In this initiative at CMS

The Medicare Rights Center (Medicare Rights) is pleased to respond to the Request for Information (RFI) regarding health plan innovation initiatives. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

For questions concerning these comments, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 and Casey Schwarz, Policy and Client Services Counsel, at cschwarz@medicarerights.org or 212-204-6271. Thank you for the opportunity to comment.

Section I. Stand-Alone PDPs

2. What challenges do you see, if any, within the current MTM program and/or benefit structure guidelines?

It is generally acknowledged that Medicare’s Medication Therapy Management (MTM) programs are not living up to desired expectations, and it remains difficult to gauge the relative success of MTM programs, given lower than expected enrollment and limited evidence on the program’s efficacy. (See: “Rucker, L.N., “Medicare Part D’s Medication Therapy Management: Shifting from Neutral to Drive,” (AARP Public Policy Institute: June 2012)).

Our firsthand experience with the MTM program also causes us to question how well MTM programs are being managed. Many callers to Medicare Rights’ national helpline, even those enrolled in MTM programs, are unclear about what the programs are and how they will benefit from enrollment. Common questions from our callers include: How will MTM help me save money on prescription drugs? Is it even “worth it” to enroll in MTM?

These questions reflect a general lack of understanding about how MTM programs can assist beneficiaries in managing multiple medications and a lack of effective education about the program and its purpose. This anecdotal experience is confirmed by a recent study which showed that less than 10 percent of eligible enrollees at top carriers received a Comprehensive Medication Review (CMR) in 2012. (See: Yochelson, M., “MTM Review Completed for Under Half of Eligible Enrollees, MA Plan Speakers Say” (Bloomberg BNA: October 1, 2014))

Along these same lines, like CMS, we were alarmed by evidence cited in the proposed 2015 Part C and D contract rule revealing racial and ethnic disparities in access to MTM. Additionally, we shared CMS’ concerns, outlined in the 2015 draft and final call letters, that significant differences in the scope, breadth, quality and impact of MTM programs...

3. Do you recommend greater flexibility for MTM targeting and/or service requirements under an enhanced MTM program to improve outcomes for beneficiaries and Medicare?

We appreciate that a demonstration program has the potential to address many long-standing concerns with MTM programs; yet, we believe that CMMI should carefully consider existing shortfalls in the MTM program as it designs an enhanced MTM demonstration. We could support an MTM demonstration that meets the following criteria:

- Involves all relevant stakeholders in the program design, including consumer advocates
- Uses appropriate standards for plan participation, such as demonstrated MTM success and high star ratings
- Delineates clear plan reporting requirements
- Provides rigorous oversight and monitoring related to the inclusion and treatment of vulnerable populations
- Evaluates the efficacy of the model and its effects on care quality and patient satisfaction

For an enhanced MTM demonstration and all other demonstrations considered in this Request for Information (RFI), meaningful opportunities to assist in shaping a demonstration must exist, both for beneficiaries and their advocates and for affected providers. It is not sufficient to discuss the general outlines of a demonstration with stakeholders. Details matter and those details are found in documents, like beneficiary notices, contracts and manuals. For participation by stakeholders to be genuinely effective, key planning and operational documents must be available for review and input.

Importantly, we suggest granting additional MTM program flexibility only to plans that meet the baseline requirements of the current MTM program, and that demonstrate success in uniformly serving enrollees with MTM services. For this demonstration and others under consideration by CMMI, the star ratings system should be considered as a metric for determining which plans are allowed to innovate. For instance, we suggest only allowing plans rated 4 stars or higher to participate in an enhanced MTM demonstration.

We also encourage CMMI to require additional reporting by plans with an enhanced MTM program on recruiting, participation and results. In addition, we ask CMMI to engage in rigorous oversight and monitoring of enhanced MTM programs, particularly with respect to the inclusion of vulnerable populations, namely communities of color, beneficiaries with limited English proficiency, and other hard-to-reach subgroups. Given CMS’ documented observations about disparate treatment, we believe careful and regulator monitoring is warranted. Finally, a third-party evaluation should be conducted to examine medication adherence, related health outcomes and patient satisfaction.

4. If CMS were to develop a PDP model test combining MTM strategies and financial incentives, how would you recommend this model be designed? Please include a description of how (by what mechanism) your proposed model design will produce net savings and preserve or enhance quality. Consider quality/outcomes measures, beneficiary protections, financial incentives, and partnership and/or implementation timelines.

