



30 WINTER STREET
BOSTON, MA 02108
TEL 617.338.6035
FAX 617.451.5838
WWW.COMMUNITYCATALYST.ORG

May 22, 2009

VIA ELECTRONIC MAIL

Senator Max Baucus, Chairman
Senator Chuck Grassley, Ranking Member
United States Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Comments on *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*

Dear Senators Baucus and Grassley:

We are writing to offer our comments on the Senate Finance Committee's description of policy options regarding expanding affordable coverage to all Americans. We applaud your attention to these vital issues and appreciate the opportunity to provide our thoughts based on our experience working with consumer groups in 43 states to improve access to quality health care for all.

Community Catalyst is a national non-profit advocacy organization working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

The committee's policy options paper offers strong proposals to extend health insurance coverage to millions of Americans. We praise the committee for these positive steps forward, which include:

- building on Medicaid and the Children's Health Insurance Program
- requiring insurers to sell policies to everyone regardless of health status
- creating an insurance exchange to help people access health insurance
- explicitly seeking to address racial and ethnic disparities

We believe the committee and Congress must go further to ensure that quality affordable health care is available to all. Our comments and suggestions for improvements grow out of our experience with Massachusetts health reform and working with consumer advocates in many other states.

Our comments follow the framework proposed by the committee, with the exception of our recommendations about market reforms, affordability and shared responsibility, which are combined because of the interlocking nature of these essential components of a reformed health care system.

Sections I, II and IV: Insurance Market Reforms, Making Coverage Affordable and Shared Responsibility

The committee's recommendations provide an initial blueprint for creating a more equitable and accessible insurance market, making coverage affordable and ensuring consumers and employers join with government in sharing responsibility for expanding coverage. However, to ensure the proposals work together to create a coherent and fair system that covers all, we recommend the committee strengthen protections for consumers across the board.

Ensure Guaranteed Issue and Fair Rating

We applaud the committee for advancing reforms that create national private insurance standards of guaranteed issue and renewal, and modified community rating.

We believe national standards should also eliminate all exclusions for pre-existing conditions, with no exceptions. Therefore, we oppose the committee's suggestion to allow temporary exclusions for pre-existing conditions as a penalty for late enrollment.

We recommend phasing out age rating entirely and creating tighter overall rate bands. Age rate bands of 5:1, as proposed by the committee, would make premiums unaffordable for many older and sicker people. This would create significant problems in implementing an individual mandate. As part of Massachusetts health reform, the state set maximum rate bands at 2:1 for age and 1.5:1 for geography. In addition, *we oppose basing health premiums on individuals' addictions, and therefore suggest the committee reject rating based on tobacco use.* Because the committee did not mention gender rating, we assume it also rejects rating based on gender and we support that stance.

Both during and following a national phase-in of these new insurance requirements, *we recommend that states be required to maintain any stricter rules already in place, as well as any rules that provide additional patient protections.*

We also support the committee's proposal to give states the option to merge the small group and individual insurance markets. Massachusetts merged these markets, which greatly reduced premiums for individuals without significantly increasing costs for small groups.

Making a Health Insurance Exchange Work

We support the committee's proposal to create a Health Insurance Exchange to organize the non-group and small group insurance market.

But we recommend the Exchange be the exclusive venue for buying individual, micro group, and small group coverage. Otherwise, there will be little incentive for people to enroll through the Exchange. This problem has surfaced in Massachusetts, where the Health Connector has enrolled few people who do not receive subsidies.¹ Because people can purchase the same health plans outside the Connector, few are using the Connector, and it therefore has limited ability to promote innovation and value in the private health insurance market. As another method of maximizing participation in the Exchange, we support the committee's proposal to provide refundable tax credits toward health premiums for people with low and moderate incomes exclusively through the Exchange.

