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

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to share our concerns about implementation of the proposed demonstration projects, State Demonstrations to Integrate Care for Dual Eligibles, which are being funded by the Centers for Medicare and Medicaid Services (CMS) pursuant to the Affordable Care Act (ACA). The dual eligible population, who are among the most vulnerable of our patients, accounts for a disproportionate share of Medicare and Medicaid spending. It is widely recognized that in the current system, care delivered to Medicare-Medicaid patients is disjointed, with each program responsible for providing different health care services. This system is also misaligned financially, which has stymied efforts to implement care coordination and instead promotes cost shifting between Medicare and Medicaid and between health care providers.

The AMA strongly supports the goals of the dual eligible demonstration projects, which are aimed at better aligning and coordinating the financing and delivery of care provided to this population, who often have complex medical and social needs and often face barriers to getting the right care in the right setting. However, we are very concerned about the implementation of these demonstration projects, especially with regard to their size and scope and, therefore, urge CMS to delay the implementation of the demonstration program for at least one year. Such a delay would allow beneficiaries, physicians, and other provider stakeholders to better understand, evaluate, and comment on the dual eligible demonstrations, and to work with CMS, interested states, and health plans to address issues raised in specific state proposals.

The proposed demonstration projects, specifically the Financial Alignment Model Demonstration Project, will significantly change how care is delivered to dual eligible beneficiaries and how providers will be paid. Given the complex medical conditions of many dual eligibles, it is critical to ensure that the proposed changes meet the needs of the population, and beneficiary choice and access to quality care must not be compromised. We urge CMS to consider the following concerns when reviewing the specific state demonstration proposals:

The size, scope, and speed of implementing the demonstration projects should be reasonable and all aspects of the project should be as transparent as possible; beneficiaries' freedom to choose their

provider should be preserved and protected; care coordination should be physician-led; the demonstration projects should include an adequate network of providers, including both primary care and specialists, in the geographic region and access to all necessary Medicare and Medicaid covered services should be provided; to protect access to care, physician reimbursement should be at least as high as current Medicare fee-for-service rates, and program savings should come from improved care coordination and quality, not from reduced provider rates; and the demonstration projects should be simple and easy to navigate for patients and providers.

Demonstration projects should be reasonable in size, scope, and speed of implementation

We share the concerns expressed by the Medicare Payment Advisory Commission (MedPAC) in its June report to Congress that the dual eligible demonstration projects are too large and are moving too quickly for the insurers involved. Most states that are pursuing a capitated model are proposing to enroll most or all dual-eligible beneficiaries in the state, or entire subgroups of beneficiaries, such as disabled individuals under 65 years old. We believe that the size and scope of the demonstration projects, as currently proposed, are too large to operate as a true demonstration, and instead, appear to be large-scale program changes masquerading as demonstration projects. It is important that any demonstration project approved by CMS be a reasonable size and scope to account for the experimental nature of the program and so that it can be properly evaluated.

The large scope also makes it more challenging to transition large groups of beneficiaries with complex care needs out of the demonstration if beneficiaries choose to leave the project or if plans fail to meet beneficiaries' needs. Many plans may be inexperienced in dealing with the dual eligible population or with managing and being at risk for all Medicare and all Medicaid benefits. Consequently, we believe that states should maintain the current care delivery models as an option for dual eligibles in the state. This is important not only to provide beneficiaries with an alternative for care, but also so that CMS and the state can conduct a robust evaluation of the program's success compared to the current delivery model, including measurable quality improvement, patient satisfaction, access to care, and overall savings.

The speed at which these proposals are moving from the drawing board to actual implementation has not allowed sufficient time for input from all stakeholders. This is further exacerbated by the fact that the proposals submitted for public comment often have not included important details on how the programs will operate, how care will be delivered to beneficiaries, how providers will be paid, or how interested parties will share in the savings. Without these details, key stakeholders cannot adequately evaluate or provide meaningful comments about the proposals. These details should be fleshed out and made available for public comment prior to approval of any demonstration project by CMS.

Demonstration projects should be as transparent as possible, publicly available, with specific guidance provided to the states on the key principles that will guide negotiations and the development of the final Memorandums of Understanding (MOUs), and by making the MOUs available for public comment by stakeholders before they are finalized and executed. In addition, measures to determine the success of the demonstration projects, including shared savings among the states, CMS, health plans, and health care providers, where appropriate, should be clearly delineated before the program begins.

Beneficiaries' freedom to choose their provider should be preserved and protected

One of the longstanding principles of the Medicare program is to allow beneficiaries the freedom to choose their physician. Many dual eligibles have developed a strong network of trusted physicians who have provided their care over many years. In addition, many dual eligibles face serious medical conditions and have complex treatment and drug regimens that have been refined and developed over time. Any disruption in this network of providers or treatment can have a negative impact on the beneficiary's health. It is imperative, therefore, that the demonstration projects preserve and protect dual eligibles' freedom to choose their provider and maintain their current treatment or drug regimen.

