November 2, 2011

The Honorable Cindy Mann
Deputy Administrator and Director
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Director Mann:

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP’s mission is to help people 50+ 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. Thus, we are writing to express our concerns regarding the Medicaid waiver requests submitted by the state of Florida on August 1, 2011, and our strong opposition to them in their current form.

AARP, representing 2.7 million older Americans residing in Florida, believes that the waiver submissions by the state of Florida should be rejected. The expansion of the current five-county pilot to a statewide managed care program under the 1115 Waiver Demonstration Amendment neither addresses the shortcomings of the current pilot program, nor recognizes the need for both a strong state oversight and a robust network of providers throughout the state. The applications for the combined 1915 (b) and (c) waivers would place the state’s frailest and most vulnerable residents into a long-term managed care program that this state is not ready to operate, and that lacks the safeguards to ensure enrollees will receive the care and services they need.

Florida Medicaid Reform 1115 Waiver Demonstration Amendment

The state seeks authority to expand the current five-county managed acute-health care demonstration waiver statewide. This expansion would provide services in 11 regions across the state with at least two managed care plans in each region. The expansion would begin a phased implementation in 2013 that would be completed by Oct. 1, 2014.

The current demonstration waiver began enrolling beneficiaries on Sept. 1, 2006. In the succeeding years, problems concerning access to care arose in the demonstration. CMS noted these concerns in its April 28, 2011, letter to the Florida Agency for Health Care Administration (AHCA). The letter referenced “concerns that have been raised about access to care in the five county pilots.” These concerns are highlighted in a recent study by Georgetown University’s Health Policy Institute which noted that the withdrawal of health care plans from markets left vulnerable enrollees without a source of care. The

1/AARP Florida Waiver Letter 11/02/11

W. Lee Hammond, President
Addison Barry Rand, Chief Executive Officer
study cited as one example the case of Wellcare, which held 55 percent of the market share in Duval County in 2008. Wellcare’s departure from the market caused significant disruption when it withdrew in 2009.¹

Based on our knowledge of the experience with Medicaid managed care plans implemented in other states, AARP is convinced that state governments must take a hands-on management approach to effectively oversee managed care contracts. States should be required to review and approve a clear and a detailed delineation of service organization and delivery. It is very important for the state to identify metrics that would be used to assess the contracts and performance of the managed care organizations in a range of relevant areas, including network adequacy, quality, patient experience, and resource use. These contracts should be available for public inspection.

Long-Term Care Managed Care Program

The state submitted waiver applications for 1915(b) and 1915(c) demonstrations to implement the Florida Long Term Care Managed Care program. The program would allow the state to require eligible Medicaid recipients to receive their nursing facility, hospice and home and community based services through managed long term care plans selected by the state. The plan would be implemented beginning January 1, 2013 and be completed by October 1, 2013.

As stated in our Sept. 1 letter to you, AARP believes that elderly and disabled enrollees will be at risk if these waiver applications are approved.

The combined 1915 (b) and (c) waiver applications submitted by Florida’s Agency for Health Care Administration (“AHCA”) for the Long-Term Care (“LTC”) Managed Care Program would, in a little more than a year’s time, subject Florida’s vulnerable senior, low-income/disabled adults to a new, untested, statewide managed long-term-care program. AARP remains highly skeptical about the capacity of the state and the ability of the managed care organizations (MCOs) to effectively implement the managed long-term care program as the first component of the statewide Medicaid mandatory managed care expansion.

Florida’s Medicaid reform legislation and the waiver requests submitted pursuant to that legislation raise many questions and concerns about the sufficiency of the program as conceived and as being implemented. There are many unanswered questions, e.g., about specific procedures, quality outcomes and measurements, transparency, and adequacy of service networks.

Accountability and Monitoring
AARP believes that states have an obligation to provide effective oversight of the programs with which they contract to provide services to its frailest and most vulnerable citizens. Florida (or any other state) should not be permitted to reduce its Medicaid role

¹ Jack Hoadley and Joan Ackler, As Legislators Wrestle to Define Next Generation of Florida Medicaid, Benefits of Reform Effort Are Far From Clear, Health Policy Institute, Georgetown University, April 2011

2/AARP Florida Waiver Letter 11/02/11
and responsibilities by simply paying (MCOs) and relinquishing these functions to them. Final accountability for the performance of its contractors, including managed care plans, must remain with the state. The state should be expected to discharge this responsibility to safeguard the millions in taxpayer dollars it administers under the Medicaid program through rigorous oversight and ongoing performance assessment of managed care contractors. The state must be required also to act in the interests of all its citizens in making sure consumers receive the right care, in the right place at the right time. Florida should not be permitted to contract away its ultimate obligation to protect its residents’ welfare, particularly for those whose need for long-term services and supports evidences a diminished ability to self-advocate. Therefore, the state should take steps to assure the Centers for Medicare & Medicaid Services (CMS) and the public that its Medicaid agency is in a position (both from a staffing and knowledge perspective) to adequately monitor and enforce contracts that include long-term services and supports for those who are frail and/or who have disabilities.

**Network Capacity**

While AHCA expresses the intention to promote the health and well being of enrollees by assuring access to services, the waiver amendment does not detail the measures or oversight review of plans. The submission indicates only that the state will “establish specific standards for the number, type and regional distribution of providers in plan networks.” At this point, there is no possible way to determine if the standards the state sets will meet the needs of enrollees. The state should first make clear the standards for network adequacy supported by evidence based research and data, and provide a clear plan for oversight review that does not simply require the submission of data to the state on an annual basis.

**Quality Initiatives**

AARP believes that quality must be assured in all the services provided. The state should require MCOs to become accredited by the National Committee for Quality Assurance (NCQA) and attain the highest level of accreditation within the first year of operation.

The state will require MCOs to report annual performance measures on Healthcare Effectiveness Data and Information Set (HEDIS) and HEDIS-like measures. The 1115 waiver amendment states that additional measures will be developed and adopted with public input. AARP believes that there should be, at a minimum, a core set of standardized reporting measures, including patient experience measures. All quality measures should align with other federal, state and private quality reporting requirements to permit comparisons.

CMS should also establish other appropriate measures for assessing long-term care quality. This is a critical need in Florida, and nationwide, as states move toward mandatory managed care programs.

The process for continually monitoring quality measures and for incorporating quality improvements by the MCOs must be built into each MCO’s contract and quality
improvement plans. It should include measures for long-term care, such as consumer experience with services, staff turnover, ability to find a direct care worker, whether the individual’s needs are met, and other tools to assess quality in long-term care.

**Long-Term Care Plan Payments**

AARP, like other consumer groups, is concerned that some of the financial incentives in the plan could place those interests above consumers’ health and long-term care needs. This is especially true in the case of the incentive payments for increased use of home and community-based services and decreased use of institutional placements. The payment rates would be adjusted by 2 percent in each of the first two payment periods, then by 3 percent in the third period and each year afterward until no more than 35 percent of the plan’s enrollees are in institutional settings.

While AARP has long taken a leadership role in advocating for home and community-based services and supports, the nature of financial incentives for specific long-term care services creates an explicit conflict of interest for an MCO in the provision of care.

Incentive payments are an appropriate way to counterbalance the risk of providing less or inappropriate lower cost care inherent in any capitated model. However, they should not encourage care in the wrong setting or “dump” patients into the community without needed care or supports. Qualifying for incentives should be determined by an objective evaluation of data and should encourage improved health outcomes, improved care management, reductions in disparities in access and outcomes based on race or ethnicity, and consumer experience.

**Grievances and Appeals**

The submission requires MCOs to have an approved internal grievance system. It also maintains a state-level panel to hear appeals of grievances that are not resolved at the plan level. The grievance and appeal process should ensure that enrollees continue to receive benefits during the grievance and appeals process.

**Eligibility and Waitlist**

AHCA states in the Program Overview for the Long-Term Care Managed Care Program that those individuals currently on the waitlist for HCBS waiver programs will not be eligible to enroll in the Florida Long-Term Care Program. Instead, those on the waitlist will only be enrolled in the Long-Term Care Program as space becomes available.

Maintenance of the current enrollment cap will ensure the state will continue to move enrollees into institutional services when less expensive community services may be more appropriate. As a result, the waitlist will continue to grow for community services. As individuals wait for an opening on the waitlist they will not receive needed services and their conditions will deteriorate. Action should be taken to increase enrollment in the HCBS program.
Choice Counseling

Though the Medicaid Managed Care Program legislation did not address "choice counseling" for recipients concerning plan/provider selection, the Aging and Disability Resource Centers should be given the first option to serve as "choice counselors." Choice counseling should be "unbiased and transparent." In addition, such counseling should be conducted by an independent entity with no attachment to health plans. Qualified LTC Managed Care Organizations and providers should not be able to self-refer or to refer to others with whom they have a financial or operational nexus.

Achieved Savings Rebate

The 1115 waiver amendment also includes the establishment of an "achieved savings rebate program" that would reward the managed care plans, without verifying appropriate spending on medical care. AARP supports a Medical Loss Ratio (MLR) approach over the "achieved savings rebate program." The MLR would provide greater accountability and transparency. AARP believes that maximum resources should be devoted to patient care rather than company overhead and profits. A fixed minimum Medical Loss Ratio would assure the state and consumers that only a certain limited percentage of funds are going to non-medical needs. AARP believes the Medical Loss Ratio provides a greater certainty of spending for medical purposes than does an achieved savings rebate approach.

Medically Needy Population

Florida submitted a concept paper for a demonstration waiver related to the Medically Needy Program. The state is seeking 1115 waiver authority to charge a premium equal to (or not exceeding) the share of cost for individuals in the Medically Needy Program with up to a six-month period of continuous eligibility prospectively. AARP is concerned about the impact of this proposal on eligibility, especially for the elderly and people with disabilities. This proposal should be denied because of its impact on eligibility.

Conclusion

Actions by the state raise serious concerns about the commitment to ensure the frailest and most vulnerable Floridians will receive the services they need or the protections they deserve. One example is the state's decision to turn down a $36 million Money Follows the Person Rebalancing Demonstration Program grant to give Medicaid enrollees, including seniors, the option for more choices in home and community-based care. This grant, that state officials sought and applied for, was later rejected after the grant was awarded by HHS. It appears that partisan politics interfered with the interests and needs of those who require long-term care.

Our hope is that AARP's views, as well as the comments made by hundreds of consumers, providers and other stakeholders in the public hearings this past summer in strong opposition to Florida's waiver submissions will result in CMS rejecting the waiver.
submission by the state of Florida. This opposition includes a broad array of stakeholders, including the Florida Medical Association.

As always, we are ready to assist in any way to improve the quality of long-term care. If you have any questions, please feel free to contact me or Rhonda Richards in our Government Affairs Department at (202) 434-3791.

Sincerely,

Joyce Rogers
Senior Vice President
Government Affairs