June 29, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: California Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Dear Ms. Bella:

Thank you for the opportunity to submit comments on California's proposal for a demonstration to Integrate Care for Medicare-Medicaid Enrollees. As detailed below, while AARP supports integration efforts generally, we have serious concerns as to this proposal in its current form.

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP's mission is to help people 50 plus have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. AARP California, representing over three million members, is the state's largest organization representing the needs, views, desires, and hopes of the 50 plus population.

AARP California has a particular interest in this project because most dual eligibles are age 50 plus. Many dual eligibles have severe and persistent mental illness, dementia or other cognitive impairments and/or multiple chronic medical conditions and require long-term services and supports (LTSS) in either an institutional, home or community setting. These factors limit their ability to be actively and effectively involved in the complex decisions the Proposal requires them to make on plan participation, plan and provider selection, care planning and implementation, and grievances and appeals. Protecting this large (1,100,000) and unique population, their rights, and their health and safety will require standards for proactive oversight and advocacy of the highest level — that equal or exceed consumer protection standards found in any other U.S. public or private health care or government benefit system.

As detailed below, we believe that California's proposal is too large, does not include adequate consumer protections, and is premature – in terms of state readiness and the availability of managed care plans capable of delivering the high quality services and supports this population needs and deserves. We believe that specific modifications in the Proposal or requirements in the

terms and conditions are warranted to better protect consumers and to ensure that they receive high quality care and support.

Scale

It is imperative that the state take a cautious approach to putting vulnerable older adults and persons with disabilities into risk-based managed care plans. The proposed capitated financing arrangement for medical services and LTSS will change incentives, undoubtedly in ways that cannot all be anticipated, particularly since most managed care plans have no experience in administering LTSS.

AARP believes CMS and California should limit the scale of this proposal to afford adequate and rigorous examination of the impact of the demonstration including performance results on quality and efficiency. California should not enroll the majority of its dual eligible population before a limited demonstration project is undertaken, evaluated and proven to effectively and safely meet the needs of the population. While we supported California's initial plan for a four county demonstration, the final Proposal includes eight counties and over 60 percent of the total state dual population (685,000 of 1.1 million) in 2013 with expansion to 58 counties by 2015. The addition of Los Angeles, a county the size of Ohio, in the demonstration's first year is particularly disconcerting. We believe that the Proposal should be scaled back to include San Mateo and Orange counties, which are both ready and appropriate for the demonstration, and San Diego which is clearly the most ready of the geographic managed care counties.

Qualified Plans

Most of the Proposal's selected managed care plans have very poor scores on patient experience measures, as reflected in the latest report of the External Quality Review Organization on the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The ratings on "Getting Needed Care" show that all but two of the plans selected have ratings of one star out of five, indicating they have "poor" performance in comparison to Medicaid plans nationwide. These plans also scored below average in the California Medical Managed Care ratings. The CMS website, Medicare.gov, includes a warning to consumers that one of the selected plans in San Diego, Molina Healthcare, has had low ratings for three years. The National Senior Citizens Law Center recently published a report summarizing the Medicare and Medi-Cal quality ratings of the selected plans based on Medicare and Medi-Cal quality ratings for the eight health plans selected by the California Proposal, Assessing the Quality of California Dual Eligible Demonstration Health Plans, May 2012. This report raises serious questions about the ability of the selected managed care plans to provide well coordinated, high quality care to this vulnerable population.

AARP also believes that all managed care plans in dual demonstration programs should be required to obtain National Committee for Quality Assurance (NCQA) accreditation. Currently, nine states and the District of Columbia require NCQA accreditation for managed Medicaid plans. We believe that establishing this baseline will emphasize the value and importance of strong quality measures with the Proposal.

Enrollment

California has proposed a passive enrollment system but with only written notices and a call in center and references to an outreach and education component that has yet to be designed. This is not an appropriate or adequate system for this population, given the high incidence of physical or developmental disabilities; mental illness, dementia or other cognitive impairments (44 percent); and multiple chronic conditions (over 50 percent). Ensuring that each participant, representative, and/or family member thoroughly understands the program, any changes in care delivery, and their options and rights will often require face-to-face outreach to members and families as well as access to competent, independent counseling. Other states have included independent Enrollment Brokers to provide this counseling. We believe that it is critical that there be a system for conflict-free, independent enrollment counseling with clearly identified, adequate, and stable funding. The Proposal only provides for assistance from community-based nonprofit organizations <u>if</u> private or public funds become available (page 27). AARP believes that this demonstration should not go forward unless and until a stable, ongoing source of funding is identified and dedicated to providing independent choice counseling for dual eligible beneficiaries as they make very complex and difficult decisions on participation in the demonstration and plan and provider selection. It is difficult to imagine how adequate outreach and counseling programs for this population could be designed, implemented and completed prior to the proposed March to June 2013 starting date.

