

STATE DUAL ELIGIBLE DEMONSTRATION PROJECTS – KEY CONSUMER ISSUES

I. SPECIFICITY/CLARITY OF STATE PROPOSALS

The demonstrations provide an important opportunity for states to design a clear program that will improve access to services and the quality of care for those dually eligible while saving money from inappropriate and/or unnecessary care. However, many of the proposals are frustratingly vague in critical areas, including provisions explaining how beneficiaries will be protected and plans will be kept accountable. Further, some proposals lack specificity on plan assignment, education of enrollees to help them make appropriate decisions, plan capacity, and network adequacy. This lack of clarity leaves many advocates concerned about what this will mean when the demonstration is operational. Finally, many states are proposing to work out the details through Memoranda of Understanding (MOU), which are not guaranteed to include stakeholder input or public transparency.

Recommendation: Require that the MOUs development processes are transparent and include stakeholder input. Make MOUs public.

II. SIZE/SCOPE

CMS intends to enroll between one and three million of the nine million dual eligibles nationwide into integrated programs, mostly through managed care organizations (MCOs). We understand and agree with the goal of determining how integrated care models can be moved to a large scale while improving quality of care. However, although these initiatives are operating under CMS demonstration authority, they are much larger than typical Medicare demonstrations, raising several concerns:

A. Unrealistically rapid scalability. Successful integrated care models (e.g., PACE, Senior Care Options in Massachusetts, etc.) have all been fairly small in scope – typically between 5,000 and 25,000 enrollees nationwide. We support the goal of using these demonstrations to find ways to expand good integrated models to substantially larger numbers of beneficiaries. But good person-centered, integrated care cannot be expanded so rapidly by the order of magnitude currently contemplated. Good models require intensive coordination between health care and service providers, so that consumers and their caregivers have every opportunity to control their care. Most managed care organizations have no experience delivering the integrated care contemplated. It is not realistic to expect that MCOs will be able to do this for hundreds of thousands of beneficiaries within a few months. As a result, these demonstrations will simply be testing existing managed care models on dual eligibles, not innovating new models of integrated care. Moreover, monitoring quality and delivery of care in such a large system is very difficult.

B. Control groups. Demonstrations are intended to test an intervention, and determining whether the intervention is successful requires a control group with which to compare results. However, most participating states plan to enroll either all of their dual eligibles, or all the dual eligibles in a large metro area, into the demonstration. Without comparison groups for evaluation purposes, how will CMS know if managed care plans are effectively improving care and lowering costs for dual eligibles?

C. *Accounting for other demonstrations.* Several other important demonstrations and initiatives intended to improve care are also in the midst of implementation, including Accountable Care Organizations and health homes. Dual eligibles in participating states will also be part of these other initiatives. How will the effect of the dual eligible integration initiatives be separated out from the effect of overlapping health care delivery system demonstrations?

D. *Undoing unsuccessful demonstrations.* Most Medicare demonstrations are deliberately modest in scale so that if they are unsuccessful, they can be disassembled with relatively little disruption to the health care system and the people involved. In this case, however, if all of a state's dual eligibles (or those in particular areas) are enrolled in integrated plans, undoing the demonstration at a later date becomes extremely difficult. After a few years, new stakeholders – especially insurance companies -- will have a strong interest in preserving the demonstration as the new status quo, even if it is not providing higher quality care.

Recommendation: Incorporate the following criteria to increase the likelihood of success from these demonstrations:

1. *Approve only real demonstrations, comprising fewer than one million beneficiaries nationwide.*
2. *Control groups.* All demonstrations must have a clearly identifiable, size appropriate, control group. For example, any proposals that include all of a state's dual eligibles, or all the dual eligibles in a large metropolitan area, should not be approved because they do not provide a useful control.
3. *Coordination with other efforts.* All demonstrations must have a clearly identified strategy to account for and, in evaluation, avoid contamination of other payment and delivery system reform demonstrations and initiatives. In areas where other significant delivery reform efforts are underway, dual eligible integration demonstrations should be scaled back or should exclude duals participating in those other initiatives.

III. ENROLLMENT

The enrollment process should be voluntary (opt-in) without any lock-in period, supported by excellent written material about the delivery systems being offered, the process for enrolling, and the availability of independent navigation assistance.

