



DATE: July 15, 2014

TO: Centers for Medicare and Medicaid Services

FROM: Jim Carnes, Policy Director, Alabama Arise/Arise Citizens' Policy Project

RE: Comments on proposed Alabama 1115 Medicaid Transformation waiver

COMMENTS TO CMS ON PROPOSED ALABAMA MEDICAID 1115 WAIVER

By Alabama Arise/Arise Citizens' Policy Project

July 15, 2014

Alabama Arise appreciates the opportunity to comment on Alabama Medicaid's proposed Regional Care Organization (RCO) 1115 waiver. Alabama Arise is a statewide coalition of 145 congregations and organizations that promote public policies to improve the lives of low-income Alabamians. Our members understand that Medicaid is the backbone of the health care infrastructure on which we all depend. When Governor Bentley appointed Arise policy director Jim Carnes as the sole consumer representative on the Medicaid Advisory Commission in 2012, we assembled a coalition of advocacy groups to monitor the commission's work and provide additional consumer input through Arise. Toward that end, the coalition drafted and submitted to the commission a set of principles for consumer-centered Medicaid reform (*see Appendix*). These principles informed Arise's response to the commission report and the resulting legislation. They continue to inform our ongoing efforts to ensure the strongest possible consumer protections in the Medicaid transformation process, as reflected in the comments we offer here.

Medicaid reform offers Alabama an unprecedented opportunity to improve patient experience, improve health outcomes and lower health costs. The 1115 waiver proposal represents a partial roadmap to achieving those goals. While the proposal hews closely to the provisions of the RCO legislation enacted last spring, that conformity presents serious limitations. More fundamentally, the proposed financing system uses a piecemeal array of Designated State Health Programs to draw federal matching funds for services and populations that could be covered more comprehensively – and at 100 percent match during the transition period – through Medicaid expansion. Additionally, while the proposal would move Alabama in the right direction on care coordination, it fails to take full advantage of the opportunity, which is unlikely to be revisited at this scale in the foreseeable future.

The following comments by Alabama Arise address these and other concerns in five broad areas: 1) financing; 2) range of beneficiaries covered under RCOs; 3) consumer engagement and oversight; 4) quality improvement and network adequacy; and 5) health equity. We also offer suggestions for two strategies that could address these concerns and strengthen the RCOs' prospects for success: 1) creating a resource hub, analogous to Oregon's Health Transformation

Center, that provides technical assistance, data analysis, innovation support, program evaluation and other services to all five RCOs individually, as well as connecting them through a learning community; and 2) leveraging new tools available through the Affordable Care Act (e.g., enhanced community needs assessment requirements for nonprofit hospitals) to accomplish RCO goals and objectives (e.g., public engagement). We further recommend enhancing the glossary of key terms.

- Financing

To support the development, transition and ongoing operation of coordinated care under the RCOs, the waiver proposes to create three separate but interrelated “funding pools” comprising both state and federal dollars: 1) funding for designated state health programs (DSHPs) that provide Medicaid-like services to Medicaid-like populations (e.g., outpatient mental health services for childless men ineligible for Medicaid); 2) transition payments to hospitals and other eligible providers to cover costs of transitioning to the RCO model; and 3) a Delivery System Reform Incentive Payment (DSRIP) program for eligible providers that links provider payment to quality outcomes. By seeking federal Medicaid matching funds for state-funded DSHP services that could otherwise be incorporated directly into Medicaid through expansion, the waiver unnecessarily perpetuates the fragmentation of care for DSHP patients, contradicting a basic premise of the RCO transformation. In so doing, the waiver creates, in effect, two tiers of services within the Medicaid financing system.

