Sound Policy. Quality Care.

May 24, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: State Demonstrations to Integrate Care for Dual Eligible Individuals

Dear Acting Administrator Tavenner,

The undersigned members of the Alliance of Specialty Medicine (Alliance) are writing to inform you of our concerns over the direction and speed of implementation of the Centers for Medicare & Medicaid Services (CMS) dual integration demonstrations and the potential adverse effects it could have on access to specialty care for the dual-beneficiary population. Therefore, we ask that **implementation be delayed by at least one year** so patients, providers and other stakeholders have adequate time to better understand, evaluate and comment on the demonstration program.

The Alliance is a coalition of national medical specialty societies representing more than 100,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

CMS' new initiative funded by the Affordable Care Act will provide 15 states with up to $1 million each to develop new ways to meet the complex and costly medical needs of individuals eligible for both the Medicare and Medicaid programs, known as "dual eligibles." While the goal of the program is to eliminate duplication of services for these patients, expand access and lower costs to this vulnerable population, we are deeply concerned about unintended consequences that are likely to impede on the initiative's stated aim.

Overarching Concerns

There are approximately 9 million dual eligible beneficiaries in the United States. These individuals qualify for both Medicare and Medicaid services and are among the most vulnerable of our population. Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to have cognitive impairment, mental disorders and characteristically have higher rates of diabetes, pulmonary disease, stroke and Alzheimer's disease.[1] Socioeconomic characteristics of this population, such as lower education, poorer health, geographic and social isolation make coordinating and providing care for this population extremely difficult which is why we strongly support efforts to improve care coordination for dual eligible beneficiaries and are encouraged to see CMS take steps to develop a

[1] MedPAC A Data Book: Health Care Spending and the Medicare Program, June 2011

better integrated and less fragmented system of care for this population. However, we are concerned at the speed and varying state approaches to implementing these demonstrations, which could disrupt patients' access to care and their choice of physician. We hope CMS will carefully weigh all stakeholder concerns before approving or accelerating demonstrations that may result in the unintended elimination of beneficiary safeguards and protections, placing at risk the health and well-being of millions of our most vulnerable citizens.

CMS recently issued several guidance documents (January 25 and March 29 "guidance") in which the agency provides the preferred, basic criteria for states wishing to participate in the dual integration demonstration. The guidance allows states to automatically enroll beneficiaries into a variety of newly created, untested, state-run managed care programs with limited experience furnishing services to the dual eligible population. As advocates for patients and physicians, we are concerned that CMS is moving too quickly with the duals demonstrations and is not taking sufficient time to ensure that access to specialty care is not inadvertently restricted. We urge CMS to proceed cautiously and offer the following issues for consideration:

Patients Could Be at Risk without Appropriate Safeguards to Ensure Continuity of Care

A cornerstone principle of the Medicare system, since its inception, has been its universality. Transferring responsibility for Medicare beneficiaries to individual states will fundamentally alter this principle and risks creating a pathway for separate standards for these lowest income beneficiaries that may potentially result in reduced access to care simply on the basis of income.

As specialty physicians, we are acutely aware of the needs of this fragile population to continue to have strong safeguards and protections to ensure limited disruptions to their care regime. The proposal by a number of states to implement passive enrollment processes and/or limit the choice of plans available to beneficiaries raises serious concerns that existing Medicare patient protections may be eroded, potentially leading to inadequate provider networks and restricted access. Dual-eligible beneficiaries may potentially be subject to harmful disruptions in care particularly if they have established provider relationships and care plans and those providers are not included in the plan the beneficiary is passively enrolled in or the beneficiaries' new drug plan has a different formulary impacting their existing therapy. CMS and states should work to ensure continuity of care is maintained for this population during the enrollment process and that protections are preserved to ensure these beneficiaries are able to see and retain access to the provider of their choice.

Access to Needed Care May Be Impacted by Inadequate Provider Reimbursement

To date, the CMS guidance and state demonstration proposals highlight efforts to build in "up-front" savings prior to the approval and implementation of a state demonstration. The lack of detail to explain where those savings will be derived from is of concern to us. As physicians who regularly interact with and understand the complexities of this population, we urge CMS to focus its efforts on achieving savings through better coordinated care and not through techniques traditionally used to restrain spending, such as provider cuts. Maintaining access to existing providers, specialty care, and other needed health services is essential to the quality and care of this special needs population.