To help ensure people and businesses buying through an exclusive Exchange have a choice of high-quality coverage, ***we recommend the Exchange provide a seal of approval only to plans that meet strong standards for quality, cost-effectiveness and network capacity. If the committee opts to establish an Exchange that is not the exclusive venue for individual and small group coverage, then the Exchange should use the same strong standards to decide which insurers will be allowed to participate.***

If the committee decides to propose multiple Exchanges, rather than one national Exchange, ***we recommend limiting the number to one Exchange per state*** in order to allow sufficient oversight and authority. Creating multiple, competing Exchanges in an area would make it extremely difficult for consumers to make informed coverage choices. ***We also believe including consumer representatives in the governance of an Exchange would help ensure the Exchange serves and protects the public.***

Making Coverage Comprehensive

We support the committee's proposal to require insurers in the individual and small group markets to provide a broad and comprehensive range of benefits. This range of benefits – from prevention and primary care to emergency and hospital care to prescription drugs and mental health services – is essential in modern medical care and treating the whole person. For that reason, ***we recommend the committee also require insurers in all markets, both inside and outside the Exchange, to cover the same broad spectrum of benefits.*** States that already impose additional benefit mandates should be allowed to retain those mandates.

In addition, we recommend insurers in all markets outside the Exchange be prohibited from imposing lifetime or annual limits on benefits, just as the committee proposed to do for insurers in the Exchange. Mandating these requirements would help protect families from inadequate insurance that fails them when they need it the most.

For children, we also recommend the committee require EPSDT services be provided as part of all insurance plans. Children are most successful when they receive medically necessary health and development services from an early age. The EPSDT program, currently operating in Medicaid, requires coverage of a wide-range of services that children's health care professionals recommend for optimal health and development (e.g., physician and hospital services, well-child care, health and developmental screenings, mental health care, vision care, and dental services). We applaud the committee for maintaining the EPSDT requirement in Medicaid and for

proposing to extend it to the Children’s Health Insurance Program. Extending it to all private insurance plans would help ensure children get the comprehensive care they need, regardless of their insurance coverage.

Within the Exchange, we support the committee’s proposal that insurers offer health plans with four different benefit levels. ***We recommend the committee more clearly define benefits and cost-sharing for each of the four insurance levels.*** Using actuarial equivalence as a standard, as the committee has proposed, would allow for significant differences in benefit limits and cost-sharing among plans in the same tier. This would make comparisons more difficult for consumers, hindering one of the main purposes of an Exchange – easier choice of plans.

We agree with your proposal to require insurers to offer plans in each benefit tier. However, to spread the risk and reduce adverse selection, ***we recommend requiring each insurer pool risk among all its Exchange plans, if the Exchange is the exclusive venue for individual and small group coverage. If the Exchange is not exclusive, then insurers should be required to pool risk for all plans inside and outside the Exchange.***

Assuring Coverage is Affordable

We applaud the committee for proposing significant subsidies to help make health care coverage affordable for all American families. We strongly support subsidizing insurance on a sliding scale for individuals earning 100 percent to 400 percent FPL. However, the committee did not specify how much these individuals would be expected to contribute to premiums. We believe the committee must go further to guarantee affordable coverage for low- and middle-income families, especially in the context of an individual mandate that requires each person to obtain insurance. Inadequate affordability protections run the risk of undermining public support for health care reform.

We recommend broader subsidies:

- ***Families earning up to 200 percent FPL should pay no premiums.*** Most families at this income level are exempt from Medicaid premiums and often rely on fuel assistance, food stamps and EITC assistance to meet their basic needs.
- ***Families earning between 200 percent and 300 percent FPL should be expected to make only modest contributions towards their premiums.*** Families in this income bracket often go into debt just to pay their basic necessities, and those in high cost-of-living areas are especially vulnerable.

But premiums are by no means the only cost families face to secure health care. Plans with high cost-sharing can leave families financially vulnerable, prevent them from getting the care they need, and leave them underinsured. This is especially true for low-income families.