We believe the criteria described in #3 will help to ensure that any enhanced MTM demonstration adequately protects Medicare beneficiaries participating in the program. We are concerned that financial incentive programs (essentially bonuses for participation) may be inappropriately marketed to steer consumers to plans participating in the demonstrations. An additional worry concerns how plans might use a financial incentive offering to “cherry pick,”
essentially by aiming to attract a healthier subset of Medicare beneficiaries. We believe that CMMI should carefully evaluate all plan marketing materials that reference MTM-related financial incentives to minimize this risk.

6. Are there any other issues or factors that CMS should take into account when considering collaboration with PDPs to develop a model that combines MTM strategies, risk stratification, differential cost sharing, and financial incentives?

With respect to an MTM demonstration and other models referenced in this RFI, we urge CMMI to approach cost sharing differentials with caution. Specifically, we ask that CMMI not move ahead with models that increase cost sharing on specific prescription medicines to dissuade or discourage beneficiaries from seeking care. Empirical literature on patient behavior makes clear that indiscriminate increases in cost sharing deter access to both necessary and unnecessary health care, and that such increases have a disproportionate impact on lower-income, vulnerable populations. (See: Wallace, N.T. et al. “How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,” Health Services Research, Vol. 43, No. 2, 2008, pp. 515-530; Tambryn, R. et al. “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons,” JAMA, Vol. 285, No. 4, 2001, pp. 421-429; Swartz, K. “Cost-Sharing: Effects on Spending and Outcomes” (Robert Wood Johnson Foundation Research Synthesis Report No. 20: December 2010))

As such, we are concerned about even targeted increases in cost sharing on specific prescription drugs or services. Should CMMI continue to explore how cost sharing differentials can be used to facilitate care adherence and affect utilization, we strongly urge that the agency begin its inquiry only by lowering cost sharing. Additionally, we do not believe cost sharing is a useful steering tool on its own—any adjustments to cost sharing must be coupled with educational initiatives for both beneficiaries and providers on the value of a given service or prescription medication.

As discussed above, in addition to collaborating with Part D plans, we ask that CMMI also meaningfully involve beneficiary advocates, prescribers, pharmacists and other relevant stakeholders in the development of an MTM demonstration program. It is essential that consumer advocates and providers are involved in the development of these demonstrations, particularly as differential cost sharing and financial incentives are considered.

7. Would it be useful to test the success of these initiatives among MA-PD plans? What aspects might be different between a model test in MA-PD versus stand-alone PDP?

We expect that MA-PD plans will operate under some different incentives compared to stand-alone PDPs with regard to initiatives to increase medication adherence and identify at-risk or non-compliant beneficiaries. Additionally, MA-PD plans may have different tools, including closer working relationships with prescribers and other providers that would affect the efficacy of an MTM demonstration program. As such, we would encourage CMMI to test these models with MA-PD plans as well as stand-alone PDPs.

8. Are there any other innovations in Part D that you would like to see tested by CMS? If so, please describe.

We encourage CMMI to explore developing a model test to streamline the Part D appeals process, namely by requiring plans to treat a presentation at the pharmacy counter as a request for a coverage determination. Current Medicare rules permit, but do not require, a Part D plan to treat the presentation of a prescription at the pharmacy as a request for a coverage determination. CMMI might also consider a pilot test to eliminate the redetermination phase of the appeal (the second plan-level review), or to require proactive outreach by plans to prescribers when a medication is refused at the point-of-sale.
Additionally, CMMI should test enhancements to beneficiary notification at the pharmacy counter, specifically exploring opportunities to individually tailor the current notice to include the reason (i.e., a utilization management or off-formulary) a prescription is refused. (See: Medicare Prescription Drug Benefit Manual, Chapter 18, § 30 “A plan sponsor is not required to treat the presentation of a prescription at the pharmacy counter as a request for a coverage determination. Accordingly, the plan sponsor is not required to provide the enrollee with a written denial notice at the pharmacy as a result of the transaction.”)

We expect that a streamlined appeals process will reduce the following: the number of beneficiaries who go without needed medications resulting from an improper denial; the length of time beneficiaries go without needed medications; the cost to and burden on the beneficiary to separately seek a coverage determination; and the costs and negative quality outcomes that result from poor medication adherence. We also hope that streamlining the Part D appeals process will reduce the burden and cost of processing appeals at higher levels, like the Independent Review Entity (IRE) and the Administrative Law Judge (ALJ), while also improving the quality and accuracy of appeals decisions at the plan-level (See: Medicare Rights Center, “Refused at the Pharmacy: How to Improve Medicare Part D Appeals,” Winter 2013).