We have significant concern that while demonstrations aspire to reduce fragmentation of care, they will in practice lead to unsustainable cuts in provider payment rates which will consequently reduce access to care. It is unclear from most state proposals what constraints plans will face, if any, in how providers will be reimbursed under these state dual integration demonstrations. Massachusetts

for example, in its demonstration proposal, indicates that "Medicare will not pay solely for Medicare services and Medicaid will not pay solely for Medicaid services." In the absence of robust competition between managed care plans, rates may be particularly at risk. It appears that in many states dual eligibles in the demonstrations may be enrolled in only two plans, or in some cases, in just one plan per region. The extreme example is Vermont, which has indicated that it plans to run its entire demonstration using the state's public managed care entity as the single plan option. While Vermont claims that rates will be based on historical Medicare rates, there is no safeguard to assure that this will continue to be the case in future years.

Moreover, even Medicare rates, due to the flawed Sustainable Growth Rate (SGR) formula, have resulted in unpredictable payments, forcing an increasing number of specialty physicians to reconsider their participation in the Medicare program. We appreciate recent Congressional action to avert the scheduled 27 percent cut in Medicare payments scheduled for March 1, but we continue to remain frustrated over the failure to provide a permanent solution to the SGR so physicians and their patients will no longer have to struggle with the uncertainty of short-term patches that yearly jeopardize access to critical specialty care. Since we are already struggling to ensure appropriate and adequate reimbursement by Medicare, we have serious concern that providers in the dual demonstrations could be reimbursed at lower Medicaid rates, compounding current efforts to ensure appropriate reimbursement and access to care.

Strong Federal Oversight Needed

Most Medicaid managed care plans have historically been focused on the care of children and families, and have little or no experience with the more complex needs of the frail elderly or patients who are mentally ill, developmentally disabled, or institutionalized. By contrast, the Medicare Payment Advisory Commission (MedPAC) reports that over one million dual eligibles are enrolled in one of almost 300 dual eligible special needs plan (D-SNP) that coordinates their care and which must meet quality guidelines set by the National Center for Quality Assurance by 2012.[i] Given the federal government provides a larger portion of financing for the dual eligible population and historically has more experience in managing dual coordination efforts; it should continue to maintain a strong oversight role in the implementation of the duals demonstration.

A significant number of states have either released or indicated a desire to participate in the dual integration demonstration through managed care plans. Given the potential variation of demonstration models between states, compounded by the potential participation of numerous health plans, CMS will be faced with a very challenging environment to effectively meet its oversight responsibilities including ensuring compliance to quality and program integrity standards. Given the vulnerability of this population, CMS should carefully ensure it has the necessary infrastructure and processes in place before accelerating large scale implementation of the duals demonstration. For example, demonstrations will need to have in place sophisticated processes to share essential information between stakeholders in order to effectively realize the potential of integrated care. At a minimum, issues such as these regarding the sharing of essential information between the states and CMS should be resolved before a state's demonstration plan is implemented or approved.

Patient-Centeredness and Shared Decision Making

Important, underlying themes of the Affordable Care Act are patient-centeredness and shared decision making. In fact, the new Center for Medicare and Medicaid Innovation established by the law was directed to establish a Shared Decision Making Program to help beneficiaries–in collaboration with

their health care providers–make more informed treatment decisions based on an understanding of available options, and each patient's circumstances, beliefs and preferences. CMS' dual eligible demonstration, which would allow states to automatically enroll patients into new plans without their prior consent, appears to be in direct conflict with this theme.

Passive enrollment happens regardless of a choice and often without either clear knowledge or desire. Knowledgeable individuals will act in their self-interest and those that do not act miss out on the benefit. Under the states' proposals, individuals are forced to respond in order to opt-out of the program either before or following enrollment, and the uninformed will be enrolled.

For dual eligible individuals making a considerable effort to maintain an independent lifestyle and actively choose and direct their own care, taking ownership and responsibility for the decisions they make, passive enrollment is offensive. On behalf of our dual eligible patients, we ask CMS to seek other forms of enrollment that might better align with shared decision making and patient-centeredness.

Conclusion

We urgently request that CMS exercise great caution in approving proposed state plans for demonstration proposals, and that it reject outright proposals which call for statewide implementation or use passive enrollment to make coverage changes for hundreds of thousands of patients at a time. Instead, we urge CMS to approach the implementation of the duals integration demonstrations with greater deliberation and to work with stakeholders to ensure the issues raised in this letter are satisfactorily addressed before subjecting millions of lives to potential disruption in their health care coverage and quality of care.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Society for Cardiovascular Angiography and Interventions

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[i] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System, June 2011, http://medpac.gov/chapters/Jun11_Ch05.pdf