



520 Eighth Avenue, North Wing, 3rd Floor

New York, NY 10018

212.869.3850/Fax: 212.869.3532

June 22, 2015

The Honorable Orrin Hatch  
Chair, Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member, Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Johnny Isakson  
United States Senate  
Washington, DC 20510

The Honorable Mark Warner  
United States Senate  
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Medicare Rights Center (Medicare Rights), I am writing to provide input on the Senate Finance Committee request for feedback on policy initiatives to improve the health and wellbeing of people with Medicare with multiple chronic conditions. We agree that policy solutions are needed to improve health outcomes and care quality for this vulnerable population, and we thank the Committee for engaging in a transparent, multi-stakeholder process to seek input on policy options. We support the Committee's broad, bipartisan goals of increased care coordination, aligned payment systems to encourage appropriate care, and enhanced health care quality.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to over 1.5 million beneficiaries, family caregivers, and professionals annually. Based on our experience working with Medicare beneficiaries—from enrollment and advertising through coverage and appeals—we encourage the Committee to consider the following recommendations as you review proposed policies and develop legislation:

**Learn from ongoing demonstration programs and test any new care models:** As the Committee contemplates new models for Medicare coordinated care, we strongly recommend considering the experience of current demonstrations. In particular, we urge the Committee to consider early lessons learned in the development and implementation of ongoing demonstrations to align the financing and delivery of Medicare and

Washington, DC Office:

1825 K Street NW, Suite 400

Washington, DC 20006

202.637.0961

[www.medicarerights.org](http://www.medicarerights.org) [www.medicareinteractive.org](http://www.medicareinteractive.org)

Medicaid benefits for dually eligible individuals.<sup>1</sup> Understanding these existing coordination efforts and their lessons on enrollment complexities, communicating with beneficiaries, and aligning acute and long-term services and supports provide important background for future coordination efforts.<sup>2</sup>

As the lead organization for the Coalition to Protect the Rights of New York's Dually Eligible (CPRNYDE), the Medicare Rights Center has first-hand experience with how this demonstration is working in New York State.<sup>3</sup> Careful thought and consideration went into developing the basic framework of the demonstration. The Centers for Medicare & Medicaid Services (CMS) and state agencies worked to ensure that consumer advocates, health plans, and other stakeholders were actively engaged in the development of program agreements and contracts.

Still, unanticipated issues have presented in the early stages of the demonstration, which is now in the enrollment phase. For example, the need for an education campaign for health care providers became clear only in the later stages of the Fully Integrated Duals Advantage (FIDA) rollout. The lack of provider education has led to confusion regarding the perceived benefits of the program, and as a result, many eligible beneficiaries have chosen to either opt out of or disenroll from FIDA.

Our experience with FIDA leads us to conclude that adequate testing of any new care coordination initiative is absolutely critical. In addition to drawing on lessons learned from existing demonstrations, we urge the Committee to ensure that any new models of care are adequately tested. The Center for Medicare & Medicaid Innovation (CMMI) provides an existing venue for such testing.

We ask that any legislation resulting from the Committee's inquiry include direction to the Secretary for the Department of Health and Human Services (DHHS) to develop and implement pilot initiatives and to rigorously evaluate those programs before permitting expansion. As detailed below, we encourage the Committee to outline important elements of any such demonstration program, including needed beneficiary protections, required stakeholder involvement, and so forth.

**Approach beneficiary cost-sharing incentives with caution and avoid any increases in cost-sharing:** We urge the Committee to proceed carefully as you consider any changes to beneficiary cost-sharing, whether in Medicare Advantage (MA) plans, Traditional Medicare, or otherwise. Some academics, health plans, and others suggest that cost-sharing should be altered on the basis of value or clinical nuance, known as value-based insurance design (V-BID), to steer individuals to the appropriate care. Under V-BID principles, health plans (or potentially health systems) alter cost sharing for specific services, prescription medicines, or health care providers to encourage beneficiaries to seek out the highest value or most clinically effective care.<sup>4</sup>

We generally support eliminating or lowering cost-sharing to facilitate access to needed, high-value health care services, such as the policies advanced through the Affordable Care Act (ACA) that eliminated Medicare cost-sharing for select preventive care. Related to this, we continue to suggest that beneficiary cost-sharing be eliminated for recently introduced non-in-person care coordination services now reimbursed by Medicare, and we urge the Committee to consider this proposal as it continues with its inquiry.

