensation. Consequently, neither CMS nor the State should rely upon historical spending for the FFS population to arrive at actuarially sound rates. Once this population is enrolled, the cost of providing for the latent demand will not result in savings but rather the opposite. The notion of prospective savings is not realistic. Ho... CMS proposes to base rates on historical spending – in both fee for service (FFS) Medicare and Medicare Advantage – and then to take savings out of the rate prospectively, ...

Our response:

However, would the State encourage and enable this population to enroll in MA plans, the current system of rate setting including risk adjusting of those rates would help ensure, with a high degree of certainty, equitable compensation to the plans and proper care coordination and integration.

Freddy Sennhauser
Mid Rogue Independent Physician Association
Mid Rogue Health Plan/CareSource



Oregon

John A. Kitzhaber, MD, Governor

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April 13, 2012

The Oregon Disabilities Commission appreciates the opportunity to provide public comment on the Oregon Health Authority's proposal to the Centers of Medicare and Medicaid Services (CMS) for Oregon's Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid.

As Oregon moves forward with Health Systems Transformation, the Commission has participated actively in the relationship between health and behavioral services provided under Coordinated Care Organizations (CCOs) and the Long Term Care (LTC) system that remains administered and funded through the Oregon Department of Human Services.

As Oregon works with CMS to create this demonstration project, the Commission realizes that this may be an opportunity for aligning what is often confusing and incompatible services and supports covered by Medicare and Medicaid. It may also offer the opportunity to cover services, equipment, or other needs not currently covered by either Medicare or Medicaid under current law.

The Commission also has many questions or concerns about this proposed Demonstration. These include the following:

- CCO Global Budget: With the carve out of LTC under HB 3650, the Commission is still unclear about whether the CCO,

or DHS, is covering important auxiliary Medicaid services for individuals with disabilities, such as transportation and employment supports.

- **CCO Governance:** The Commission believes that the needs of individuals with disabilities ought to be brought to the table, both in the implementation of CCO governance at the state level (administrative rules, reviews of CCO RFPs) and at the community level the CCO serves. As such, the Commission recommends that an individual with a disability serve on any stakeholder committee dealing with implementation of CCOs, and that an individual with a disability serve on the Community Advisory Committee of each CCO.
- **CCO Ombudsperson:** The Commission recommends that each CCO have an Ombudsperson to represent enrollee interests.
- **LTC-CCO Coordination:** The Commission understands the importance this proposal places on coordination between health services and long term services and supports. In this vein, how are potential partners (staff, providers, and enrollees) included in these coordination efforts?
- **Enrollment:** The proposal outlines passive enrollment into CCOs. This is a concern among some individuals with disabilities, many of whom have been with their primary care physician for a long time and may have complex medical needs that could be disrupted with a change in provider. What are the standards for opting out of the CCO, if the individual's provider is not covered by the CCO? Alternatively, is it possible for the CCO to allow the individual to continue seeing that physician?
- **LTC system referred to in the report:** The report does not clarify which LTC is referred to until much later in the report. The Commission recommends defining the LTC system at the outset of the report to include long stay nursing facility and home and community based services, rather than short-stay nursing facility care and post-acute care.

- Congregate Housing with Services: The Commission understands the benefits of this model, but is still concerned of unintended consequences for individuals with disabilities. Will this run counter to community integration? Will individuals still retain the right to see the provider of their choice? These are two crucial questions the Commission has for this model of service delivery.
- Financial incentives and penalties: The Commission is concerned about this aspect of shared accountability and how it can be enforced under the financial separation of CCOs and LTC under HB 3650.
- CCOs that disband: The Commission is concerned about CCOs that may go away, leaving individuals with Medicaid to return to the fee-for-service system. While they still have Medicaid eligibility, they may nevertheless struggle to find a provider willing to take Medicaid fee-for-service.

