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January 26, 2016

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 comment on the policy options document created by the Bipartisan Chronic Care Working Group of the Senate Finance Committee. We applaud the Committee for engaging in a transparent process to develop policies to improve care for Medicare beneficiaries with multiple chronic conditions, and we continue to support the identified 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 two million beneficiaries, family caregivers, and professionals annually. Below we outline basic principles and detailed comments on specific proposals identified by the Working Group for the Committee's consideration. First and foremost, as the Committee moves forward, we encourage you to consider the following overarching principles:

- Pursue innovations in both traditional Medicare and Medicare Advantage (MA);
- Learn from ongoing demonstrations and test any new or revised care models;
- Couple targeted MA policies with system-wide MA improvements; and
- Incorporate robust, detailed, and specific beneficiary protections.

Pursue innovations in both traditional Medicare and Medicare Advantage: We applaud the Working Group for identifying opportunities to improve care for beneficiaries with chronic conditions who receive coverage

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through both traditional Medicare and MA plans. While enrollment in MA continues to grow—with 31 percent of people with Medicare now enrolled in an MA plan—most older adults and people with disabilities continue to receive coverage through the traditional Medicare program.¹ As the Committee develops legislation, we urge a balanced approach that advances innovations in both traditional Medicare and MA.

Keeping with this goal, we also encourage the Committee to pursue opportunities to improve adherence and medication therapy management, strengthen appeals processes, enhance beneficiary notice and education, and more for people enrolled in stand-alone Part D plans. While some of the options identified by the Working Group may benefit individuals with MA plans that include prescription drug coverage, we note the absence of options for those with stand-alone 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.

Learn from ongoing demonstration programs and test any new or revised care models: As the Committee contemplates new and revised care models, we strongly recommend considering the experience of ongoing demonstrations. In particular, we urge the Committee to consider early lessons learned in the development and implementation of existing demonstrations to align the financing and delivery of Medicare and Medicaid benefits for dually eligible individuals.² 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 care models for individuals with multiple chronic conditions.³

As the lead organization for the Coalition to Protect the Rights of New York’s Dually Eligible (CPRNYDE), Medicare Rights has first-hand experience with how this demonstration is working in New York State.⁴ 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.

The absence of provider education also led to diminished provider involvement in the care coordination provisions of the FIDA demonstration, notably the formation of Interdisciplinary Teams (IDTs) that allow a beneficiary to work with his or her healthcare providers to develop a plan of care that is truly person-centered. New York has also experienced several of the recently reported challenges affecting managed care organizations and their ability to coordinate care for dually eligible individuals, including facilitating effective communication with beneficiaries and their caregivers.⁵

¹ Jacobson, G., Damico, A., Neuman, T., and M. Gold, “Medicare Advantage 2015 Spotlight: Enrollment Market Update,” (Kaiser Family Foundation: June 2015), available at: <http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/>

² 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>

³ 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

⁴ For more information about the CPRNYDE coalition, see: <http://www.nyduals.org/about-us/>

⁵ Government Accountability Office (GAO), “Additional Oversight Needed of CMS’s Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries,” (December 2015), available at: <http://www.gao.gov/assets/680/674340.pdf>

Our experience with FIDA leads us to conclude that adequate testing of any new or revised care model is absolutely critical. Demonstrations allow the opportunity to fully vet model designs, develop targeted consumer protections, modify or course-correct as needed, and conduct rigorous evaluations, assessing both cost-effectiveness and healthcare quality. As such, we believe that many of the policy options identified by the Working Group would be best pursued as demonstration programs, prior to expansion on a national scale. The Center for Medicare & Medicaid Innovation (CMMI) provides a venue for such testing, and we urge the Committee to maximize this resource as it develops legislation.

Couple targeted MA policies with system-wide MA improvements: The Working Group identifies several policy options to fundamentally alter the MA program, including allowing MA plans to customize benefits, expand supplemental benefits, incorporate hospice care, and so forth. As the Committee explores these and other options reliant on MA plans, we urge you to also address long-standing challenges with the MA program. In particular, we strongly encourage the Committee to enhance support and education to assist beneficiaries as they select among MA plans and to strengthen the MA appeals process.

Enhance beneficiary supports for comparing and choosing among MA plans: In general, we find that older adults and people with disabilities find selecting among multiple MA plans a dizzying experience. We encourage people with MA to revisit their plan's coverage each year, as annual changes to plan benefits, cost sharing, provider networks, utilization management tools, and other coverage rules are commonplace. Yet, despite regular plan changes, research suggests that inertia is commonplace.