---

<sup>1</sup> For more information on these demonstrations, see: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

<sup>2</sup> Medicaid Payment and Access Commission (MACPAC), "Experiences with Financial Alignment Initiatives Demonstration Projects in Three States," (2015), available at: [www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf](http://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf)

<sup>3</sup> For more information about the coalition, see: <http://www.nyduals.org/about-us/>

<sup>4</sup> Testimony of Joe Baker, President of the Medicare Rights Center, prepared for the U.S. House Energy & Commerce Committee, Subcommittee on Health (February 26, 2014), available at: <http://www.medicareriights.org/pdf/022614-house-e&c-testimony.pdf>

Yet, we strongly urge the Committee to avoid any policies allowing cost-sharing increases intended to steer older adults or people with disabilities away from perceived low-value care. Empirical literature on patient behavior makes clear that indiscriminate increases in cost-sharing deter access to both necessary and unnecessary health care, and that such increases have a disproportionate impact on lower-income, vulnerable populations.<sup>5</sup>

As such, we are concerned about targeted increases in cost-sharing on specific prescription drugs or services. And while V-BID models are being tested in the private market, this framework has yet to be tested within the Medicare population, who have comparatively more extensive and pervasive health care needs. Should the Committee adopt a V-BID model as part of legislation, we urge you to include an explicit prohibition on any increases in cost-sharing.

At the same time, we believe transparency and accountability is critically important to the design of any V-BID model. For example, assertions about which care is deemed “high-value” should be supported by an evidence-base that is made publically available in formats accessible to beneficiaries and their health care providers. It is also critical to ensure that any evaluations, lessons learned, or outcomes resulting from the use of V-BID be made publicly available, in part to allow any successful, applicable designs to be applied across all parts of Medicare.

Additionally, beneficiary and health care provider education is needed in any V-BID design. In general, we find Medicare beneficiaries are not positioned to evaluate high-value versus low-value services. According to a 2006 RAND study, added cost-sharing has little utility in controlling service use once a patient enters the health care system.<sup>6</sup> This finding confirms what we know to be true through our experience serving people with Medicare: health care providers—not beneficiaries—order services and ultimately drive utilization trends. Cost-sharing incentives demand a high level of sophistication and knowledge on the part of beneficiaries to assess care options that are ultimately recommended by their doctors.

As such, we do not believe that V-BID models should be pursued in the absence of complementary efforts to better inform and educate consumers about high-value vs. low-value care. Education is also a necessary prerequisite to V-BID for the provider community. Some V-BID models assume that providers are necessarily prescribing the highest-value care and refrain from recommending the lowest-value care. Yet, we know that prescribing trends are not uniform across settings or across providers. V-BID must be coupled with education to facilitate appropriate prescribing by physicians and other health care providers.

**Incorporate robust, detailed, and specific beneficiary protections:** Naming adequate consumer protections is vital to the design of any new or enhanced care model intended for individuals with multiple chronic conditions. Protections related to enrollment, marketing, grievances and complaints as well as denials and appeals must be incorporated, and we encourage the Committee to ensure any legislation spells out these protections.

First and foremost, beneficiary choice must be preserved through opt-in and opt-out mechanisms. This must include real opt-out options that retain meaningful access to health care providers and services outside of the

---

<sup>5</sup> Wallace, N.T. et al. “How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,” *Health Services Research*, Vol. 43, No. 2, 2008, pp. 515-530; Tambryn, R. et al. “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons,” *JAMA*, Vol. 285, No. 4, 2001, pp. 421-429; Swartz, K. “Cost-Sharing: Effects on Spending and Outcomes” (Robert Wood Johnson Foundation Research Synthesis Report No. 20: December 2010

<sup>6</sup> RAND, “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate” (January 2006), available at: [http://www.rand.org/pubs/research\\_briefs/RB9174.html](http://www.rand.org/pubs/research_briefs/RB9174.html)

program. As appropriate, we also encourage stepped opt-in options, meaning Medicare beneficiaries can opt-in to some aspects of a program but not others. For example, current Accountable Care Organization (ACO) data sharing rules do not share data about alcohol or substance abuse treatment, but beneficiaries retain the option to allow such data sharing where warranted. Additionally, passively enrolling beneficiaries into new or enhanced care models should be prohibited. Where possible, facilitating personal choice should be prioritized.

In addition, special considerations should be made around program marketing—restricting or prohibiting marketing when warranted. In general, we do not believe it is appropriate to fully market new programs to Medicare beneficiaries, particularly for any untested model. We believe increased marketing restrictions are necessary particularly when a program incorporates any changes to cost-sharing (like the V-BID models described above), financial rewards, or other bonuses.

