

June 27, 2012

Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Sebelius:

We are organizations advocating for the interest of people who are dually eligible for Medicare and Medicaid (dual eligibles). Among the organizations represented are those from states currently pursuing a demonstration project to integrate care for this population. We have been working in our states and nationally to shape these projects so that they can meet the laudable goals they set out to achieve: better care, delivered more cost effectively.

Like you, we have a strong desire to see dual eligibles' access to medical care and long term services and supports improved. We also understand the pressures at both the state and federal levels to achieve Medicare and Medicaid savings, and like you, are actively seeking concrete alternatives to short-sighted and dangerous cuts in eligibility, benefits or provider reimbursement or to changing the very nature of the programs.

The duals demonstration projects are premised on the idea that savings could be achieved through improving care. And, we believe that this may indeed be the case. But, as states have rapidly rolled out their proposals, we have become increasingly concerned that claims of potential savings and/or the speed with which those savings can be achieved is being overstated. In particular, we have three closely related concerns: that savings targets are not yet transparent, that the assumptions on which projected savings are based may be either opaque or overly optimistic and that insufficient safeguards are in place to guard against the potential for either windfall profits or catastrophic losses, either one of which would undermine the goals of the demonstration, and cause harm to people with disabilities and seniors.¹

Most of the demonstration proposals are virtually silent on the issue of savings targets, yet we hear behind-the-scenes projections from stakeholders, for instance in Ohio, that they can achieve savings exceeding 4-7%. By contrast, the state of California has disseminated a complex and nearly indecipherable set of data about potential savings that appears, at best, overly optimistic. In most instances, the underlying evidence for claims of savings has not been made publicly available. Recent guidance from CMS about the methodology for determining rates under the capitated financing model states that savings targets will be selected for each year of the demonstration. We believe it is essential for states and CMS to provide the public with these targets, along with the underlying financial assumptions, prior to CMS approving the project.

¹ While there are many other issues that must be addressed in order to ensure that these demonstration projects truly meet the needs of consumers (including enrollment protocols, network adequacy, consumer empowerment and more) we are commenting specifically on the issue of financial incentives because it is so fundamental to the outcome of this effort.

Among the key data states and CMS must provide is information about current rates of preventable hospitalizations, institutionalizations, emergency room visits and medication usage rates. They must also provide data regarding the cost of the upfront, and no doubt significant, investments in increased primary care and community-based long-term supports and services (LTSS). Unless it is clear how states plan to achieve savings and how those savings “net out” against necessary service enhancements, it is impossible to make a reasonable judgment of the state’s plan.

For those states choosing to use the capitated financing model, a critical part of achieving savings targets will involve getting the capitated payment right. The recent guidance from CMS offers stakeholders a view into how this will be done, but also raises serious concerns about whether it will, in fact, provide an adequate rate to serve the needs of the most complex dual eligibles. This requires using risk adjustment methodologies that adequately account for the complex needs of individual beneficiaries. These methodologies must capture information about an individual’s functional capacity as well as information about their race, ethnicity and socioeconomic status. However, because getting the risk adjustment right is difficult, especially when we are still at the early stages of developing capitated financing and integrated care systems for this very vulnerable population, the other essential step in the process is creating a shared-risk model between the federal and state government and the plans/delivery systems.

Using risk-sharing strategies, especially in the first one-to-three years of the demonstration projects, rather than to assume that federal and state savings will come “off the top” with all the risk shifted down to the plan and/ or provider (and ultimately beneficiary) level is critical to the success of the projects. One state (Michigan) acknowledges this dilemma in its draft demonstration proposal:

Fully-developed and dependable risk methodologies applicable to special populations including those needing long term care, those who have intellectual/developmental disabilities and those with serious mental illness, those who have a substance use disorder are not yet available, and hence risk is not adequately predictable. Without predictability, **risk sharing is imperative in order to attract qualified management entities**. As predictive methodologies become sufficiently reliable, management entities would be expected to take a progressively greater proportion of risk, eventually resulting in full risk contracts. (emphasis added)

More worrisome is the possibility that without these strategies, over-payment to plans could undermine the goal of cost savings, while underpayment could compromise quality or encourage “cherry picking.” We understand that CMS is still determining whether to use risk-sharing strategies. While we know that Medicare has not traditionally used risk-sharing mechanisms, there is precedent in states, for instance in the Massachusetts Senior Care Options (SCO) program, for this approach. In that program, the state and the federal government, at the end of each contract year, share percentages of gains or losses. This has been a successful approach for the SCO program, and we urge CMS to adopt this structure for the demonstration programs as well.

