



OPTIONS FOR REAL MEDICARE REFORM

Executive Summary

Medicare is the nation's only federal health insurance program. It provides access to health care financing and services for 43 million older adults and people with disabilities, thus also enhancing economic security for them and their families. Medicare has served our country well for decades as a balanced, public-private partnership funded by a combination of payroll taxes and general revenues. It is administered by private insurance companies, with services delivered by private physicians, hospitals, and other medical providers. Further, Medicare's low administrative costs have made the program, historically, a good bargain for taxpayers.

Certain structural and programmatic improvements are needed, however, to preserve and enhance Medicare for the beneficiaries for whom the program is intended, and for taxpayers, who participate in paying for it. Policy changes and changes in emphasis in agency interpretations should better recognize Congress' original intent that Medicare provide qualifying individuals with health care coverage to help pay essential medical bills.

Adjustments to Medicare should also align coverage with the health care needs of the 21st century: management of chronic conditions now replaces payment of high hospital bills as the most significant healthcare challenge facing older people and people with disabilities. Medicare continues to under-serve beneficiaries with chronic conditions. Those who administer the Program too often deny coverage by imposing an improvement or restoration-potential standard on payment for certain services. Since 60% of Medicare beneficiaries have two or more chronic conditions, such limitations on medically necessary care dramatically reduce the value of Medicare and fair access to care. Medicare coverage and services must be delivered without reference to such unauthorized standards.

Medicare's benefit package does not currently include routine vision, hearing, and dental coverage. Such services are critical to the well-being of Medicare beneficiaries and their addition to the benefit package will substantially enhance the benefit.

Increased emphasis on delivering benefits through private plans threatens Medicare's stability and its future as an effective and economically sound program. This threat is particularly glaring as the current Medicare payment system pays private plans, on average, 14% more than would be paid for the same services in the traditional public program. To the extent that private plans remain a vehicle for delivering Medicare coverage, they must do so at no greater expense to taxpayers than traditional Medicare.

The Center for Medicare Advocacy recommends the improvements to Medicare discussed in this Report to the Obama Administration and the 111th Congress. They will enhance Medicare for current and future beneficiaries and, in some instances, will also inform the larger health care reform debate about critical coverage and appeals issues that need to be addressed in providing fair health care access for all.

The Center's recommendations are based on the experiences of the real people that we have represented since 1986. The proposals we outline are beneficiary-centered, focusing on making the Medicare program more responsive to the emerging needs of beneficiaries. Proposals are offered in the areas of coverage, access to information, beneficiary protections, and appeals; they do not include provider payments or financing strategies, proposals for a research agenda, or suggestions for program administration or cost containment.

In keeping with our beneficiary-focus, we note that some of our proposals address overarching structural issues, applicable to all segments of the program, while others are targeted to a specific issue (or issues) arising in one part of the program.

The report is organized into subject areas, under each of which are proposals for Executive orders/actions, administrative changes, and legislative actions.

1. OVERARCHING ISSUES

Executive Orders – The President should:

- **Improve Access to Services for Persons with Limited English Proficiency.**

Persons with Limited English Proficiency (LEP) continue to have difficulty accessing health care information, educational materials, and services. Confusion exists whether Title VI of the Civil Rights Act of 1964 and the current Executive Order concerning access to services for persons with LEP, Executive Order 13166, apply to Medicare Parts B, C and D. Additionally, not all federal programs use the same standards and categories in their collection of race, ethnicity, and language data. The Administration should strengthen Executive Order 13166 to clarify that Title VI and the requirements of the Executive Order apply to all parts of Medicare, and to instruct all health agencies to coordinate their race, ethnicity, and language data collection fields and efforts.

Administrative and Regulatory Action – The Centers for Medicare & Medicaid Services (CMS) should:

- **More Effectively Use Its Monitoring and Enforcement Authority.**

CMS has significant statutory authority and a mandate to monitor the performance of contractors and providers and to enforce, among other things, the requirements of the Nursing Home Reform Law and the requirements imposed on Medicare Part C and D private plans.

With respect to nursing homes, the components of the public oversight system (the standards of care, the survey process, and the enforcement remedies) need to be strengthened, as repeatedly recommended by the Government Accountability Office, the Office of Inspector General, and others.

With respect to oversight of Part C and Part D plans, CMS should impose civil money penalties and other remedies for violations of the statute, regulatory and sub-regulatory guidance documents, and the contract with the plans. The Office of Inspector General and the Governmental Accountability Office continue to report that CMS oversight of plan activities has not been as thorough and consistent as it should be. Oversight should be strengthened with regard to marketing, appeals and other beneficiary protections, and accounting and financial reporting, for example. CMS should use its existing authority to provide additional protections for beneficiaries so they receive the benefits to which they are entitled, and for taxpayers to ensure that the federal dollars allocated to Part C and Part D plans are spent appropriately.

- **Broaden Its Approaches to Informing Beneficiaries about the Quality of Care Provided by Medicare-Contracted Healthcare Providers.**

Over the years, the Medicare program has explored a variety of ways to describe the quality of care provided to beneficiaries by Medicare-contracted healthcare providers. Approaches have been haphazard and have not resulted in reliable reporting vehicles with uniform measures and data sets across all healthcare settings. Reporting approaches must be mindful of the diversity of the populations served by the Medicare program, with particular attention to language, ethnicity, and education.

- **Involve Beneficiary Advocates in Developing and Testing Information that Is Disseminated through 1-800-MEDICARE.**

Medicare's toll-free number is a first-line source of information for Medicare beneficiaries, especially for the vast majority who do not use the Internet. Government reports have repeatedly documented long waits and misinformation provided to callers. While under the best of circumstances, beneficiaries can get basic information about Medicare benefits through the toll-free number, they are rarely able to pursue resolution of complex problems. CMS should establish a working group of State Health Insurance Program Counselors and other advocates and interested parties to assist with the development and review of scripts, to monitor calls, and to provide input on making the system work for beneficiaries.

- **Make Available More Detailed Data about the Medicare Program.**

Medicare beneficiaries and their advocates, providers, and researchers rely on information about the Medicare program to ensure that the program is running smoothly, as well as to understand how Medicare health policies affect access to affordable, high quality health care for older people and people with disabilities. To promote this goal, CMS should make publicly available more information about the program, including claims data, appeals data, and data on enrollment and disenrollment from Part C and Part D plans.