According to one analysis, from 2006 to 2010, only 13 percent of beneficiaries switched prescription drug plans during each annual enrollment period, despite changes in premiums, cost sharing, and coverage.⁶ Similarly, a series of focus groups conducted by the Kaiser Family Foundation in 2014 validates much of what we hear on our national helpline. According to the findings, "Seniors say they found it frustrating and difficult to compare plans due to the volume of information they receive...and their inability to organize the information to determine which plan is best for them."⁷

This and other research underscores the need to strengthen assistance for people who must evaluate and select among multiple MA plan options, including through individualized counseling, decision-making tools, and beneficiary notices.⁸ Should the Committee continue to explore policy options that will necessarily make the MA benefit more complex (even as those complexities may improve MA benefits for some individuals) it must also pursue policies to enhance support for individuals in evaluating and comparing MA plans year-to-year. Towards this end, we urge the Committee to pursue the following:

- **Increase funding for State Health Insurance Assistance Programs (SHIPs):** Adequate funding for SHIPs nationwide is absolutely vital to ensuring that people with Medicare are supported in making plan decisions. Sustained by federal, state, and local funding, SHIPs are the go-to resource for people with Medicare and their families who have questions about Medicare and related programs. Yet, in a 2014 nationally representative survey of 1,600+ seniors, only 38 percent were aware of the availability of free consumer

⁶ Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?" (Kaiser Family Foundation: October 2013), available at: <http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/>

⁷ Jacobson, G., Swoope, C., Perry, M., and M.C. Slosar, "How are Seniors Choosing and Changing Health Insurance Plans?" (Kaiser Family Foundation: May 2014), available at: <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>

⁸ See also, McWilliams, J.M., Afendulus, C.C., McGuire, T.G., and B.E. Landon, "Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking," *Health Affairs* 30:9 (September 2011)

counseling through SHIPs and only 15 percent had used these services to compare health plans.⁹

While the Bipartisan Budget Act of 2015 averted a proposed 42 percent cut to SHIPs, providing level FY2016 funding for the program at \$52.1 million, additional resources are required to meet growing needs. If SHIP funding had kept pace with inflation and the increasing number of Medicare beneficiaries since FY2011, FY2016 funding should amount to \$63.8 million.¹⁰ As the Committee explores policy options that make MA plans more complex, it is critical to ensure that SHIPs are adequately resourced to help beneficiaries understand their options, so they can decide what coverage is best suited to their health and financial needs.

- Strengthen Plan Finder: While Plan Finder has improved since its inception, its persistent shortcomings are well documented. According to a 2014 GAO report, despite CMS oversight and improvements, beneficiaries still encounter inaccurate and out-of-date information on Plan Finder.¹¹ On an ongoing basis, Medicare Rights provides detailed recommendations to CMS about needed improvements to Plan Finder, drawing directly from our experience serving 2,500+ beneficiaries during open enrollment. Among our recommendations are to add appropriate MA plan content, most notably more accessible information on provider networks, to ensure the clarity and accuracy of mail order information, to improve the accuracy of cost sharing data, and more.¹²

As with increased resources for SHIPs, we encourage the Committee to consider how to make Plan Finder a more useful and dynamic decision-making tool for the purposes of comparing MA plans, especially in light of any proposals that would necessarily make comparisons even more challenging through the addition of specialized or targeted benefits.

- Improve beneficiary notices: We also urge the Committee to advance needed improvements to standard beneficiary notices, both to encourage people with Medicare to evaluate their coverage options and to make plan comparisons easier. Most importantly, we encourage the Committee to support policies to strengthen the Annual Notice of Change (ANOC) through the addition of individually tailored content. The ANOC is a required, summary document mailed to Part D and MA enrollees ahead of the annual open enrollment period. The ANOC provides general information on plan variables that may change each year.

We continue to advocate for an individualized ANOC to better serve beneficiary needs, specifically one that details which specific providers are leaving a plan network, which specific prescription drugs are no longer on the plan formulary, where utilization management tools will be newly applied, and so forth—customized according to the actual providers, services, and prescription drugs that an individual beneficiary utilizes. Should MA plans be permitted to tailor benefits on the basis of a chronic condition (a Working Group option that we strongly prefer as a demonstration), the need for individualized beneficiary content in the ANOC becomes that much more acute.

⁹ KRC Research, “Seniors’ Opinions about Medicare Prescription Drug Coverage, 9th Year Update,” (Medicare Today: July 2014), available at: <http://www.medicaretoday.org/MT2014/KRC%202014%20SURVEY/KRC%20Survey%20of%20Seniors%20for%20%20Medicare%20Today%2007-25-2014%20FINAL.pdf>

¹⁰ National Council on Aging (NCOA), “State Health Insurance Assistance Program (SHIP) National Fact Sheet,” (July 2015), available at: <https://www.ncoa.org/resources/ship-national-fact-sheet/>

¹¹ GAO, “CMS Has Implemented Processes to Oversee Plan Finder Pricing Accuracy and Improve Website Usability,” (January 2014), available at: <http://www.gao.gov/products/GAO-14-143>

¹² Medicare Rights Center, “Plan Finder Observations During Fall Open Enrollment: October 14 – December 7, 2013” (May 2014), available at: <http://medicarerights.org/pdf/2013-plan-finder-memo.pdf>

Improve the beneficiary experience with MA denials and appeals: 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 in MA plans. CMS' 2013 audit findings suggested significant room for improvement by MA plans related to coverage determinations, appeals, and grievances. For example, the 2013 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.¹³

