mhpa Medicaid Health Plans of America

Submitted via email: dualeligibles@cassidy.senate.gov

January 20, 2023

The Honorable Bill Cassidy, M.D.
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tom R. Carper
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Robert Menendez
Member of Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

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

Dear Senators Cassidy, Carper, Scott, Warner, Cornyn, and Menendez:

The Medicaid Health Plans of America (MHPA) appreciates the opportunity to respond to your Request for Information (RFI) to support efforts to improve coverage for individuals that are dually eligible for Medicare and Medicaid. We applaud this important initiative to address the complexities of providing care for this population and that considers the diversity of their needs, the variability across states to support their care, and the different financial incentives that drive health system behaviors on outcomes and efficiencies.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 130 managed care organizations (MCOs) serving more than 49 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA's members include both for-profit and non-profit, national and regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost- effective, and quality health care for Medicaid beneficiaries.

MHPA supports the delivery of care for dually eligible individuals that is coordinated, integrated, and aligned in furtherance of quality care and better outcomes. We encourage approaches that increase value to the health care system through more effective use of public resources and the elimination of silos that create care fragmentation. Dually eligible individuals have considerable

medical and non-medical needs and experience high rates of chronic illness, with many having multiple chronic conditions and/or social risk factors. About half of the dually eligible population use long-term services and supports. Compounding the challenges of meeting their health and social needs are the complexities inherent in having accountabilities split between two programs and often multiple payers. We support this RFI as a critical step forward toward improving the quality of care and the care delivery experience for dually eligible beneficiaries.

Our responses to select questions follow.

Question 1. How would you separately define integrated care, care coordination, and aligned enrollment in the context of care for dually eligible beneficiaries? How are these terms similar and how are they different?

Integrated care, care coordination, and aligned enrollment are all important aspects of improving care for dually eligible beneficiaries. Definitions and considerations for each of these terms in the context of care for dually eligible beneficiaries are as follows:

Integrated Care

Integrated care for dually eligible beneficiaries is the delivery of highly coordinated health benefits across the full continuum of services and care needs from an operational level. This includes Medicare and Medicaid programs working alongside private plans to provide a unified approach to accessing benefits, administering processes, and coordinating services across a single network of contracted providers. Integrated care supports a seamless beneficiary experience, promotes continuity in care, reduces care gaps, improves health outcomes, and avoids duplication of services for more cost-effective care.

Considerations

- The Centers for Medicare & Medicaid Services (CMS) encourages states to provide integrated care, which they define as "provid[ing] the full array of Medicaid and Medicare benefits through a single delivery system in order to provide quality care for dual eligible enrollees, improve care coordination, and reduce administrative burdens."[1]
- In many instances, the dually eligible population must navigate an uncoordinated set of benefits, eligibility criteria, providers, and cost-sharing requirements. This fragmentation can lead to stress for the individual and their caregivers, poorer health outcomes, and individuals receiving incomplete care in inappropriate settings. Integrated care is vital to avoid the consequences of fragmented care.
- Given the heterogeneous demographic characteristics and complex care needs of the dually eligible population, integrated care models that incorporate both medical and social needs are critical.

[1] Integrating Care | Medicaid

- Studies should continue to consider the impact of integrated care on lowering costs and improving health outcomes, looking at how integration addresses duplicative and unnecessary services, ensures members receive the care they need when they need it, and can lower hospitalizations and readmissions for enrollees.
- Financial savings resulting from more efficient and better integrated care can potentially accrue primarily to acute care expenditures on the Medicare side,[2] so any new federal policies designed to promote more Medicare and Medicaid integration should include a mechanism for incentivizing or sharing savings with states on the Medicaid side.
- Working towards integrated care will include actions that encourage Medicare and Medicaid to work together (e.g., data sharing to promote transitions of care, contracting methods that facilitate Medicare and Medicaid plan engagement, integrated Medicare, and Medicaid member materials).