Recommendation: Expand Alabama Medicaid to serve low-income adults. Arise believes expansion would promote successful RCO transformation in a variety of ways, including: 1) bringing new federal dollars (at 100 percent match through 2016) into the system and freeing up for discretionary use state dollars that currently fund DSHPs in their entirety; 2) bringing working adults into the Medicaid population, thereby broadening and diversifying the pool of participants in RCO care transformation; 3) improving health outcomes across a broader segment of the state population; and 4) strengthening community support for the Medicaid program. At the very least, expansion should be a benchmark during the five-year waiver period.

- Range of beneficiaries covered under RCOs

Alabama seeks a waiver of the comparability provision in order to exclude certain categories of beneficiaries from the RCO system. Arise opposes categorical exclusion of dually eligible beneficiaries, patients in long-term care facilities or utilizing home and community-based

waiver services and people with developmental disabilities from the RCO waiver. We believe that excluding these patient categories hinders the attainment of the demonstration project's stated "triple aim" of improving patient experience, improving health and reducing costs. The excluded populations account for the highest costs in the Medicaid program, and better coordinating their special care needs (including long-term services and supports) with their medical care will help reduce costs, improve care and increase patient choice. The *Alabama State Plan on Aging 2014-16*, published by the Alabama Department of Senior Services, includes the following explanation of cost savings available through expanded use of less restrictive long-term care services:

Alabama's current long-term care support system relies largely on Medicaid funded services. Currently, Alabama's Medicaid program does not have an option for people who are not completely independent and do not fully require the services of a nursing home, which may often lead to these Medicaid beneficiaries having no choice but nursing home placement. In Alabama, the average nursing home costs \$5,200 per month. Assisted living, which is not covered by Medicaid, costs approximately \$2,600 per month. Home and community-based waivers are for Medicaid eligible individuals who meet nursing home level of care and this option costs, on average, less than \$1,000 per month. (Page 28)

In the above-cited document and elsewhere, the State of Alabama acknowledges its over-reliance on the most restrictive and expensive long-term care service options. Under the proposed waiver, individuals in the excluded populations will languish in a "second-tier" Medicaid system that both denies them consumer choice and self-direction and fails to pursue a readily achievable major cost reduction. By the state's own reckoning, cited above, Medicaid could save \$50,400 per year for every nursing home resident who transitioned to home- and community-based services. Arise strongly urges that Medicaid incorporate long-term care beneficiaries into the RCO structure from the outset with the goal of maximizing opportunities for transition. We further recommend that Medicaid allow sufficient time for consultation with stakeholders (including consumers, medical providers, suppliers and family/community caregivers) and for collaboration among state agencies in program design. Ultimately, the success of these efforts will depend on the availability of affordable accessible housing and qualified caregivers, which will require innovative coordination among public and private entities. On a related issue, the waiver proposal allows individuals in certain categories to opt out of the demonstration program and continue to be served through the fee-for-service delivery system. However, it does not offer this protection to individuals with special medical needs whose systems of care are subject to disruption under the RCO system.

Recommendation: Ideally, the RCO proposal should be expanded to include voluntary participation (preferably with an opt-in provision, but at minimum an opt-out) by

dually eligible beneficiaries, those in long-term care facilities or utilizing home and community-based waiver services, beneficiaries with developmental disabilities (recipients of services through the intellectual disabilities waiver), recipients of rehabilitative substance abuse services, and children in foster care. In the absence of such expansion, we recommend that the waiver set substantive requirements for the statutorily mandated review of long-term care services (e.g., a comparative analysis of cost savings from existing HCBS waiver programs and the budgetary impact of the current nursing home reimbursement system, as well as an assessment of care requirements and quality safeguards for patients with complex medical needs).

Recommendation: Expand opportunities for nursing home residents to choose home- and community-based care, and take maximum advantage of funding incentives for such transition. Use demonstrated savings to enhance the full range of long-term services and supports.

Recommendation: Extend the opt-out provision to medically fragile individuals with precarious systems of care.