We are very concerned that states are proposing to use passive enrollment without the prior consent or approval of dual eligible beneficiaries. We believe that the demonstration projects must allow dual eligibles the ability to "opt-in" to a given plan, rather than being allowed to "opt-out" after being passively enrolled into a plan. This approach protects the autonomy and independence of individuals and their freedom to choose a plan which best meets their health care needs. We strongly urge CMS to reconsider allowing states to use passive enrollment for the capitated Financial Alignment Demonstration Project. Even with an opt-out provision, passive enrollment could have a negative impact on this medically vulnerable population, particularly if an individual's physician, treatment, or medications are not covered by the plan in which they have been enrolled. Rather than allowing states to passively enroll dual eligibles in a plan, CMS should encourage states to empower dual eligibles with understandable information about their options including covered benefits, choice of providers, formularies, and cost sharing. Giving dual eligibles the freedom to opt-in to a plan also improves the likelihood of patients' compliance with the care coordination features and thus overall success of the program. We also strongly urge CMS to adhere to its initial guidance prohibiting states from implementing lock-in periods. The demonstration projects should include policies that allow beneficiaries to disenroll at any time from a plan if it does not meet their health care needs.

Care coordination should be led by a physician

Dual eligibles are a diverse population with complex medical and social needs. Under the current system, care covered by Medicare and Medicaid is often disjointed and fragmented. Efforts to improve care coordination can have a positive effect on the quality of care provided to dual eligibles. Care coordination should be led by a physician and involve a robust partnership among the physician, patient, the patient's family, and other health care providers. Care should be coordinated across all elements of the health care system and the patient's community, including the use of social services where appropriate. The primary goal of care coordination should be to help arrange for the services most appropriate to the patient's needs with cost containment a legitimate but secondary objective.

A care coordination system must ensure physicians have the ability to place their patients' interests first. Payment to providers should reflect the physician and non-physician work that falls outside of the face-to-face visit and could include payments for specific care coordination services. Physicians should receive a monthly care management payment on top of fee-for-service payments for individual services. Physicians should also share in any savings associated with improved care coordination led by the physician as well as additional payments for achieving measurable quality improvements.

The demonstration projects should include an adequate network of providers

The demonstration projects should include an adequate network of physicians and other health care providers reasonably necessary to ensure that all enrollees will have timely access to the medical care they need on an in-network basis. Provider networks must include a sufficient number of primary care physicians and specialists within the geographic region to meet the complex medical needs of this population. The standards for network adequacy should include the following:

- Number of physicians in the geographic region who are participating in the plan. This information should be presented as a percentage of all physicians practicing in the geographic area. This information should also be further delineated by specialty (e.g., geriatric, orthopedic, primary care).

- Number of physicians in the geographic region who are participating in the plan and accepting new patients. This information should be presented as; (1) a percentage of all physicians in the geographic region; and (2) a percentage of all physicians who are participating in the plan. This information should also be further delineated by specialty (e.g., geriatric, orthopedic, primary care); wait times for appointments; physical accessibility — e.g., access to public transportation; and geographic accessibility.

- The plans must have a process in place for beneficiaries to receive care from an out-of network provider if no in-network provider reasonably acceptable to a beneficiary is available on a timely basis.

- States should maintain oversight of the managed care plans serving Medicaid enrollees. The state should impose regular oversight of the plans to evaluate adequacy of the plan's network as the population and needs of providers and enrollees shift over time.

To protect access to care, physician reimbursement should be at least as high as current Medicare fee-for-service rates, and program savings should come from improved care coordination and quality, not from reduced provider rates

In order to protect access to care for Medicare-Medicaid beneficiaries, CMS should ensure the demonstration projects maintain adequate reimbursement rates for physicians. Current Medicaid payment levels are woefully inadequate in many states. To realize true coordination between the programs, physician reimbursement for treating dual eligibles should be at least as high as Medicare fee-for-service payment rates. The demonstration projects should not be used as a vehicle to reduce provider reimbursement to woefully inadequate Medicaid rates. As CMS has indicated, savings should come from improved care coordination and improved efficiencies in the system—not on the backs of providers. To help maintain an adequate network, the states should also continue to provide full reimbursement for Medicare deductibles and co-payments for all dual eligibles.

The demonstration projects should be simple and easy to navigate for patients and providers

The current fragmented system is difficult to navigate with the provision and payment of services split between Medicare and Medicaid. An integrated system should include mechanisms that simplify the process for beneficiaries and providers. Materials provided to beneficiaries should be easily understandable and include information on covered benefits, deductibles, co-payments,

prescription drug formulary, prior authorization requirements, and the provider network. To help simplify the process, plans should consider using the Uniform Explanation of Coverage Documents and the Standardized Definitions form developed by the Department of Health and Human Services.

In conclusion, we would like to reiterate that we support the goals of the Dual Eligibles Demonstration Project. Finding high-quality ways to care for the dual eligibles population is, and should be, a priority, but we believe that CMS should slow down implementation of the demonstration projects so that the concerns that we and other stakeholders have expressed can be addressed. We also believe implementation should be slowed down so states can provide more details about their proposal, including how the program will operate, how care will be delivered to beneficiaries, how providers will be paid, or how interested parties will share in the savings. Interested stakeholders should also be given adequate time to respond once these details are made clear. Thank you in advance for your consideration.

Sincerely,

James L. Madara, MD