- **Increase Accountability to Beneficiaries by Extending Public Comment Periods for Notices of Public Rule-Making and Providing Beneficiary Advocates Longer Comment Periods on Informal Guidance and Notices and Letters to Beneficiaries.**

Currently, comment periods are often only thirty or sixty days and may include a holiday period. Notices or letters going to beneficiaries, for which notice and comment rulemaking are not used, are often provided to advocates with only a day or two turnaround for comments. Advocacy organizations are typically understaffed and significantly challenged to respond so quickly to long and complex NPRMs or documents describing confusing and difficult to digest information to beneficiaries.

Legislative Action - Congress should:

- **Restore Equity in Payment between Traditional Medicare and Medicare Advantage.**

The Medicare Modernization Act of 2003 (MMA) provided generous subsidies to Medicare Advantage plans that amount to over \$15 billion a year. These subsidies have led to a proliferation of private plans. Indeed, the average payment to private plans is 14% more than payments to traditional Medicare. The Chief Actuary acknowledges that, in 2008, the Medicare Advantage overpayments caused Part B premiums to increase by about \$3 per month per beneficiary.

The Congressional Budget Office (CBO) estimates that equalizing the payment policies for Medicare Advantage plans with those for traditional Medicare would save Medicare at least \$150 billion over the next nine years. One approach to restoring equity between traditional Medicare and Medicare Advantage would be to enact Section 401 of H.R. 3162, which provides for a phased-in equalization of payments between Medicare Advantage plans and traditional Medicare, and limits enrollment into Medicare Advantage plans that bid a certain percentage over the traditional Medicare amount.

- **Repeal the 45% Rule.**

The MMA contains a provision that affects the integrity of the Medicare program. It establishes a standard to review Medicare's solvency based on the source of Medicare funding rather than on program costs. The MMA provision requires the President to recommend Medicare reductions when the Medicare Trustees project, for two consecutive years, that 45% of Medicare funding will come from general revenues at a set future date. Medicare Parts B and D were designed by Congress to be funded primarily from general revenue. Thus the 45% mark is all but guaranteed to be reached. No other federal program funded by general revenues is subject to such a standard of solvency. This provision should be repealed.

- **Repeal the 2010 Premium Support Demonstration.**

Another provision of the MMA establishes a demonstration project whereby the traditional Medicare program would compete with Medicare Advantage plans in selected regions of the country. Beneficiaries in traditional Medicare would pay higher Part B premiums if the “bid” for traditional Medicare exceeded the benchmark amount. Since Medicare Advantage plans are overpaid, as compared to the traditional program, those plans would have an unfair advantage, and it is likely that beneficiaries who reside in the comparative cost adjustment areas would pay more for Part B than would other beneficiaries. This provision should be repealed.

- **Eliminate the Part B Income-Related Premium.**

Medicare now requires individuals and couples with incomes above a certain amount to pay an increased Part B premium. The provision is troubling in that it moves Medicare away from a social insurance program that provides health benefits uniformly to all eligible individuals, and towards an income-related program. The risk is that the current high-level support for the Medicare program will erode as more individuals find themselves having to pay more for their benefits, and that the social insurance nature of the program will be eliminated. Additionally, the income-related surcharge, as currently designed, causes hardships for individuals who are assessed a higher premium but whose income has been reduced, placing the burden on them to demonstrate that their Part B premium should not be increased. Congress should eliminate the Part B income-related premium provisions.

- **Protect against High Out-Of-Pocket Expenses in Traditional Medicare.**

Medicare beneficiaries who use many services have high out-of-pocket costs. Beneficiaries in traditional Medicare have no protection against high costs as there is no monetary cap on out-of-pocket expenses. Some beneficiaries have supplemental coverage to help with these costs because they have retiree health benefits, they have purchased a Medigap policy, or they are dually eligible for Medicare and Medicaid. Even with supplement coverage, however, beneficiaries paid about 16 percent of their income for their care in 2005; those without supplemental coverage paid about 30 percent. Congress should ease these financial burdens by adding a cap on out-of-pocket expenses in traditional Medicare.

- **Increase Resources for CMS for Oversight, Monitoring, and Enforcement.**

CMS is an enormous agency administering complex programs affecting the lives of over 100 million people. While it has considerable authority for monitoring, oversight, and enforcement relating to the programs it administers, it has limited resources to carry out that authority. For example, federal payments for enforcing federal standards of care for nursing facilities are less than one-tenth of one percent, as compared to the amount that is spent on that care. This amount is too small to permit effective oversight of nursing

home quality. Congress should assist the agency in doing its job well by providing additional resources.

2. IMPROVEMENTS FOR LOW-INCOME BENEFICIARIES

Executive Orders/Actions – The President should:

- **Establish a White House Office of Low-Income Programs**

Such an office could provide inter-and intra-agency coordination among all low-income programs authorized by federal law to promote ease of enrollment and retention of benefits by beneficiaries through, for example, more uniform eligibility rules and applications, cross-program deeming of eligibility so that receipt of one benefit would entitle the individual to other benefits without further application.

Administrative and Regulatory Action - CMS should:

- **Reduce Reassignment of Low-Income Beneficiaries to New Plans Each Year.**

Each year, more than 1.5 million low-income beneficiaries must change plans in order to avoid paying premiums because the plans in which they are enrolled do not qualify as benchmark plans, eligible for the low-income subsidy, for the following year. CMS partially ameliorated these circumstances for two years, under demonstration authority, by creating a “de minimus” rule that allowed beneficiaries already enrolled in a plan whose premium rose to no more than \$2 above the benchmark to retain that plan at no cost. CMS eliminated this option with new regulations that are effective for the 2009 plan year. CMS should repeal the new regulations and replace them with three mutually agreeable approaches.

First, CMS should reinstate its “de minimus” rule. Second, CMS should, as it considered in its proposed rule (January 8, 2008) and as is consistent with current CMS guidance, allow all non-enhanced PDPs the option of offering their plan to LIS beneficiaries for no premium. Third, CMS should calculate the benchmark premium without consideration of rebates applied by MA-PDs to reduce their Part D premiums. Such calculation would reflect the true cost to the MA-PD and would thus make MA-PD costs comparable to those of PDPs.

- **Adopt a Process of Intelligent Assignment or Beneficiary-Centered Assignment for Dual Eligibles and State Pharmaceutical Assistance Program Enrollees in Part D Plans.**

Current systems for enrolling low income beneficiaries into Part D plans, under CMS’s interpretation of the “:random assignment” requirement of the statute, do not take into account the individual’s drugs, pharmacies, or utilization management tools imposed by the plan on formulary drugs. The result is that beneficiaries may have great difficulty

gaining access to drugs they need. States have successfully used a more beneficiary-centered approach; research supports several approaches that save beneficiaries money and in some instances, save the federal government money.