Recommendation: Whenever possible, RCOs should contract with community-based support services (e.g., those funded by the Ryan White Care Act for people living with HIV/AIDS, Independent Living Centers, Area Agencies on Aging and substance use disorder and mental health clinics). Further, because mutual trust among providers is essential for maintaining a continuum of care for beneficiaries, RCO risk-bearing entities should be required to seek input from non-risk-bearing community-based services in the design of RCO policies prior to certification.

- **Consumer supports, engagement and oversight**

Medicaid reform is more likely to ensure quality services that meet consumer needs if consumers and advocates are involved at all levels of planning and implementation. Meaningful consumer involvement reflects both the broad diversity of the patient population and the multiple stages of decision-making, monitoring and assessment. While the waiver requires each RCO to have a Governing Board of Directors that includes community representatives, along with a Citizens' Advisory Committee, it does not require the RCO to define the community it serves, thus omitting any means of assessing adequate community representation. Alabama Arise appreciates our statutory role in recommending consumer representatives, but the statutory language alone is not sufficient to ensure successful consumer involvement and

protections. Medicaid's power to approve governing board members and to approve the selection process for the Citizens' Advisory Committees (CACs) appears to overshadow advocates' statutory role in this process. The relationship between the CAC and the board remains undefined in the proposal. For example, can CAC members (other than those also serving on the board) attend board meetings? What are the minimum expectations for the relationship between the CAC and beneficiaries? How will the RCO seek input from and disseminate information to beneficiaries? The proposal defers to the RCO contract process on standards related to special populations, data collection; privacy, utilization review and other topics. Arise is concerned that this approach invites variability from region to region that may hinder quality of care and transparency. A key to the success of RCO transformation (across the patient, provider and budgetary perspectives) will be rigorous attention to appropriate provision of services. Nowhere in the proposal do we find requirements for Medicaid or RCOs to collect, evaluate and report data on RCO eligibility determinations, approvals, denials, appeals and grievances. To ensure maximum opportunity for success, the state must employ aggressive, clearly defined quality and accountability safeguards that emphasize consumer protection, support and engagement.

Additionally, we are concerned that new legislation allowing the appointment of an executive committee by each RCO board could exempt important decision-making from consumer oversight.

Recommendation: Medicaid should establish an independent statewide ombuds office and consumer hotline, with annual reporting, to provide both individual assistance and advocacy for system improvement. In response to similar comments by Arise and others during draft proposal review, Alabama Medicaid determined that "it lacks the statutory authority to create an ombudsman program for RCO members." Arise strongly disagrees, noting that the ombuds role is an administrative function in no way prohibited or limited by the RCO statute. The waiver proposal should specify basic requirements for consumer protection at the RCO level – e.g., a robust appeals process that links consumers directly to Medicaid review staff; and a clearly articulated definition of the community the RCO serves.

Recommendation: Medicaid and RCOs should be required to collect data on RCO eligibility determinations, approvals, integration of services, denials, appeals and grievances including number, speed, service type, outcome and beneficiary characteristics (including race, primary language, gender and disability). Evaluation of these data should be a part of regular RCO reviews. Medicaid should set quality

standards that include speed of eligibility determinations; patterns of approvals and denials or reductions in service from previous levels; degree of integration of services across settings; speed of appeals processing and grievance resolution. These standards should be incorporated into criteria for RCO certification. Medicaid should establish progressive sanctions for RCOs whose service determinations, appeals and grievances fall below minimum standards. Data and performance assessments with respect to RCO service determinations, appeals and grievances, as well as any progressive sanctions imposed, should be publicly available and posted on the Alabama Medicaid website. Medicaid should make readily available to beneficiaries consumer comments and other performance-rating information about providers and RCO administration.

Recommendation: Medicaid should monitor beneficiaries' experience in accessing providers. RCO contracts should require providers to demonstrate that they are treating all RCO beneficiaries the same as all other patients they serve (e.g., comparable appointment access and wait times, safeguards against denial of service to patients who exhibit behavioral or substance use problems, etc.).

