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July 11, 2011

Donald M. Berwick, M.D.

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Hubert H. Humphrey Building, Room 445-G

200 Independence Avenue, SW

Washington, DC 21244-1850

Re: **Medicare and Medicaid Programs; Opportunities for Alignment under Medicaid and Medicare CMS-5507-NC**

Dear Dr. Berwick:

National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on the afore-referenced proposed rule which solicits comments on options for the Centers for Medicare and Medicaid Services to more effectively align benefits and incentives to prevent cost-shifting and improve access to care for the dual-eligible population. The dual-eligible population refers to those patients who are eligible for Medicare and Medicaid programs.

NPAF is a non-profit organization dedicated to improving patient access to healthcare services through both federal and state policy reform. Its mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. NPAF has a fifteen year history of serving as the trusted patient voice. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). In 2010, PAF resolved 82,963 cases nationally and provided information to almost 4 million online contacts. Approximately eleven percent of these patients were dual-eligible beneficiaries. PAF's Patient Data Analysis Report (PDAR), which will be described in greater detail later, provides detailed analyses of these patients and informs the comments provided within this letter.

### Dual Eligibles as Beneficiaries

A recent study by the Kaiser Family Foundation concluded that dual eligibles constitute a costly segment of beneficiaries for both programs and include individuals with some of the most severely disabling chronic conditions.<sup>1</sup> Dual eligibles are more likely to have co-morbidities. Three in five dual eligibles suffer from multiple chronic physical conditions and 20 percent have more than one mental/cognitive condition. Roughly half of non-dual eligible Medicare beneficiaries have more than one chronic physical condition and only 5 percent have more than one mental/cognitive condition.<sup>2</sup> Another important

<sup>1</sup> Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. Available at: <http://www.kff.org/medicaid/upload/8081.pdf>.

<sup>2</sup> *Id.*, at 1.

finding of the Kaiser study is that significant co-morbidities among dual eligibles, make service use high and care coordination across Medicare and Medicaid particularly challenging.<sup>3</sup> Care coordination for patients who are beneficiaries of both the Medicaid and Medicare programs is a challenge. Patients with multiple chronic conditions rely heavily on Medicare physician and hospital services and turn to Medicaid to meet their long-term care needs.<sup>4</sup>

The Patient Advocate Foundation understands the access to care challenges that the dual eligible population experiences. Its case managers help dual-eligible patients navigate the complex coverage issues of each program and try to help patients get the care they need. The PDAR is a rich data repository of access challenges stratified by variables that help inform those interested in better understanding access to care challenges faced by patients in this country. As case managers assist patients in navigating the healthcare system, they meticulously document each step of the process and the various issue resolutions. To capture the complexity of the healthcare market and the myriad of issues PAF case managers resolve, 260 variables are collected for each case management patient. These variables include patient demographic information, disease-specific issues, employment, insurance-specific and personal finance issues, as well as the various contacts made to secure resolution of the case. PAF's PDAR highlights the precise challenges faced by actual dual eligible patients. The PDAR is a document that can serve as an important tool for federal and state policymakers in their attempts to better understand the access to care challenges faced by this population.

Roughly 65% of dual eligible patients that contact PAF for assistance in navigating the complexities of coverage issues qualify for both programs on the basis of disability. To underscore this unfortunate outcome, the vast majority of dual-eligible patients in need of access to care assistance are those least likely to be able to assist themselves. They are the medically vulnerable whose reliance on these programs is dire. The dual-eligible age cohort that contacted PAF caseworkers most frequently was the over-65 age cohort. These data reveal older dual-eligible patients are most likely to have access to care problems.

PDAR data reveal another interesting fact about dual eligible patients contacting PAF for assistance in navigating the health system. The dual eligible persons who need this assistance are more likely to be low income. Almost 50% make \$11,000 or under and 41% make from \$12,000 – \$23,000. In other words, only 9% of dual eligible patients needing assistance from PAF made over \$23,000. Clearly, the income level and the limited resources associated with low incomes must be considered in efforts to assure care coordination for dual-eligible patients. A final noteworthy fact about dual eligible patients contacting PAF for assistance is that the most prevalent access to care issue confronting dual eligible patients in 2010 was coordinating health insurance benefits and services (49%) followed by medical debt crisis (42%).

### The Alignment Initiative

This initiative is an important one for dual eligible beneficiaries. NPAF understands it is an effort to advance dual eligible beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. The first step will commence the important journey to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. NPAF has organized its comments into the six broad categories identified in the proposed rule.

#### 1. *Coordinated Care*

CMS notes that models already exist that integrate care for dual eligibles, but that enrollment in them remains very low. The Medicare Shared Savings Program offers a promising model for integrating the care of dual eligibles. CMS should assist Medicaid managed care plans that have difficulty identifying those in their Medicaid managed care products who are about to become Medicare eligible by providing that information to them within a time interval most likely to be helpful to them. Care coordination for dual eligibles

<sup>3</sup> *Id.*, at 2.

<sup>4</sup> *Id.*, at 3.

should not be limited to treatment coordination but should include benefit coordination. Dual eligible patients should be provided information regarding the resources available to them not only by SHIPS counselors but by patient advocacy groups that provide senior services such as the Patient Advocate Foundation. Finally, CMS should ensure that any effort to coordinate the care that dual beneficiaries receive includes consumer protections for them.<sup>5</sup> For example, setting dollar thresholds for appeal rights may unintentionally exclude dual eligibles.