Care Coordination

Care coordination is the combined efforts of a patient's payers, health care and social services providers, and community-based organizations (CBOs) to organize and effectively coordinate their services and supports to deliver the best possible care to that patient.[3] Care coordination promotes awareness and communication between payers and providers with respect to the services and care activities delivered to a beneficiary and helps ensure that needed services for the beneficiary are being provided in a manner that decreases gaps in care and reduces duplicative or unnecessary care. Care coordination can be defined at the patient level or plan/provider level.

- **Care coordination at the patient level.** Patient-facing care coordination employs a care management team or interdisciplinary care team model that removes the responsibility from the member to contact two separate Medicare and Medicaid plans. The plan initiates outreach and engagement on a member's behalf to assist with navigation of both programs.
- **Care coordination at the plan/provider level.** Plan and provider level coordination requires a seamless partnership of all stakeholders including the sharing of information in a two-way exchange. When care is not coordinated, there may be disruptions due to non-parallel processes, time frames, and requirements. Care coordination should include information sharing through a single data exchange system that contains all relevant information to facilitate coordinated care.

Considerations

- Person-centered care is vital for efficient and culturally competent care coordination. As defined by CMS, person-centered care is "integrated health care services delivered in a

[2] MACPAC Report. March 2021. Chapter 4: Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations. Available at: https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-4-Establishing-a-Unified-Program-for-Dually-Eligible-Beneficiaries-Design-Considerations.pdf.

[3] https://www.ahrq.gov/ncepcr/care/coordination.html

setting and manner that is responsive to the individual and their goals, values, and preferences, in a system that empowers patients and providers to make effective care plans together."[4]
- To assist in delivering person-centered care, an individual's care manager specifically tailors the care plan to meet the individual's needs while accessing both Medicare and Medicaid benefits. This improves both the care experience and health outcomes for members. Additionally, this coordination lowers costs by removing duplicative and unnecessary services and ensuring that members receive the care they need when they need it.
- Health risk assessments (HRA) are a valuable tool for providing an individualized assessment of needs and should be incorporated into the development of a care plan for any dually eligible beneficiary. HRAs are required for care delivered for dually eligible individuals through integrated programs and D-SNPs while dually eligible beneficiaries in traditional Medicare Advantage or Fee-for-Service (FFS) Medicare may not receive an HRA.

Aligned Enrollment

Aligned enrollment is an arrangement in which a dually eligible beneficiary receives Medicare and Medicaid benefits through the same organization or closely related organizations that use the same network of contracted providers. Aligned enrollment occurs when a dually eligible beneficiary enrolls with the same organization for both D-SNP (Medicare Advantage) and Medicaid. Aligned enrollment can occur organically or through state requirements.

More specifically, federal regulations define aligned enrollment as "the enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization."[5]

Considerations

- Medicaid benefits for dually eligible individuals are often administered across multiple programs and organizations in a state or may be administered exclusively through a FFS program for some or all dually eligible beneficiaries. Aligned enrollment in these instances is difficult to define and the value will vary for each individual depending on what Medicaid benefits are most meaningful to them. Beneficiaries often do not understand how these plans work together and it can be very confusing and uncertain for the beneficiary.
- One of the challenges faced by Medicare-Medicaid Plans under the Financial Alignment Initiative was relatively low rates of participation. More consideration needs to be given to how to increase the number of beneficiaries enrolled in aligned Medicare and Medicaid

[4] Person-Centered Care | CMS Innovation Center
[5] 42 C.F.R. § 422.2

managed care programs that offer integrated benefits. There are tools such as default and passive enrollment that can facilitate enrollment of a portion of the population that ordinarily would not be reached. To meet the policy goal of expanding access, it's important that states can leverage both brokers and facilitated enrollment in their efforts to include individuals that have not taken action to select a coverage option.