- **Change Deeming Requirements for the Part D Low-Income Subsidy (LIS) to Ensure that Anyone Eligible for Medicaid at Any Time during the Year Is also Eligible for the Entire Following Year.**

CMS's current process for determining those "deemed" eligible for Part D LIS for the following year looks at those eligible for Medicaid, SSI, and Medicare Savings Programs in any month after June of the current year. This limitation results in roller coaster eligibility for some, especially those who receive Medicaid through the medically needy program. While this situation is a challenging one to resolve most favorably to the beneficiary, an improvement would be to allow anyone in one of those programs at any time during a year to qualify for the entire following year.

- **Ensure that Part D Plans Provide Requisite Reimbursements to Individuals Receiving the Low-Income Subsidy Whose Eligibility for the Subsidy Is Retroactive.**

Although Part D plans are required by law to reimburse members whose eligibility for the low-income subsidy is retroactive to a period when they were paying full plan cost-sharing, government reports and inquiries by members of Congress suggest this is not happening. CMS can audit plans whose members include such individuals and withhold future payments until the plans demonstrate their compliance. Going forward, CMS should withhold certain payments from plans until they demonstrate compliance.

- **Direct States to Use Actual Family Size, Following the Interpretation Used by the Social Security Administration for the Low-Income Subsidy, in Assessing Eligibility for Medicare Savings Programs.**

Medicare beneficiaries with dependents should have their eligibility for Medicare Savings Programs measured against standards representing the actual size of their families. An individual whose income supports a spouse and two children should be judged by the standard for a family of four. Instead, in 2005, 30 states used a family size of no more than two, regardless of the number of dependents of the applicant. The MSP statute is clear about using "actual family size;" CMS should direct states to use that standard for all MSP applications.

- **Direct States to Ensure that All Eligible Medicaid Recipients, Including Those Whose only Income is Supplemental Security Income, Are Enrolled in the Qualified Medicare Beneficiary (QMB) Program.**

All poor (under 100% federal poverty limits) Medicaid beneficiaries age 65 or older and those under 65 with disabilities who have completed the 24-month waiting period for Medicare are eligible to be QMBs and thus to be excused from all Medicare cost-sharing.

States do not enroll all such beneficiaries in the QMB program, especially those not entitled to premium-free Part A. Because the cost-sharing protections for QMBs are clearer and stronger than they are for non-QMB dually eligible individuals, it is beneficial to the individual to have such enrollment. In the past, CMS has directed states to enroll these individuals, but it has not done so recently. CMS should send a State Medicaid Director letter outlining the issue and directing states to enroll all those eligible for the QMB program.

- **Clarify, through Amendments to Regulations Concerning Third Party Liability, that States Should not Require Beneficiaries to Appeal Coverage Denials from a Primary Payor – especially Medicare – before They Can Get Medicaid Coverage for a Service.**

Coordination of benefits between Medicare and Medicaid should not fall on the beneficiary; the beneficiary, in fact, should be unaware of any coverage misalignments, which should be resolved among Medicare, Medicaid, and the provider in question. Too often the burden falls on the beneficiary who is unable to determine how to proceed. This occurs in Part D, where states are providing safety net coverage, and, most especially, in connection with wheelchair coverage where providers are reluctant to serve dual eligibles because of the processing complexities between the two programs. Policies should be developed that allow the beneficiary to receive the services seamlessly.

- **Clarify Requirements for Medicare Advantage Plans Enrolling Dual Eligibles Concerning Coordinating with Medicaid Benefits.**

Currently, Medicare Advantage plans have no requirement to help their dually eligible enrollees gain access to Medicaid benefits that wrap around or otherwise complement their MA benefits. Regulations issued September 18, 2008 direct MA Special Needs Plans for Dual Eligibles to have contracts with State Medicaid programs to provide Medicaid benefits, starting in 2010. This requirement should be less stringent, addressing data-sharing and benefit coordination rather than full scale benefit provision, but it should also be expanded to apply to all Medicare Advantage plans.

- **Expand Requirements for Medicare Advantage Special Needs Plans.**

In regulations issued September 18, 2008, CMS set forth new regulatory requirements for Special Needs Plans that reflect requirements included in MIPPA. The regulations do *not* address in detail network requirements, protections during transitions, supplemental benefits, or benefits coordination, except for the requirement that plans for dual eligibles have a contract with the state Medicaid agency in the states in which they operate. CMS should add greater specificity to its current requirements.

Legislative Action - Congress should:

- **Deem Individuals Found Eligible for Supplemental Nutrition Assistance Program (SNAP, Formerly Food Stamps) and/or Low-Income Home Energy Assistance Program (LIHEAP) to Be also Eligible for Medicare Savings Programs and the Part D Low-Income Subsidy.**

Eligibility requirements for SNAP and Food Stamps are generally less generous than those for LIS and MSP, suggesting that those eligible for the former are highly likely to also be eligible for the latter. Because LIS and LIHEAP are administered by the same Department – Health and Human Services – deeming related to those two programs might be accomplished administratively, rather than legislatively. Since the SNAP program is administered by another Department and MSP is administered by the states, legislation might be required to required deeming related to those programs.

- **Eliminate Asset Tests for Programs for Low-Income Medicare Beneficiaries. Alternatively, Increase the Assets Levels.**

Currently, people with very low incomes but with countable assets of more than \$4,000 for Medicare Savings Programs (MSP) or \$8,100 (for 2009) for the Part D Low-Income Subsidy (LIS) cannot qualify for these programs. The asset test is a significant barrier that low-income beneficiaries face when trying to get needed assistance with rising prescription drug and other health care costs. People who saved for retirement and still have very limited incomes should not be penalized. Alternatively, the asset level could be increased to reflect the average assets of those with qualifying incomes.

- **Make the Qualified Individual Program Permanent.**

The Qualified Individual (QI) program, one of the MSPs, pays the Part B premium for people with incomes of about \$14,000. An individual receiving QI also receives the Part D low-income subsidy; the combined value of the benefits is about \$4800 in 2008. The QI program has been unstable in recent years, with reauthorizations made for short periods of time and often at the last minute before the program was scheduled to expire. Such instability causes havoc and uncertainty in the lives of those beneficiaries who rely on the benefit and runs counter to the goal of the Medicare program of providing health care security to those in greatest need. Congress should make the QI program permanent and guaranteed through a variety of approaches that would fold it into other Medicare Savings Programs.