We recommend stricter limits on out-of-pocket costs:

- ***Cap the amount of out-of-pocket expenses that patients face.*** All cost-sharing should count towards this out-of-pocket maximum, including deductibles, co-payments and co-insurance. This would protect the sickest families from facing unlimited health care costs.
- ***Set lower caps for families below 300 percent FPL.*** Since individuals in lower income brackets would be subsidized in the highest coverage tiers, under the committee's proposal, higher tiers should require lower out-of-pocket maximums. Combined, the out-of-pocket maximums and the premium subsidies will create a comprehensive affordability scale that takes into account all health care costs.
- ***Exempt families below 300 percent FPL from deductibles.*** Deductibles prevent low-income individuals from accessing needed care. Since under the committee's proposal individuals below 300 percent FPL would be subsidized for coverage in the high- and medium-option tiers, deductibles should be prohibited in those tiers. This would be consistent with Massachusetts' approach; there are no deductibles in Commonwealth Care, the subsidized program for individuals up to 300 percent FPL.

Individual Mandate

Community Catalyst believes an individual mandate should not compel people to spend more on coverage than they can afford or to purchase inadequate insurance. Evidence shows support for an individual mandate hinges on perception that the amount people will be required to pay is affordable. For instance, a 2008 poll shows 67 percent of Americans surveyed support a requirement that all Americans have health insurance; support drops to 19 percent if the plan is too expensive.ⁱⁱ

We recommend the committee establish an affordability scale for the individual mandate that takes into account out-of-pocket costs as well as premiums. Specifically, we recommend exempting anyone from the mandate whose premium plus out-of-pocket expenses totals more than 9 percent of income, and setting a lower limit for people earning less than 600 percent FPL. We also support exempting people with incomes less than 100 percent FPL.

Inevitably, a good affordability scale will exempt many low- and moderate-income people who are not able to access subsidies or do not have an offer of employer-sponsored insurance. In Massachusetts, many people just above eligibility levels for subsidies (300 percent FPL) who do not have an offer of employer-sponsored coverage are not subject to mandate penalties, since no affordable plan is available.ⁱⁱⁱ

We suggest reducing penalties for the individual mandate, especially for people with low-incomes, to gain political support and not impose financial burden on consumers. Penalties currently proposed by the committee could be unaffordable for families.

Tying penalties to premium amounts is problematic with a private market that allows for rating differences—*older people should not have higher penalties than others with the same income, nor should people who live in one location face higher penalties than those in another location*. Penalties should also be lower for people with lower incomes. Once people get beyond the subsidy scale, a penalty based on a percentage of the premium is highly regressive.

For example, in Massachusetts the penalty, while significant, is much less than the cost of insurance, and is the same for all people at a given income level; it does not vary based on premium rating factors.^{iv}

We suggest implementing the mandate only after private insurance rating rules and tax credits for coverage are in place. People also need time to learn about the insurance options, responsibilities, and subsidies available. *We believe the initial open enrollment periods suggested by the committee are too short and should be extended*. As noted above, we also strongly oppose the committee’s suggestion to allow temporary exclusions for pre-existing conditions as a penalty for late enrollment.

We recommend a broad definition for hardship exemptions. An exemption process should also consider, as Massachusetts does, situations that may prevent people from buying insurance, including disproportionately high housing or utility costs; significant medical debt; loss of employment due to illness; financial hardship; or an emergency.

Employer Mandate

We support requiring employers to either contribute to health insurance for their employees and their families, or pay an assessment to help fund subsidies.

Section III: Public Plan

Community Catalyst strongly supports the inclusion of a public plan as part of health reform. A public plan would give the public more choice. It would also create a benchmark against which to measure the performance of private insurers and help “bend the curve” to lower the overall rate of growth of the U.S. health system. The public plan would also provide a broader platform (beyond Medicare) for delivery system innovations and “pay for quality” initiatives the committee discussed in its delivery system reform options paper.

Section IV: Role of Public Programs

Medicaid

The Senate Finance Committee coverage options document lays out three main approaches and multiple possible permutations for Medicaid and for covering low-income people in a reshaped health care system. We support strengthening and expanding Medicaid as a platform for coverage for low-income people.

Therefore, we endorse Approach 1, which keeps children, families and disabled people in Medicaid and extends the programs to more people by increasing eligibility for pregnant women, children and parents to 150 percent FPL and for adults without dependent children to 115 percent FPL.