CMS' most recent summary report determined that MA plans had shown improvement in overall audit scores for 2014, including notable improvements in coverage determinations, appeals, and grievances.¹⁴ It is encouraging that general improvements have been documented; yet, no specifics have yet been released. Still, we continue to find that beneficiaries struggle to navigate an onerous MA appeals process, resulting in delayed access to needed care, reduced adherence to treatment protocols, and higher health care costs. Year after year, the top trend on Medicare Rights national helpline concerns denials of coverage and questions about how to manage an appeal—most often from those enrolled in MA and Part D plans.¹⁵

As the Committee continues to develop policy options related to MA, we urge 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. Options to improve the MA appeals process include:

- Increased transparency and public data on how MA plans manages denials, appeals, and grievances;
- Strengthened support for beneficiaries, SHIPs, and other professionals to assist with MA appeals;
- Enhanced CMS monitoring and enforcement of plan requirements related to appeals; and
- More proactive involvement by MA plans and health care providers in the management of appeals.¹⁶

Importantly, we believe the Committee's efforts should complement initiatives already underway at CMS to improve the Part D appeals process, including planned enhancements to beneficiary denial notices and strengthened data collection at each stage of the appeals process.¹⁷ In addition, we encourage the Committee to draw on lessons learned from a recent CMS pilot initiative examining how plan outreach to prescribers and collaboration with pharmacists can facilitate improved access to needed prescription drugs, without requiring the beneficiary to formally request coverage after a rejection at the point of sale.¹⁸

¹³ CMS, "Common Conditions, Improvement Strategies, and Best Practices based on 2013 Program Audit Reviews," (August 2014), available at: <http://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Program-Audits.html>

¹⁴ CMS, "The 2014 Part C and Part D Program Audit and Enforcement Report," (October 2015), available at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2014_Part_C_Part_D_Program_Audit_Annual_Report.pdf

¹⁵ Sutton, C., Bennett, R., Sanders, S. and F. Riccardi., "Medicare Trends and Recommendations: An Analysis of 2012 Call Data from the Medicare Rights Center's National Helpline," (2014), available at: <https://www.medicarerights.org/2012-medicare-trends>; Morales, S., Bennett, R., and S. Sanders, "Medicare Trends and Recommendations: An Analysis of 2013 Call Data from the Medicare Rights Center's National Helpline," (2015), available at: <https://www.medicarerights.org/2013-medicare-trends>; Morales, S., Schwarz, C., and F. Riccardi, "Medicare Trends and Recommendations: An Analysis of 2014 Call Data from the Medicare Rights Center's National Helpline," (2016), available at: <http://www.medicarerights.org/pdf/2014-helpline-trends-report.pdf>

¹⁶ Medicare Rights Center, "Medicare Snapshot: Stories from the Helpline, Managing Medicare Advantage Denials of Coverage and Appeals," (October 2014), available at: <http://www.medicarerights.org/pdf/medicare-snapshot-101614.pdf>

¹⁷ CMS, "Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (April 2015), available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Announcements-and-Documents-Items/2016Announcement.html>

¹⁸ For additional information refer to the CMS webinar "2016 Point of Sale (POST) Pilot Event" hosted on January 21, 2016

Incorporate robust, detailed, and specific beneficiary protections: Naming adequate consumer protections is vital to the design of any new or revised 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. Public reporting, rigorous oversight, and independent evaluations are also essential.

Further, it is critically important that multiple and diverse stakeholders—including beneficiaries and consumer advocates—are given ample opportunity to weigh in on any new or revised models, including in the initial design and throughout implementation. Below we identify consumer protections specific to the policy options identified by the Working Group and provide additional input on these concepts.

Advancing Team-Based Care:

Providing Medicare Advantage Enrollees with Hospice Benefits: We appreciate the Committee’s attention to the coordination challenges that MA enrollees face when electing hospice care. Medicare Rights frequently receives calls on our national helpline from people facing billing disputes, typically related to Durable Medicare Equipment (DME) and prescription drugs, and cost complications arising from the divided responsibility between traditional Medicare and an MA or Part D plan during or after hospice care.

As such, we appreciate the Committee’s desire to address these issues. Yet, we urge caution with respect to the Working Group proposal to integrate hospice care into the MA benefit package. CMMI recently solicited comment on a demonstration to test hospice benefit integration in MA plans, and we suggest the Committee support this testing through a well-designed demonstration with adequate beneficiary safeguards tailored to the unique needs of hospice patients and their families.¹⁹

Our comments to CMMI on the potential design of an MA hospice demonstration stressed the need to consider patient choice and appeal rights as a condition of our support. We believe a well-designed MA hospice demonstration program is one that:

- Preserves patient autonomy—namely beneficiaries’ ability to affirmatively elect (or not) hospice care;
- Allows open access to all Medicare certified hospice providers;
- Establishes well-defined, expedited appeal rights; and
- Evaluates the efficacy of the model and its effects on care quality and patient satisfaction.²⁰

Under traditional Medicare, hospice beneficiaries benefit from an open network, particularly as hospice care presents unique challenges with regard to finding an appropriate provider. The time frame for finding a hospice provider is often very short and there is generally a need to initiate services quickly. Additionally, hospice care often involves unique religious, social, and cultural needs that make restrictive networks inappropriate. Should the Committee pursue a demonstration to integrate hospice in MA plans, we urge that participating health plans be required to contract with any willing Medicare-approved hospice provider. At a minimum, hospice-specific network adequacy standards should be implemented and closely monitored.