- **Align the Medicare Savings Programs (MSP) and the Part D Low-Income Subsidy (LIS) to Allow Enrollment in One Program to Provide Automatic Access to the Other.**

LIS is administered by the Social Security Administration, a federal agency; MSP is administered by the states, and state rules can and do vary. Under authority in the Part D statute, the Secretary of the Department of Health and Human Services (HHS) allows people receiving MSP benefits to be deemed eligible for LIS without having to apply

separately. The opposite is not true. An individual who has applied and been found eligible for LIS is not deemed eligible for MSP benefits. The Medicare Improvements for Patients and Providers Act (MIPPA) has corrected a significant discrepancy between the two programs. Starting in 2010, MSP and LIS asset levels will be the same and both will be indexed. The MIPPA provision on assets creates sufficient alignment between the two programs that two-way deeming should be authorized.

- **Recalculate the Part D Benchmark to Reduce Reassignment of Low-Income Beneficiaries Each Year.**

More than 1.5 million people who are eligible for the LIS are being reassigned to new drug plans during the 2008 open enrollment period because the plan they are in no longer qualifies as a low-income benchmark plan; hundreds of thousands of other individuals will be in non-benchmark plans but will not be reassigned. Reassignment increases the likelihood of disruption of drug regimens while beneficiaries learn about the formulary of their new plan. The low-income benchmark premium amount is calculated using the weighted average of the premiums of both stand-alone prescription plans (PDPs) and Medicare Advantage plans with drug coverage (MA-PD) in each region. Most MA-PDs use their overpayments to buy down the Part D premium, so most have \$0 drug premiums. As a result, the weighted average is lower than it would be if only the PDP premiums were used to determine the benchmark amount or if the actual Part D cost to MA-PDs were used. The statute requires consideration of MA-PD premiums even though people eligible for LIS cannot be auto-enrolled in an MA-PD.

Congress should amend the statute by eliminating MA-PD premiums from the calculation. Alternatively, Congress should amend the statute to use the actual MA-PD premium before the rebate.

- **Provide Internal Revenue Service (IRS) Authority to Share Data with the Social Security Administration to Identify Individuals Likely to Be Eligible for Low-Income Assistance to Allow for Targeted Outreach.**

Participation in low-income programs is generally low, due to many factors. Experience with the economic stimulus payments from 2008 demonstrates the success of using IRS data to target outreach. For that program, the IRS identified individuals who did *not* file income tax returns due, presumably, to having too little income to do so. Outreach to such individuals resulted in 80% actually receiving the stimulus check. Authority to IRS to share data with SSA has the potential to improve the lives of beneficiaries by getting them into programs that will increase their income and their access to medical services.

- **Repeal the Provision of the Medicare Act of 2003 (MMA) that Prohibits States from Receiving Federal Financial Participation for Covering Part D-Covered Drugs, so that Medicaid Programs Should Pay for Cost-Sharing and Non-Formulary Drugs.**

The MMA created an anomaly with respect to how Medicare and Medicaid treat dual eligibles. In all aspects but Part D, Medicaid acts as a supplemental or wrap-around policy to Medicare coverage. Medicaid pays for Medicare's cost-sharing and for those services not covered by Medicare. Part D is the only portion of Medicare for which this is not true. Many states have used their own money, without federal match, to protect their lowest-income residents from out-of-pocket costs that can be difficult for them to pay. Congress should repeal this section of the MMA and amend the portion of the law concerning state payments for dual eligibles – known colloquially as the clawback – accordingly.

- **Repeal the Provision of the Balanced Budget Act of 1997 that Allows States to Pay Medicare Cost-Sharing for Qualified Medicare Beneficiaries at the Medicaid Payment Rate Rather than the (Usually Higher) Medicare Payment Rate.**

Since passage of the BBA in 1997, at least 35 states have adopted the provision, which has, according to a Congressionally-mandated study released in 2003, resulted in reduced access to Medicare providers for Qualified Medicare Beneficiaries. Congress should repeal the provision.

- **Repeal the Provision of the Medicaid Law that Prohibits Qualified Medicare Beneficiaries from Receiving Retroactive Medicaid Coverage, As All Other Medicaid Beneficiaries Do.**

Qualified Medicare Beneficiaries are the only group of Medicaid beneficiaries who are not entitled to retroactive benefits. Other recipients of Medicare Savings Program benefits – Specified Low Income Medicare Beneficiaries, Qualified Individuals, and Qualified Disabled and Working Individuals – are all entitled to retroactive coverage. Often beneficiaries do not learn of the program until they have a medical crisis, but under the current rule, their eligibility would not help pay for the medical situation that brought the program to their attention. Congress can easily remedy this by repealing a very small provision in the law.

3. IMPROVING MEDICARE FOR BENEFICIARIES WITH DISABILITIES AND CHRONIC CONDITIONS

Administrative and Regulatory Action - CMS should:

- **Clarify that Persons with Chronic Conditions Are Entitled to Necessary Services to Improve, Maintain, or Slow Deterioration of a Health Condition or Injury.**

While the Medicare statute and regulations recognize that persons with chronic conditions are entitled to necessary services to improve, maintain, or slow deterioration of a healthcare condition or injury, CMS's direction to providers is often confusing and contradictory, resulting in loss of care or complicated Medicare appeals in order to

restore necessary services. CMS should clarify the statutory and regulatory standard – that beneficiaries are entitled to services that are necessary to improve, maintain, or slow deterioration of a health condition or injury.

- **Clarify that the “Primarily for Use in the Home” Requirement for Power Operated Vehicles (POVs) Includes Using the POV Primarily Outside the Home.**

Some Medicare beneficiaries have difficulty with mobility activities of daily living (ADLs) to the extent that they are not able to stand or walk without assistance or without considerable and taxing effort. For many in this category, a POV is of greater utility for movement outside the home. CMS should clarify its regulations to reflect this critical need and emerging use pattern, including payment rates that reflect the need for stronger, more durable POV. The clarification should include the recognition that the beneficiary otherwise requires a considerable and taxing effort or the assistance of others in order to leave the home.

- **Clarify Medicare Coverage of Computer-Assisted Technologies for Augmenting Speech, Hearing, and Thought Integration, Including Establishing a Study Panel to Facilitate Coverage Policy Development.**

Increasingly, Medicare beneficiaries are using a variety of technologies that augment speech, hearing, and thought integration. It is often unclear how CMS will treat new technologies with respect to coverage recognition and classification. This clarification should be included in CMS’s regulations that allow coverage of medical supplies, appliances, and devices when documented by licensed physicians, therapists, and other recognized practitioners. Recommendations from a study panel of experts should guide or inform the coverage process.