Recommendation: The waiver should provide more specific safeguards for transparency. Medicaid should set basic guidelines for communications between the board and the CAC and between both bodies and beneficiaries.

Recommendation: While we understand that direct consumer or consumer advocate participation on an executive committee is likely to be unfeasible, given the need for ready availability and timely decisions, we urge Medicaid to develop rules and procedures that ensure transparency and accountability of executive committee proceedings – e.g., a requirement that that they report back to the full board within three days of meeting.

- Quality improvement and network adequacy

Meaningful Medicaid reform will address the central role that Alabamians' poor health outcomes play in the state's escalating health care costs. Increasing access to, utilization of and quality of preventive and primary care will reduce delayed interventions, preventable hospitalizations and chronic illness, which in turn will reduce costs. Governor Bentley recognized this relationship when he charged the Medicaid Advisory Commission with proposing "new care delivery models that support quality care and cost control" (Executive Order No. 35, Oct. 25, 2012). As the only consumer representative on the Medicaid Advisory

Commission, Arise raised the concern that the commission report focused primarily on cost predictability and control while directing only cursory attention to quality concerns. We find the same imbalance in the waiver proposal. To emphasize budgetary goals over defined health outcome goals could lead to cost-cutting that denies access to essential care. Further, Medicaid reform provides a unique opportunity to rethink Alabama’s long-standing “bare bones” model and consider offering more comprehensive services designed to improve the state’s health outcomes, not just to meet minimum standards for federal funding.

Special needs require special accommodation. Managed care that is well-suited to the average patient may not be adequate for individuals with complex health profiles, such as children with special health care needs, people with disabilities, frail elders, people with HIV/AIDS, and people with mental illness. Often, these individuals rely on particular care providers capable of delivering the full range of appropriate services (from weighing a patient in a wheelchair to intervening when the patient becomes ill), as well as complex drug regimens. Where the state has already demonstrated its ability to provide services in appropriate community-based settings (e.g., to persons with mental illness and intellectual disabilities), those supports should be strengthened and refined. Adding or expanding behavioral health, social services and transportation and coordinating them with medical services will likely produce substantial efficiencies. On a related note, Arise heartily supports the proposal to expand the Health Home program. Where the state has not provided appropriate community-based services (e.g., to prevent unnecessary nursing home admissions), supports must be created and expanded.

Accessible managed care requires a robust provider network. To comply with federal law, Medicaid should set standards for access ensuring that patients have a choice of providers (including those who speak their language and understand their cultural beliefs) and do not have to wait long or travel far for necessary care. Alabama should expand efforts to address our chronic health care provider shortage, particularly in rural areas. Low payments to providers are another obstacle to maintaining robust networks.

Recommendation: The state should go beyond federally required services to include prescription drugs, long-term care focused on home- and community-based services, behavioral health care, social services and supports, and transportation in a comprehensive plan.

Recommendation: The waiver proposal should include a clear definition of “medical necessity” that meets Olmstead Decision/ADA standards and Medicaid person-centered care requirements. The definition should promote individualized services to

help people with special needs achieve, as closely as possible, their own goals of inclusion, independence and productivity. Participation by such individuals in RCOs should reflect risk-adjusted capitation rates and should be strictly voluntary until Medicaid demonstrates the system's capacity to meet their needs.

Recommendation: Primary care provider payments should be as close to Medicare rates as possible (higher than Medicare for specialists) and adjusted for patient health and functional status. RCOs should aggressively recruit into their provider networks all qualified practitioners and suppliers who currently serve Medicaid disability and high-risk populations. The waiver should require Medicaid to set benchmarks, test regularly and report publicly on RCO provider network adequacy. RCOs should be required to establish specific benchmarks for increasing the diversity of their provider pools, to develop and implement strategies for meeting the benchmarks and to report publicly on outcomes.

Recommendation: The waiver should require RCOs to set quality standards for care coordination, collect necessary data and report regularly on findings.