Finally, regarding coverage for services and supports: The Commission sees this Demonstration as an opportunity to cover services and supports that normally are not covered by Medicare and Medicaid – housing modifications, assistive devices, and other equipment, services and supports. As OHA works with CMS in finalizing the scope of this Demonstration, the Commission would welcome being a partner in proposing coverage that would not only further the independence of individuals with disabilities, but would also serve as a cost savings to the Medicaid program.

Please contact our staff coordinator, Max Brown, if you have any questions or need any other information. He can be reached at 503-945-6993, or by email at max.brown@state.or.us.

Sincerely,

Sherry Stock, Chair
Ruth McEwen, Vice Chair
Martha Simpson

Janet Campbell
Tina Treasure
Frank Armstrong
Ann Balzell
Marcie Ingledue
Robert Pope
Ted Wenk



April 13, 2012

The State Independent Living Council (SILC) has been very interested in, and actively involved in many aspects of Oregon's efforts to transform our Medicaid system and once again, welcomes this occasion to provide further input. We understand this opportunity is focused on Oregon Health Authority's proposal to the Centers of Medicare and Medicaid Services (CMS) for Oregon's Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid. Therefore, we must caution that our input on this single aspect of the much more expansive transformation underway, can't possibly be as comprehensive as we'd like because implementation of the new CCO based service delivery system itself, undergoes changes in scope, definition and expectations daily. The results from this fluidity must also be reviewed for its impact on those served under this project.

We applaud the stated intention of creating a system that simplifies what are often confusing and incompatible services and supports covered by Medicare and Medicaid. The encouraged creativity and flexibility to cover services, equipment, or other needs not currently covered by either Medicare or Medicaid under current law, is also welcomed. Local control, coordination and planning that operates under a person-centered model is exciting. The SILC does still have some questions, concerns and comments as follows:

- Oregon's exemplary record of utilizing home and community based services must not be eroded in the transformation process.
- Enrollees must be assured the ability to continue with their primary care physician, some which have partnered with them for a long time to treat and manage complex medical needs.
- Uniformity of access to quality services across the state must be guaranteed

- CCOs and its individual Providers, must comply fully with the Americans with Disabilities Act. This expectation must be clearly stated and enforced
- Enrollees must fully understand their enrollment and opt-out opportunities
- The work we've started on improving and defining integrated grievance and appeals processes must be completed and in place for enrollees in this demonstration when it begins. Closer monitoring of complaints and grievances will be crucial in this project to identify and correct any negative trends as well as promote quality improvement. Consistent tracking of such, issuance of understandable NOAs and more are vital.
- Enrollees must be fully educated on the availability of the stated "specialized services or other types of supports that would be uniquely beneficial" to health, improve the quality of care or ensure affordable delivery of services will be "individually determined by the CCO in the best interests of the member."
- Whether the CCOs or DHS will be responsible for covering important auxiliary Medicaid services for individuals with disabilities, such as transportation and employment supports, must be clarified.
- The needs of individuals with disabilities must be present at the table - at all levels. To ensure that, at a minimum: 1. Each CCO must establish a mandatory seat on their local Community Advisory Committee; 2. The individual holding that seat must be provided training and ongoing technical assistance to ensure the knowledge needed to be a representative of all types of disabilities; 3. They must be connected to the Oregon Disabilities Commission and OHA Ombuds Office.
- Each CCO must establish an Ombuds position and that position must have a formal relationship with the OHA Ombuds Office.
- Effective coordination between LTC-CCO must exist and inclusion of people with disabilities in the further development and monitoring of this relationships must be guaranteed
- Any development of "Congregate Housing with Services" must be done so with assurance that individuals with disabilities won't experience unintended consequences, such as segregation from the community, requirement to only receive care offered on-site, etc.

Once again, the SILC sees numerous opportunities in the proposed State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid, for increased quality, access, flexibility and creativity. In addition, we support the opportunity for these actions to result in cost savings to the Medicaid program. Please contact us for further support, technical assistance or other assistance.