Legislative Action - Congress should:

- **Eliminate the “Homebound” Requirement for Accessing the Medicare Home Health Benefit.**

Medicare currently requires an individual to be “homebound” to be eligible for home health services. Studies have shown the requirement to be anachronistic and not reflective of the needs of beneficiaries in the 21st century. Congress has liberalized the homebound requirement by allowing Medicare beneficiaries to attend senior centers and other congregate sites to receive medical social services. Congress should go further and create a new paradigm for accessing the home health benefit – one that recognizes the value of community integration, use of mobility devices and aides. This change would provide, for those who are physically able, the flexibility to leave home for a variety of purposes without losing necessary home healthcare services.

4. IMPROVE ACCESS FOR BENEFICIARIES WHO NEED POST-ACUTE CARE

Administrative and Regulatory Action - CMS should:

- **Count Time in Hospital Emergency Rooms and in Observation Status toward Meeting the Three-Day Prior Hospitalization Requirement for Access to Medicare-Covered Skilled Nursing Facilities (SNFs).**

In order to receive Medicare-covered SNF care, a beneficiary must satisfy a three-day prior hospitalization requirement. Medicare beneficiaries who have been in a hospital setting in excess of three days, but not all of it as an admitted patient, are denied access to the Medicare SNF benefit. In calculating the three-day hospital stay requirement, CMS counts only time in the hospital after formal admission to in-patient status; it disregards (for purposes of subsequent SNF coverage) all time spent in the emergency room or on observation time (although it bundles all the time for purposes of hospital reimbursement). CMS should include time in the emergency room and in observation status in calculating the three-day hospital stay requirement.

- **Rescind the Notion of Hospital "Observation Services" and Delete All References to "Observation Services" in Hospitals from the CMS Manuals.**

Beneficiaries are frequently being considered in observation status, rather than inpatients in acute care hospitals, for lengthy periods, and are often never formally admitted to inpatient status. Since patients in observation status are in beds in the hospital overnight receiving care, they rarely realize that they have not actually been admitted as inpatients. So-called "observation services" are paid for under Part B while inpatient hospital care is a Part A benefit. As a consequence, Medicare hospital patients considered in "observation status only" must pay for their drugs and other services and, if they subsequently go to a skilled nursing facility, they fail to qualify for Medicare-covered care in the SNF, which requires a prior three-day inpatient stay.

The CMS Manuals' definition of observation services – short-term treatment and assessment provided to a beneficiary in an acute care hospital for no more than 24 or 48 hours – actually describes the diagnosis component of hospital care. This care should not be "unbundled" from the treatment provided to hospital inpatients. Moreover, CMS's Manual provisions are not being followed, as many patients remain in the hospital far beyond the 24-48 hours described in the Manual as the outer time limit for observation services. Nor are beneficiaries receiving notice when they receive observation services under Medicare Part B rather than inpatient hospital coverage under Part A.

CMS should rescind all Manual provisions discussing observation services. The concept of observation services interferes with beneficiaries' Part A benefit by denying Part A coverage for diagnosis and by unbundling the diagnosis component of care from treatment. Observation services are in conflict with the Medicare statute, which authorizes coverage of services under Part A that are "medically reasonable and

necessary care for diagnosis and treatment of illness and injury." At a minimum, CMS should promulgate regulations defining observation status – e.g., what it means, when it can be used, notice that hospitals and SNFs must give beneficiaries. The regulations should require that all time spent in the hospital, including time described solely as “observation status,” be counted toward the three-day prior hospitalization requirement.

- **Clarify for Purposes of Durable Medical Equipment (DME) that Non-Skilled Parts of Nursing Homes or Convalescence Homes Are Considered the Individual’s Home.**

CMS regulations provide that an institution used as a home may not be a hospital or a Critical Access Hospital (CAH) or a SNF. Beneficiaries residing in non-skilled parts of SNFs, non-skilled convalescent care facilities, and assisted living facilities, nonetheless, are denied Medicare payment for DME on the basis of being institutionalized. CMS should make more explicit in its regulations and in guidance that these settings are not institutions for purposes of DME, but rather, constitute the home.

- **Protect Home Health Benefit Recipients from Discharge for Short Hospitalizations.**

To ensure continued access to home health benefits for people with short hospital stays, CMS should specify that a home health agency may not discharge a patient or terminate the patient’s plan of care, if, during the 60-day plan of care, the patient goes to the hospital for a short period of time and then returns home.

Legislative Action - Congress should:

- **Repeal the Medicare Statutory Three-Day Prior Hospitalization Requirement for Accessing the Skilled Nursing Facility Benefit. Alternatively, Count All Time in the Hospital.**

Advances in medicine and changes in care patterns, including greater movement between acute and extended care settings, render obsolete a three-day prior hospitalization requirement. Currently, the requirement unduly penalizes persons who, due the nature of their illness or new treatment paradigms, need only a short (less than three day) acute hospital stay, yet require longer recuperative care in skilled nursing facilities. This provision should be repealed.

Even those who are actually in a hospital for three days, in many situations, have begun their hospital stay in the emergency room or have been held for “observation and assessment,” or both, before being “admitted” to inpatient status. CMS does not include time in an emergency room or in observation status as counting toward meeting the three-day stay requirement. Congress should amend the statute to require that all time in Medicare-participating hospitals is included in calculating the three-day prior hospitalization requirement for accessing the skilled nursing facility benefit.

5. IMPROVING MEDICARE FOR BENEFICIARIES IN PART C AND PART D

Executive Orders – The President should:

- **Strengthen the Prohibition against Discrimination in Health Plan Benefits Design.**

Despite a statutory prohibition against approval of Medicare Advantage plans with plan and benefit designs that are likely to discourage enrollment by some otherwise-eligible beneficiaries, many Medicare Advantage plan designs result in plan enrollees with chronic conditions or high health care needs paying more out-of-pocket for their services than if they remained in traditional Medicare. The Administration should extend Executive Order 11246, which prohibits government contractors from participating in discriminatory employment practices, to prohibit all federal government agencies from contracting with organizations that offer health plans, benefit structures, and cost-sharing structures that discriminate on the basis of disability or high health care usage.

- **Increase Transparency in Health Plan Information.**

Open, thorough, and accurate information about health plan benefits, services, utilization and costs to individuals and to the federal government is needed, both by the individuals who utilize federal health care programs and by the federal government in its oversight and regulation of the providers and insurance companies with which it contracts. Yet Medicare beneficiaries find that the information made available by health and prescription drug plans, including information on the Medicare and plan websites, often does not accurately reflect actual costs to them or the standards for making medical necessity determinations. Similarly, the Governmental Accountability Office and the Office of Inspector General have both reported that plans do not provide all of the information needed by CMS in its oversight capacity, particularly with regard to administrative costs. Plans and providers often claim that they cannot provide requested information because it is proprietary. The Administration should issue an executive order that requires all health plans and other health care providers that enter into contracts to provide benefits under federal health care programs to disclose fully and make public all information regarding beneficiary cost-sharing; and to disclose to the appropriate agency all required and requested information, including information the entity claims is proprietary.

Administrative and Regulatory Action - CMS should:

- **Improve Protections against Misleading Marketing Practices.**

Despite recent legislative and administrative efforts to curb misleading marketing practices, these practices continue. CMS should tighten the marketing rules, for example, by further restricting communications between plans and current enrollees, by re-designing its rules on agent compensation, by restricting “file and use” review to standardized documents, and by developing standards for print and media advertising.

- **Award a One-Time Amnesty and Waive the Late Enrollment Penalty.**

Some beneficiaries did not enroll in Part D when they first became eligible for the program because of its complexity or because they did not understand the need to enroll at that time. If these beneficiaries choose to enroll in Part D at a later date, they are assessed a late enrollment penalty of one percent of the national average premium for every month of delayed enrollment. The penalty is waived for people who can demonstrate that they had other drug coverage that is as good as Medicare drug coverage or who are eligible for the low-income subsidy. For those not eligible for waiver, the late enrollment penalty serves as a deterrent to enrollment in Part D. Congress should enact a one-time amnesty bill that waives the late enrollment penalty for all those who have not yet enrolled in the program.

- **Clarify Definition of Part D Drug.**

Much confusion remains about when a drug is covered under Part D drug or when it is covered under Part B. CMS should clarify in regulation the standards for coverage of drugs under Part B versus Part D, and how drugs are to be delivered when the drugs are covered under Part D but the delivery mechanisms are not, for example, intravenous drugs.

- **Clarify Utilization Management Practices.**

Most drug plans use utilization management tools such as a tiered cost-sharing, quantity limits, and step therapy to control costs and to manage safety. For beneficiaries, however, there is no real distinction between a drug that is not on their plan's formulary and a drug that is subject to utilization management. The process for getting coverage of that drug is the same. Additionally, some plans impose more than one utilization management tool on some drugs, requiring beneficiaries to go through separate processes to get coverage. Finally, some plans impose utilization management tools on a substantial number of their formulary drugs, calling into question whether their formularies satisfy statutory and regulatory requirements. CMS should clarify in regulations the practices that fall within utilization management tools and provide guidance on the percentage of a plan's formulary that can be subject to these tools.

Legislative Action - Congress should:

- **Repeal Part D and Replace It with a Prescription Drug Benefit in Traditional Medicare. Alternatively, Add a Drug Benefit in Traditional Medicare.**

The Part D prescription drug benefit is offered by private companies that enter into annual contracts with CMS. Plan sponsors can decide not to renew their contract or, more commonly, they can change their benefit structures or consolidate plans. Because the changes reflect plans' business strategies rather than beneficiaries' needs, they translate into reduced coverage and increased costs to beneficiaries each year. For example, the overwhelming majority of beneficiaries will pay significantly higher

premiums in 2009 if they remain in their 2008 plan; many plans have increased cost-sharing significantly for costly drugs. Moreover, each year, more than a million low-income subsidy (LIS) recipients, generally high users of prescription medications, must be reassigned to plans when their current plan no longer qualifies for the subsidy.

To create a stable prescription drug benefit that does not change based on the business plan of the plan sponsors, Congress should repeal Medicare Part D and include an outpatient prescription drug benefit in Medicare Part B. Alternatively, Congress should amend Part D to add a prescription drug benefit offered through the traditional Medicare program.

- **Develop Standardized Benefit Packages and Limit the Number of Plan Choices in Medicare Parts C and D.**

Both Medicare Part C and Medicare Part D are predicated on the beneficiary making a knowing and informed choice on how to receive his or her health care. Yet the number of plans and the variations in benefit structures make the process of choosing very difficult, particularly for beneficiaries with limited education or limited mental capacities. As a result, some beneficiaries choose inappropriate health plans. Most beneficiaries do not change their prescription drug plans, even when the benefit structure changes and another plan may be more appropriate for them during the next calendar year, because of the difficulty of choosing plans. Congress should limit the number of Part C and Part D plans that each organization may sponsor during a given contract cycle. Congress should also require the development of standardized benefit packages, similar to the standardized Medigap benefit packages, for both Part C and Part D, using a process similar to the development of the Medigap standard plans.

- **Eliminate “Lock-In” for Medicare Parts C and D. In the Alternative, Adopt Additional Special Enrollment Periods and Conform Part C and Part Enrollment Periods.**

Beneficiaries are “locked in” to their Medicare Advantage plan or Part D plan even if their plan institutes benefit changes or their health care needs change, and the plan no longer provides them with adequate health care coverage. Congress should enact a number of protections for individuals in this situation. First, Congress should eliminate the lock-in provisions. Alternatively, Congress should create additional special enrollment periods so that a beneficiary may leave the plan when the plan no longer meets his or her medical needs, including if the plan eliminates coverage for, increases cost-sharing for, or adds utilization management requirements for a prescribed medication (other than for safety reasons). Additionally, if Congress does not eliminate the lock-in, Congress should make enrollment periods for Part C and Part D plans co-extensive by either eliminating the Part C open enrollment period or by extending the open enrollment period to Part D plans.

- **Protect against High Out-Of-Pocket Expenses in Part C and Part D Plans.**

Beneficiaries enrolled in Medicare Advantage plans that are actuarially equivalent to Part A and Part B covered services are often offered reduced cost-sharing for some benefits, such as doctor visits, and increased cost-sharing for other services, such as home health care. Thus, beneficiaries with high health care needs can pay substantially more for care in a Medicare Advantage plan than in traditional Medicare. Enrollees in a prescription drug plan experience very high costs if they reach the Part D coverage gap, known as the doughnut hole. While in the gap, they are responsible for the full cost of their prescriptions; at the same time they must continue to pay their drug plan premiums. Congress should ease these financial burdens by prohibiting Medicare Advantage plans from imposing cost-sharing that is greater than the cost-sharing imposed under traditional Medicare and by eliminating the Part D coverage gap.

- **Allow Payments by ADAP Programs and Indian Health Service to Count Towards the Part D Out-of-Pocket Limit.**

Once a beneficiary's out-of-pocket expenses exceed the yearly limit, the beneficiary has reached the catastrophic level and is eligible for reduced cost-sharing. Only out-of-pocket expenses for formulary drugs that are paid for by the beneficiary, by a family member or other person acting on his/her behalf, by a charity, or by a state pharmacy assistance program are counted. Payments made by other programs, including AIDS Drug Assistance Programs (ADAPs) and the Indian Health Services (IHS), do not count toward the limit. Such uncounted payments increase the amount the beneficiary must spend before the reduced cost-sharing for high drug expenses begins. This can cause a burden on beneficiaries who use very costly drugs, such as those covered by ADAPs. Congress should reduce expenses by allowing payments by ADAP and IHS programs to count towards the out-of-pocket limit.

6. STANDARDIZING PROCEDURES TO SIMPLIFY OPERATIONS OF THE PROGRAM FOR BENEFICIARIES

Administrative and Regulatory Action - CMS should:

- **Improve Notices Provided to Beneficiaries about Appeal Rights.**

Beneficiaries who believe that Medicare should pay for or cover the care they need may use the appropriate appeals process to challenge a denial of care. One of the biggest barriers to filing and pursuing appeals is the fact that many beneficiaries do not even know they have a right to appeal. CMS should improve the way notice is provided, particularly in regard to some hospital, hospice, and Part D claims; should improve the content of current notices; and should require that standard notices be used at all levels of appeals and for all parts of Medicare.

- **Issue a Monthly Medicare Summary Notice (MSN).**

The Medicare Summary Notice provides beneficiaries with information about Medicare coverage of services they received. It is the notice of the initial determination and includes information about appeal rights for denied claims. CMS decided last year to issue MSNs on a quarterly, rather than a monthly, basis. As a result, beneficiaries may be billed by providers before they are informed of their appeal rights. For high health care users, the quarterly MSNs are too long to go through carefully, making it harder to check for denied claims and to check for fraudulent claims. CMS should rescind its current policy and require that MSNs be issued monthly.

- **Clarify Fast Track Review Appeal Rights.**

The statute and regulations provide for fast-track review of termination of care/discharge from certain settings. The regulations need to clarify that once the beneficiary has gone through the expedited determination and expedited reconsideration by the Quality Improvement Organization (QIO), the beneficiary has the right to appeal to the administrative law judge (ALJ).

- **Identify Services Eligible for Prior Determination Process.**

CMS issued regulations that allow beneficiaries to request prior determination from CMS whether Medicare will pay for certain expensive services. The regulations establish a dollar amount and say that CMS will publish a list of services for which prior determination may be available under this process. CMS should develop and publish the list.

- **Provide a Supply of On-Going Medication Pending Appeal.**

Part D transition guidance provides for access to on-going medication pending an appeal or an opportunity to speak with the prescribing physician about a medication change when a Medicare beneficiary enrolls in a new prescription drug plan. The guidance should be codified in regulation. The regulation should also provide for a beneficiary to have access to necessary medications in all situations pending an appeal.

- **Allow Tiering Exception for Specialty Drugs and to Generic Tiers**

The Medicare statute grants beneficiaries the right to request an exception to a lower-cost tier if they need to take a higher cost drug in certain circumstances. CMS limited this right by precluding a request to reduce cost-sharing to that of a tier for generic drugs and by precluding a request for a tiering exception for drugs placed on a specialty tier. CMS should eliminate these restrictions on the ability to request a tiering exception.

- **Clarify the Opportunity to Present Evidence to the Qualified Independent Contractor (QIC).**

After a Part C plan or a Part D plan reviews its initial decision on a health or prescription drug claim, a dissatisfied beneficiary has the opportunity for review by the Qualified Independent Contractor (QIC). The regulations allow the beneficiary to present his/her case to the QIC, but the QIC policies and practices have no mechanism for beneficiaries to do so. CMS should modify the Part C and Part D regulations to provide for better opportunities for beneficiaries to present their case to health and prescription drug plans and to QICs.

- **Establish Time Frames for Decisions by Administrative Law Judges (ALJs) in Part C and Part D Appeals.**

CMS has determined that the 90-day time frame for ALJs to issue decisions in Part A and Part B cases does not apply to appeals brought under Part C and Part D. CMS issued proposed regulations that establish time frames for decisions, including expedited time frames in certain Part D cases, but they have not been made final. CMS should issue the regulations concerning time frames in final form.

Legislative Action - Congress should:

- **Eliminate the Qualified Independent Contractor Level of Review.**

Congress created the Qualified Independent Contractor (QIC) level of review in Part A and Part B appeals to provide beneficiaries with the opportunity for independent, external review of unfavorable redetermination decisions issued by Medicare Administrative Contractors (MACs). The QIC reconsideration review is in addition to the Administrative Law Judge (ALJ) level of review, which provides beneficiaries with the opportunity to present testimony and other evidence at a hearing before a neutral adjudicator. Rather than providing beneficiaries with the opportunity to present their case to a neutral reviewer, the QICs have become a barrier to review by Medicare ALJs. Data about QIC review indicate that the QICs uphold the Part A and Part B MACs at a higher rate than ALJs, with no opportunity for participation by beneficiaries, as occurs at the ALJ level. The QIC does not appear to be working as Congress intended, Congress should reduce administrative costs and remove a barrier to effective administrative review by eliminating the QIC reconsideration level of review.

- **Simplify the Part D Appeals Process.**

The Part D statutory appeals provisions provide for coverage determinations, exceptions, and grievances. CMS, through guidance, added a prior authorization process that appears to parallel the exceptions process, though without all of the beneficiary protections. These processes are confusing for beneficiaries, their advocates, and their prescribers. Rules are not followed, and beneficiaries have difficulty gaining access to medications they need. Congress should simplify the Part D appeals process by combining coverage

determinations, exceptions, and prior authorizations into one process, and by strengthening beneficiary rights when drug plans do not comply with the rules.

7. ASSURING QUALITY OF CARE FOR MEDICARE BENEFICIARIES

Executive Orders – The President should:

- **Extend the Utilization of Health Information Technology to Address Disparities in Health Care.**

Disparities in access to health care information, in access to health care, and in health outcomes for racial and ethnic minorities and people with disabilities have been well documented. Health information technology (IT) may provide new and creative ways of reaching these populations and ultimately in eliminating documented disparities. The Administration should extend Executive Order 13410, which directs federal agencies to maintain and update IT systems for use between federal agencies and non-federal entities, and require such entities to explore how IT can be used to lessen disparities among racial and ethnic minorities and people with disabilities, with an emphasis on health integration, health education, and access to services.