- The Medicaid and CHIP Payment and Access Commission (MACPAC) published a report that provides an overview of recent studies examining the effects of integrated care on Medicare and Medicaid spending and outcomes for dually eligible beneficiaries.[6] Data on outcomes of models that align enrollment is somewhat limited and additional studies could help inform future policy considerations.

Question 2. What are the shortcomings of the current system of care for dual eligibles? What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?

A joint federal-state program like Medicaid can be operationally challenging for both states and health plans, as states have varied populations and approaches to providing health care for dually eligible populations. Some key challenges and recommendations include:

Medicare-Medicaid: Programmatic Differences

Different types of dually eligible beneficiaries receive different levels of Medicaid assistance. A total of 12.2 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2019.[7] A majority of beneficiaries (71 percent)[8] were full benefit dual eligibles, making them eligible for full Medicaid benefits, and the remainder were partial duals, eligible only for Medicaid assistance with Medicare premiums and sometimes cost sharing.

Several fundamental differences in the Medicare and Medicaid programs present challenges for integration. Medicaid is a state-federal partnership, meaning that it is administered by states and funded by both federal and state dollars. Because the program is driven by states, the benefits provided under Medicaid vary across the nation. Conversely, Medicare is a federal program, making it fairly uniform from state to state in terms of who qualifies, and which benefits are available. Due to these structural and programmatic differences, there are administrative, operational, and regulatory misalignments between Medicare and Medicaid that need correction to make it feasible for states and health plans to reach higher levels of integration. Foundational program attributes like separate financing, differences in eligibility and benefits, redundant and

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[6] Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps : MACPAC

[7] MedPAC/MACPAC. Databook: Beneficiaries dually eligible for Medicare and Medicaid. February 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf.

[8] MedPAC/MACPAC. Databook: Beneficiaries dually eligible for Medicare and Medicaid. February 2022. Available at: https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf.

sometimes conflicting administrative requirements, primacy of payer and cost shifting, can all hinder integration.

Furthermore, enrollment periods and processes often conflict between Medicare and Medicaid which can cause confusion along with misaligned coverage months and waiting periods for dually eligible individuals.

Medicare-Medicaid: Lack of Benefit Harmonization

The dually eligible population typically experiences complex medical and social needs that require a highly coordinated set of services to manage their conditions. Given the complexity and variability of needs, accessing a wide range of services and supports can be confusing to coordinate and navigate. Dually eligible individuals often live with functional limitations, unmet behavioral and social health needs, and literacy challenges, thereby increasing the difficulty of managing stress. Some dually eligible individuals also face housing insecurity and struggle to access healthy foods. When left to navigate confusing and complex program rules and to coordinate care benefits on their own, beneficiaries can experience incomplete care in inappropriate settings and worse health outcomes.

Most dually eligible beneficiaries are still navigating two separate programs and experiencing fragmented care because they are **not** enrolled in integrated care plans or models.

- Nationally, **less than 10%** of all beneficiaries who are dually eligible for Medicare and Medicaid are enrolled in an integrated health plan.[9]
- Some states require legislative and/or regulatory approval for policy changes to promote integration, such as removing LTSS carve-outs.

Harmonizing the state-centric Medicaid benefits with the more uniform Medicare benefits can present challenges. Neither Medicare or Medicaid was designed to address the complex social and medical issues often faced by dually eligible beneficiaries, nor were the programs designed to easily work with one another. Because Medicaid and Medicare generally serve beneficiaries with different needs, the processes, procedures, and even benefits vary. When state-specific requirements are overlaid, it can be very costly and resource-intensive for even sophisticated entities to design plans that allow dually eligible beneficiaries to understand and easily access care.