Also, we have long advocated for the inclusion of appeal rights for hospice beneficiaries, particularly as we hear from helpline callers who lack an adequate appeals mechanism if they disagree with their hospice provider’s

¹⁹ CMMI, “Request for Information on Health Plan Innovation Initiatives at CMS,” (Fall 2013), available at: <https://innovation.cms.gov/files/x/hpi-rfi.pdf>

²⁰ Medicare Rights Center, “RE: Request for Information on Health Plan Innovation Initiatives at CMS,” (November 2013), available at: <http://www.medicarerights.org/pdf/110314-health-plan-innovations-rfi.pdf>

decision to provide or withhold specific treatments. We urge that an MA hospice demonstration include well-defined appeals rights for any plan determinations. In particular, we suggest that beneficiaries and their families be able to appeal any aspect of the hospice plan of care to an Independent Review Entity (IRE) that will issue a decision within 24 hours.

Allowing End Stage Renal Disease Beneficiaries to Choose a Medicare Advantage Plan: Medicare Rights regularly serves beneficiaries with End Stage Renal Disease (ESRD) who face significant health care costs because they are barred from electing an MA plan and they cannot limit their out-of-pocket exposure through the purchase of a supplemental Medigap plan. As such, we encourage the Committee to allow open enrollment for people with ESRD in MA plans. We also encourage the Committee to provide Medigap guaranteed issue or open enrollment rights for individuals with ESRD at the federal level, as exists for beneficiaries who are eligible for Medicare due to age.

That said, we are concerned that limited networks and coverage restrictions may prove especially challenging for people with ESRD. Should the Committee move forward with this proposal, enhanced monitoring and oversight will be essential. It will be critical to ensure that MA antidiscrimination provisions are not violated and that MA enrollees with ESRD have adequate access to needed services.

Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations: The Working Group identifies Dual-Special Needs Plans (D-SNPs) as a potential model for the integration of Medicare and Medicaid benefits. To date, a limited number of D-SNPs are “fully integrated,” meaning that the plan contracts with Medicaid to provide some Medicaid benefits. As noted above, more complete integration of Medicare and Medicaid benefits is currently being tested through CMMI demonstrations. These ongoing state-level demonstrations, testing a number of fee-for-service and managed care models, are only beginning to yield results and lessons.²¹

With these demonstrations still ongoing and only preliminary evaluation results released, we are concerned it is premature to advance proposals that would require Medicare-Medicaid integration and/or expand models still in the testing phase. In particular, we expect the demonstrations will yield valuable lessons with respect to network design, beneficiary and provider education and uptake, reimbursement structures, appropriate supplemental benefits, incentive structures, and adequate beneficiary protections. The demonstration programs vary in regard to geographic area, target population, enrollment timelines and processes, care delivery models, financing, the scope of benefits, and beneficiary protections. Hence, robust analysis of both the implementation and outcomes of varying models should be conducted before redesigns are implemented nationwide.²²

Improving Care Management Services for Individuals with Multiple Chronic Conditions: Medicare Rights could support the addition of payment for a high-severity chronic care management (CCM) code with adequate education initiatives for both beneficiaries and health care providers. The current CCM codes referenced by the Working Group are still relatively new. We generally find that beneficiaries are not familiar with the CCM codes, and also that there is some lack of awareness among health care providers. In

²¹ For preliminary findings from the first year of the capitated financial alignment demonstration, see: Walsh, E.G., “Report on Early Implementation of Demonstrations under the Financial Alignment Initiative,” (RTI International, October 2015), available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf>

²² For an explanation of varying state models, see: M, Musumeci, “Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS,” (December 2015), available at: <http://kff.org/medicaid/issue-brief/financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared-states-with-memoranda-of-understanding-approved-by-cms/>

particular, we observe that some beneficiaries are confused by how CCM codes are reflected in their Medicare Summary Notices and by the Part B coinsurance associated with these codes.

As such, we encourage the Committee to develop a proactive strategy for beneficiary and provider education as a part of any policy to introduce a high-severity chronic care code. As discussed below, we strongly support the identified proposal to waive the Part B cost sharing associated with the current CCM codes and with any newly introduced codes.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries: We strongly support the identified proposal to study the need for behavioral health services among individuals with a chronic illness and support the proposed GAO study. We often observe that behavioral and mental health care is underutilized among seniors and people with disabilities, and we believe these critical services can provide significant relief to people with Medicare who need them.