Tina Treasure, Executive Director



Ann Balzell, SILC Chairperson

Jeanine Meyer-Rodriguez, Service Employees International Union 503 - 4/13/12

TO: Oregon Health Authority

FROM: Jeanine Meyer Rodriguez, Meghan Moyer, SEIU 503

RE: SEIU 503 Comments, Oregon State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid Services

Date: April 13, 2012

The following comments address concerns raised by the OHA proposed Rules and Guidance documents relating to: State Demonstration to Integrate Care for Individuals Dually Eligible for Medicare and Medicaid, the Strategic Framework for Long Term Care, and DRAFT Guidance documents related to the MOU requirement on shared accountability between CCO's and LTC Partners.

Areas of concern include: Clients' rights and choices, roles of LTC partners in care coordination with CCO's, and the metrics used to measure and incent behaviors in shared financial accountability between CCO's and LTC.

Clients' Rights and Choices

(LTC Strategic Framework 2-10-12 states; LTC placement decisions should balance: The preferences and goals of the person; the right of the person to live as independently as possible; in the least restrictive setting; and the cost of living arrangement.

- **Clarify that a client's choice about where to live and who comes into their home will not be superseded by the CCO/LTC shared savings incentive system.**
- LTC placement decisions should also include the adequacy of care and service related to a person's underlying health conditions.

Care Coordination

- **CCO's should be responsible for all care coordination directly with LTC providers to avoid duplication.**
- There is an expectation that the AAA/APD role of case manager can be transformed into one of care coordinator for persons receiving LTC services. This may shortchange the care coordination role by putting an agency in between LTC providers and the CCO. CCO's are already responsible for creating access to Non-Traditional Health workers and will need to coordinate those services with LTC services.

- AAA/APD provide case management services however, care coordination is a daily activity focused on providing the right care at the right time to maximize health and lower costs.
- **Clarify the role LTC providers will play on care teams** Homecare Providers are paid solely based on the assessment of ADL and IADL assistance and therefore, care coordination activities would need to be assessed for time spent and then paid for by the CCO. Additionally, the use of properly trained homecare workers for additional tasks beyond ADL and IADL assistance, such as wound care, medication assistance, administration of feeding tubes and condition monitoring, should be considered as potentially valuable new contributions to quality, cost-effective care in a multi-disciplinary team environment. Opportunities to contract with CCOs on a competitive basis to provide these services should be extended under Oregon's model.

Shared Financial Accountability

- **Shared savings should accrue to providers of long term care based on demonstrated value.** Providers who meet the goals and objectives of Oregon's model (improved health for populations, improved care for individuals and reduced cost to the system) should be able to bid for a contract with the CCO.
- Providers include: nursing facilities, assisted living facilities, residential care facilities, specialized living facilities, adult foster homes, and in-home services and supports provided by individual home care workers or in-home service agencies. Shared savings for individual care providers could be allocated to the Homecare Commission and distributed through the collective bargaining process.

**Health System Transformation and the Long Term Care System:
Partnering for success and savings.**

Meeting the ambitious goals of health system transformation in Oregon is a significant undertaking. Never before have the many providers within the acute health care system had a reason to collaborate and work cooperatively as they do now.

Coordinated Care Organization Implementation Proposal
Principles & Values from an Area Agency on Aging Perspective

As we look at how long term care will interface with the CCOs, O4AD has started with the development of the principles and values that we feel are most important in this partnership.

Person Centered: In order to meet the triple aim goals, it is critical to keep the total person and their needs at the center of any type of care plan. We have to meet them where they are – that is our starting point. The individual has to be involved and has to have choice within their options for care. They are the drivers of the plan.

While the individual client is the driver of the plan, it is the responsibility of the CCO and of the long-term care system to help educate the client in their respective areas. When we talk about choice, many think this means simply presenting all options for care. However this also means presenting a realistic look at the consequences of each option. Personal responsibility is necessary from the client and it is the goal of health system transformation to promote better health through prevention and early intervention. Empowering an individual to educate him or herself, to invest in the outcome of their own health care plans is good for the person but also good for providers. A client engaged in their care and health is more likely to weigh carefully the possibilities for care and have a better idea of how activities and choices outside of medical care will impact their health.