The Proposal includes a mandatory six month lock-in period. The most highly valued protection in any consumer situation is the ability of the dissatisfied to take their business elsewhere. Allowing consumers the right to opt out at any time would incent plans to provide high quality medical and support services and good customer service. Particularly in light of the poor track record of the selected plans on patient experience measures, we believe that any mandatory lock-in period is inappropriate. Allowing disenrollment at will would also provide the best early warning sign that there are issues that beneficiaries are unable to resolve within the plans. At a minimum, consumers should have the right to disenroll at any time for cause, *e.g.,* a proposed reduction of the quantity or quality of care or an involuntary change in the provider of long-term services and supports.

<u>Timing and Oversight Capacity</u>

Even if all the issues addressed above could be quickly resolved, we believe the proposed starting date is not viable. The Proposal calls for the enrollment of 685,000 individuals starting by June 1, 2013. Many states' less expansive integration proposals have adopted later starting dates, or in response to stakeholder concerns, have delayed starting their programs to 2014. California should be required to delay implementation until 2014 so the considerable work that needs to be done can be accomplished before implementation.

Because of California's dire financial condition, a high number of vacant positions within the Department, and the restructuring and changing job responsibilities attendant to this momentous undertaking, the state has severe capacity issues that we believe will affect its ability to effectively

design and oversee this demonstration. The ongoing budget crisis in California is driving premature implementation of this proposal for the wrong reasons and is hindering the development of the checks and balances systems required to make this demonstration successful.
It is generally acknowledged that a fee-for-service system rewards over utilization while a capitated payment system rewards underutilization. While the better coordination and high quality care envisioned in the Proposal may make reductions in total care, services and costs possible, a capitated system's inherent financial incentive to simply spend less remains. Consumers, California and CMS will best be served by a robust, multi-faceted system of checks and balances. We are uncomfortable having this demonstration move forward until the state is able to address the key design issues sufficiently in advance of implementation so all stakeholders know what is being proposed, and what role the various state agencies, the EQRO, consumers and others will have in overseeing and evaluating the demonstration.

Appeals and Grievances

The Proposal lacks adequate detail on an appeal and grievance system and relies on the capitated managed care plans to assist beneficiaries with appeals and grievances (page 29) despite the plans' inherent conflict of interest. The dual eligibles will need ready access to adequately funded, independent, and conflict free advocacy assistance to ensure that they receive access to the full range of benefits and rights afforded by both Medicare and Medicaid. Advocacy will be complicated by the significant differences as well as overlaps in Medicare and Medicaid benefits and by disparate appeals processes, with differing coverage standards set by federal and state law, regulation and policy; different administrative and judicial forums, procedures and timetables; and different governing state and federal case law. Ensuring that benefits and rights are maintained and protected under both programs will require highly skilled, professional staff with sophisticated knowledge, medical and legal expertise, and experience.

Many grievances and appeals will be decided based on medical opinion and evidence. In contests between the plans, their attorneys and their health care professionals, dual eligibles will be at a distinct disadvantage. To counterbalance the plans' monopoly on medical records and expertise, enrollees should have access to an independent medical and functional assessment for the purposes of rebutting plan proposals to deny or reduce services.

Financial Incentives

While the Proposal appropriately includes financial incentives for plans and providers based on quality measures (page 30), AARP believes that incentives should also be based on consumer experience measures (i.e., CAHPS scores) since most of the plans selected clearly need to improve their performance in this critical area.

Capitation Rates

The Proposal indicates it will seek a waiver to obtain "flexibility related to actuarial soundness if required for the blended payment rate" (page 35). AARP is concerned about flexibility regarding the requirements for actuarial soundness given the state's dismal fiscal condition. AARP has been

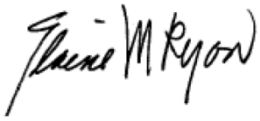
very vocal about the unrealistic estimates of state budget savings relating to this demonstration advanced in the state budget process and what that may mean for beneficiaries if the demonstrations are inadequately funded and estimated budget savings are not realized. The benefits and services to which beneficiaries are entitled need to be crystal clear and funding needs to be adequate to provide those benefits and services. The lack of specificity as to the flexibilities and changes to Medicaid rules that the state contends are needed, make it impossible for consumers and other stakeholders to meaningfully assess the impact that the demonstration will have on access and quality.

While we believe that it is possible to create an integration demonstration program that would improve care and quality of life for dual eligible individuals, this Proposal, in its present form, falls far short. AARP remains committed to working collaboratively with California and CMS on creating and implementing a high quality dual eligible financial alignment demonstration that will improve the delivery of care as well as improve health, functional outcomes and quality of life for beneficiaries.

Thank you for the opportunity to comment on this Proposal. If you have questions, please feel free to contact Katie Hirning at (916) 556-3030 or KHirning@aarp.org.

Sincerely,

Katie Hirning
AARP California



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