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United States Senate

WASHINGTON, DC 20510–4802

July 10, 2012

The Honorable Kathleen Sebelius
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201-0001

Dear Madam Secretary,

One of the most important provisions of the Affordable Care Act is its creation of the Federal Coordinated Health Care Office to more effectively integrate benefits for seniors and individuals with disabilities who are dually eligible for Medicare and Medicaid. In a short time, this office has launched a number of initiatives designed to better understand and serve the diverse needs of dually eligible beneficiaries, as well as to improve the quality and coordination of their care. I commend you and your dedicated staff for pursuing these opportunities. It is my great hope and belief that some of these demonstrations will, over time, yield effective new approaches to care delivery for dual eligibles – approaches that Congress can subsequently choose to put into operation program-wide through statute.

While I strongly support the Coordinated Care Office's mission, I am very concerned that the capitated model under the Financial Alignment Initiative, as currently structured, runs counter to both the letter and the spirit of the statute regarding the Federal Coordinated Health Care Office as I envisioned it when writing that section of the health reform law. For all of the reasons outlined in this letter, I urge you to take immediate steps to halt this initiative as currently structured and to take the time necessary to develop a well-designed and thoroughly evaluated care coordination model for dual eligibles that meets the standards outlined in the law. I specifically urge you to:

- **Focus on providing high-quality care as the primary goal instead of up-front programmatic savings – which was never the intent of the law**. The most important goal of the Coordinated Care Office is to improve the quality of care for each of the different sub-populations of dual eligibles – whether or not such approaches save money. I am extremely concerned about CMS's guidance stating that "absent savings for both payers, the [Financial Alignment Initiative] will not go forward." The assumption of a savings target before this initiative even begins will create an enormous amount of pressure on managed care companies – many of whom have never served this population – to take shortcuts in order to achieve savings. This is of particular concern given that some states are proposing to enroll dual eligibles in plans that have not demonstrated their ability to deliver high quality care for this population. Instead of building sophisticated networks of coordinated care that improve quality and reduce waste and inefficiency, these plans are likely to limit benefits including long-term services and supports, cut provider payment rates, or both – further threatening access to care. If savings are a foregone conclusion, it is unclear how CMS would be able to conduct an objective evaluation of whether or not these models actually save money. The potential

for any savings must be carefully evaluated, not assumed from the beginning. And, under no circumstance should state and federal budget savings be the litmus test by which all care coordination concepts for duals are judged. That was not the intent of the law.

- **Rigorously test new care coordination concepts and make recommendations to Congress about programmatic changes that show promise for broad implementation**. Without any testing or evaluation, some states have proposed to enroll 100% of dual eligible individuals – or entire sub-populations – into the Financial Alignment Initiative. Demonstration programs should not start out with a design and scale that arbitrarily assumes the success and universal applicability of the concepts they are intended to test. And, demonstrations must have the necessary infrastructure from the beginning to monitor access to health care and the quality of that care, including for specific sub-populations of beneficiaries. Finally, instead of relying solely on a model that relies on multiple state efforts, CMS should also test a model that brings care for dual eligibles under the federal umbrella.

- **Guarantee that dual eligibles retain all the rights and the same access to care as all other Medicare beneficiaries**. As the details of state proposals emerge, it is becoming increasingly clear that the rights and choices of Medicare beneficiaries – rights and protections I have vigorously defended for years – could be diluted. The statute creating the Coordinated Care Office is very clear on this point: *"Nothing in this section – "(1) requires mandatory integrated care under the Medicare or Medicaid programs...(3) promotes the development of Medicaid managed care for dual eligible individuals; or (4) prevents dual eligible individuals from electing to remain in the original Medicare fee-for-service option, or the right to make such election being protected."* The passive enrollment currently contemplated as part of this initiative runs counter to federal law. Freedom of choice is a bedrock principle of Medicare that must be maintained for dual eligibles, just as it is being maintained for those beneficiaries who are not dually eligible. Placing the burden of opting-out of coverage on frail and elderly beneficiaries is not an adequate substitute for affirmative consent. Alternatives to "passive" enrollment – such as effective beneficiary outreach and education campaigns – should be fully considered.

