Submitted electronically via dualeligibles@cassidy.senate.gov

January 13, 2023

Senator Bill Cassidy, M.D.
Senator Thomas R. Carper
Senator Tim Scott
Senator Mark Warner
Senator John Cornyn
Senator Robert Menendez

Re: Bipartisan Request for Information on Improving Care for People Dually Eligible for Medicare and Medicaid

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The Health Care Transformation Task Force (Task Force) appreciates the opportunity to respond to the Request for Information aimed at improving care and outcomes for beneficiaries who are dually eligible for Medicare and Medicaid.

The Task Force is a consortium of private sector stakeholders that support accelerating the pace of transforming the delivery system into one that better pays for value. Representing a diverse set of organizations from various segments of the industry – including providers, payers, purchasers, and patient advocacy organizations – we share a common commitment to transform our respective businesses and clinical models to deliver a health system that achieves equitable outcomes through high-quality, affordable person-centered care. We strive to provide a critical mass of policy, operational, and technical support that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

As noted in the RFI, dual eligibles represent a small proportion of Medicare and Medicaid beneficiaries, but account for a disproportionate share of overall spending, due to the complexity of this population coupled with the fragmented and disjointed system of care in which they exist. The fact is that our current system fails at affording all individuals high quality, equitable, patient-centered care. This affects all consumers and patients but likely affects the dual eligible population exponentially, due to their high utilization of care and circumstances that impact their health.

The Task Force has long held that the best way to improve equity, quality, and patient-centeredness is by advancing the adoption of value-based care models that create provider accountability for the cost and quality of care. It is the belief of the Task Force's membership that value-based care and payment approaches that transform care delivery should be designed to improve outcomes for the most vulnerable populations, which will in turn create a system that provides the highest quality and efficient care for all consumers. Thus, while the questions posed in the RFI specifically relate to the dually eligible beneficiary population and their unique

challenges, we hope that our comments are received in the context of strategies that will improve the system overall. We must also acknowledge the critical need for improved communications between CMS, states, and health plans to facilitate high quality care delivery for this population.

## Addressing the Needs of the Most Vulnerable via Value-Based Care and Payment

The challenge for dual eligible beneficiaries is straightforward: Medicare and Medicaid operate as separate programs. The different coverage and payment policies across these two programs leads to cost shifting that often results in inappropriate utilization (both underuse and overuse), and uncoordinated and fragmented care, all of which lead to high costs and poor outcomes.[1] To improve coordination, the Task Force recommends looking to the findings and lessons learned from the Financial Alignment Initiative (FAI) demonstration.

Critical to addressing the challenges faced by the dually eligible population is fixing the inconsistency in payment strategies between Medicare and Medicaid. This includes "lesser-of" payment policies which lead to providers receiving lower reimbursement when serving a dually eligible patient, compared to one who is a Medicare-only beneficiary; and allowing states to not cover Medicare cost-sharing if the Medicaid payment rate for a service is lower than the Medicare payment rate.

A recent Health Affairs article noted that these policies are associated with reduced access to primary care, which results in dually eligible beneficiaries not having access to care coordination and a medical home for their needs. The authors concluded that as payment policies for Medicare and Medicaid evolve in recognition of what is needed to incentivize equitable patient-centered care, so too should policies related to payment for dual eligible beneficiaries. **The Task Force urges Congress to support innovative payment and care delivery models that address the interplay between Medicaid and Medicare payment policies and reduce confusion and disruption for patients**. We urge this to occur through the development of a national payment and care delivery strategy, reflecting the structure and mission of the *Program of All-inclusive Care for the Elderly* (PACE) model, which currently is an optional benefit at the state level, making it inconsistently available to all dually eligible beneficiaries.