Supports that are person centered will impact the success of CCOs and long-term care partnerships. These supports include:

- Medical
- Social
- Housing
- Community
- Behavioral health
- Dental
- Family or other natural supports.

The social model and the difference from the medical model: Recognizing that the overarching principles of medical care and long-term care are very different will help with the formulation of care plans for dual and triple eligibles. The medical model functions to meet a goal of stopping an illness. It is about care when a person is sick and the best outcome is a return to health. The medical model works with tests and quantitative data in large part. It is, in general, episodic care.

Long-term care is based on a social model. It operates to work with a person's functional ability. Long-term care assumes the client has a chronic care issue. In long-term care, a removal of the illness or sickness is not the outcome as that is not possible. As individual ages, their physical self adjusts to increasing limitations. But, while many have searched for it, there is no way to reverse aging or the particular set of 'symptoms' it brings. This is a very important difference in medical care versus long-term care. Success or meeting goals cannot be measured in long term care by a return to health. Instead, long-term care is dealing with finding the best ways to age with health, with management of chronic conditions and with the highest level of quality of life. The end goals are significantly different.

In the social model of care that long-term care operates under, the total person is at the center of care. Their ongoing needs are the consideration in order to help them manage their conditions in the *long term*. Housing, transportation, income, access to healthy food, family and others relationship, employment all define a quality of life for the individual.

Flexible: In order to meet the goals of long-term care, operating under the social model, flexibility is key. Flexibility is not only key to allowing greater choice for the individual client, but it is also key to lowering costs of care overall. The flexible use of funds that can be used for the person centered care plan will impact the overall health outcomes for the individual. Entitlement programs are in general very rigid in their requirements for use. However, this rigidity does not allow room for modification or innovation in care. If there is a better way to provide care for the individual but it falls outside of what can be offered via the Medicaid system, even if it's at a lower overall cost, there is no choice but to go with the higher priced option. The individual client does not have the funds to pursue an alternative option outside of what Medicaid will provide thus it is a vicious cycle – you can see the care you could have but you can't access it so you will spend more Medicaid dollars overall. This approach does not make sense.

Flexibility is often viewed with skepticism. A call for flexibility is often considered a call to be able to spend more dollars for administration or other types of non-program costs. However, the principles of the CCO design require flexibility in order to meet the needs of the client and to coordinate care across systems. Long-term care would benefit from flexibility in order to better meet needs more efficiently.

The ability to try new things in long-term care is dependent on the flexibility. As has been suggested with CCOs, development of standards rather than detail can provide the ability of local regions and health systems to meet needs and think 'outside of the box' as they work to provide:

- Emphasis on primary prevention
- Building a seamless continuum of care
- Building community capacity
- Emphasis on disproportionate unmet, health related needs.

These principles apply to the needs of the long-term care system. A similar approach that is driven by goals rather than by detail could provide far greater benefits to the client, to the long-term care system and to the overall strategy of care for dual and triple eligibles.

Build on successes: When creating the system of CCOs, there is a key opportunity through coordination with the long-term care system to build on things that are already working. Long-term care in Oregon has been known as an innovative system that focuses on care in the home and the community that realizes greater savings than automatically placing a client in a more restricted level of care such as a nursing facility. Long-term care has continually brought savings to the state – to demonstrate this, simply multiply even a small percentage of the Medicaid long-term care Medicaid case load that is currently receiving care in their home by the cost of nursing facility care and you will quickly see the savings that are realized daily.

The long-term care system, however, has suffered from continual cutting to the very foundation that brings these savings to the state. As Oregon begins this investment in acute healthcare, it is important to not take the savings from long-term care for granted and continue to lose ground through constant cuts to programs, services and necessary administration. Rather, as is being requested by OHA to CMS, the opportunity to reinvest savings from long-term care back into long-term care should be considered as this system is being asked to not only coordinate with CCOs, but to also continue to realize budget savings and to increase those savings through this new level of coordination.