Finally, we believe the success of the program also hinges on the protection of dual eligibles through the use of additional safeguards, such as:

- *Quality incentives:* Any incentive payments to providers or plans must be fully transparent and based on meeting or exceeding quality targets that include consumer-centric measures that include medical and non-medical metrics as well as those that measure patient experience.
- *Incentives to keep people in the community:* Financial incentives must focus largely on maintaining and fostering independence among dual eligibles in community settings and moving people in institutional settings to the community to the extent possible and desired by the individual.
- *LTSS spending targets:* States should be required to ensure LTSS expenditures, as a percentage of total expenditures on dual eligibles, remain at or above current percentages, and community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above current percentages.

* * *

We support the shift toward better integrated, more comprehensive and coordinated care for dual eligibles. And, we support the need to get health care costs under control. But, we believe the emphasis must necessarily be on creating delivery systems that work for the populations they serve. If states can get that right, the savings should follow. A rush to meet savings targets is short-sighted and dangerous. As Michigan notes in its demonstration proposal: “This initiative recognizes that change is a process and that it will take time to achieve meaningful results. To that end, this proposal will **default to what is solid in the long run and reject short term but transitory victories such as near term cost savings.**” (emphasis added).

We welcome the opportunity to discuss these issues with you and your staff.

Sincerely,

National Organizations

American Association on Health and Disability
Association for Gerontology and Human Development in Historical Black Colleges and Universities
Center for Medicare Advocacy
Community Catalyst
Direct Care Alliance
Disability Rights Education and Defense Fund
Families USA
LeadingAge
Lutheran Services in America Disability Network
Medicare Rights Center
National Association of Professional Geriatric Care Managers

National Centers for Independent Living
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Health Law Program
National Multiple Sclerosis Society
National Senior Citizens Law Center
PHI – Quality Care through Quality Jobs
Services and Advocacy for GLBT Elders (SAGE)
Southeast Asia Resource Action Center

State-Based Organizations

Arizona

Arizona Center for Law in the Public Interest

California

California Health Advocates
Center for Health Care Rights
Congress of California Seniors
Disability Rights California
Southeast Asia Resource Action Center – California

Colorado

Colorado Center on Law and Policy
Colorado Cross Disability Coalition

Connecticut

New Haven Legal Assistance Association

Hawaii

Hawaii Disability Rights Center

Illinois

Health & Medicine Policy Research Group
Illinois Network of Centers for Independent Living

Massachusetts

Boston Center for Independent Living
Disability Policy Consortium
Massachusetts Law Reform Institute

Michigan

Michigan Campaign for Quality Care
Michigan Consumers for Healthcare
Michigan Disability Rights Coalition
Michigan Poverty Law Program

Minnesota

Center for Elder Justice and Policy

Missouri

Paraquad

New Mexico

Health Action New Mexico
Senior Citizen's Law Office

New York

Center for Disability Rights, Inc.
Center for Independence of the Disabled, NY
Empire Justice Center
PHI – New York
Regional Center for Independent Living
Selfhelp Community Services, Inc.

North Carolina

North Carolina Justice Center

Ohio

Ohio Alliance for Retired Americans
Ohio Association for Area Agencies on Aging
Ohio Statewide Independent Living Council
Tri-County Independent Living Center, Inc.
UHCAN Ohio

Oklahoma

Oklahoma Policy Institute

Oregon

Disability Rights Oregon

Rhode Island

Rhode Island Disability Law Center

South Carolina

South Carolina Appleseed Legal Justice Center

Tennessee

Tennessee Disability Coalition
Tennessee Justice Center

Texas

Center for Public Policy Priorities
Coalition of Texans with Disabilities
Disability Rights Texas
Southern Disability Law Center
Texas Legal Services Center

Vermont

Vermont Legal Aid

Virginia

Virginia Poverty Law Center

Washington

Northwest Health Law Advocates

Wisconsin

Disability Rights Wisconsin

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