In sum, we believe that a demonstration project that tests a simplified, streamlined appeals process has the potential to increase adherence and diminish beneficiary, plan and provider costs. Additionally, a demonstration of this kind could give a more complete picture than data currently allows about what happens to those who are turned away at the pharmacy counter but never request a coverage determination.

**Section II: Medigap**

10. If CMS were to develop a model test in Medigap or Retiree Supplemental health plans to provide case management and related care coordination services to high-cost, medically-complex beneficiaries, how would you recommend this model be designed? Please include a description of how (by what mechanism) your proposed model design would produce net savings and preserve or enhance quality. Consider quality/outcomes measures, beneficiary protections, financial incentives, population characteristics, and partnership and/or implementation timelines. Please include information about how CMS could coordinate with state regulators for Medigap plans.

In general, we strongly encourage the development of more comprehensive care coordination for beneficiaries who would benefit from those services. Yet, we encourage CMMI to thoughtfully consider whether a secondary insurer is the appropriate entity to manage such programs. While we are generally supportive of enhanced care coordination demonstrations, including that suggested here, we ask CMMI to consider the following:

- Medigap and Retiree plans rely on Medicare determinations of medical necessity, participation and enrollment requirements for health care providers, and limiting charges. Thus, we expect Medigap plans would be limited in their capacity to directly manage the delivery of health care services. Given these limitations, we would expect that Traditional Medicare (the primary insurer) is better suited to coordinate patient care, such as in demonstration programs already underway, like the Accountable Care Organization (ACO) models.

- We expect that some care coordination services may be more seamlessly integrated into existing Medigap and Retiree plans. Health support activities focused on providing additional aid, education and direction is likely a better fit for secondary insurers than coordination services reliant on changes to beneficiary cost sharing or efforts intended to alter beneficiary or provider decision-making. In any case, we would ask that CMMI clearly define what care coordination activities are allowable under a Medigap and Retiree plan demonstration.
• Looking ahead, we suggest carefully considering the quality outcomes, such as improved health, enhanced medication adherence and increased patient satisfaction, that would warrant making a Medigap or Retiree plan demonstration permanent. This will be particularly important for CMMI to consider if, in the long-run, the agency expects to reimburse supplemental insurers for making these services available to enrollees. We would strongly encourage clearly-defined, outcome-focused standards be established to evaluate the relative success and return on investment of a Medigap or Retiree plan demonstration.

• Moreover, we believe that existing Medigap protections, namely guaranteed renewability, may make retrospective changes to Medigap plans problematic. To the extent CMMI wishes to pilot test these models with an eye towards implementing permanent changes, working with state regulators will be essential.

• Finally, if these demonstrations prove successful in improving health care quality and reducing Medicare costs, we would encourage CMS to make such benefits and services available to other Medicare beneficiaries—including those who retain secondary insurance through Medicaid, Tri-Care or other insurers.

Lastly, one of the listed rationales for soliciting input on a Medigap and Retiree plan demonstration is the argument that comprehensive coverage may lead to overutilization of health care services. Given this, we encourage CMMI to revisit data that show that indiscriminate increases in cost sharing limit access to both necessary and unnecessary care, and to acknowledge that existing Medicare controls prohibit Medigap and Retiree plans from paying for care that is not medically necessary. (See: National Association of Insurance Commissioners (NAIC), Senior Issues Task Force, Medigap PPACA Subgroup “Medicare Supplement Insurance First Dollar Coverage and Cost Shares: Discussion Paper” (October 31, 2011))

12. Are there any other issues or factors that CMS should take into account when considering possible opportunities to collaborate with Medigap and Retiree Supplemental plans to develop programs to provide case management and related care coordination services to beneficiaries?

Like described above, we urge CMMI to approach with extreme caution any pilot programs that increase beneficiary cost sharing in Medigap and Retiree plans or otherwise seek to curtail perceived overutilization of services, such as through restricted networks. Imposing increased costs or more restrictive networks on beneficiaries with Medigap or Retiree coverage risks discouraging or creating barriers to needed care for middle and low-income individuals.

As with the enhanced MTM demonstration program described above, we would encourage CMMI to involve the full range of relevant stakeholders in the development of a Medigap and Retiree plan demonstration, including: insurers, employers and consumer advocates. Again, we want to stress the importance of making this participation meaningful—through regularly engagement and ongoing opportunities to review demonstration-related content, including beneficiary notices, contracts, etc.