Congressional Intent

Federal and state policymakers have long been keenly aware of the challenges inherent in coordinating Medicare and Medicaid benefits on behalf of dually eligible beneficiaries. While we have made some legislative strides – including language I authored in the 2003 Medicare prescription drug bill to provide Medicare prescription drug coverage to dual eligibles – much more work is required to develop thoughtful solutions to resolve the challenges facing this vulnerable population. Congress created the Federal Coordinated Health Care Office with the specific mission of: 1) more effectively integrating benefits under Medicare and Medicaid and 2) improving the coordination between the federal government and the states so that dual eligibles could fully access the benefits they are entitled to under Medicare and Medicaid. Not only does the Coordinated Care Office appear to be off-course in terms of its mission, the Financial Alignment Initiative also seems to be in direct conflict with the eight, very specific, statutory goals Congress outlined for the office – none of which mentions savings.

Major Concerns

Broad Implementation without Testing and Evaluation

In creating the Coordinated Care Office, Congress sought better evidence about the effectiveness of new care coordination models for dually eligible beneficiaries. The process Congress envisioned was one that invested in testing well-designed, thoroughly evaluated demonstrations *before* expanding successful demonstrations more broadly. Such a process would involve:

- First, surveying the states to determine current best practices in caring for the duals;
- Second, creating appropriately scaled demonstration projects that are well-designed, transparent, and scientifically validated in order to test new concepts of care;
- Third, developing consistent standards to evaluate the effectiveness of those new concepts prior to testing through demonstration projects;
- Fourth, implementing targeted demonstration projects that recognize the diverse needs of varying groups of dual eligibles; and
- Fifth, making annual recommendations to Congress about concepts showing promise for adoption in Medicare and/or Medicaid more broadly.

As currently structured, this initiative does not meet any of those intended objectives. I am also extremely concerned that the deadline for states to submit their final proposals took place before the National Quality Forum, at the direction of HHS, released its final report outlining a national quality strategy for dual eligibles. While the report represents a significant step forward, it also identified "a large number of measure development gaps" – gaps that should be addressed before undertaking such a large demonstration project that includes dual eligibles.

Size and Scope of "Demonstration"

- *Size of participating population*. CMS has noted its intention to test two new models – a capitated, managed care model and a managed fee-for-service model – for *up to* 2 million Medicare-Medicaid enrollees. States may seek approval to move an additional one million persons into these "demonstrations." This would greatly exceed the size of any previous CMS demonstration changing the way Medicare beneficiaries receive care, even though this demonstration is extremely complex. While it is clearly important to have an adequate sample size in order to evaluate demonstration programs, these changes appear to go far beyond what is necessary or appropriate in order to test new models of care.

- *Permanent Change in Policy*. Such large "demonstrations," spread across dozens of states, each using a different program design, would be very difficult for CMS to monitor and evaluate. MedPAC Commissioners have stated that such large "demonstrations" would be very difficult to modify or stop once underway, effectively making them a permanent change in policy. It is unclear whether every state will have the resources and capacity to closely monitor the "demonstration" plans, and how CMS intends to collaborate with each state on oversight and monitoring.

Lack of Transparency, Testing and Evaluation

CMS has also noted that "all programs will be rigorously evaluated as to their ability to improve quality and reduce costs. Meaningful engagement with stakeholders and ensuring beneficiary protections will be a crucial part of developing and testing these models." I am therefore troubled by state proposals to enroll large majorities of the dually eligible population or subpopulations into statewide managed care demonstrations before they have been evaluated and proven effective at improving quality of care. Approval of these state proposals at their current size and scope prior to a thorough evaluation would more closely resemble a waiver than it would a demonstration, circumventing the ACA's requirement that the Secretary expand the duration and scope of demonstrations under the Innovation Center authority only if she first finds that such an expansion would reduce spending without reducing quality of care, or would improve quality of care without reducing spending, and if the chief actuary of CMS certifies that the expansion will not increase spending.