Marketing restrictions may also be necessary to prevent gamesmanship by a health system or private health plan, such as the “cherry picking” of healthier or sicker beneficiaries. We encourage the Committee to seek input from medical subject matter experts, consumer advocates, and other key stakeholders to identify potential bases for improper discrimination or targeting.

Finally, complaint and appeal tracking and resolution systems, with adequate funding and training, should be included of any new or expanded care model. As discussed below, current MA and Part D appeals processes often fail Medicare beneficiaries. New policies and programs may be even more likely to result in confusion, misinformation, and access concerns.

In sum, we ask that any legislation developed by the Committee to advance new or expanded care models, whether in Traditional Medicare, through MA plans, or otherwise, explicitly name these needed beneficiary protections. We also encourage the Committee to ensure Medicare beneficiaries and consumer advocates are positioned to provide ongoing feedback throughout program development and implementation. Any legislation drafted by the Committee should provide adequate direction to the DHHS Secretary to ensure input is solicited on an ongoing basis from beneficiaries and consumer advocates as new or enhanced care coordination programs are developed and tested.

**Ensure rigorous oversight and require transparency:** Transparency and reporting are critically important to any new policies intended to alter the delivery of care for those with multiple chronic conditions. We strongly encourage the Committee to create mechanisms to make publicly available data and information about any new or expanded programs to improve care for individuals with chronic health needs. As appropriate, we urge the Committee to request regular reports, Government Accountability Office (GAO) analyses, and independent evaluations to continuously assess any new or expanded care models. The population identified through the Committee’s exploration is—by definition—an extremely vulnerable one. Given this, we strongly encourage that any legislation designing new or expanding on existing care initiatives include adequate accountability, transparency, and reporting.

Specifically, new or expanded care coordination programs should include performance measure targets, require data collection and public reporting on specific performance measures, and name a rigorous, third-party evaluation process. Where private health plans are involved, these requirements are needed to ensure that any relevant data or lessons learned are not inappropriately labeled “proprietary.” Further, it is important that reporting schedules for key performance information identified at the outset to ensure unanticipated issues can be spotted early and mid-course corrections can be effectuated.

**Integrate Medicare prescription drug (Part D) plans:** Access to prescription drugs is vitally important to the health and well-being of individuals with multiple chronic conditions, and any attempt to adequately coordinate care for these individuals must address their medication needs. Stand-alone Part D prescription drugs plans are not well-positioned to participate in care coordination activities given that, by design, they lack relationships with health care providers, and access to full information about their enrollees' health needs and circumstances.

Research supports our observation that this division is a barrier to the success of current programs aimed at increasing medication adherence, like the Medication Therapy Management (MTM) programs.<sup>7</sup> We also see shortcomings related to this divide in the context of Part D appeals, where information about a beneficiary's individual medical situation is not readily available to the Part D plan or pharmacy benefit manager (PBM).

Involvement by stand-alone Part D plans will be vital to any successful effort to enhance care coordination for individuals with multiple chronic conditions. In particular, their involvement is needed to facilitate communication among disparate entities, namely pharmacists and prescribers, particularly when access to medications is denied. As such, we urge the Committee to pursue avenues to integrate stand-alone Part D plans into any new or enhanced care models, particularly for beneficiaries with Traditional Medicare.

**Address alarming trends concerning MA and Part D coverage denials and appeals processes:** Individuals with chronic conditions are more likely to need multiple services and prescription drugs, and are therefore more likely to face coverage restrictions and utilization controls, most notably in MA and Part D plans. Annual audit findings by CMS suggest significant room for improvement by MA and Part D plans in the administration of utilization management tools and beneficiary appeals processes. As the Committee expressly references MA plans in its request for feedback, we ask that you explore opportunities to improve the beneficiary experience with denials of coverage, appeals, and grievances in both MA and Part D plans.

Specifically, recent CMS audit results determined that, among audited sponsors, 89 percent issued denial letters to beneficiaries that either failed to include an adequate rationale or contained incorrect information, 78 percent failed to demonstrate sufficient outreach to obtain additional information necessary to make an appropriate clinical decision, and 56 percent made inappropriate denials when processing coverage determinations. At the same time, 61 percent were shown to apply unapproved quantity limits and 50 percent were shown to apply unapproved utilization management practices.<sup>8</sup> In 2013, CMS notes that nearly all enforcement actions (89 percent) stemmed from non-compliance resulting in "...inappropriate delays or denials of access to health services and medications for enrollees."<sup>9</sup>