Section III: Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PD) Plans

14. Would you recommend that CMS implement a model test that would allow VBID for beneficiaries with specific chronic conditions?

In general, we urge CMMI to approach V-BID models in Medicare Advantage (MA) with caution. We are encouraged by the opportunity that V-BID models present to lower cost sharing for high value services and prescription medications to enhance adherence and access among lower-income, vulnerable populations. Yet, we remain concerned by V-BID models that incorporate higher cost sharing to deter the use of low-value care.
As discussed above, we do not believe that cost sharing alone is an appropriate trigger to steer beneficiary utilization. Medicare beneficiaries participate in a complex health care system, where health care providers largely direct treatment decisions. As such, V-BID models must include complementary educational initiatives for both beneficiaries and health care providers on high-value versus low-value care. Additionally, V-BID models should only be implemented where there is a clearly defined, well-established evidence base to define value.

15. What factors and design principles should CMS consider if it were to develop such a model test? Some potential factors to consider are which chronic conditions and characteristics of the population to target, which quality measures to track, and what beneficiary protections to include.

We could support a V-BID demonstration in MA that meets the following criteria:

- Prohibits increased cost sharing on “low-value” care
- Uses appropriate standards for plan participation, such as high star ratings
- Involves all relevant stakeholders in the program design, including consumer advocates
- Requires a transparent, evidence-based criteria for identifying “high-value” services and prescription drugs
- Requires MA plans to engage in complementary educational initiatives for beneficiaries and providers
- Provides rigorous monitoring for discriminatory practices or other unintended consequences
- Evaluates the efficacy of the model and its effects on care quality and patient satisfaction

As noted above with respect to an MTM demonstration, we believe that CMMI should only allow high-performing plans the opportunity to innovate. We suggest allowing participation only by plans with 4 stars or higher. Additional beneficiary protections that should be incorporated in a V-BID MA demonstration include: an “opt-in” participation design and a mechanism for de-selecting participation. In addition, individual plan designs should be carefully reviewed to ensure that cost sharing adjustments do not unduly encourage or discourage particular sub-groups within the target population from participating in the demonstration. Finally, a third-party evaluation is needed to carefully assess any V-BID MA demonstration, examining health outcomes, care quality and patient satisfaction and sustained consumer engagement.

16. What changes in cost sharing elements, such as co-pays, MOOPs, deductibles, and/or premiums, (cost sharing) should be varied and what would be the intended impact of these changes? Should there be any restrictions on the magnitude of such changes? What existing requirements or standards present a barrier to implement such changes?

As noted above, we strongly encourage CMMI to limit cost sharing adjustments to only lower cost sharing—not increased cost sharing. Further, we suggest that CMMI allow lower cost sharing only in instances where there is a well-established, evidence-base that illustrates a particular service or prescription medication is “high-value.” For example, CMMI might consider including coverage for the National Diabetes Prevention Program (National DPP), administered by the Centers for Disease Control (CDC) in partnership with government agencies and community-based organizations, within a V-BID demonstration. We encourage CMMI to develop a standardized list of health care services or prescription drugs that may be subject to altered cost sharing in consultation with clinicians and other experts. (See: [http://www.cdc.gov/diabetes/prevention/index.htm](http://www.cdc.gov/diabetes/prevention/index.htm); Medicare Diabetes Prevention Act (S. 452/H.R. 962))

17. Please include a description of how (by what mechanism) your proposed model design would produce net savings to CMS without adversely impacting patient care or outcomes.

We appreciate that V-BID models have the potential to enhance health care transparency, both with respect to cost and value. Similarly, as demonstrated by the literature, diminished cost sharing has the potential to improve adherence and
health care outcomes, particularly among lower-income, vulnerable populations. (See: V-BID Center “Brief: V-BID in Action: The Role of Cost-Sharing in Health Disparities” (July 2014))

A V-BID demonstration focused on lowering cost sharing for specific services and prescription drugs for the chronically ill may facilitate better outcomes and also lower costs to the Medicare program. That said, we do not expect these savings to be quickly apparent, nor do we think CMMI should expect immediate savings from a V-BID demo. Importantly, CMMI should establish improved care quality as the primary goal of a V-BID demonstration, with cost savings as a secondary goal. Lastly, a rigorous third-party evaluation on improved health outcomes, patient satisfaction and engagement, medication adherence and care quality is needed to assess an MA V-BID demonstration.