HB 5030 Budget Note to the Legislature – Department of Human Services

Recommendation for the Triple Eligibles

Alignment and Coordination: While the budget note report suggests that, “two separate systems will continue to produce misaligned incentives, cost-shifting between CCOs and the LTC system and poor outcomes for beneficiaries.” Experience at the Transfer Area Agency level, serving over 50% of the Medicaid long-term care caseload, shows that alignment and coordination are not only possible but also very productive.

Staff from each system, CCO and LTC can work together in concert for the benefit of the client in the following ways, which have been tested or demonstrated in Transfer Area Agency service areas:

- Location of a long-term care staff person in a medical/health home setting
- Long-term care staff working as a member of the overall health care (acute, mental health, etc) team to address issues in a coordinated way
- Access to data and client documentation by long-term care staff and by CCO staff – in order to truly understand the facets of care that are being provided and the gaps that are not being met
- CCO staff co-located with long-term care staff

- Non-service clients. Those individuals who are seeking care but do not qualify for entitlement services will still need staff to help them with their concerns. In order to bend the curve of health and long-term care costs, those individuals who are at most risk of premature or unnecessary entrance into the Oregon Health Plan or the Medicaid long-term care system need help to meet emerging needs. Programs such as Oregon Project Independence and Aging & Disability Resource Centers provide a blueprint for cost efficient and effective interventions to address those needs.

Mutual Accountability: The need for mutual accountability is opportunities to not only avoid inappropriate cost shifting but to establish the necessary communication to devise a new system of integrated care. Integrated service plans and interdisciplinary teams can provide not only client information but also shared support in the goal of better client health and care.

Mutual accountability is also mutual support. Mutual support and coordination will help alleviate the concerns around cost shifting due to communication.

Suggested areas for mutual accountability and support from the experiences of Transfer Area Agencies include:

- Education and training
- Health promotion activities
- Vetting of communication issues – and devising solutions
- Supporting long-term care providers in new ways – from both CCOs and LTC
- Vetting of long-term care provider and placement issues, level of medical need and risk of failure in living situations by the interdisciplinary team comprised of CCO and LTC staff
- Care planning that takes into account costs – and the efficient use of funds
- Support provided for long-term care providers or clients of a CCO
 - Telephone support line
 - Check list for ALF (Assisted Living Facility) triage
 - On-call Registered Nurse
 - Home visits from medical professional

In order to avoid cost shifting, there is also a need for more behavioral support for providers. The rise of mental health and behavioral issues in clients utilizing Medicaid, in long-term care or acute care, has a dramatic effect on the success of any care plan.

Taking treatment into the community is another strategy to avoid cost shifting. With methodology in place to provide payment to the provider for the visit, treatment in the community avoids unnecessary transport to an emergency room, hospital or urgent care office when perhaps a significantly lower level of intervention is necessary.

Specific Areas of Transfer Area Agency Expertise

Care Transitions: Currently, there are care transition pilots in place through various Transfer Area Agencies. To maximize on that experience, agreements need to be in place between CCOs and Area Agencies to address the provision of care transitions. The Transfer Area Agencies have the expertise in pilots, training and grants that have all been a part of

implementing care transitions. We are very aware of the cost issues and failures that can be a potential challenge to the overall success.

Recommendations for seniors and people with disabilities to retain their independence for as long as possible to delay or prevent their entrance into the Medicaid system.

The budget note report endorses the importance of the Aging & Disability Resource Centers (ADRCs) as a vital part of health reform success. However, it is important to remember that the current fully functioning ADRCs are funded through pilot project federal grants that are coming to a conclusion. The ADRC model is considered a best practice nationwide for bending the curve of people entering Medicaid funded care. In order for the successes of the ADRCs that are existing in Oregon to continue, funding will need to come from the Health System Transformation initiative. Unlike other states, Oregon currently does not invest any funds in the ADRCs.

There is the possibility of expanding the use of state general fund for Medicaid match to fund ADRC programs. This will only be possible through the continuation of ADRCs in the state.