Data Availability

The exchange of data between plans, states, and CMS to facilitate both enrollment and care delivery is often limited or lacking. Not receiving updated and accurate data creates challenges for health plans to use in bids, benefit design, member enrollment, and outreach. Utilization data and historical diagnosis data includes distinctive qualifiers that a member may have, which enables plans to reach out in a timely manner, positively impacting member care. Improved demographic

[9] https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf

and clinical data -- and the interoperable exchange of that data -- is critical for administrative efficiencies and delivery of quality care. Additional toolsets, technical assistance, and the creation of a standardized information system for states to utilize could improve communication between states and the federal government, as well as assist plans in addressing enrollees' social needs to better inform care, remove barriers to care and healthy living, reduce disparities, and advance health equity.

State Resources and Workforce Bandwidth

Many states do not have the capacity and the expertise to prioritize integration efforts. The unwinding of pandemic related programs also continues to challenge state workforce bandwidth. We believe that federal support for states, including financial and technical resources, would help address the challenges of administering programs for the dually-eligible.

- ***Recommendation: Improving coordination and integration between the Medicare and Medicaid program via education and technical Assistance***

  While states continue to rely on CMS for education and technical help regarding Medicare rules and regulations, it is critical that states feel empowered to design and implement fully integrated programs should this be a federal policy priority. CMS currently offers technical assistance to states, but there is ample opportunity for federal policymakers and other stakeholders to further invest in long-term educational opportunities for state Medicaid directors and agencies. For example, helping states fund a Medicare-focused full-time employee will signal to other providers, beneficiaries, and CBOs that states are willing to make serious investments in long-term integration.

Question 11. How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?

Geography can have significant implications for the delivery of care to dually eligible beneficiaries with specific challenges related to urban areas and rural and sparsely populated areas.

Urban Settings

Urban areas are often not designed in ways that are sensitive to the needs of seniors and/or people with disabilities. Local partnerships to enhance livability of these communities or provide extra support to navigate care and services would be helpful for the dually eligible population. Community navigator roles within the care model often become critical in many cases as well. There are generally more community resources available in urban areas, and transportation is often more readily available, but these resources are often more complex and less intuitive and may require assistance for members to access. It may also be important for urban providers to furnish additional benefits to assist with the inflow of aged and/or disabled patients,

such as meeting patients curbside for their appointments, or creating parking with easy access to ramps or elevators. Dense urban areas may also have more aged and/or disabled members living in multi-family units in older buildings; additional considerations to ensure the adequacy and appropriateness of living situations may be more necessary than in rural areas.

Rural and Sparsely Populated Areas

About 15% of the U.S. population lives in a rural location.[10] Residents in these less populated areas often face additional barriers that limit their access to health care services. Necessary services are not always available and other issues such as internet access, transportation, financial limitations, health care literacy, and a lack of trust can widen the gap. On average, rural counties have four times fewer specialists per capita than urban areas.[11] Other services such as behavioral health, maternity care, substance use disorder treatment, oral health, hospice, and palliative care may also be reduced as compared to urban and suburban areas. Consistent access to health care continues to be a challenge across populations and geographies.

Twenty-one percent or 2.6 million dually eligible individuals live in rural areas. Based on these numbers, the dually eligible population residing in rural communities accounts for about 5 percent of the total rural population. A recent study indicates that the age-adjusted gap in death rates between urban and rural dually eligible individuals 65 and older doubled, from 9.7 per 1,000 to 19.9 per 1,000, from 2004 to 2017.[12]

According to ATI Advisory, half of all dually eligible beneficiaries (and one quarter of rural dually eligible beneficiaries) have access to a meaningfully integrated health plan product, though only seven percent are enrolled in one. Integrated plan options should be available for all dual beneficiaries.[13] States are at different stages of integrating care for their dually eligible populations. For example, a few states, such as Arizona, Idaho, and Tennessee, have maximized their Medicare Improvement for Patients and Providers Act (MIPPA) authority and are providing fully integrated care. Other states, such as North Dakota, do not have D-SNPs, and no other integrated options are available. Variation in how states exercise MIPPA authorities may also reflect variations in state capacity and competing priorities.