A national strategy would be comprised of 1) making programs like PACE a national standard (as opposed to the current environment in which a state has the option not to offer it); 2) include FMAP funding so that state Medicaid agencies can more easily transition; and 3) adequate Medicare reimbursement to encourage providers to participate in new and innovative models. One innovative design would be to develop a truly integrated ACO model and provider-sponsored Medicare Advantage plan that manages the care and costs of dually eligible beneficiaries. A step in this process would be for Congress to hold hearings, and allow providers with successful experience caring for dually eligibles to demonstrate their effective models.

Other components that are recommended for consideration in development of a national strategy include:

- Applying successful practices employed by Medicare Advantage D-SNPs for coordinating payment and care for dually eligible beneficiaries;

[1] Improving Care for Individuals Dually Eligible for Medicare and Medicaid: Preliminary Findings from Recent Evaluations of the Financial Alignment Initiative, the Commonwealth Fund, November 2019

- Expanding PACE. To qualify for PACE currently, a person must be age 55 or older, live in a PACE service area, and be certified by the state to need a nursing home level of care. PACE is an example of a truly integrated model; thus, by adding states and communities into the current model, and expanding the eligible population to include other dually eligible beneficiaries beyond those who are nursing home eligible, outcomes and value could be significantly improved for dually eligible beneficiaries;
- Identifying which benefits and services are being underutilized by dually eligible beneficiaries and establishing policies that specifically support strategies to achieve appropriate utilization (ideally within the context of a national strategy as described above); and
- Identifying successful practices emerging from the Medicare Advantage Value-Based Insurance Design (VBID) demonstration, that may be applicable to dually eligible beneficiaries.

## Improving Coordination Between State Medicaid Agencies, Plans, and Medicare

The burden of having to navigate two separate programs is felt most severely by dually eligible beneficiaries who are not enrolled in either a Fully Integrated Special Needs Plan (FIDE - SNPs) or a Highly Integrated Special Needs Plan (HIDE-SNPs). FIDE and HIDE SNPs have developed innovative systems to integrate Medicare and Medicaid care delivery for the most vulnerable among the dually eligible, but at a national level fewer than ten percent of dually eligible beneficiaries are enrolled in an integrated health plan.[2]

Currently, inconsistent state processes make it difficult to clearly identify and support beneficiaries with partial dual eligibility. For example, the frequent occurrence of eligibility review for partial duals can impact enrollment and status changes which in turn can impact benefits and/or enrollment in D-SNPs. **For this reason, the Task Force recommends limiting reviews of eligibility for partial dual status to no more than one time annually.**

Another example of inconsistency is reflected in how different states define criteria for eligibility categories for Medicaid assistance, and how these may not always align with CMS' defined categories for partial dual eligibles. For example, the QMB-only category is inconsistently categorized as either full or partial, depending on the state. **The Task Force recommends better alignment of qualifying eligibility categories by encouraging better consistency across states. Congress should work with CMS and states to define a universal grouping that allows plans to consistently identify partial dual eligibles and full-benefit dual eligibles; we believe this will drastically reduce inaccurate enrollment errors**. In addition, states also should be required to provide an eligibility crosswalk-translation. This translation should align with MMR data reported to CMS. We refer to this issue as well in the next section on improving data collection.

Integrated care is the ultimate goal for any healthcare model. True integration exists when the provider has accountability for the total cost of care and the outcomes for both Medicare and Medicaid funding, addressing the total needs of the patient — including clinical, social, and behavioral — with a comprehensive plan of care. Integration can refer to financial integration (in which the provider has accountability for total cost of care and outcomes for both

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[2] MedPAC June 2021 Report, Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans

Medicare and Medicaid funding) and clinical integration (in which there is one comprehensive care plan that addresses patients' medical and social needs). PACE offers the best example of both financial and clinical integration, in that it establishes a three-way contract between CMS (Medicare), the state (Medicaid) and the PACE program (Provider). Under this arrangement, PACE not only coordinates all care needs and benefits under both Medicare and Medicaid, but is also able to integrate financial, clinical, and social needs under the direction of an Inter-Disciplinary Team (IDT). It does this under a capitated, 100 percent full-risk method. Traditional Medicare and Medicaid models operate separately under different coverage and payment policies that lead to cost shifting, which then results in inappropriate utilization and poor outcomes. Only through an integrated network can those risks are mitigated if not eliminated. Care coordination is certainly important, but only one piece of integrated care.