A. *Passive enrollment.* We oppose passive enrollment into the demonstrations. Poor, sick individuals with multiple chronic conditions should not be passively enrolled into an experiment; an opt-in enrollment process is most suitable for this population. To be successful, the demonstration would need to have excellent information, excellent enrollment assistance, and a product, i.e., benefit and services package, superior to what is available to prospective enrollees currently. Passive enrollment allows plans guaranteed enrollment without demonstrating that their product is worth having. Free choice of provider has been a tenet of the Medicare program since its beginning and people dually eligible for Medicare and Medicaid have been protected by statute from mandatory Medicaid managed care enrollment except when that right is explicitly waived through a statutorily-defined

process. As noted, managed care has been used primarily for healthier populations; most MCOs have little experience with high needs individuals. Passive enrollment with opt-out is attractive to plans precisely because the opt-out is not likely to be exercised, but not necessarily because the enrollee is satisfied with the plan. Lack of enrollment assistance, failure to receive or understand a notice, language barriers, and cognitive limitations may all factor into individuals not opting out of plans into which they have been passively enrolled.

B. Lock-in. We support the CMS position that beneficiaries may not be locked into a demonstration for any period of time. Lock-ins are particularly harmful if passive enrollment is permitted. Passive enrollment with lock-in puts dual eligibles, the sickest Medicare beneficiaries, in a less protected situation than all other Medicare beneficiaries. Currently in Medicare, dual eligibles can opt out of a Medicare Advantage or a Part D plan at any time, with the change effective the following month. Thus, demonstration duals would have fewer rights. The purpose of the demonstrations is to improve delivery of care to duals and thus to improve their situation. While some duals may have no regular relationships with providers, others, with complex care needs, may have well established relationships with many providers, relationships they could lose if locked into a plan they did not affirmatively choose.

C. Enrollment assistance. We favor enrollment being accomplished through an independent enrollment broker in all the demonstrations. The independent broker must have specialized training in working with the complex, heterogeneous population of those dually eligible. In addition, extra resources should be provided to existing trusted sources of information that serve the population to be enrolled. These might be State Health Insurance Programs, Aging and Disability Resource Centers, Area Agencies on Aging, Independent Living Centers, recovery centers and other similar entities. Entities serving difficult to reach populations, including the homeless and limited English-speaking beneficiaries, must also be enlisted and supported. Resources must be sufficient to allow for “high touch” communication that involves opportunities to relay information orally and in person.

Recommendation:

1. *Voluntary enrollment.* Require voluntary (opt-in) enrollment.
2. *Broker.* The state must provide an independent enrollment broker, skilled in working with this population, to facilitate the demonstration.
3. *Education and materials.* CMS and the state must provide adequate funding to community-based organizations to educate beneficiaries about their enrollment options. The enrollment process should be supported by excellent linguistically and culturally competent written materials that are also available in alternative formats such as Braille, CD, large-font print, and sign language translation.

IV. STATE READINESS

The aggressive timeline that many states are proposing for enrolling large numbers of dual eligibles (beginning in 2013) raises several concerns, especially when the proposals lack specificity on key

provisions. For example, states and CMS must verify that integrated care entities will have the experience and expertise to care for the complex needs of the members they will serve and that they have conducted careful program design and extensive on-the-ground preparation, including engagement of stakeholders. In addition, states and CMS must ensure that the plans have adequate standards for in-home services, appropriate quality measures, and systems for how savings will be realized. Managing these contracts is a new challenge for states and CMS and will require new systems and additional expertise. Some state proposals have acknowledged the daunting nature of the challenge they face and have proposed waiting until 2014 to start their program.

Recommendation: Slow down the demonstrations as per SIZE/SCOPE discussion in Section II. Require that states provide CMS with a detailed statement/assessment of readiness and to demonstrate their expertise, prior experience, and current and future capacity (such as staff and financial resources) to oversee their responsibilities in managing new care models for the dual eligible population. This statement should be made public and should identify the different approaches that will be used to serve diverse groups of dual eligibles, such as those requiring long-term services and supports.

V. PLAN READINESS

A. Experience. Dual eligibles are a complex, heterogeneous group, whose only unifying characteristic is that they are eligible for two publicly-financed health insurance programs. Evaluating this population requires expertise in evaluating both medical and social needs of the person, an approach the existing medical managed care model does not provide. Further, developing effective models of care for dual eligibles takes an intensive, long-term commitment from providers, payers, and beneficiaries of the services.

While some Medicaid managed care plans have a history of serving low-income children and families, most *do not* have experience serving the needs of the most vulnerable and expensive dual eligibles, those requiring long-term services and support (LTSS). Similarly, Medicare Advantage (MA) plans have covered medical care for a portion of the Medicare population, but generally have not covered the LTSS population. Few MA plans have demonstrated success in improving medical care for dual eligibles. Over time, managed care organizations may demonstrate that they can provide good integrated care, including LTSS, to dual eligibles. However, inadequate preparation and rush enrollment to meet an arbitrary deadline could result in disruptions in care and poorly-planned transitions that will hurt real people.

B. Network adequacy. Because the dual eligible population is diverse, with high needs and complex medical conditions, plans must have robust networks of providers, including primary care providers, specialists in conditions that affect the population, long-term services and supports providers, and other services to address their needs. Networks must be physically and programmatically accessible to persons with disabilities in terms of facilities, equipment and scheduling, and be linguistically and culturally competent. Only plans with a proven track record of providing high quality Medicare and/or Medicaid services should be permitted to participate in the demonstrations and poor performing plans or providers should not be included as part of the network.

Plans should build networks around the needs of their members, incorporating as much as possible the existing providers on whom members have relied. Before a plan is allowed to accept members, it must demonstrate network adequacy. Further, periodic monitoring is required to determine if networks continue to be sufficient to meet member needs.

The current compressed timetable in many states will not allow for developing good network standards. Some very good and exciting work is being done with stakeholder groups at the state level hammering out details of how to build and test genuinely adequate networks for this population. The issue of LTSS network adequacy, for example, is being discussed for the first time in many places. Issues of accessibility are being addressed more directly than in the past. But the dialogue needs more time. Enrolling providers will be an ongoing challenge, as will monitoring of network capacity over time.

Medicare Advantage network standards can be used as a start for determining access to Medicare services and providers, but those standards need to be tailored to account for the unique needs of dual eligibles. Network standards for certain Medicaid services, like LTSS, do not yet exist. Once standards are set, the short time between choosing plans and enrolling members will not be adequate for plans to develop, and for the states and CMS to test the adequacy of the networks. Mechanisms need to be developed to identify network problems and to suspend enrollment until issues are addressed. Uncertainty about network standards and network adequacy make any enrollment lock-in unthinkable.

C. Access protections. Dual eligibles with dementia, other cognitive impairments and mental health impairments are vulnerable and in need of specific protections that are physically and programmatically accessible to treatment and network adequacy. Integrated care plans must be required to include in their provider networks an adequate number of particular specialty providers, such as neurologists and psychiatrists. In addition, provider networks must also include safety net provider agencies that serve dual eligibles with serious mental illnesses such as community mental health centers that in many states are obligated to provide services to this population. Finally, CMS must ensure that prescription drug coverage in integrated care plans complies with all of the protections required in the Part D program, including all formulary requirements.

D. Protection and Enhancement of Long-Term Services and Supports. The integration of Medicare and Medicaid services will only be successful if the prominent role that LTSS play in the independence, integration, and wellness of people with disabilities and elders is emphasized by states and plans with which they contract. Otherwise positive health outcomes and opportunities for cost savings will decline. A primary concern is that providers unfamiliar with LTSS systems will:

- Deny or reduce LTSS because of health care providers' unfamiliarity with community-based LTSS, including the fundamental role it plays in people with disabilities' and seniors' ability to live in the least-restrictive setting;
- Substitute traditional medical services for LTSS such as consumer-directed Personal Care Assistance or peer-driven mental health recovery programs, which have strong records of enhancing health and independence while limiting short- and long-term institutional placements; and

- Deny or reduce LTSS in order to achieve quick savings instead of investing in services that over time increase health and reduce costs such as providing adequate Durable Medical Equipment for people with complex physical disabilities or home care for elders.

Recommendation:

1. *Slow down.* 1) Slow down and scale back to allow time to develop a) appropriate networks that are physically and programmatically accessible as well as linguistically and culturally competent to meet the diverse needs of the target populations; b) enrollment targets that do not outpace network capacity; and c) systems for plans to monitor vigorously network capacity during the life of the demonstrations.

2. *Experience.* Plans must demonstrate in advance that they have expertise in serving all the beneficiaries in the demonstration: from younger people with physical disabilities to older people with cognitive impairments and everyone in between, including people with mental illness and relatively healthy people with low incomes. Plans that are unable to specify how they will improve care for specific sub-populations should not be allowed to participate. This may mean scaling back the initial size of the demonstration to a smaller number of sub-populations.

3. *Readiness.* CMS and states must conduct a rigorous readiness review prior to starting enrollment to ensure that all plans have the necessary systems and capacity in place to serve the new enrollees. The review should not simply be a pass-fail announcement to the public. Rather, standards and detailed results of the review should be made public.

4. *Diverse populations.* All managed care demonstrations must include a detailed explanation of how contracting plans will meet the diverse needs of the targeted populations.

5. *Standards.* Allow time to develop appropriate networks which are physically and programmatically accessible and linguistically and culturally competent to meet the diverse needs of dual eligibles; enrollment targets that do not outpace network capacity; and systems for plans to monitor vigorously network capacity during the life of the demonstration.

6. *Specialty providers.* Assure that plans include adequate specialty providers, provider networks, and safety net provider agencies that serve dual eligibles, including those with serious mental illnesses, dementia, and other cognitive impairments. Require that prescription drug coverage in integrated care plans comply with all of the protections required in the Part D program, including all formulary requirements.

7. *LTSS access.* States must require and plans must demonstrate verifiable proposals to ensure access to LTSS funded through Medicare and Medicaid, with sufficient appeals, advocacy, and ombudsperson options for consumers that are specifically tailored to LTSS.

VI. PLAN QUALITY

The integration of long-term services and supports, other Medicaid services, and all Medicare services is a complex and delicate task that requires extensive knowledge of local resources and demonstrated ability to provide quality care. Only plans with a proven track record of providing high quality Medicare and/or Medicaid services should be permitted to participate in the demonstrations.

Plan selection should not be on an "all comers" basis (as Medicare does now) and poor performing plans should not be included.

Although CMS guidance states generally that past plan performance on both the Medicare and Medicaid side will be part of the approval criteria, CMS and some states have taken steps demonstrating a willingness to allow marginal performers to participate in the demonstrations. For example, CMS has issued guidance allowing Medicare plans with a below average (less than three stars) Medicare star rating to participate in the demonstrations. Per the guidance, plans that have been below average for three years in a row would not be eligible for passive enrollments of new members, but would be allowed to transition passively members in their other Medicaid and Medicare products into the demonstration plan and would be allowed to market to new members. Plans that have been below average for just one or two years would be allowed to receive passive enrollments.

This policy was adopted despite the fact that Medicare considers plans with summary plan ratings of less than three stars to be "out of compliance with the requirements of the Part C or D programs." (CMS 2013 Call Letter at 87). Plans that have been below average for three consecutive years are identified by Medicare as "Low-Performing Plans" and are considered to "have demonstrated a serious lack of commitment to the programs and their enrollees." (CMS 2013 Call Letter at 87). In 2013, CMS will issue notices to individuals enrolled in these plans "alerting them to the organization's low rating and offering an opportunity to contact CMS to request a special enrollment period (SEP) to move into a higher quality plan for 2013." (Call Letter at 87.)

California has already chosen two plans to participate in the demonstration that have below average star ratings – one of which has been below average for three years in a row qualifying it as a "Low-Performing Plan." On the Medicaid side, plan quality concerns also have emerged, including specifically the choice of plans with low star ratings under the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, the only national comparison rating for Medicaid programs. Again, California provides the example, with seven of the eight plans chosen receiving the lowest CAHPS rating of one star.¹

Recommendation: Tighten the guidance so that only the highest performing plans, on both the Medicare and Medicaid side, participate in the experiment this demonstration represents. Medicare plans with that are poor performing plans - any plan below three stars -- should not be included.

VII. CONTINUITY OF CARE AND TRANSITIONS

The existing relationship between dual eligible beneficiaries and their established providers should be preserved during the demonstration plan transition period in order to avoid disruptions in care. Dual eligibles who are undergoing a course of treatment, whether short-term or longer-term, or who have a plan of care for long-term services and supports should not have to stop receiving this care just

¹ For a full analysis of the Medicare and Medicaid quality ratings for California plans, see NSCLC, *Assessing the Quality of California Dual Eligible Demonstration Health Plans* (May 2012), available at www.nsclc.org/index.php/assessing-the-quality-of-california-dual-eligible-demonstration-health-plans/

because their provider is not in a plan network. In the event that a provider transition does occur, it should be done in a way that does not put the beneficiary's safety or health at risk.

