United States House of Representatives
Committee on Ways and Means, Subcommittee on Health
Hearing on Medicare Payment Advisory Commission's (MedPAC)
June Report to Congress
June 19, 2012

Mr. Chairman and Members of the Committee:

The National Senior Citizens Law Center (NSCLC) appreciates the opportunity to submit this statement for the record on the recommendations in the June 2012 Medicare Payment Advisory Commission (MedPAC) report to Congress. NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults through advocacy, litigation and counseling of local advocates. NSCLC supports the goal of ensuring that Medicare-Medicaid enrollees (dual eligible individuals) have seamless access to high quality health care.

In the June Report, the Commission discusses the Centers for Medicare and Medicaid Services' (CMS) efforts to collaborate with states to develop integrated care programs for dual eligible individuals. As part of this effort, CMS awarded 15 states contracts of up to $1 million to design a program that covers primary, acute, long-term care and behavioral health. NSCLC supports the demonstration. We hope that states will use the opportunity presented by the demonstration to develop innovative, person-centered systems of care. As advocates for low-income older adults, we are committed to ensuring the demonstrations include strong consumer protections. NSCLC is pleased to see the Commission call attention to concerns regarding ensuring beneficiary protections in the demonstration, and we share the Commission's concerns.

As the report notes, an implementation date of January 1, 2013 gives CMS and the states a short period of time to prepare for implementation and to resolve several demonstration issues-including project scope, plan standards, and passive enrollment-that could have negative effects on dual-eligible beneficiaries' access to and quality of care. We are pleased to see that several states have decided on a later implementation date. Time is needed to work out the many details that must be in place for individuals to safely transition into new systems. There are far too many key areas where CMS and the states have not yet decided on direction.

Scope of the demonstration:

The Commission questions whether the large scope of many of the demonstration proposals is in the best interest of the beneficiary. With many states proposing to enroll

most or all of the dual-eligible beneficiaries in the state, the proposals appear to be large-scale program changes rather than true demonstrations. Not only does the large scale call into question the characterization of those proposals as a "demonstrations," but it introduces a host of issues jeopardizing quality care, such as: plan capacity, beneficiary access, and ability to evaluate the demonstrations.

For example, in California, the state seeks authority to transition close to 700,000 duals into capitated managed care plans in year one and all of its 1.1 million dual eligible individuals by 2015. Los Angeles County, which was selected for the demonstration's first phase, will transition all of its dual eligibles, over 350,000 individuals, into one of two health plans in 2013. If the plans fail to meet beneficiaries' needs, it would be very difficult to transition so many individuals with complex care needs out of the demonstration, further complicating access to providers and care management plans.

The California example also demonstrates why the Commission's concern that the demonstrations are not going to be evaluated properly is well founded. As the Commission points out, if most or all of a state's dual eligible beneficiaries are enrolled in the demonstration, there is not a sufficient sample of comparable beneficiaries in Medicare fee-for-service to be able to test whether the demonstration improved care and reduced cost. NSCLC agrees with the Commission that proposals to use a pre/post demonstration study design are not as strong as studying an intrastate control group. NSCLC recommends that CMS require each state to maintain a clearly identifiable, size-appropriate control group, and that the agency disfavor proposals that include all of the dual eligible individuals in a state or metropolitan areas.

Plan Experience:

The Commission draws attention to the lack of experience participating plans have with the dual eligible population, and the need for information from CMS and states on how both will ensure that beneficiaries receive the care they need, given that lack of plan experience. We add to the Commission's concern the fact that few plans have any experience providing the long term services and supports (LTSS) that will be part of the demonstrations.

In the California example, Los Angeles County proposes to enroll all of its dual eligible individuals into one of two health plans. One plan was recently sanctioned for Medicare access problems, and the other recently received a CMS compliance notice for poor quality.[1] Combined, the two plans currently serve just 7,000 dual eligible

[1] National Senior Citizens Law Center, Assessing the Quality of California Dual Eligible Demonstration Health Plans, available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Plan-Ratings-Report-May-2012.pdf.

individuals in their Dual Eligible Special Needs Plans (D-SNPs).[2] Neither plan has any experience providing LTSS. The California proposal validates the Commission's doubt that all health plans participating in the capitated model have the experience and capacity necessary to care for large numbers of vulnerable individuals.[3]

Underscoring its concern regarding plan experience, the Commission highlights the following areas where additional information is needed from CMS and the states:

- Will plans participating in the demonstration be able to establish provider networks and provider payment rates that encourage high-quality care and care coordination for services?
- How will CMS and states balance having plans available to participate in the demonstration, with selecting plans with enough experience for a reasonable expectation of success?
- What standards will plans participating in the capitated model need to meet? How much will these standards change during negotiations between the state and plans?
- How will plans be selected for participation?
- What role will quality rankings play in selecting plans in each state?

NSCLC hopes that CMS and the states will have clear answers and a plan for all of Commission's questions before any demonstration proposal is approved. NSCLC recommends that CMS and the states require plans to demonstrate in advance that they have expertise in serving all beneficiaries in the demonstration. Plans that are unable to specify how they will care for specific sub-populations should not be included for participation. This will require plans to develop appropriate provider networks, and will require plans to establish systems to vigorously monitor network capacity. CMS and the states should allow time for network development before implementing a demonstration.

In addition, we appreciate the Commission's call for CMS and states to designate resources for monitoring beneficiary experience in the plans. Currently it is not clear that CMS and states will dedicate sufficient resources for oversight and monitoring.

[2] Health Net, MQR #7a–Attachment 5 in *California's Dual Eligible Demonstration Request for Solutions - Los Angeles County Application* at 289-91 (February 29, 2012) ("*Health Net Medicare Disclosures*"), available at *www.dhcs.ca.gov/provgovpart/Documents/Duals/RFS%20Applications/Health%20Net%20LA%20County%20Large%20Format.pdf*.

[3] MedPAC Report to Congress: Medicare and the Health Care Delivery System (June 2012) at 82.

Passive Enrollment:

NSCLC has consistently argued that enrollment should be based on a voluntary system in which dual eligibles must "opt in" to the integration model. An "opt-in" enrollment system honors the autonomy and independence of the individual by preserving for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries.

Instead of this voluntary system, CMS and states propose to use passive enrollment with an opt-out mechanism. The Commission raised the concern—which we share-- that in a passive enrollment system every state may not have the resources and information it needs to make intelligent assignments. Moreover, passive enrollment assumes that plans will have the capacity to meet the needs of all the dual eligibles who are enrolled and, as the Commission noted, there are questions about whether every health plan will offer high-quality care and care management models appropriate to all enrollees.

Although we continue to object to passive enrollment, NSCLC commends CMS for its decision not to allow states to "lock in" individuals into plans on the Medicare side of enrollment. However, despite CMS' position, several states continue to propose to lock individuals into a plan. As noted above, the Commission expressed concerns that plans may not be able to meet the complex needs of all the duals eligibles whom they enroll. Those concerns highlight why it is critically important that CMS maintain its prohibition on lock-ins so that individuals who cannot be served in a plan can promptly disenroll in order to get the care they need. Although the Commission only addressed the Medicare side of the enrollment issue, NSCLC believes that disenrollment from managed care for both Medicare and Medicaid services must be a continuing option for any dual eligible individual in a demonstration plan.

NSCLC appreciates the Commission's attention to the demonstrations, and values CMS' effort to better coordinate care for dual eligibles. Thank you for the opportunity to submit our views on this report. If you have any additional questions, please contact Fay Gordon at (202) 683-1992 or fgordon@nsclc.org.