Concurrent with recommending use of the PACE method to improve coordination, the Task Force recommends Congress pursue the following:

- Encourage CMS to provide educational opportunities and forums to support state partners in understanding D-SNP and CMS requirements and policy changes;
- Require all state Medicaid agencies to have a Medicare and dual eligible subject matter expert as well as ombudsman program representatives with knowledge about PACE and other Special Needs Plans;
- Require increased, consistent, and regular communication between CMS, states, and plans offering D-SNPs; and
- Address the lack of alignment between CMS regulatory requirement timelines and the D-SNP contracting process.

## Improving Data Collection to Support Improving Care for Dually Eligible Beneficiaries

The Task Force believes that the health care system as a whole must be designed to ensure that patient diversity is taken into account; this applies to the dually eligible population as well as all consumers. CMS currently stratifies measures based on dual eligibility status. Beyond that, **our members recommend that CMS strive to stratify clinical data within the dual eligible population itself based on race, ethnicity, language, and other social and economic variables, and social drivers of health.** Doing so requires a comprehensive system of person-level data collection. Many of the Task Force's payer and provider members are already collecting granular patient-level data and going beyond CMS' requirements as finalized in the CY 2023 Medicare Advantage and Part D Final Rule. However, there is concern about the lack of standardized data. **We strongly recommend that standardization techniques be applied on the receiving end of the data**, i.e. that CMS develop standardization algorithms that can be applied to data received from MA plans and from providers. CMS should also look at ways to improve the use of data that the agency collects directly from beneficiaries during the application and renewal process for both Medicare and Medicaid. This would involve supporting states' Medicaid agencies in the process.

The Task Force is also concerned by the lack of consistent use of eligibility categories across states and CMS, which can lead to a lack of continuity of coverage, care coordination, and coordination between the plan, the state, and beneficiaries. Congress should work with CMS, states, and health plans to identify opportunities for data consistency and information sharing specifically related to the dually eligible population.

Finally, the Task Force previously recommended that CMS should prioritize measures with identified disparities in treatment or outcomes for selected social or demographic factors. This could be captured by looking at measures of incidence and outcomes in diabetes, hypertension, obesity, asthma, and heart disease.

## Minimizing Disruption for Beneficiaries

Minimizing disruption for beneficiaries requires ongoing communication and engagement at both the payer and provider levels. Any changes to the ways in which dually eligible beneficiaries access care will require CMS to develop communications materials, and accompanying guidance for how payers, providers, and other beneficiary-facing organizations use these materials to convey the changes to beneficiaries and their caregivers, and respond to their questions. **We urge Congress to explore best practices in consumer education and engagement, particularly for vulnerable populations, which may require additional communication modalities, as well as longer and more consistent communication channels.**

The Task Force believes it is essential that states provide plentiful, widely accessible, and robust assistance to Medicaid beneficiaries and their families as they explore the public and private programs available to them, navigate eligibility and enrollment requirements, and weigh other factors that affect their ability to live independently. Unfortunately, the current environment is one in which beneficiaries receive inconsistent options counseling. **The Task Force recommends the establishment, for dually eligible beneficiaries, of a strong Ombudsman service that provides options counseling in a timely and continuous manner so that critical information is available when decisions for enrollment need to be made**. Further, a comprehensive, competent, and conflict-free options counseling program would promote and protect the interests of consumers, caregivers, providers, policymakers, and taxpayers. Awareness, understanding and an ability to fully explain PACE and/or D-SNPs as an option is critical to the options counseling requirement.

