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United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

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March 27, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner,

As members of the Senate Committee on Finance, we have an obligation to ensure Medicare beneficiaries receive high quality health care and taxpayer dollars are spent wisely. On February 21, 2014, the Centers for Medicare & Medicaid Services (CMS) issued its annual Medicare Advantage Advance Notice and Proposed Call Letter for 2015 (referred to below as the Notice). We are concerned that some of the policies in this Notice may dampen innovative efforts to provide health care and lower costs. Specifically, we are concerned about two specific proposed changes effecting Home Risk Assessments (HRAs) and the Total Beneficiary Cost (TBC) limit. However we applaud CMS's efforts to bolster important beneficiary protections.

Medicare Advantage (MA) organizations often contract with private entities to conduct HRAs. HRAs are similar to the "Welcome to Medicare Visit" or annual wellness visit that is conducted in a physician's office. The health professional conducting the HRA can not only identify health-related conditions, but observe environmental factors that may be causing or exasperating an illness. This type of information could prove to be invaluable to a patient's physician and make a real difference in the patient's quality of life.

We understand that CMS is concerned that data collected during these visits may not be used to enhance the medical care and treatment of enrolled beneficiaries, but rather increase payments to plans. However, an overreach and overly strict effort to oversee the use of HRAs in this proposal may in fact dissuade MA plans from using this tool for beneficial purposes. The follow up visit requirement referenced in the Notice, for example, could have a detrimental impact on those beneficiaries who are homebound or frail and find it impossible or very difficult to see a doctor in-person.

In place of the current proposal we urge CMS to think of alternative ways to ensure the information collected as part of an HRA is provided to the beneficiaries' primary care physician and will be integrated into the patient's care plan. For instance, CMS should look to prescription drug data to ensure necessary follow up care is provided, and MA plans should be required to

assign a primary care provider to all beneficiaries who receive an HRA. The plan should attest that a detailed report is delivered to each physician and an easily understood care plan, with actionable next steps, is provided to the beneficiary. The beneficiary should also know who will receive such information.

Separately, CMS should set standards for health professionals who provide HRAs. Given the intimate nature of these visits, these standards should go above and beyond any standards in place for the Medicare Annual Wellness Visit.

While these recommendations could be implemented fairly quickly, CMS should look to better integrate HRAs with care coordination over the long run as well. In the 21st century, primary care providers should have instant access to all of the information they need to prepare a comprehensive prevention and care plan for their patients. Integration can be achieved through interoperable electronic health record technology or the creation of other tools like a patient registry with a secure web-portal. This health information should be provided to practices on an individual patient level but also at the population level to support proactive, planned care. Finally, CMS should hold home health risk assessments to high quality standards, reflecting changes in best practices and clinical evidence.

Additionally, we urge CMS to exercise caution when finalizing 2015's TBC limit. There have been a variety of payment changes called for in statute and administratively over the last two years. While we believe setting a TBC limit is a powerful tool to ensure beneficiaries receive value from their MA plan, we urge CMS to set a realistic limit that takes into account plans' changes in plan payment over the last several years.

Finally, we applaud CMS for proposing ways to protect the interest of enrollees who are affected by "significant" provider network terminations. Last year, in several states across the country, there was—and continues to be—beneficiary confusion after MA organizations dramatically restricted provider networks. In determining whether a change is "significant," CMS could consider a combination of factors such as a percentage of physician types leaving a given network or the overall percentage of physician terminations.

To that end, we support CMS's proposal to improve beneficiary notices such as the Annual Notice of Change to contain a clear explanation of an enrollee's rights if a plan terminates a provider from its network. MA organizations should provide CMS information about the steps the plan will take to ensure affected enrollees can locate new providers that meet their individual needs. CMS should also ensure affected providers have sufficient time to exercise their appeal rights before enrollees are notified of network changes. Such changes will help beneficiaries understand what the provider networks in their MA plan will look like *before* they have to make decisions about enrolling in a particular plan.

Thank you for your attention to these matters and we look forward to your response.

Sincerely,

Ron Wyden

Chuck Sch

Bill Nelson

Bob Carey, Jr.

Mark R Warner