- Health equity

Health disparities among racial and ethnic groups are persistent and contribute to higher costs of care for everyone. Despite national and state efforts to reduce disparities, Alabamians of color continue to experience poorer health than their White counterparts, including higher rates of infant mortality, low birth weight, lower life expectancy and increased prevalence of chronic diseases. Regional Care Organizations provide paths to advance racial and ethnic health equity.

Recommendation: The proposal should require Medicaid and RCOs to follow the National Culturally and Linguistically Appropriate Services (CLAS) standards to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs” (HHS Office of Minority Health). Medicaid should require CLAS-compliant cultural competency training for all Medicaid and RCO staff in contact with the public. In addition to beneficiary notification requirements delineated in the waiver proposal, Medicaid should evaluate the effectiveness of such communications and develop notification strategies that would make beneficiaries more receptive and more likely to understand.

Recommendation: Medicaid should implement clear strategies, including extensive consumer education, to monitor and reduce multidimensional health disparities. Medicaid should participate in a multi-agency state effort to identify and achieve health equity goals. Annual reporting of RCO-level quality outcomes by race, ethnicity, gender and primary language should be required.

Recommendation: Each RCO should meaningfully and systematically engage representatives of critical population and community stakeholders to develop a community health assessment and a plan for addressing identified needs and reducing or eliminating health disparities in the community. The community health assessment should follow recognized national guidelines, such as those developed by the Public Health Accreditation Board (PHAB), the national accrediting body for state, local and territorial health departments.

- Health System Transformation Hub

When the Alabama Medicaid Advisory Commission looked to Oregon Medicaid’s community care organizations (CCOs) as a model for the RCO system, the resulting proposal omitted a crucial factor in Oregon’s success: a Health Transformation Center that links all of the state’s 15 CCOs through technical assistance, innovation support and accountability/quality assessment. The idea for the Center began with a statutory provision for “innovation agents” who would work in and among the CCOs to foster creative problem-solving. During waiver negotiations, CMS called for stronger accountability provisions, which led to the concept of a “hub” that would coordinate the innovation agents along with other cross-CCO functions. For example, the resulting Transformation Center facilitates learning networks in which CCOs, their community advisory councils and other participants learn from recognized experts and each other. These learning communities create opportunities for peer-to-peer learning and networking, identify and share information on evidence-based best practices as well as emerging best practices, and help advance innovative strategies in all areas of health system transformation. The Transformation Center also coordinates state- and CCO-level strategic planning for and monitoring of quality, utilization, health disparity and cost containment measures. Arise believes a similar hub linking Alabama’s five RCOs could significantly accelerate and strengthen the transformation process by amplifying “lessons learned” across the RCO network, reducing administrative redundancy, enhancing statewide data analysis, etc. Such a hub could assume several of the key functions outlined in the waiver proposal – e.g., coordination of DSRIP incentives or an equivalent initiative; development and implementation of health equity

strategies; and RCO quality monitoring and evaluation. The hub's budget could encompass costs already assumed for these and other currently embedded functions, along with potential savings from efficiencies and scale, and potential grant funding.

Recommendation: Medicaid should establish a hub analogous to the Oregon Health Transformation Center to provide technical assistance, innovation support and accountability/quality assessment across the RCO network. Medicaid responded to a similar recommendation at the proposal draft stage by noting that it will “consider options for providing ongoing technical assistance and support to RCOs.” Arise believes that such provisions are crucial to RCO success and should be defined clearly in the waiver.

- New ACA tools

The Affordable Care Act creates a number of new tools and opportunities that can help Alabama's RCO transformation succeed. For example, the newly strengthened community needs assessment requirement for nonprofit hospitals offers a mechanism and process that could enhance RCOs' understanding of and responsiveness to their communities. The ACA also offers strong incentives to expand home- and community-based care.