Recommendation: Adopt the following principles with respect to continuity of care:

1. *Open networks.* All providers currently delivering care to a dual eligible beneficiary should be given the opportunity to join the provider network of the beneficiary's demonstration plan as long as the provider meets the plan credentialing and accreditation standards, remains in good standing under the Medicare and Medicaid fee for service programs, has met identified quality measures, and is willing to accept the plan's payment rate and other terms and conditions of network participation. Should the provider choose not to join the network, the plan should allow for a single-case agreement to be established in order to preserve existing and beneficial relationships.

2. *Current providers.* States should inform dual eligibles who are joining or being assigned to a plan whether any of their current providers are not in the plan's network and should inform beneficiaries of the specific date when care delivered by that provider will no longer be covered as well as how they can retain access to their providers, including leaving the demonstration. A "current provider" should be defined as any provider who has treated the beneficiary face-to-face in the prior 12 months. Demonstration programs that utilize auto-assignment should base assignment on the best interests of the individual and place the beneficiary in the plan with the network that best captures the beneficiary's current and most recent providers. Beneficiaries should have the right to appeal to the state or completely disenroll if they are auto-assigned to a plan with a network that does not include one of their current providers or that is not equipped to address their specific health and long-term service and support needs.

3. *Transition period.* Beneficiaries who have to change providers because of participation in a demonstration should be given up to 12 months to satisfactorily complete a transition to providers within the plan because of the complexity of their needs. During that period, they can continue to see any Medicare or Medicaid provider, regardless of the provider's network participation status. Any provider that is not in the beneficiary's plan network should be paid the Medicare fee-for-service (FFS) reimbursement rate or the Medicaid FFS reimbursement rate in the case of long-term care providers (except in states that have already implemented Medicaid managed care). Plans should coordinate with out-of-network providers to ensure that the transition to a network provider is seamless for the beneficiary. However, in no event should a beneficiary already residing in a long-term care facility at the start of the demonstration be required to move to a different facility just because the facility is not in her/his demonstration plan's network. Plans should be required to enter into single case agreements with the facility for as long as the beneficiary wishes to remain there.

4. *Part D.* Beneficiaries who experience a change in their Part D coverage as a result of the demonstration should continue to receive coverage for their existing medications at current cost-sharing levels, regardless of the demonstration plan formulary, for a transition period of at least 90 days. This coverage should be extended indefinitely in the case of non-formulary drugs when the beneficiary's physician certifies the medical necessity of the prescription.

5. *Benefit continuation.* Any service, supply, or drug that was authorized or received coverage approval prior to the demonstration should continue to be covered by the demonstration plan under the same terms and conditions, as long as medically necessary.

6. *Care plan.* Demonstration plans are responsible for developing and implementing a continuity of care transition plan any time a beneficiary is required to move to another network provider or disenroll from the plan and must provide information on the appeals and grievance process. Plans should give the beneficiary adequate written advance notice of any required change in providers and should conduct outreach by telephone or through an in-person meeting to explain how this will affect the way that the beneficiary accesses care.

VIII. QUALITY MEASUREMENT

A. *Standards.* It is essential that quality be monitored continually throughout the demonstration to ensure that, at the very least, minimal standards are met, and to assess whether promised improvements in quality occur. Existing quality measures are limited, especially for the dual eligible population and for long-term supports and services. Moreover, even the best measures can only provide a limited picture of patient care. These demonstrations are an opportunity to develop better measures, and must go beyond traditional metrics. We are encouraged that the current discussion draft of quality measures requires plans to report HEDIS, CAHPS, and HOS, and are consistent with existing Medicare requirements, including Part D. This is a good floor from which to begin. Demonstration plans must be held to at least the same standards as other aspects of Medicare.

In the area of LTSS, where Medicaid is the primary payer, there are considerably fewer nationally validated measures, but these demonstrations should strive to develop them. Quality measures used by existing programs that integrate care for dual eligibles, such as the Program of All-inclusive Care for the Elderly (PACE) and fully integrated dual eligible special needs plans, should also be considered by the demonstrations.

B. *Quality domains.* As a way to drive quality improvements as well as work to reduce health disparities (racial, ethnic, language, gender and disability), we suggest domains where CMS, states and plans should go further to develop specialized measures. These domains are: 1) care coordination, 2) access/availability, 3) patient-centered care, 4) prevention, and 5) effectiveness of care. We have additional thoughts on specific measures within each domain. All data should also be publicly reported and stratified by demographic group, to allow transparency and monitoring.