18. Are there other flexibilities or changes to Medicare policies or regulations (in addition to changes to cost sharing) that you believe could enhance plans’ abilities to successfully implement VBID?

We urge CMMI to approach granting additional plan design and other flexibility to MA plans with caution. While we could be supportive of a narrow V-BID demonstration that meets the criteria described above, we remain concerned that too much flexibility risks allowing plans to devise discriminatory plan designs. Similarly, we are concerned that increasingly complex cost sharing structures may become overly confusing and complicated for consumers—adding to the existing, and well-documented, difficulty that beneficiaries face when attempting to compare multiple plan variables during Medicare open enrollment each year (See: Jacobsen, G., Swoope, C., Perry, M., and M. Slosar, “How are Seniors Choosing and Changing Health Insurance Plans?” (Kaiser Family Foundation: May 2014))

As such, we only support granting flexibility according to transparent, well-developed criteria established by CMMI in consultation with other stakeholders, including clinicians, researchers and consumer advocates. In addition, we urge rigorous oversight of any plans granted flexibility to adjust cost sharing—with specific review to ensure that plans are not “cherry picking” healthier or sicker consumers through cost sharing adjustments on specific services or treatments. Additionally, CMMI should undertake efforts to ensure that tested plan designs—and the implications of those designs for coverage and cost sharing—are clear to consumers, particularly as individuals seek to compare and contrast plan offerings. We expect that consumer focus groups will be an especially important tool here.

20. Are there other considerations that CMS should take into account when designing a VBID model?

It is important to stress the need for beneficiary and provider education as a complement to any V-BID design. We find that Medicare beneficiaries are not positioned to evaluate high-value versus low-value services. Cost sharing incentives demand a high level of sophistication and knowledge on the part of beneficiaries to assess care options that are ultimately recommended by their doctors. Similarly, we hear from beneficiaries who are confused by what to derive from the cost sharing associated with a given service or prescription drug. In some cases, callers to our helpline equate high-cost care with high-value care. As such, we do not believe that V-BID models should be pursued in the absence of complementary efforts to better inform and educate consumers about high-value versus low-value care.

Education is also a necessary prerequisite to V-BID for the provider community within a plan’s network. We know that prescribing trends are not uniform across settings or across providers. As such, providers must be made aware of differential cost sharing facing their patients, so that those providers can match V-BID principles to their prescribing practices accordingly.

Finally, as stressed previously, meaningful stakeholder engagement, including by beneficiary advocates and health care providers, is essential to the development of a MA V-BID demonstration. Again, we ask that this involvement be ongoing and allow the opportunity to provide input on program details and implementation, not solely on broad principles related to the demonstration’s design.
Hospice:

24. What factors should CMS consider if it were to develop a model that integrates hospice benefits concurrently with curative care in the MA population? In your response, please consider quality and outcomes metrics, beneficiary protections, and any other design factors you think are important.

We urge CMMI to consider patient choice and appeal rights in the design of a hospice MA demonstration. Specifically, we could support a hospice MA demonstration that meets the following criteria:

- Preserves patient autonomy—namely beneficiaries’ ability to affirmatively elect (or not) hospice care
- Allows open access to all Medicare certified hospice providers (no limited networks)
- Establishes well-defined, expedited appeal rights
- Involves all relevant stakeholders in the program design, including consumer advocates
- Evaluates the efficacy of the model and its effects on care quality and patient satisfaction

Patient choice and autonomy are historic hallmarks of the Medicare hospice benefit. Any demonstration program that incorporates hospice care into MA plans must ensure that a beneficiary’s ability to elect hospice care (or not) is protected. Similarly, hospice beneficiaries in Original Medicare benefit from open access to Medicare-certified hospice providers. Should CMMI move forward with an MA hospice demonstration, we would prefer that beneficiaries retain open access to providers, as opposed to being limited to an MA plan’s provider network.

We have long advocated for the inclusion of appeal rights for hospice beneficiaries. In Original Medicare, the hospice provider creates the plan of care and if it is suspected to be inadequate, the patient has no mechanism to challenge it. We urge an MA hospice demonstration include well-defined appeals rights. In particular, we suggest that beneficiaries and their families be able to appeal any aspect of the hospice plan of care to an Independent Review Entity (IRE) that will issue a decision within 24 hours.