Medicaid provides the benefits – including comprehensive pediatric services (EPSDT) – and cost-sharing protections low-income people need, provides access to providers who specialize in the care of low-income people and also safeguards vulnerable populations’ rights to care. It is therefore a highly effective system of serving, protecting, and improving the health of the most vulnerable in our society.

We do not support Approach 2. We believe shifting the bulk of the Medicaid population to private plans that could vary significantly in their structure would be administratively burdensome for states, confusing for beneficiaries, and less cost-effective than a Medicaid expansion. Providing some services and cost-sharing through a wrap-around mechanism, as this option proposes, would weaken the coordination of care and could lead people to forgo needed care.

Approach 3, expanding Medicaid coverage for the population that has historically been eligible for Medicaid while using the Exchange as a mechanism to extend coverage to new populations, most closely resembles the Massachusetts approach. However, in the Massachusetts model, plan design – including benefits, cost sharing and delivery system – is specifically tailored to meet the needs of low-income people. This eliminates the need for cumbersome wrap-around requirements. ***If the committee were to choose to proceed with Approach 3 instead of Approach 1, we strongly recommend the kind of tailoring used in Massachusetts.***

We note the cost of financing coverage for non-categorical adults does not appear to be parallel across all options. Under Approach 1, it appears this is ultimately a shared federal-state responsibility, yet under the other options the federal government would fully fund this group. While we support Medicaid as a coverage structure for all low-income people, we are mindful of the limited financial capacity in many states, and ***we support full federal financing for non-categorical adults.***

We are concerned that across all three options, states would lose discretion to extend eligibility levels higher up the income scale with federal match. Uniform federal eligibility and subsidy standards may be inadequate in high-cost states.

Therefore, we believe the federal government should set a floor on eligibility, but should continue to encourage states to expand financial protection higher up the income scale by providing federal matching funds for categorical populations above 150 percent FPL. It should also allow states to use Medicaid to supplement benefits and federal subsidy payments for adults without dependent children.

We support the committee’s proposal to set a floor for Medicaid provider rates. Inadequate provider participation in Medicaid is a common problem that limits patients’ access to care, even

though they have coverage. There are particular shortages of pediatric sub-specialists, as well as oral and mental health providers who specialize in treating children. Adequate payment rates are one important way to increase participation.

Another means of addressing provider shortages, raised by the committee in its delivery system reform paper, is providing bonuses to primary care providers and general surgeons. While the committee suggested this for Medicare only, we recommend using the same strategy for Medicaid. We urge the committee to pay special attention to expanding the corps of Medicaid providers who specialize in treating children (e.g. sub-specialists, oral and mental health providers), as well as those who reflect the diverse backgrounds of Medicaid patients.

Community Catalyst has done some work in the U.S. Virgin Islands and heard first-hand stories of the hardship caused by the capped Medicaid funding they currently receive. We therefore strongly support the elimination of the current discriminatory cap on Medicaid funding in the territories.

Children with special needs

We are concerned the committee does not lay out any options for children with special health care needs, such as chronic illnesses and disabilities, who are often vulnerable to high health care costs even when they have coverage. Wrap-around coverage is important and appropriate for these children, because they require intensive services and often have private coverage that does not pay for services such as durable medical equipment. ***We urge the Committee to raise the income cap on the Family Opportunity Act and create incentives for states to implement the Act.***

The Family Opportunity Act (part of the Deficit Reduction Act of 2005) allows families of children with severe disabilities who make less than 300 percent FPL to ‘buy-in’ to Medicaid. ***Raising the income cap over 300 percent FPL would help more middle-class families with catastrophic health care costs keep their children at home and prevent them from falling into poverty***, where they would become eligible for fully paid services through Medicaid. Currently, only four states have implemented a Medicaid buy-in program under the Family Opportunity Act. Incentives for taking up this program, such as a higher federal match rate, would help extend the benefits of the buy-in to more families in more states.

Children’s Health Insurance Program (CHIP)

We applaud the committee’s efforts to expand CHIP coverage to families with incomes up to 275 percent FPL. However, a number of states currently have higher eligibility levels. ***We recommend that states be able to maintain the flexibility to set higher eligibility levels and still receive the federal match.***

We support the committee’s proposal to extend EPSDT services to children in CHIP. The EPSDT program requires coverage of a wide range of medically necessary services that emphasize prevention and promote optimal growth and development of children.