## Importance of Building Upon the Current System

The Task Force recommends building upon the current systems in place rather than starting from scratch. While starting over may seem attractive at the outset, any effort to replace a current system with entirely new policies, regulations, and infrastructure will overwhelm the already overburdened and understaffed workforce that serve the dual eligible population. The concern is that dual eligible beneficiaries, who are already vulnerable, will pay the price.

**Rather than build a new system, the Task Force recommends building upon the existing PACE model of care**. The U.S. Department of Health and Human Services issued a final report in September of 2021 titled "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care," which included findings such as full-benefit dual eligible beneficiaries in PACE are significantly less likely to be hospitalized, to visit the Emergency Department (ED), or be institutionalized, while their mortality risk is not significantly higher, compared to regular MA enrollees. This is possible because PACE is designed to enroll people who have frailty levels qualifying for nursing facility care, but who are treated at home as long as possible. In addition, data from the National PACE Association shows the following:

- *Lower Hospitalization Rate*: A 24 percent lower hospitalization rate than dually eligible beneficiaries who receive Medicaid nursing home services.

- *Decreased Rehospitalizations*: 16 percent less than the national rehospitalization rate of 22.9 percent for dually eligible beneficiaries aged 65 and over.
- *Reduced ED Visits*: Less than one emergency room visit per member per year.

The Task Force recommends that Congress pursue the following actions to improve upon the current system:

- Make PACE a mandatory benefit for all states;
- Apply the best features of PACE — specifically as they relate to full financial and clinical integration for patients attributed to ACOs and for those enrolled in Medicare Advantage — to other models;
- Continue with Congressional and Administrative actions to make D-SNPs permanent while also mandating additional levels of coordination in areas such as the grievance and appeals process; and
- Test Medicaid-Medicare Plan (MMP) demonstrations and implementing new state flexibilities to improve enrollee experiences in D-SNPs.

## Expansion of Access to Supplemental Benefits

Related to building upon the current system is the importance of expanding eligibility for supplemental benefits beyond the current requirements. Supplemental benefits, and more specifically, Supplemental Benefits for Chronically Ill (SSBCI) can improve beneficiaries' health outcomes, and simultaneously serve to reduce their need for higher cost care and subsequent potential to "spend down" into Medicaid. Supplemental benefits such as nutrition support and transportation are both shown to improve overall health by making it more feasible for beneficiaries to access needed care and to comply with their care protocols. **The Task Force recommends that Congress do what is necessary to increase access to supplemental benefits by working to provide plans with the ability to add "social need" to the factors that are used to determine eligibility for these benefits.** We also recommend and encourage CMS to support the proposed Addressing Social Determinants in MA Act of 2021 (H.R. 4074) which would enable health plans to offer certain supplemental benefits that are currently only available to beneficiaries who are chronically ill, have socioeconomic risk factors or are low income.

## Role of Geography in Dually Eligible Coverage

**The Task Force strongly recommends that there be continuous assessment of the extent to which dually eligible beneficiaries have access to telehealth**, and the underlying broadband necessary to access care regardless of geographic location. We also urge Congress to address several issues – which apply both to rural and to underserved urban locations – including the lack of providers and smaller-than-necessary networks, and the need for supplemental benefits and flexibility in provision of non-clinical benefits such as transportation.

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The Task Force appreciates the opportunity to advise Congress on opportunities to improve the provision of care for dually eligible beneficiaries, and advance our shared goals of creating a high quality, equitable, and efficient health care system for all. Please contact HCTTF Senior Director Tanya Alteras (Tanya.Alteras@hcttf.org) with questions or follow up regarding these comments

## ABOUT HEALTH CARE TRANSFORMATION TASK FORCE

Health Care Transformation Task Force is a unique collaboration of patients, payers, providers and purchasers working to lead a sweeping transformation of the health care system. By transitioning to value-based models that support the Triple Aim of better health, better care and lower costs, the Task Force is committed to accelerating the transformation to value in health care. To learn more, visit **WWW.HCTTF.ORG**.

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