Recommendation: Medicaid should identify and engage provisions of the Affordable Care Act that align with RCO goals and functions. For example: 1) RCOs should provide coordination and technical support to non-profit hospitals in their region for community needs assessments required by the ACA so that such assessments can contribute meaningfully to RCO community engagement, community health assessment, quality improvement and health equity efforts; 2) In the interest of improving care and reducing cost, Alabama should take full advantage of the opportunity to incorporate the health home model, with its 90 percent federal match rate, into a rebalancing plan for long-term care under the RCOs; 3) Alabama should pursue funding through the Balancing Incentive Program (deadline August 2014 or until funds are exhausted) to increase access to non-institutionally based long-term services and supports – *Note: In a 2010 survey by AARP and the National Association of States United for Aging and Disabilities, Alabama Medicaid officials indicated that Alabama was “somewhat likely” to apply for the Balancing Incentive Program;* and 4) Alabama should apply for funding available through the ACA to deliver critical health, development, early learning and family support services to children and families through an expanded maternal, infant and early childhood home visiting program.

- Glossary

Technical language, including medical terminology, administrative nomenclature and associated acronyms, is an indispensable condition of Medicaid waivers. Equally essential is a glossary of key terms in plain language that bridges the gap between specialist and layperson. Arise applauds the inclusion of a glossary in the waiver proposal but finds it incomplete.

Recommendation: Medicaid should promote transparency, accessibility and consistency in the waiver process by expanding the glossary to include all technical terms used in the proposal (e.g., “collaborator”; “mental health worker”; “targeted case management:), as well as other concepts integral to RCO operation (e.g., “community health assessment”; “medical necessity”).

Respectfully submitted,

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Appendix

Patients First: Principles of Consumer-Centered Medicaid Reform

Arise Citizens' Policy Project has assembled a coalition of 17 advocacy organizations (see attached list) to provide consumer input on the Medicaid reform process. We offer the following eight core principles of consumer-centered Medicaid reform, with a focus on Medicaid managed care:

- 1. Better health is the bottom line.** Meaningful Medicaid reform will address the central role that Alabamians' poor health outcomes play in the state's escalating health care costs. Increasing access to and utilization of preventive and primary care will reduce delayed interventions, preventable hospitalizations and chronic illness, which in turn will reduce costs. To set budgetary goals apart from defined health outcome goals could lead to cost-cutting that denies access to essential care.
- 2. Consumer engagement is essential.** Medicaid reform is more likely to ensure quality services that meet consumer needs if consumers and advocates are involved at all levels of planning and implementation. Meaningful consumer involvement reflects both the broad diversity of the patient population and the multiple stages of decision-making, monitoring and assessment.
- 3. Effective consumer outreach includes education and assistance.** Getting patients enrolled in Medicaid coverage is not enough. New enrollees need information, in the language they speak, about how plans work and assistance with navigating the system, as well as means to address consumer problems and resolve disputes. The state should work with trusted consumer and community organizations that know patients' needs to identify and plan these processes and develop the necessary resources.
- 4. Successful managed care treats the whole person.** Medicaid reform offers Alabama an unprecedented opportunity to reject the "bare bones" model in favor of more comprehensive services designed to improve the state's health outcomes, not just to meet minimum standards for federal funding. The state should go beyond federally required services to include prescription drugs, long-term care focused on home- and community-based services, behavioral health care, social services and supports, and transportation in a comprehensive plan.
- 5. Special needs require special accommodation.** Managed care that is well-suited to the average patient may not be adequate for individuals with complex health profiles, such as children with special health care needs, people with disabilities, frail elders, people with HIV/AIDS, and people with mental illness. Often, these individuals rely on particular care providers capable of delivering the full range of appropriate services (from weighing a patient in a wheelchair to intervening when the patient becomes ill), as well as complex drug regimens. Where the state has already demonstrated its ability to provide services in appropriate community-based settings (e.g., to persons with mental

illness and intellectual disabilities), those supports should be strengthened and refined. Where the state has not provided appropriate community-based services (e.g., to prevent unnecessary nursing home admissions), supports must be created and expanded. Alabama should adopt a clear definition of Medical Necessity that promotes individualized services to help people with special needs achieve, as closely as possible, their own goals of inclusion, independence and productivity. Participation by such individuals in managed care should reflect risk-adjusted capitation rates and should be strictly voluntary until Medicaid demonstrates the system's capacity to meet their needs. Once enrolled, these patients must have the right to opt out if their plan fails to provide the necessary supports.