We recommend plans sold through the Exchange include EPSDT as the standard for all children – but, at a minimum, insurers make available to CHIP-eligible families a benefit package that meets the EPSDT standard. We believe a more limited benefit package with a wrap-around is more cumbersome and sets up significant barriers for low-income families who are already struggling with many complex issues. It may ultimately lead them to forgo necessary care.

We support the committee's proposal to extend the Medicaid cost-sharing limits to CHIP. Even small increases in premiums or co-payments can prevent low-income families from enrolling in insurance or accessing care.

Quality of Care in Medicaid and CHIP

We support the committee's recommendation to extend the quality of care provisions from CHIPRA to all Medicaid populations. The pediatric quality of care components passed in CHIPRA were a significant step forward for improving children's health care. Expanding the reach of these initiatives will enhance care for all in Medicaid. The best way to ensure we improve health outcomes is to combine broad coverage efforts with the highest quality of care.

Other Improvements to Medicaid

Enrollment and Outreach

We strongly support the suggestions for improving enrollment and retention, such as elimination of face-to-face eligibility interviews, requiring 12-month continuous eligibility and eliminating asset tests for acute care services.

These efforts will help reduce administrative barriers for eligible low-income families trying to enroll in and maintain steady coverage through Medicaid. The face-to-face interview requirement poses serious burdens (e.g., time off from work, child-care, transportation) on low-income families who are already struggling to make ends meet. Requiring 12-month continuous eligibility reduces administrative costs for state Medicaid agencies, allows children and families to access medical care when they need it, and assures health care providers that they will receive payment for services delivered.

Based on the Massachusetts experience, we also believe explicit support for community-based outreach and enrollment activities and multi-lingual consumer assistance lines can contribute substantially to successful enrollment and retention.

Federal Matching Funds

We support the proposal to implement counter-cyclical financial support for Medicaid to assist states. Historically, federal counter-cyclical support to states has included a maintenance of effort requirement on eligibility levels and processes, and we would recommend inclusion of such a requirement going forward as well.

Medicaid Disproportionate Share Hospital Payments (DSH)

We are sensitive to the fact that the original intent of the Medicaid DSH program – to support hospitals providing extensive care to low-income people -- has not always been honored by states or hospitals. - At times, states receiving DSH funds have used complicated formulas to draw down federal DSH dollars, then directed funding elsewhere, or handed out DSH funding carte blanche. This lack of transparency in the way DSH is calculated and distributed needs to be addressed, and we applaud the committee for taking this on.

Still, we believe an accountable, transparent DSH program will remain an important component of the safety net in many communities. Though coverage expansions in national health reform should reduce the uncompensated care burdens shouldered by many hospitals, the changes are unlikely to completely negate the need for uncompensated care. For example, some hospitals with service areas and payor mixes that predominantly reflect lower-income populations and/or populations that would be ineligible for coverage under an expansion would still require appropriately tailored DSH payments. DSH funding should also be available to DSH hospitals offering expanded services, such as failure to thrive clinics, youth violence intervention programs and public health initiatives to vulnerable, underserved communities, provided those services meet an identified community need.

We are concerned the committee's first proposed option, which would give HHS sole responsibility for distributing DSH funds, leaves states with no flexibility to direct funds to the areas of greatest need. Given the variability in state and local environments with regard to payor mix, numbers of uninsured or low-income residents and fiscal capacity, *we believe that state control of disbursing DSH funds is still appropriate*. However, there must be stricter federal standards and oversight in place. Recognizing both the structural flaws and continued relevancy of state and local involvement in the Medicaid DSH program, we support establishing federal standards that would achieve the following:

- *Build a transparent reporting system that shows how DSH funds are being distributed* and used to reimburse providers for uncompensated care and specialized services tailored to an identified community need.
- *Condition DSH funding on the adoption of consumer-friendly hospital billing and debt collection policies.*
- *Maintain access for low-income individuals to all medically necessary services.*
- *Effectively and equitably target funds to states and providers that serve a disproportionate share of low-income patients* in a fair, transparent manner based on state need and economic capacity.