Additionally, we ask that CMMI clarify the following statement: “Medicare beneficiaries are required to forgo curative care to receive access to palliative care services offered by hospices.” Under current law, Medicare beneficiaries retain the ability to receive curative care for health care needs unrelated to the condition for which a person elects hospice, known as the related condition. Should CMMI move ahead with an MA hospice demonstration, we ask that the agency adequately define what “curative” treatment is allowed alongside palliative care within an MA hospice demonstration. Finally, as with other demonstrations under consideration, we suggest CMMI include a third-party evaluation.

Section IV. Medicaid Managed Care

28. Would you recommend that CMS implement a Medicaid managed care model test in any of the areas listed below? Why or why not?

- Pharmacy and medication therapy management
- Value-based insurance design (as described in Section III)
- Remote access technologies
- Hospice care
- Long term services and supports
- Behavioral health Provider incentive arrangements such as accountable care organizations

Through the Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE), our organization is working with like-minded community-based organizations, health plans, state agencies and other stakeholders to shape New York State’s Medicaid Managed Long-Term Care (MLTC) program and its Fully Integrated Duals Advantage (FIDA)
financial alignment demonstration. (See: http://www.nyduals.org/) Drawing on this experience, we ask CMMI to consider the following:

- **State capacity:** Medicaid demonstrations require intensive involvement by state Medicaid agencies in planning and providing significant oversight, particularly because Medicaid demonstrations affect highly vulnerable populations. Many states are already heavily engaged in Medicaid reforms, including Medicaid expansion, financial alignment demonstrations and transitions to Medicaid managed long-term care. As such, we strongly suggest that CMMI engage in a careful evaluation of any state Medicaid agency to ensure there is existing capacity to appropriately implement and manage a Medicaid managed care demonstration program.

- **Demonstration size and scope:** We suggest that any future Medicaid managed care demonstration be limited in size and scope. We believe that demonstration authority should be used for true demonstrations, namely experiments testing approaches and concepts. As such, we do not generally endorse state-wide demonstrations, demonstrations involving large populations, or demonstrations involving a large number of private plans. Smaller demonstrations also make it easier to make adjustments based on experience and to protect beneficiaries from potential harms.

- **Voluntary participation:** As noted above with respect to an MA VBID demonstration, we strongly suggest that beneficiaries retain the ability to freely opt-in or opt-out of a demonstration program. In this case, beneficiaries should be allowed to freely switch to a non-participating Medicaid managed care plan or to fee-for-service Medicaid if they choose not to participate in a demonstration plan. In addition, demonstrations should not utilize passive enrollment, which is not considered voluntary participation.

- **Stakeholder participation:** As with the Medicare demonstrations described above, meaningful stakeholder participation in demonstration design and monitoring is critical. Stakeholders who should necessarily be consulted include: consumer advocates, health care providers, and health plans. For stakeholder participation to be genuinely effective, key planning and operational documents and, most especially, the managed care contracts that define the obligations of the managed care plans, must be available for stakeholder review and input.

- **Accountability:** Medicaid demonstrations, because they are experiments, should be held to the highest degree of accountability and transparency. Any Medicaid managed care demonstration should include performance measure targets and should detail collection and public reporting of specific performance measures. As discussed with the Medicare demonstration above, every demonstration should include a rigorous, third-party evaluation process.

To achieve these goals, contracts with Medicaid managed care plans participating in demonstrations must include provisions that ensure that all relevant data can be released for the purposes of performance and quality measurement and that access will not be blocked by claims that the information is proprietary. Further, it is important that state Medicaid agencies design reporting schedules for key performance information so that issues can be spotted early and mid-course corrections can be effectuated.

- **Quality health plans and providers:** As with Medicare demonstrations, any Medicaid demonstration should be limited to high quality health plans and providers with strong track records in serving the affected population.

- **Long-term care:** The principles outlined above are particularly applicable to any Medicaid managed care demonstration involving long-term care. Further, in states that have only recently moved dually eligible and Medicaid-only seniors and persons with disabilities into Medicaid managed care, we would suggest allowing ample time for that particular transition to occur before layering on additional demonstration programs.
In closing, particularly with this high-need, vulnerable population, we suggest that CMMI define improvement in the quality of care for beneficiaries as the primary goal of any Medicaid managed care demonstrations. While we understand that efficiency and cost impacts must be considered, it is important to recognize that the cost savings expected from improvements in care are not typically immediate. As such, cost savings should be considered a secondary goal of Medicaid managed care demonstrations.