Expanding Innovation and Technology:

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees: We appreciate that the proposal identified by the Working Group and endorsed by the Medicare Payment Advisory Commission (MedPAC) has the potential to improve care for people with multiple chronic conditions enrolled in standard MA plans (as opposed to SNPs).²³ Yet, we believe that any such care model should be adequately tested prior to expansion on a national scale. We encourage the Committee to support the development of any such testing by CMMI, which Medicare Rights could support with the incorporation of adequate consumer protections. Concerning this proposal, we urge the Committee to draw on lessons learned from ongoing demonstrations, including the Medicare-Medicaid financial alignment demonstrations (as described above) and the recently announced Medicare Advantage Value-Based Insurance Design (MA-VBID) demonstration.²⁴

We believe that this proposal raises important questions about how to support beneficiary choice and the importance of providing adequate assistance to people with Medicare in making plan selections. While this proposal has the potential to improve plan benefits for people with chronic conditions, it also introduces additional complexity in MA plans that already exceedingly complex. As referenced above, research consistently demonstrates that older adults and people with disabilities continuously struggle to compare and contrast many plan variables (cost, network, coverage, restrictions, etc.) among many plan options.²⁵

Should the Committee opt to pursue this option (ideally through a demonstration program), we urge you to address these persistent challenges through increased support for SHIPs, enhancements to Plan Finder, improvements to beneficiary notices, like the ANOC, and more. In short, we believe that any proposal to introduce additional complexities to MA plans must be accompanied by a strategy to adequately support and assist Medicare beneficiaries in making plan comparisons.

²³ MedPAC, “Chapter 14: Medicare Advantage Special Needs Plans,” (March 2013), available at: [http://www.medpac.gov/documents/reports/chapter-14-medicare-advantage-special-needs-plans-\(march-2013-report\).pdf?sfvrsn=2](http://www.medpac.gov/documents/reports/chapter-14-medicare-advantage-special-needs-plans-(march-2013-report).pdf?sfvrsn=2)

²⁴ CMMI, “Medicare Advantage Value-Based Insurance Design Model, Request for Applications,” (October 2015), available at: <https://innovation.cms.gov/Files/reports/VBID-RFA-10-9-15.pdf>

²⁵ For a sample of this literature, see: Hoadley, J., Hargrave, E., Summer, L., Cubanski, J., and T. Neuman, “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?” (Kaiser Family Foundation: October 2013), available at: <http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/>; Jacobson, G., Swoope, C., Perry, M., and M.C. Slosar, “How are Seniors Choosing and Changing Health Insurance Plans?” (Kaiser Family Foundation: May 2014), available at: <http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/>; and McWilliams, J.M., Afendulus, C.C., McGuire, T.G., and B.E. Landon, “Complex Medicare Advantage Choices May Overwhelm Seniors—Especially Those with Impaired Decisionmaking,” *Health Affairs* 30:9 (September 2011)

Importantly, as presented by the Working Group, the identified proposal only allows for reductions in cost sharing for items or services that treat a chronic illness or prevent the progression of a chronic disease. We agree that only lowered and waived cost sharing should be pursued—no increases in cost sharing should be introduced as a deterrent to accessing health care services. We believe this important not only to facilitate beneficiary access to needed care, but also to limit the potential for “cherry picking” or other potentially discriminatory plan practices. Importantly, however, we urge the Committee to ensure that adequate monitoring and oversight is incorporated in any future proposals to limit the potential for risk-avoidance or other gaming, fraud, and abuse.

Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage

Enrollees: We appreciate the Working Group’s interest in this topic, and we agree that enhanced access to social supports and non-medical services may benefit older adults and people with disabilities with chronic health needs. Medicare Rights continues to support carefully designed demonstration programs that allow managed care plans to provide additional supplemental benefits to enrollees. Should the Committee explore this area further, we encourage complementary efforts in traditional Medicare, such as through Accountable Care Organizations (ACOs).

For example, we strongly support policies in the Medicare-Medicaid financial alignment demonstrations that expand on available supplemental benefits. Examples of enhanced benefits made available through the demonstration include OTC (over the counter) medication cards, non-health related transportation services, and adult dental coverage, which is not currently covered by Medicare and is not always available to Medicaid beneficiaries outside of enrollment in a demonstration. In New York, beneficiaries enrolled in the FIDA demonstration are also eligible for a number of home-and-community-based services and supports, including home modifications, home-delivery of medically tailored meals, and other items or services not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the beneficiary’s health and overall wellness.

In addition, we supported the general design of the MA V-BID demonstration recently announced by CMMI. In addition to allowing participating MA plans to lower cost sharing for “high-value” services and health care providers, the demonstration allows plans to provide supplemental benefits, consistent with current MA rules, to enrollees with targeted conditions (as opposed to requiring that these benefits be provided to all enrollees).²⁶

We encourage the Committee to draw on lessons learned from these demonstrations prior to any expansion. Further, Medicare Rights could support a demonstration that expands on available supplemental benefits for MA enrollees, so long as the program includes adequate consumer protections. We believe a well-designed demonstration that adds to existing MA supplemental benefits is one that:

- Incorporates rigorous monitoring and oversight to prevent gaming and adverse selection;
- Includes carefully constructed policies related to the marketing of supplemental benefits;
- Ensures adequate consumer counseling to ensure holistic evaluation of plan variables;
- Provides safeguards to allow for plan switching when warranted; and
- Evaluates the efficacy of the model and its effects on care quality and patient satisfaction.