CMS' findings are generally reflective of what Medicare Rights continues to observe among Medicare beneficiaries who are denied access to a needed medication or health care services. Beneficiaries struggle to navigate onerous MA and Part D appeals processes—resulting in delays in access to needed health care services,

---

<sup>7</sup> Yochelson, M., "MTM Review Completed for Under Half of Eligible Enrollees, MA Plan Speakers Say" *Bloomberg BNA*, October 1, 2014

<sup>8</sup> CMS, "Common Conditions, Improvement Strategies, and Best Practices based on 2013 Program Audit Reviews," (Memo from G. Mulcahy to All Medicare Advantage Organizations and Prescription Drug Plans; August 27, 2014), available at: <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Program-Audits.html>

<sup>9</sup> CMS, "The 2013 Part C and Part D Program Annual Audit and Enforcement Report," (Issued by the Medicare Parts C & D Oversight and Enforcement Group; October 16, 2014), available at: <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Program-Audits.html>

abandonment of prescribed medications, reduced adherence to treatment protocols, and higher than appropriate out-of-pocket health care costs for older adults, people with disabilities, and their families.<sup>10</sup>

We ask that you explore opportunities to improve the beneficiary experience with denials of coverage, appeals, and grievances as part of any legislative package to improve care delivery for those with multiple chronic conditions. We believe the Committee's efforts should complement initiatives already underway at CMS to improve the Part D appeals process. These include enhancements to beneficiary denial notices, the creation of a pilot program to improve the beneficiary experience at the point-of-sale, and strengthened data collection at each stage of the appeals process.

**Include carefully designed education initiatives:** Adequate educational initiatives are needed to inform both beneficiaries and health care providers about new or enhanced programs for individuals with multiple chronic conditions. Subject matter and readability experts should design beneficiary-facing educational content, and input from consumer advocates, who routinely work with Medicare beneficiaries, should be solicited as materials are developed. And, critically, all content should be vetted through beneficiary focus group testing.

Additionally, existing networks, like the State Health Insurance Assistance Programs (SHIPs), should be engaged and provided additional resources as new programs are rolled out or expanded. When any new care model is implemented, SHIP counselors need adequate training and resources in order to anticipate questions from beneficiaries and caregivers as well as to respond accurately and quickly.

Finally, in addition to providing basic information about any new programs, educational content must be developed to make any relevant quality information useable and understandable. Central to usability is ensuring all content is available in multiple accessible formats and languages. As the Committee develops legislation, we urge you to include specific language about beneficiary education needs, providing appropriate guidance to the DHHS Secretary on the kinds of campaigns, resources, and tools required.

**Promote person- and family-centered care and facilitate meaningful consumer engagement:** People who experience chronic disease or disability are the best experts on living with their conditions. In the management of complex conditions, self-direction, person-centeredness, and consumer empowerment are key tools to sustaining and improving health. Individuals and families know best what will work for their lives. When they are in the driver's seat, they can work with their health care providers to develop a care plan that has a much greater chance of success than a care plan that fails to incorporate their perspectives, goals, and values.

From a policy standpoint, this means that care models should include patient involvement at all levels of care: individuals and caregivers must be engaged in care design and redesign, in policy and governance, and at the community level. Meaningful consumer engagement goes beyond a focus group or survey; rather, it must encompass mutually beneficial partnerships at every level of care. While carefully constructed education initiatives are critically important to the design of any care model, as discussed above, we encourage the Committee to adopt a definition of "consumer engagement" that goes further than basic education as it develops new, or expands existing, care models for individuals with chronic health needs.<sup>11</sup>

---

<sup>10</sup> Letter to MedPAC from 30+ consumer advocates and health care providers (October 10, 2014), available at: <http://www.medicarerights.org/pdf/101014-medpac-part-d-appeals.pdf>; Letter to MedPAC from the Medicare Rights Center (September 20, 2013), available at: <http://www.medicarerights.org/pdf/092013-part-d-appeals-medpac.pdf>

<sup>11</sup> For more on meaningful consumer engagement, see: Carman, K.L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., and J. Sweeney, "Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies," Health Affairs, 32, no. 2

In closing, we appreciate the opportunity to provide comments and to share the lessons learned from our work with Medicare beneficiaries and their families. We hope these recommendations will help the Committee develop initiatives that improve the health and well-being of people with multiple chronic conditions. We welcome the opportunity to provide more detailed comments as specific proposals are identified and considered. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Baker". The signature is fluid and cursive, with the first name "Joe" and last name "Baker" clearly distinguishable.

Joe Baker  
President  
Medicare Rights Center