Administrative and Regulatory Action - CMS should:

- **Require CMS to Update the Requirements of Participation for Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs).**

CMS has not updated the Requirements of Participation for SNFs and NFs since 1991, but it has convened panels of experts to recommend changes to the State Operations Manual's guidance for surveyors. Facilities may not be cited with deficiencies for violating surveyor guidance, however; they may only be cited for violating the law or regulations. CMS should use the extensive information it has collected from its expert panels to revise and update the regulatory requirements that SNFs and NFs must meet.

New rules should expressly prohibit nursing facilities from using "documentation by exception" (i.e., documenting when care is not provided, as opposed to when care is provided). The regulation permitting distinct part certification by nursing facilities, 42 C.F.R. §483.5(b), should be repealed. This regulation allows facilities to set aside separate Medicaid wings for Medicaid beneficiaries, violating privacy laws and the Nursing Home Reform Law's requirement to protect the confidentiality of information about residents.

- **Amend Reimbursement Regulation and Policy to Assure that They Are Consistent with the Requirements of Participation, Pay for High Quality Care, and Are Enforced.**

Reimbursement policy needs to be consistent with standards of care that are required by federal law. Medicare reimbursement for SNFs identifies various cost centers, such as nurse staffing, but SNFs do not necessarily spend the reimbursement as CMS intends. CMS should take actions to ensure that reimbursement is spent, as intended, to provide high quality care to residents.

- **Strengthen the Nursing Facility Survey and Enforcement Systems.**

CMS should strengthen the survey and enforcement processes for skilled nursing facility and nursing facilities by promulgating regulations that would, for example, (1) set out the process for calculating the duration of noncompliance (for purposes of imposing civil money penalties (CMPs)); (2) amend the informal dispute resolution (IDR) process to allow residents and families to participate in facilities' IDR proceedings and to allow residents and families to have their own IDR process to address survey agencies' not citing deficiencies; and (3) require that CMPs collected by states be used for the protection of residents and prohibit their use for provider activities, such as industry-led voluntary quality improvement activities. CMS also should (1) provide additional training and surveyor guidance to state survey agencies and federal surveyors on how to determine scope and severity of deficiencies more accurately; (2) strengthen its oversight of states' survey and enforcement activity; (3) improve the complaint investigation system; and (4) implement existing authority to sanction states' inadequate survey and enforcement activity.

- **Resist Industry Efforts to Abandon the Enforcement System and to Replace It with an Oversight Model that Relies on Self-Regulation, Technical Assistance, Quality Assurance, and Customer Satisfaction.**

The nursing home industry has many ongoing initiatives that are intended to present a voluntary, collaborative system to monitor quality of care as an alternative to the public regulatory system. CMS needs to reject these efforts, which undermine the 1987 Nursing Home Reform Law, and to discontinue its participation in the industry's *Advancing Excellence in America's Nursing Home* campaign.

Legislative Action - Congress should:

- **Identify Methods to Improve Oversight of Nursing Homes Owned by Private Equity Firms.**

Private-equity firms have been taking over large nursing home corporations, creating enormous concerns about the quality of care in the facilities. Legislation is pending in Congress to improve the transparency and accountability of nursing home owners,

particularly large multi-state corporations and private equity firms. The legislation should be strengthened and supported.

8. IMPROVING AND EXPANDING MEDICARE COVERAGE

Executive Orders – The President should:

- **Prohibit the Usage of Improper Review Standards for Coverage Determinations.**

Individuals with multiple sclerosis, Amyotrophic Lateral Sclerosis (ALS), and other chronic conditions who need continuing health care services to ensure that their condition does not deteriorate and/or that they can maintain their current level of functioning are frequently denied care on the grounds that they will not improve, that they are “chronic and stable,” or that they need “maintenance therapy.” Coverage denials on these grounds and on other “rules of thumb” conflict with Medicare regulations, with court decisions, and with requirements that a health care plan reflect an individualized assessment of each person’s physical, psychosocial, and functional needs. An executive order should clarify that the restoration potential of a beneficiary is not a deciding factor in making the coverage determination, should require that coverage determinations be made using the appropriate federal coverage criteria and not “rules of thumb,” and should require that decisions be made based on an individualized assessment of the patient’s needs.

Administrative and Regulatory Action - CMS should:

- **Prohibit The Use of Rules of Thumb to Deny or Limit Coverage.**

CMS contractors and Medicare Part C plans, in making coverage determinations, use rules of thumb or screens that result in the denial of coverage. A beneficiary with a degenerative disease, for example, may be determined not to need skilled services because his or her condition is allegedly “stable,” despite the Medicare law’s requirement that his or her need for skilled care be determined based on his or her individual circumstances. CMS should clarify, for all its contractors, including Medicare Part C plans, that such screens or rules of thumb are impermissible for denying or reducing coverage.

Legislative Action - Congress should:

- **Repeal the 24-Month Waiting Period for Medicare for People under 65 with Disabilities.**

The 24-month waiting period for Medicare for individuals who have been found disabled under the Social Security Disability Income (SSDI) program creates an extreme medical and financial hardship. Persons waiting for this benefit are often without other medical insurance, or churn on and off of various medical assistance programs, and have limited

ability to work. This gap in coverage is costly to the public, as it generally bears the cost of indigent care. No health-related rationale exists for this waiting period.

- **Remove the Statutory Exclusion of Routine Dental Services, Vision Care, and Hearing Aids and Devices from Medicare.**

Medicare beneficiaries are limited in their access to Medicare coverage for routine, preventive dental services, including fillings, extractions, cleanings, and related oral health care. Medicare beneficiaries also are limited in their access to routine vision care such as eyeglasses and related services not involving a specific disease or injury to the eye. Similarly, Medicare beneficiaries do not have access to coverage for hearing aids and related devices to augment hearing. Congress should eliminate the exclusion of routine dental, vision, and hearing coverage.

- **Add a Coordinated Care Benefit in the Traditional Medicare Program as a Benefit under Medicare Part B (Supplemental Medical Insurance).**

Care coordination is widely recognized as a key component of health and wellness, particularly as people cope with co-morbidities and other conditions that require the services of multiple clinicians and other allied healthcare practitioners and social services. Thus the statute should be amended to add care coordination to the definition of services as a benefit in the traditional Medicare program under Medicare Part A just as currently recognized under Medicare Part A for hospice care.

CONCLUSION

These recommendations for executive, administrative and legislative action, if adopted, will go a long way to returning the focus of Medicare to the beneficiaries for whom it was created. They would also make Medicare an efficient and economic program for the taxpayers who share in its financing. We urge approval of these recommendations in order to improve access to health care and economic security for all Americans.

December 18, 2008