Because all quality measurement is an evolving field, measures must be updated as guidelines and standards change. Where no good measures exist, CMS must use the demonstrations as an opportunity to work aggressively to develop them.

C. *Assessment.* The demonstrations must go beyond traditional quality metrics. There must be rigorous monthly (or more frequent) assessment of access to care, and reporting of encounter data. The demonstrations must also build in mechanisms for regular on-the-ground reports from beneficiaries, caregivers, counselors, ombuds agencies, and elsewhere to assess quality of care that is not reflected in measures.

Recommendation:

1. *Standards.* Use existing Medicare quality standards as a minimum floor for quality measurement.
2. *Domains and assessment.* Use these demonstrations to work with measure stewards and others to develop and refine measures. Build in other ways to assess quality and access, including encounter data and regular stakeholder reporting.

IX. OVERSIGHT AND EVALUATION

Good oversight of these new demonstrations depends on the timely collection, review and public availability of data. As noted in the June 2012 MedPAC Report to Congress, it is important that data collection captures whether the plans are limiting access to care, providing low quality care, and that the data produce evidence to determine if the demonstrations are improving overall quality and lowering costs. Data collection and evaluation should include a comparable control group to determine if an intervention is successful. As previously noted, evaluations should take into account overlapping demonstrations that could impact outcomes.

Oversight should occur at multiple levels and involve consumers and their caregivers. States, CMS and managed care organizations should collect and review data regarding plans’ payment rates and medical loss ratios, including administrative costs of subcontractors. To guard against limits to care, all plans should report to an independent state ombudsman denials of service, including partial denials (e.g., when a patient receives fewer hours than recommended by the treating provider), and in the case of home and community based services, the adequacy of the workforce. Access to providers should be monitored, in part, by collecting and regularly reviewing payment rates to providers and the numbers of providers in each plan by category. Plan reports should be double-checked by “secret shopper” surveys to determine if listed providers are actually taking new patients. All reports should be transparent and available to the public on a very timely basis (e.g. monthly) to identify problems as they emerge.

Recommendation:

1. *Data collection.* Collect sufficient data to determine if plans are maintaining or expanding access to care, providing high-quality care, addressing health disparities, and lowering costs.
2. *Oversight.* Develop and implement systems of oversight at multiple levels to ensure that beneficiaries are adequately protected.
3. *Transparency.* Data collection, evaluation, and oversight efforts should be timely, transparent and available to the public.
4. *Ombudsperson.* Fund an ombudsperson program for each demonstration to receive and respond to complaints and to monitor overall demonstration activity.

X. REBALANCING AND REINVESTMENT OF SAVINGS

Medicare and Medicaid integration provides opportunities to promote greater rebalancing of long-term services and supports from institutional settings to home and community-based services. While many states clearly articulate goals to rebalance, proposals are often vague about financial incentives to promote rebalancing. We encourage CMS to ensure meaningful aging and disability stakeholder engagement in establishing incentives. CMS should also encourage states to offer options for self-direction of home and community-based services. Finally, some states have proposed carving out long-term services and supports in nursing homes and other institutional settings. This will significantly decrease their ability to incentivize rebalancing and preventable hospital admissions from such facilities. CMS should not approve demonstrations that carve out nursing home and institutional services.

States realizing savings from their demonstrations have an opportunity to reinvest the money into the project or services that benefit dual eligibles or other vulnerable individuals. Several states mentioned reinvesting savings back into their demonstrations. While other states do not mention reinvestment in their proposals, it is possible they are considering it. Reinvesting and rebalancing are important, otherwise, there is no new funding, no new slots, and the same number of people remain on waiting lists.

Recommendations:

1. *Financial incentives.* Ensure meaningful aging and disability stakeholder engagement in developing financial incentives to rebalance.
2. *Self-direction.* Encourage states to provide options for self-direction of home and community-based services.
3. *Carve outs.* Prohibit carve outs of nursing home and institutional services.
4. *Reinvest savings.* Encourage states to use demonstration savings to reinvest in home and community-based services and supports.

In summary, we realize that the demonstrations are designed to test new approaches and some details will evolve over time, but we urge you to consider the issues outlined in this document. Our goal is to advance the demonstrations so that they can succeed in identifying new and improved ways of providing quality care to distinct dual eligible populations.