It is important to note that the provision of supplemental benefits is an area that must be closely monitored to guard against discriminatory practices, essentially plan designs that seek to attract healthier individuals or

²⁶ CMMI, “Medicare Advantage Value-Based Insurance Design Model, Request for Applications,” (October 2015), available at: <https://innovation.cms.gov/Files/reports/VBID-RFA-10-9-15.pdf>

dissuade sicker individuals. Oversight is also needed to limit gaming, such as the delivery of supplemental benefits to those who do not have a true medical or social need for such services.

How supplemental benefits are marketed is also an important concern. It is critical that Medicare beneficiaries evaluate plan options holistically—taking into account the plan premium, cost sharing, provider network, and coverage rules and restrictions, in addition to any supplemental benefits. As described above, significant improvements are needed to ensure that people with Medicare are adequately supported in comparing and contrasting MA plan options. Should additional supplemental benefits be made available (preferably through a demonstration program), it will be critical to strike a balance that allows for the marketing of those services alongside adequate assistance and support to facilitate plan selection based on all variables.

Finally, where supplemental benefits are tied to specific chronic condition, it will be important to consider what mechanisms, such as Special Enrollment Periods, will be available to individuals who sign up for an MA plan believing supplemental benefits will be available to them, only to later discover that their particular diagnosis does not qualify them for those services.

As described above, the complexities of marketing and plan selection lead us to believe that additional testing is warranted before any expansion of supplemental benefits in MA plans is pursued. For instance, CMMI opted not to allow participating plans in the MA V-BID demonstration to market lower cost sharing or supplemental benefits. Given the concerns described above, we supported this determination.²⁷ Should CMMI revisit this policy, we will encourage the agency to proceed cautiously.

Maintaining ACO Flexibility to Provide Supplemental Services. Medicare Rights supports the identified proposal to clarify that ACOs participating in the Medicare Shared Saving Program may provide social services or transportation services for which there is no payment under fee-for-service Medicare. As described above with respect to MA plans, we appreciate that the provision of social services can help to facilitate improved well-being and health outcomes among people with Medicare who have multiple chronic conditions.

Alongside this proposal, we believe the Committee must explore options to ensure that ACOs and community-based organizations, like Area Agencies on Aging and Aging and Disability Resource Centers, are appropriately resourced to invest in the infrastructure and collaborative partnerships necessary to facilitate the delivery of such services. In addition, we encourage the Committee to consider the need for adequate monitoring and oversight of ACOs to limit risk avoidance through “cherry picking” or strategic patient selection and to protect against fraud and abuse.

Identifying the Chronically Ill Population and Ways to Improve Quality:

Ensuring Accurate Payment for Chronically Ill Individuals: As identified by the Working Group, we agree that adequate risk adjustment for MA plans is critical to facilitating access to needed care. We note that CMS recently proposed re-adjusting the HCC Risk Adjustment Model based on dual status, to better predict costs for beneficiaries who have some level of Medicaid assistance, either through full Medicaid benefits or

²⁷ Medicare Rights Center, “RE: Medicare Advantage Value-Based Insurance Design Model,” (September 2015), available at: <http://medicarerights.org/pdf/091515-ma-vbid-comments.pdf>

through a Medicare Savings Program.²⁸ We understand that CMS will seek stakeholder input on a more detailed version of this proposal in the draft 2017 MA and Part D call letter. As such, we encourage the Committee to consider the input gathered by CMS from multiple and diverse stakeholders as it explores options to ensure capitated payments to MA plans are adequately risk-adjusted.

Providing Flexibility for Beneficiaries to be Part of an Accountable Care Organization: The Working Group solicits input on allowing Medicare beneficiaries to voluntarily align with an ACO. We support this concept, so long as the system for voluntary alignment is carefully designed. In particular, we encourage the Committee to proactively design a strategy for beneficiary education.

In addition, we strongly urge that older adults and people with disabilities retain the ability to see the healthcare provider of their choice, including those providers not participating in the ACO to which the beneficiary is aligned. The ability to choose among healthcare providers in an open network is an important hallmark of traditional Medicare and a beneficiary right that should be preserved.

Should the Committee pursue voluntary alignment policies, we encourage you to draw on the experience of CMS' recent demonstration involving mailings asking beneficiaries to identify or confirm their primary care physician associated with a given ACO. Resulting from this demonstration, Medicare Rights and SHIPs heard directly from beneficiaries who were confused by the notices and from those who mistook the notices for fraudulent "phishing" scam letters.²⁹ Based on this experience, we believe that a successful voluntary alignment policy must include:

- Enhanced education from CMS for community-based organizations, SHIPs, and 1-800-MEDICARE call center operators about ACOs and how they operate. These trusted resources will be the first place that beneficiaries turn to, and they should be adequately supported to provide accurate and useful information.
- Collaboration by ACOs with community-based organizations to provide unbiased information and advice. Local resources should have relationships with ACOs so that the specific benefits, scope of the ACO group, and information about partner organizations can be communicated.
- Detailed information for beneficiaries, created by CMS, about ACO providers and on the expected value of seeing providers in an ACO. In particular, unbiased, understandable printed resources are needed. These resources should be available in multiple languages and in alternative formats (large print, Braille) and should clearly describe the process for and information about opt-out rights.
- CMS guidance to ACOs on allowed beneficiary education by ACOs and participating providers. We hear from health care providers who believe that they are prohibited from explaining the ACO or its benefits to their patients, or even from answering their questions about the ACO and the payment structure. Clear guidance is needed so that providers can answer questions and help beneficiaries make informed choices.³⁰

²⁸ CMS, "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017," (October 2015), available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RiskAdj2017ProposedChanges.pdf>

²⁹ See CMS FAQ on voluntary alignment, developed after the initial wave of beneficiary mailings: <https://innovation.cms.gov/Files/x/pioneeraco-volntalignmentfaq.pdf>

³⁰ For more detailed comments on beneficiary alignment in Next Generation ACOs, see: Coalition for Better Care, "RE: Next Generation Accountable Care Organization (ACO) Model Request for Applications," (May 2015), available at: <http://www.nationalpartnership.org/research-library/campaigns/campaign-for-better-care/coalition-for-better-care-comments-on-next-generation-aco-model.pdf>

We also believe that any ACO model requires transparency about provider incentives and clear communication about beneficiary rights to seek second opinions and to seek care outside of an ACO. Also, as ACOs share more significantly in savings, it will become increasingly important to monitor ACOs to limit risk avoidance and gaming through “cherry picking” or strategic patient selection. As such, we urge the Committee to ensure that CMS has the resources needed to engage in adequate tracking and oversight.

Developing Quality Measures for Chronic Conditions: We agree with the “top areas” for quality development identified by the Working Group, including the categories: patient/person and family engagement, shared decision-making, care coordination, hospice-Alzheimer’s, and targeted conditions in “community-level” measures. We encourage the Committee to incorporate “high-priority measure gaps” identified by the National Quality Forum (NQF) workgroup on persons dually eligible for Medicare and Medicaid, including:

- Goal-directed, person-centered care planning and implementation;
- Shared decision-making;
- Systems to coordinate healthcare with non-medical community resources and service providers;
- Beneficiary sense of control/autonomy/self-determination;
- Psychosocial needs;
- Community integration/inclusion and participation; and
- Optimal functioning (e.g., improving when possible, maintaining, managing decline).³¹

Empowering Individuals & Caregivers in Care Delivery:

Encouraging Beneficiary Use of Chronic Care Management Services: Medicare Rights continues to strongly support waiving the Part B coinsurance associated with the recently introduced Chronic Care Management (CCM) codes, and we thank the Working Group for soliciting additional comment on this option.³² Empirical literature on patient behavior makes clear that indiscriminate increases in cost sharing are shown to deter access to both necessary and unnecessary health care, and that such increases have a disproportionate impact on lower-income, vulnerable populations.³³ Conversely, evidence demonstrates that decreases in cost sharing can improve adherence, and may contribute to improved outcomes, such as through reduced hospitalizations and emergency room visits.³⁴ Given this, we continue to 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 that eliminated Medicare cost sharing for select preventive care.

Further, we believe that a sizable population would benefit from waiving the cost sharing associated with the CCM codes. While many beneficiaries with traditional Medicare have supplemental health plans, such as through Medigap or retiree insurance, 14 percent of people with Medicare had only traditional Medicare in 2010—exposing them to a 20 percent coinsurance for all Part B services and other health care costs. According to the Kaiser Family Foundation, this group included, “...a disproportionate share of beneficiaries under age 65

³¹ NQF, “Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement: 2015 Recommendations from the Measure Applications Partnership,” (August 2015), available at: https://www.qualityforum.org/Publications/2015/08/Advancing_Person-Centered_Care_for_Dual_Eligible_Beneficiaries_through_Performance_Measurement.aspx

³² See the June 2015 letter from Joe Baker, President of the Medicare Rights Center, to the Senate Finance Committee’s Chronic Care Working Group on its initial request for comment: <http://medicarerights.org/pdf/062215-mrc-sfc-chronic-care-letter.pdf>

³³ Swartz, K. “Cost-Sharing: Effects on Spending and Outcomes” (Robert Wood Johnson Foundation Research Synthesis Report No. 20: December 2010

³⁴ V-BID Center, “The Evidence for V-BID: Validating an Intuitive Concept,” (November 2012), available at: <http://vbidcenter.org/wp-content/uploads/2014/11/V-BID-brief-Evidence-Nov2012.pdf>

with disabilities, the near poor (those with incomes between \$10,000 and \$20,000), and black beneficiaries.”³⁵ Indeed, this is the exact population that we expect would most benefit from the care management services now made available through the CCM codes.

As noted above, we continue to believe that additional educational efforts—both for Medicare beneficiaries and health care providers—are needed to increase awareness about the CCM codes. We encourage the Committee to couple the waiver of cost sharing for the CCM codes with support for CMS to adequately educate people with Medicare and health care providers about the CCM codes and associated services.