States that fail to meet or enforce these federal requirements would forfeit their right to receive federal matching funds for DSH.

Transparent Reporting

We strongly support your proposed option to require individual hospitals to report uncompensated care cost data to CMS. We recommend requiring hospitals to report the specialized services they provide based on identified community needs. DSH is the biggest public program to cover uncompensated care costs, yet there is no uniformity in reporting that makes it easy to decipher whether a DSH hospital is using funds appropriately. Reporting should be consistent with existing Medicaid procedures: hospitals report to the state, and the state reports to CMS, in accordance with federal rules and formats.

To further transparency and create uniformity, we recommend that hospitals receiving Medicaid DSH funds be required to report separately the amounts of charity care they provide and bad debt they accrue using the definition of “charity care” found in the Instructions to Schedule H, Form 990. This information should be reported based on cost, not charge, and should be made available to the public.

Consumer-friendly Conditions for Receiving DSH

States may choose to set higher standards, but hospitals receiving DSH funding should be required to demonstrate the following:

- They have established financial assistance policies that clearly delineate eligibility criteria and describe what patients must do to apply, and they notify patients and the public they may be eligible for free care and public coverage programs.
- They screen all patients without insurance for their eligibility in public programs (e.g. Medicaid and CHIP) and the hospital’s financial assistance policy, and they help patients apply. Hospitals that have not taken these steps should not be paid for bad debt they incur.
- They use fair billing and debt collection practices.
- They engage in meaningful community benefits assessment and planning that meets identified community needs and regularly involves the community – including representatives of the targeted underserved populations.

Maintaining Access to Medically Necessary Services

We are very concerned about granting the secretary of Health and Human Services authority to designate the hospital services that would be eligible for DSH payment. DSH funding should be available for all medically necessary services to ensure that low-income individuals’ access to care is not limited to a subset of services, such as emergency or outpatient care. A broad definition of “medically necessary” services would state:

Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include but not be limited to inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act; emergency care; and prescription drugs.

Furthermore, paying solely for Medicaid and uncompensated care claims would not allow states to help cover the costs that DSH hospitals face in serving large vulnerable populations that would not necessarily be part of a claim for a specific service. Many states currently incorporate coverage for services such as interpreters, failure to thrive clinics, youth violence intervention programs and public health initiatives into their rates. We recommend that DSH funding remain available to support such services when offered in response to an identified community need.

Dual Eligibles

The need to reform the health care system is particularly acute for people who are dually eligible for Medicare and Medicaid. Sicker than most – almost seven-eighths live with one or more chronic conditions – they must also negotiate two separate systems of care in Medicare and Medicaid. Despite a disproportionately high outlay of public funds, dually eligible beneficiaries are more likely to report forgoing care, experiencing medical errors, paying high out-of-pocket costs and being unnecessarily placed in hospitals and nursing homes.

A number of integrated care models – such as the PACE programs and some Medicare Advantage Special Needs Plans (SNPs) – have attempted to address the issues dually eligible beneficiaries face, successfully reducing hospitalization and nursing home costs to both public programs. However, the legislative and regulatory frameworks governing these models have not provided a structure sufficient to support them, making it difficult to bring them to scale.

We believe the committee’s proposals regarding dually eligible beneficiaries are a good start. With additional provisions, however, the committee could succeed in building workable, sustainable models of care that will improve these beneficiaries’ health outcomes while simultaneously reducing the costs associated with their care.

Waiver Authority for Dual Eligible Demonstrations

We appreciate the committee’s proposal to create a new Medicaid demonstration authority of five years in order to explore new pathways for coordinating care for dually eligible beneficiaries. ***However, we recommend promising care models for dually eligible beneficiaries also be eligible for pilot program designation through the Chronic Care Management Innovation Center (CCMIC) proposed in the committee’s delivery system reform policy options document.*** This designation would allow innovative approaches to be fully tested for a longer period of time and across many more sites than demonstration projects. And, if a pilot program shows improve health outcomes for dually eligible beneficiaries and reduced costs, it can more easily move to scale and evolve into a permanent program.