## 2. *Fee-for-Service (FFS) Benefits*

CMS should first consider the fact that fee-for-service payment policies are *ipso facto* detrimental to dual eligible patients as they discourage care coordination. Behavioral health issues are a documented challenge for the dual-eligible population. Kaiser Family Foundation has analyzed dual eligible data and found dual eligible patients age 80 or older are more likely to have multiple chronic conditions compared to younger duals. Half of persons age 80 or older have both physical and mental/cognitive conditions, compared to about a third of younger dual eligibles.<sup>6</sup> CMS should assure the greatest number of dual eligible beneficiaries receive home health benefits as possible, so long as quality of needed care is not forsaken. Therefore, NPAF encourages CMS to work with the states to identify successful home health care programs so that they might be replicated nationwide or to expand the caregiver support programs that allow seniors to remain in their homes and communities with support.

## 3. *Prescription Drugs*

One important challenge faced by patients that cannot be overstated is access to prescription drugs. The most prevalent disease suffered by dual eligible patients contacting PAF is diabetes. Access to pharmaceuticals is extremely important to this population and to most patient populations. Thus, NPAF strongly encourages CMS to expand its L1NET demonstration which allows a pharmacist to bill a specialized prescription drug plan available under the demonstration and get immediate confirmation of payment, facilitating immediate dispensing of the drug.

## 4. *Cost Sharing*

The issue regarding cost sharing is unnecessarily complex, and the burden of that complexity rests with the dual eligible patient. State Medicaid agencies are liable for Qualified Medicare Beneficiary (QMB) cost sharing. Medicaid is required to pay Medicare cost-sharing for dual eligibles who are QMBs, regardless of whether the service is normally covered under Medicaid, or whether the provider is enrolled as a Medicaid provider. While the law is well-intended, in some states, where the provider is not enrolled as a Medicaid provider, the claims processing system will reject the claim. CMS should work with those states to mend this automated system challenge. It should also provide information to the dual eligible patients in those states to contact CMS' Medicare and Medicaid Coordination Office directly when faced with a cost-sharing bill. Institutional providers that care for these patients should not be penalized if states do not submit a timely remittance advice to receive a payment adjustment. Their leadership should likewise be able to contact the Office for a remedy.

<sup>5</sup> Kaiser Family Foundation Program on Medicare Policy, *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid* (Menlo Park, CA: Kaiser Family Foundation, January 2011), available online at <http://www.kff.org/medicare/upload/8138.pdf>.

<sup>6</sup> Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. Available at: <http://www.kff.org/medicaid/upload/8081.pdf>

## 5. Enrollment

Some states have complex recertification requirements that unnecessarily burden the patient population in general and dual eligibles in particular. A Medicare Payment Advisory Committee (MedPAC) report described the inherent difficulties faced by dual eligibles when it summarized how the Medicare and Medicaid programs often work at cross purposes to reduce costs. The report noted, “States’ longstanding use of “Medicare maximization” strategies—raising a state’s federal match dollars through illusory financial arrangements—underlines the importance of designing financially integrated approaches that successfully balance state flexibility with adequate fiscal controls and the need for carefully specified policies.”<sup>7</sup>

## 6. Appeals

The lack of a coordinated appeal system between the Medicare and Medicaid programs places dual eligible beneficiaries in a precarious position when appealing benefit determinations. Within Medicaid program, states may have differing appeal timeframes for fee-for-service patients and those enrolled in managed care plans. They are likely to differ from, and be less generous than the appeal timeframes under the Medicare program. CMS should require states to adopt the Medicare appeal timeframes for dual eligible beneficiaries unless the state timeframe is more generous. This requirement should help to mitigate the appeal challenges faced by this population, but it will certainly not eliminate them.

NPAF commends CMS’ desire to seek an open, transparent, and accountable Alignment Initiative process. As the next step identified in the Alignment Initiative process is to continue to engage stakeholders, including beneficiaries, payers, providers, and States, NPAF encourages CMS to consider the inherent value of nonprofit patient advocate organizations as an important stakeholder. As the trusted patient voice, they are able to inform policymaking efforts of how the aforementioned six broad categories affect beneficiary access to care. The preceding sections provide but a snapshot of the infinite potential that the Patient Advocate Foundation’s patient data can play to assist CMS policymakers in making data-driven decisions.

As noted above, this rule is an important one as it assures states are accountable for assuring that there is sufficient access to quality services for their Medicaid populations. NPAF would be pleased to respond to any questions about our recommendations that may arise in the future. We are also available to discuss, in greater detail, our suggestions regarding a role for the nonprofit community in the implementation of the rule.

Respectfully submitted,



Nancy Davenport-Ennis  
Chief Executive Officer and President



Rene Cabral-Daniels, JD, MPH  
Chief of Staff

<sup>7</sup> CMS FFY 2007 MSIS Data; Medicare Payment Advisory Commission, *Aligning Incentives* (June 2010), Coordinating the Care of Dual-Eligible Beneficiaries, Chapter 5, 133.