Eliminating Barriers to Care Coordination under ACOs: Medicare Rights generally supports initiatives to waive beneficiary cost sharing under ACOs in targeted, thoughtful ways to encourage appropriate utilization of care. As noted above, in 2010, an estimated 14 percent of older adults and people with disabilities had traditional Medicare only and would stand to benefit from lower cost sharing for needed services and treatments. As described above, research studies consistently draw a link between affordability and adherence, demonstrating that unaffordable cost sharing limits access to needed health care.³⁶

We urge the Committee to establish these processes through rulemaking, with detailed clinical support for the particular reductions and ACO participation as well as transparent standards for determining when and what cost sharing may be waived. While waiving deductibles may increase access to preventive and other annual services and waiving copayments or coinsurance for specific services is promising, we believe it is essential that these cost sharing carve outs are—by objective measure—high-value. We encourage the Committee to review our comments to CMMI on the importance of transparency in this respect related to the MA-VBID demonstration as it considers parallel initiatives in the context of ACOs.³⁷

Consistency across ACOs is important to allow for unbiased and accurate beneficiary and provider education and to ensure that consumer protections and safeguards are in place. These protections and safeguards must include allowing only lowered or waived cost sharing for high-value services—not increased cost sharing as a deterrent. Finally, as noted above, we do not believe that lowered or waived cost sharing alone is sufficient to promote improved utilization. We strongly believe that any such changes must be coupled with adequate educational initiatives, targeting both beneficiaries and health care providers.

Expanding Access to Prediabetes Education: As supporters of the Medicare Diabetes Prevention Act of 2015 (S. 1131/ H.R. 2102), we encourage the Committee to include expanding access to prediabetes self-management services among the policy options considered moving forward.

Other Policies to Improve Care for the Chronically Ill:

Increasing Transparency at Center for Medicare & Medicaid Innovation: Medicare Rights agrees that transparency in models tested by CMMI is critical, as is creating ample opportunity for input from multiple, diverse stakeholders. As reflected in our comments here and in response to CMMI proposals, the details of a

³⁵ Cubanski, J., Swoope, C., Boccuti, C., Jacobson, G., Casillas, G., Griffin, S., and T. Neuman, “A Primer on Medicare: Key Facts about the Medicare Program and the People it Covers,” (March 2015), available at: <http://kff.org/report-section/a-primer-on-medicare-what-types-of-supplemental-insurance-do-beneficiaries-have/>

³⁶ See: Swartz, K. “Cost-Sharing: Effects on Spending and Outcomes” (Robert Wood Johnson Foundation Research Synthesis Report No. 20: December 2010; and V-BID Center, “The Evidence for V-BID: Validating an Intuitive Concept,” (November 2012), available at: <http://vbidcenter.org/wp-content/uploads/2014/11/V-BID-brief-Evidence-Nov2012.pdf>

³⁷ Medicare Rights Center, “RE: Medicare Advantage Value-Based Insurance Design Model,” (September 2015), available at: <http://medicarerights.org/pdf/091515-ma-vbid-comments.pdf>

care model's design are essential to promoting beneficiary awareness and engagement. At the same time, we do not seek to unnecessarily slow the pace of change or hamper needed innovations in payment and delivery system reforms. As such, we encourage the Committee to balance these priorities. Of the policies presented by the Working Group, we believe the option requiring formal notice and comment rulemaking for all mandatory models and a 30-day comment period for all other demonstrations comes the closest to striking this balance.

Additionally, while we agree that it is critical for CMMI to solicit stakeholder input on initial model design, we believe it is equally important that multiple, diverse stakeholders—including beneficiaries and consumer advocates—have the opportunity to weigh in during implementation, both to share lessons learned and to provide input on mid-course corrections or shifts. As such, we urge the Committee to explore the establishment of multi-stakeholder advisory committees, with public reporting, for all CMMI demonstrations.

Finally, we encourage the Committee to explore creating an independent ombudsman program for the purposes of monitoring and assisting beneficiaries in all demonstration programs underway at CMMI. Ombudsman programs are being successfully used in the financial alignment models for dually eligible beneficiaries as well as to monitor the Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program.³⁸ These independent entities are responsible for monitoring beneficiary access to care, in addition to limiting beneficiary confusion and promoting enhanced understanding. With an increasing number of delivery and payment system models ongoing at CMMI, we believe a dedicated ombudsman is warranted.

In closing, we thank the Committee for the opportunity to comment on the policy options identified by the Working Group, and we applaud the Working Group for the thoughtful development of these recommendations. We hope our comments will help the Committee fine-tune initiatives to improve the health and well-being of people with Medicare who have multiple chronic conditions.

We welcome the opportunity to continue to engage with the Committee as you develop these concepts further. If you have questions concerning our comments or need additional information, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961. Thank you.

Sincerely,



Joe Baker
President
Medicare Rights Center

³⁸ For more information on the ombudsman programs for the Medicare-Medicaid financial alignment demonstrations, see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html>; For more information on the Competitive Acquisition Ombudsman, see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Competitive_Acquisition_Ombudsman.html