Cost-Effectiveness Test

We commend the committee’s ingenuity in creating incentives for states to coordinate care for dually eligible beneficiaries, and believe allowing states applying for Medicaid 1915(b) waivers to count Medicare savings in the cost-effectiveness test is a positive step forward. To date, too few states have established formal mechanisms for coordinating duals’ care. For example, while the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) requires SNPs serving dually eligible beneficiaries to contract with states, many states have been reluctant to do so because there is little financial incentive for them.

The proposed modification of the 1915(b) waiver will provide some incentive to states interested in contracting with SNPs. ***But we recommend the committee consider developing alternative options for states without a strong SNP presence or those that are still primarily fee-for-service environments.*** These options, which should be tied to firm standards for care coordination, might include:

- Allowing states applying for Medicaid 1915(c) and 1115 waivers to count Medicare savings in the cost-effectiveness test
- Providing financial incentives/grants to states to develop integrated care and/or care management programs, modeling them after other initiatives such as Money Follows the Person or the Transformation Grants.
- Making adjustments to the federal financial participation ratio to help states fund the upfront costs required for developing integrated care programs
- Developing gain sharing arrangements – similar to the North Carolina model – between the federal government and state Medicaid agencies
- Medicare contracting directly with states for the risk-based management of all Medicare services for dually eligible beneficiaries

Office of Coordination for Dually Eligible Beneficiaries

We strongly support the creation of an Office of Coordination for Dually Eligible Beneficiaries (OCDEB) that would be directly responsible for developing standards, procedures, tools and focused payment reform policies to assist and encourage integration efforts. In addition to the broad roles outlined in the committee’s proposal, we recommend the OCDEB:

- Oversee the designation and implementation of models of integrated care delivery systems, including fully integrated dually eligible SNPs that meet stringent care coordination criteria
- Provide resources to state Medicaid agencies in their efforts to coordinate and align primary, acute and long-term care benefits for dually eligible beneficiaries
- Serve as a liaison between CMS central and regional offices to ensure consistent application of CMS rules and policies relating to dual eligible beneficiaries
- Develop uniform strong dually eligible beneficiary protections with respect to enrollment, quality measures and reporting, contracting, member materials, grievance and appeals, and beneficiary information
- Develop policies and procedures that guarantee shared state and federal oversight of integrated care plans for the dually eligible population
- Identify additional incentives for states to integrate care, such as options that fairly allocate savings between states and the federal government

Medicare Coverage

We also support completely phasing out the waiting period for Medicare coverage for disabled adults. This will not only help vulnerable adults get the care they need, but will ease the burden on states, which currently serve much of this population through Medicaid.

Section VI: Prevention and Wellness

We support the committee's proposal to award grants to promote improved care coordination and access to preventive services and treatment, since these are important features in ensuring high-quality, cost-effective care. *We recommend these grants support multi-disciplinary teams that provide chronic disease self-management and nutritional counseling to beneficiaries and their families.* In addition, beneficiaries and their families should play the central role in developing an individualized plan of care for health and human services. While state grant programs might assist low-income beneficiaries and their families in developing these care plans, the language should clearly give beneficiaries and their families the leadership role in determining their care plans. *Grants should also be given to states for rolling out evidence-based programs that increase consumer and caregiver engagement, such as the Chronic Disease Self-Management program. We also recommend the committee target some of the grants to improve primary care for children and to help address racial and ethnic disparities.*

We urge the committee to fund grants to support community health workers to reach out to people in medically underserved areas, with special attention to low-income, minority and immigrant communities.

Section VII: Long Term Care Services and Supports

We support the committee's proposals to expand access to home and community-based long-term-care services. This overdue rebalancing of our approach to long-term-care reflects the preferences of older adults and people with disabilities. In order to ensure the committee's proposals actually result in an expansion of community care, *we recommend targeting a portion of the available funds to developing a workforce capable of meeting the growing needs of an aging population.*

Section VIII: Options to Address Health Disparities

Reforming the health care delivery system provides a unique opportunity to address racial and ethnic disparities in health care and outcomes. Incorporating provisions into the law to tackle these disparities will help ensure that all Americans get the right care at the right time and right place, regardless of income, race, ethnicity or primary language.