Infringement on Beneficiary Rights and Protections

- *Passively enrolling dual eligibles into unproven managed care plans.* Freedom of choice is a hallmark of the Medicare and Medicaid programs, yet under the demonstration as currently designed, Medicare beneficiaries who happen to be poor or disabled would be held to a different standard than other Medicare beneficiaries. Passive enrollment would undoubtedly lead to disruptions in access to care, significant confusion among seniors and their families, and additional administrative burdens for Medicare and Medicaid instead of greater administrative simplification. Beneficiaries should not be moved out of their current coverage without their affirmative consent.

- *Locking dual eligibles into Medicaid managed care plans that they were involuntarily enrolled in.* I also understand that some states have proposed to "lock-in" passively enrolled beneficiaries for six months. Not only are there persisting questions about the standards of care provided by some of the managed care plans that duals would be passively enrolled in, and whether those plans could adequately meet their health care needs, there is also the very serious risk that locking duals in would preclude their participation in proven models of care – such as the Program of All-Inclusive Care for the Elderly (PACE). Medicare beneficiary enrollment protections should not be more limited for dual eligibles than any other Medicare enrollees, especially given the diverse health needs and vulnerability of the duals population.

- *Inadequate Beneficiary Education.* All dual eligibles deserve to be educated about their options and allowed to choose the care that best meets their needs. Unfortunately, the speed at which this proposal is progressing seems to preclude any substantive education and outreach to dual eligibles and their families.

Benefit and Service Disruptions

- *Relying on models of care that do not work for this population, leading to reduced access*. Medicaid managed care is a model that has not been shown to work for even small numbers of dual eligibles because of the varying range and intensity of services required to meet their special health care needs. With very few exceptions, Medicaid managed care has been limited to healthy adults and children. MedPAC has pointed out that many of the health plans participating in the demonstrations have little experience caring for this population or delivering the full range of services proposed – a concern that is exacerbated if dual eligibles are involuntarily assigned to a plan. Congress charged the Federal Coordinated Health Care Office and the Centers for Medicare and Medicaid Innovation, with testing new and innovative models of care coordination, not with recycling old ideas already proven to be ineffective for this population and risking the health of millions by forcing them to comply. If more Medicaid managed care had been the goal, Congress would have passed legislation saying that.

- *Enrolling dual eligibles in Medicaid prescription drug coverage when they are entitled to prescription drug coverage through Medicare*. Not only would such an approach be counter to the statutory goals of the Federal Coordinated Health Care Office, they would also be in direct conflict with Section 103 of Public Law 108-173.

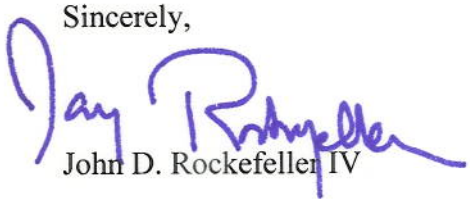
- *Lack of provider infrastructure*. These Medicare beneficiaries have spent years developing relationships with physicians and other providers that are likely to be affected if they are moved involuntarily into a managed care plan that does not include their provider in-network. Moreover, the Government Accountability Office (GAO) has found that CMS has typically lacked the high-quality data necessary to make sure that states' managed care payment rates are appropriate.

Conclusion

I know that we share the goals of better program management and better health outcomes for dually eligible beneficiaries, and I strongly support the focus and attention by your Department on improving care for this population. However, as you move forward, I urge you to reject state proposals not designed as careful pilots, to assure full protection of beneficiaries' rights and access to high quality medical care, and to thoroughly evaluate the effectiveness of new models of care before expanding them on a larger scale.

I would welcome the chance to discuss this further with you, and look forward to working with you further on these important initiatives. I look forward to receiving your reply no later than Friday, July 20th.

Sincerely,



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