Expanding home- and community-based long-term care can improve outcomes and save money.

Managed care for individuals who depend on long-term services should employ proven care models based on consumer choice and self-direction. Program planning should allow time for consultation with stakeholders (including consumers, providers, suppliers and managed care organizations), for collaboration among state agencies in program design, and for working with CMS to obtain approval. Ultimately, the success of these efforts will depend on the availability of affordable accessible housing and qualified caregivers, which will require innovative coordination among public and private entities. Whenever possible, Medicaid should contract with community-based support services (e.g., those funded by the Ryan White Care Act for people living with HIV/AIDS). The Affordable Care Act offers strong incentives to expand home- and community-based care – for example, by combining “rebalancing” initiatives with the health home model that brings a 90 percent federal match.

7. Accessible managed care requires a robust provider network. To comply with federal law, Alabama should set standards for access ensuring that patients have a choice of providers (including those who speak their language and understand their cultural beliefs) and do not have to wait long or travel far for necessary care. Alabama should expand efforts to address our chronic health care provider shortage, particularly in rural areas. Low payments to providers are another obstacle to maintaining robust networks. Primary care provider payments should be as close to Medicare rates as possible (higher than Medicare for specialists) and adjusted for patient age and health status. Managed care plans should aggressively recruit into their provider networks all qualified practitioners and suppliers who currently serve Medicaid disability and high-risk populations.

8. Quality and accountability bring Medicaid reform full circle. To ensure that managed care in Alabama achieves the dual goals of improving health outcomes and lowering health care costs, the state must employ aggressive quality and accountability safeguards, such as the following:

- full use of oversight authority under federal and state law;
- full compliance with the Americans with Disabilities Act, the Rehabilitation Act of 1973, and the Olmstead decision;
- full compliance with federal and state sunshine and disclosure laws;
- financial incentives to reduce harmful or unnecessary care;

- independent ombudsman to maintain consumer hotline, address consumer complaints, identify systemic problems and propose solutions to the state, and issue a public report annually on the type and number of complaints;
- a robust appeals process that links consumers directly to Medicaid review staff;
- cultural competency training for all Medicaid and plan staff in contact with the public;
- clear strategies to assess and improve quality of managed care, including annual reporting of quality outcomes by race, ethnicity, gender and primary language;
- clear strategies to monitor and reduce multidimensional health disparities;
- smart, consumer-friendly cost containment strategies that do not cut eligibility, benefits or provider fees (options include reducing payment for preventable complications and readmissions, and expanding use of generic drugs);
- penalties for plans that skimp on services; and
- per-patient payment rates that adequately reflect the cost of providing comprehensive care to the population served, which will be higher for people with complex health needs.

We, the undersigned consumer advocacy organizations, endorse the guidelines set forth in “Patients First: Principles of Consumer-Centered Medicaid Reform”:

AARP Alabama

AIDS Alabama

Alabama Appleseed Center for Law & Justice, Inc.

Alabama Arise and Arise Citizens’ Policy Project

Alabama Association of Area Agencies on Aging

Alabama Council of Community Mental Health Boards

Alabama Disabilities Advocacy Program

The Arc of Alabama, Inc.

Community Action Association of Alabama

Disabilities Leadership Coalition of Alabama

Family Voices of Alabama

Federation of Child Care Centers of Alabama (FOCAL)

Greater Birmingham Ministries

Independent Living Resources of Greater Birmingham

Legal Services Alabama

United Cerebral Palsy of Alabama

VOICES for Alabama’s Children