Collect standardized data

We praise the committee for seizing the opportunity to advance steps to address racial disparities. We support the committee's proposals that would set new standards and requirements for collecting standardized data on the race, ethnicity and primary language of people in Medicare, Medicaid, and CHIP. We also support the proposal to require reporting of disparities in Medicaid and CHIP. We are pleased to see the proposed mandate that government-required reports on quality include breakdowns by race, ethnicity and primary language. All of these efforts will help provide the data needed to design and target initiatives to reduce disparities.

We recommend the committee establish benchmarks for the reduction of disparities and provide financial incentives to providers and insurers who meet those benchmarks.

Require Culturally and Linguistically Appropriate Care

We support the committee's proposal to apply Culturally and Linguistically Appropriate Services (CLAS) standards to all private insurers in the Exchange, as a good first step. We urge the committee to go further – ***require all public and private insurers and providers to meet all 14 CLAS standards.***

We support the committee's proposal to extend the 75 percent federal matching rate for translation services to all Medicaid beneficiaries who need it, and ***we urge the committee to provide funding for language assistance services in all public programs, including Medicare and CHIP.***

Eliminate the Five-Year Waiting Period

We strongly recommend the committee completely eliminate the five-year waiting period for Medicaid eligibility for all legal immigrants, both children and adults, nationwide.

Guaranteeing access to Medicaid is essential to ensure these families are able to remain productive members of society.

Fund Broad-Reaching Consumer Assistance Services

We also strongly encourage the committee to extend consumer assistance services, including multi-lingual help-lines, to a broad cross-section of the population, while retaining a special focus on racial, ethnic and linguistic minorities and people for whom English is not their primary language.

In today's fragmented health care system people are too often shut out, confused, and frustrated. This leaves many without insurance, including some who may qualify to enroll. It also contributes to inefficient, poor quality care that drives up costs for everyone. Both the coverage and delivery system options papers developed by the Senate Finance Committee propose a number of important steps to address this problem including the expansion of medical homes, the

creation of a health insurance exchange, and Medicaid enrollment simplifications and enhancements.

Nonetheless, if the Massachusetts experience is any guide, a vigorous and sustained program of consumer assistance, including both community-based outreach and a call-in center capacity are needed to ensure people get the coverage and care they need. In addition, by aggregating the experiences of many individuals, these services can also provide important information on the progress of health reform and identify implementation challenges as they arise.

Consumer assistance services could be delivered through state offices or through private nonprofit organizations, and funded either by direct appropriation or with a small percentage of the insurance surcharges used to finance the exchange. We urge the committee to establish and support these vital services.

* * *

We thank you again for the opportunity to provide comments on this important set of proposals. We look forward to working with the committee as it continues its work.

Sincerely,



Robert Restuccia
Executive Director

ⁱAs of April 2009, only 21,863 people were enrolled in unsubsidized plans in the Connector, while 169,000 were enrolled in subsidized plans. Commonwealth Connector meeting materials April 9, 2009. Commonwealth Care Quarterly Update and Commonwealth Choice Enrollment Update.

ⁱⁱ Kaiser Family Foundation and Harvard School of Public Health. January 2009. The Public's Health Care Agenda for the New President and Congress.

ⁱⁱⁱ The Massachusetts individual mandate exempted about 144,000 people from penalties in 2007, its first year (including people with low incomes who do not have to pay taxes). About 60,000 people paid penalties for not purchasing an affordable offer of insurance. Massachusetts Department of Revenue. 2008. Data on the Individual Mandate and Uninsured Tax Filers: Tax Year 2007.

^{iv} The 2009 Massachusetts penalties: \$0 under 150% FPL; \$204/yr between 150-200% FPL; \$420 between 200-250% FPL; \$624 between 250-300% FPL; and \$1,068 for all other income levels.