Addressing the specific challenges that rural dually eligible beneficiaries face will involve additional resources to address and invest in social isolation prevention, housing, assistive technology, broadband, and the direct care shortage. Some considerations include:

[10] Healthcare Access in Rural Communities Overview - Rural Health Information Hub
[11] Rural Health State Stats (healthcarevaluehub.org)
[12] Advancing Health Equity And Integrated Care For Rural Dual Eligibles | Health Affairs
[13] A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf (atiadvisory.com)

- ***Healthcare Workforce***

  A key challenge to effective dual eligible coverage is the healthcare workforce. Provider shortages can overburden the health care workforce and pose a significant challenge to meeting population health needs. For example, as more mental/behavioral health professionals move away from insurance-based payment, we remain concerned about having enough contracted professionals to meet the growing needs of the dually eligible population, particularly in rural areas where providers are already sparse. In addition, a recent Kaiser Family Foundation study found that nearly every state reported a home and community-based workforce shortage in one or more HCBS setting for 2022.[14]

  To mitigate the effects of provider shortages, MHPA recommends taking steps to encourage investments in and augmentation of the health care workforce. We also believe that ensuring fiscal soundness and sustainability of health care programs encourages and supports provider participation and is critical to supporting access to services. States should also be encouraged to consider removing barriers to family members being allowed to serve as paid caregivers.

- ***Telehealth***

  Improving access to broadband services can help address the digital divide and promote health equity, particularly for rural communities. Technology, specifically telehealth, is an important avenue for facilitating the patient-provider connection. We encourage solutions for increasing access to broadband internet services and smart-enabled devices for dually eligible beneficiaries and recommend support for the continued coverage of telehealth services. One solution to this challenge would be to establish permanent coverage of telehealth services beginning with making the telehealth waivers enacted to address the COVID-19 public health emergency (PHE) permanent. Specifically, we recommend permanently waiving geographic and originating-site limitations for telehealth and permanently removing the in-person requirements for mental health services furnished through telehealth. Telehealth services provide an important opportunity to assist dually eligible beneficiaries in rural areas with transportation or mobility challenges.

- ***Behavioral Health***

  Rural areas experience a lack of access to the full range of behavioral health care services, challenges with mental health care workforce recruitment and retention, and technology barriers impacting telehealth visits.[15]

[14] Watts, et. al., KFF: Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey, November 2022. Available at: https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/

[15] Mack B., et al., National Rural Health Association, Policy Brief, “Mental Health in Rural Areas,” February 2022. Available at: https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Mental-health-in-rural-areas-

In additional to technological solutions and workforce investments, the relaxation of supervision requirements for licensed professional counselors, licensed marriage and family therapists, and other mental health professionals who provide services incident to a physician as part of the primary care team could support access to behavioral health services via strengthened primary care management of behavioral health conditions. We believe the provision of services by an expanded team of licensed behavioral health professionals can support timely access to care.

- ***Network Adequacy Flexibilities***

  We also encourage Congress, CMS, and health plans to work together to consider additional network adequacy flexibilities to support innovative delivery models that do not rely on traditional time and distance standards (e.g., telehealth). Time and distance standards can be overly prescriptive and limit the ability to serve the 2.6 million dually eligible individuals living in rural areas. We refer you to MHPA's response to the CMS Request for Information (RFI) on Medicaid and CHIP Reform for additional information on network adequacy available here: https://medicaidplans.org/wp-content/uploads/2022/04/FINAL-MHPA-Medicaid-Access-and-EquityPDF.pdf

Once again, MHPA appreciates the Committee's effort to improve coverage for dually eligible individuals. MHPA member plans are committed to working with Congress to ensure dually eligible beneficiaries have appropriate access to care that is aligned to achieving the best outcomes for patient health.

Please feel free to reach out to me directly at sattanasio@mhpa.org with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio
Vice President, Government Relations and Advocacy

policy-brief-2022.pdf; see also, Centers for Disease Control and Prevention. "Anxiety and Depression: Household Pulse Survey". https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm.