May 3, 2010

Dear Senator,

The freedom to choose your own health plan—and the right to easily disenroll from that plan and choose another—should be a key provision in any health care reform design.

An **amendment to the FY 2011 budget** has been adopted in the House that would force older people, who are eligible for Medicare and Medicaid, to be enrolled into a managed health care program they did not freely choose. Here is the language from the House budget:

> "Notwithstanding any general or special law to the contrary, the executive office of health and human services shall make all reasonable efforts to renegotiate the commonwealth's 1115 waiver to permit passive opt-out enrollment for the senior care options plan as expeditiously as possible."

"Passive opt-out enrollment" is a euphemism for automatic assignment or forced enrollment. Under this amendment, state government would automatically enroll more than 130,000 low-income seniors on Medicare and Medicaid into Senior Care Options (SCO) plans—taking away consumer access to Medicare fee-for-service (FFS). Currently, Massachusetts has only 4 Senior Care Options plans. These seniors would then have to actively disenroll themselves to get out of plans they did not pick.

We are strongly against forced health care enrollment for the following reasons:

- This would rob seniors of their fundamental freedom to choose their own health care delivery program.
- This change may disrupt the current arrangements and established relationships that dually eligible seniors have with their health care providers. If enrollees do not have a relationship with a provider and cannot access their services in a timely manner they may seek care at higher cost-settings, such as emergency rooms, or may not seek care at all.
- This amendment would nullify the voluntary enrollment and disenrollment feature of the SCO law (Chapter 118E: Section 9D) which says: "The division shall ensure that enrollment in the program is voluntary. No disincentives for selecting a fee-for-service delivery system shall be included as part of any agreement or waiver regarding the program. The division shall ensure that all enrollees in a SCO have the right to disenroll from the program in any month upon submitting a notice of disenrollment to the division or contracted entity." This language was agreed to by all the groups that helped draft this legislation in the late 1990s.

- This amendment would cost the Commonwealth $989.26 million if implemented under current federal cost sharing law for the period 2010 to 2024, according to a 2008 study by The Lewin Group. (1) Federal law does not allow Medicare savings to accrue to the state, therefore any savings gained by passive enrollment would need to be returned to the federal government; Massachusetts would not see a financial gain in the first 14 years of the program.
- Under federal law Medicare beneficiaries must always have the choice of Medicare fee for service plans on a continuous basis. (2) There is no Medicare waiver allowed to this policy. The Executive Office of Health and Human Services cannot "renegotiate the commonwealth's 1115 waiver" to passively enroll Medicare beneficiaries into a managed care plan as the House amendment instructs; rather it would require Congress to make a fundamental change to Medicare laws.
- It is possible to seek a waiver from CMS to passively enroll people on Medicaid into managed care organizations—but if those people happen to be dually eligible for Medicare—they can't be forced to give up Medicare FFS.
- If Massachusetts seeks to force elderly Medicaid enrollees into managed care, while their Medicare benefits remained fee for service, it would create absolute chaos for elders and their providers. Any hope of improving coordination of their care would be lost despite the improvements achieved through the current voluntary SCO program. It would be difficult for providers to administer and nearly impossible for consumers to understand.
- There are hospitals and doctors' practices that have not agreed to be part of the SCO network. SCO networks need to be specialized and closely integrated with the SCO's staff working to coordinate care. If elders are forced to enroll, they will either need to discontinue their relationship with their physician or hospital, or SCO programs will be forced to work with networks of providers that are not committed to the SCO program. In areas where there is some SCO penetration there may be only a few primary care physicians participating in a program. This means that tens of thousands of elders would have to involuntarily change primary care providers, or worse, not have a primary care provider at all.
- Passive enrollment will create significant barriers to access to care for large numbers of elders. In many parts of the Commonwealth, there are either no SCO plans, or only one SCO plan. This is true not just in rural areas like Western Massachusetts and the Cape—there are many pockets of unserved cities and towns in suburban and urban areas as well.
- If passed into law, the provisions of this amendment would suddenly swell SCO enrollment from 14,000 to 130,000 recipients. Thousands of seniors would seek to disenroll from plans that do not have their doctor, or specialists, or hospitals in the network. The patient 'churning' that would be created by this dynamic would be incredibly costly to the state and to the SCO programs, and are counterproductive to the goal of efficient, effective use of taxpayer money.

- Seniors may not even realize they have been passively enrolled in the program until an acute need arises. Elders may show up at their doctor's office and learn for the first time that they have been enrolled in a managed care network that their doctor does not belong to. This is a situation we must seek to avoid at all costs.
- Elders need to fully understand what it means to be in a managed care plan, the concept of a network, the role of the care manager, and the need for them to be active in the design of their care plan. All of this work requires 'informed consent' by the elder and cannot be accomplished by automatic enrollment in a SCO plan.
- Mandatory enrollment in SCO plans would effectively shut down other valuable programs currently working with dual eligibles. The PACE and Community Choices programs, which are targeted exclusively to divert people from nursing homes, could end if all referrals go directly into SCOs. Programs like PACE, Choices and SCO should all be options available to consumers as part of a continuum of long term care supports.

Our objections to this amendment do not mean that we oppose the SCO program. The coordination of health and long term care services provided through the use of SCOs collaborating through an innovative collaboration with Aging Services Access Points (ASAPs) is an important option for elders. Many of us were involved in the multi-year drafting of the SCO law, and one of us is a current SCO program provider.

What we object to is forcing low-income people to enroll in this model as an automatic default. We believe that seniors are smart enough consumers to be able to pick their own health care delivery approach—without having the General Court forcing them into one.

The Lewin study has suggested: "Dual eligibles themselves have little incentive to voluntarily enroll in managed care organizations. In the FFS setting, dual eligibles receive an extraordinarily comprehensive benefits package at essentially no cost." (3) The plan that will be most attractive to seniors on MassHealth is the plan that offers them the best set of benefits. This is true for all consumers—and we respect the right of elders to respond to programs that best address their needs. We should not steer consumers away from programs that they believe are the most advantageous for them.

We urge you to reject any efforts to add "passive enrollment" language into the Senate budget—and to aggressively oppose such language in Conference Committee. We look forward to working with the General Court and SCO plans to come up with other solutions to inform seniors of the full range of health and long term care plans that are available to them, as long as they have the right to choose an approach without coercion.

Thank you for your consideration.

Al Norman
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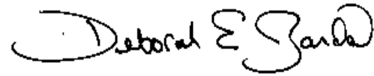

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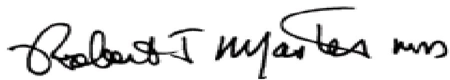

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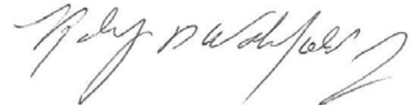

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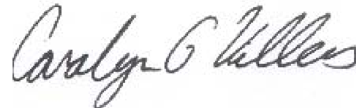

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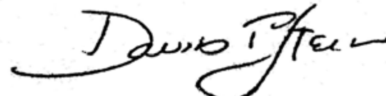

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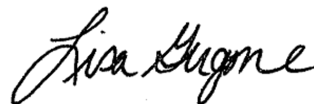

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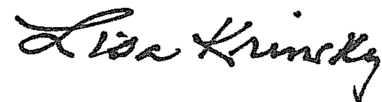

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Footnotes:

(1) "Increased Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities." The Lewin Group, November, 2008. Table 9.
(2) 42 USC 1395w-21(a)(1) (Medicare); 42 USC 1396u-2(a)(2)(B) (Medicaid); 42 USC 1315 (Medicaid waivers). See attachment below
(3) The Lewin Group, op.cit. p.1.

Medicare law citations

Medicare:

Part C—MEDICARE+CHOICE PROGRAM[314]

ELIGIBILITY, ELECTION, AND ENROLLMENT

Sec. 1851. [42 U.S.C. 1395w–21] (a) Choice of medicare benefits through medicare+choice plans.—

(1) In general.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this title—

(A) through the original medicare fee–for–service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1860D-1.

Medicaid:

PROVISIONS RELATING TO MANAGED CARE

Sec. 1932. [42 U.S.C. 1396u–2] (a) State Option to Use Managed Care.—

(1) Use of medicaid managed care organizations and primary care case managers.—

(A) In general.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State—

(i) may require an individual who is eligible for medical assistance under the State plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

(I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m) or section 1905(t), and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) Definition of managed care entity.—In this section, the term "managed care entity" means—

(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

(ii) a primary care case manager, as defined in section 1905(t)(2).

(2) Special rules.—

(A) Exemption of certain children with special needs.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

(i) is eligible for supplemental security income under title XVI;

(ii) is described in section 501(a)(1)(D);

(iii) is described in section 1902(e)(3);

(iv) is receiving foster care or adoption assistance under part E of title IV; or

(v) is in foster care or otherwise in an out–of–home placement.

(B) Exemption of medicare beneficiaries.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

(C) Indian enrollment.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)[188]) unless the entity is one of the following (and only if such entity is participating under the plan):

(i) The Indian Health Service.

(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self–Determination Act (25 U.S.C. 450 et seq.).

(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).