SNP Alliance

Working to Change Policy and Practice for High-Risk Beneficiaries

SNP Alliance Response: Bipartisan Dual Eligible Beneficiaries RFI

January 12, 2023

Senator Bill Cassidy, M.D.
520 Hart SOB
Washington, DC 20510

Senator John Cornyn
517 Hart Senate Office Bldg.
Washington, DC 20510

Senator Mark R. Warner
703 Hart Senate Office Building
Washington, DC 20510

Senator Tim Scott
104 Hart Senate Office Building
Washington, DC 20510

Senator Thomas R. Carper
513 Hart Senate Office Building
Washington, DC 20510

Senator Robert Menendez
528 Hart Senate Office Bldg.
Washington, DC 20510

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

The Special Needs Plan (SNP) Alliance is a national, non-profit leadership association addressing the needs of high-risk and high-cost populations through specialized managed care. We represent 26 health plans offering over 550 plan benefit packages (PBPs) and 175 contracts through SNPs and Medicare-Medicaid demonstration plans (MMPs). SNP Alliance plans have over 2.75 million beneficiaries enrolled in 47 states and the District of Columbia—totaling nearly 55% of the national SNP and MMP enrollment. Our primary goals are to improve the quality of service and care outcomes for complex populations and to advance integration for those dually eligible for Medicare and Medicaid. The SNP Alliance appreciates both the focus of this bipartisan group of Senators on this critical, and often overlooked, issue, as well as the opportunity to provide feedback on this congressional RFI on dual eligible beneficiaries.

Integrated Medicare and Medicaid D-SNP programs for dually eligible individuals have been in existence for over 25 years, with investment from Congress, plans, and states in the hundreds of millions, if not billions. While there is good evidence that integrated programs are beneficial for the dually eligible population, fully integrated programs are not widely available—resulting in limited access and low enrollment. Barriers to integration persist, including confusing choices between multiple competing programs, state administrative and political obstacles to Medicaid managed care programs, carve outs of key services, and lack of state expertise and resources. Further, multiple uncoordinated regulatory and policy silos for Medicaid and Medicare within the Centers for Medicare & Medicaid Services (CMS) result in continued misalignment of incentives between the programs. While Congress created the Medicare-Medicaid Coordination Office (MMCO) to move integration policy forward, MMCO still lacks clear authority over many of the policy, operational and technical processes needed to establish integrated programs and to address these issues.

Following SNP permanency established in the Bipartisan Budget Act of 2018 (2018 BBA) and implementation of its integration requirements for D-SNPs, more work is needed to further advance integration and align enrollment through the D-SNP platform to simplify access for dually eligible

individuals. The SNP Alliance firmly believes building off the D-SNP model and platform is the best way forward. Eliminating the D-SNP model and platform and creating a new program would be a mistake, setting back the great strides already made to improve services for the 4.5 million dually eligible individuals enrolled in D-SNPs in 47 states, and would disproportionately harm a population that is already vulnerable.

The SNP Alliance is pleased to share our perspective and longstanding expertise on policies and technical and operational improvements that can increase access to integrated care as well as improve the level of integration achieved through these D-SNP/state partnerships. As described below, there are key legislative and regulatory modifications necessary to facilitate closer partnerships between DSNPs and states to enable them to reach their full integration levels and capacities with the goal of simplifying access and navigation through the complexities of Medicare and Medicaid for dually eligible individuals.

We continue to work toward this goal and stand ready to work with Congress and stakeholders on improving the D-SNP model to further advance integration and align enrollment. The SNP Alliance appreciates your efforts and attention to the dually eligible population. This RFI, and the work and attention that has resulted, will help us move forward in advancing integration for these beneficiaries. We are happy to meet with your offices at any point to discuss the pressing issues impacting the dually eligible population, in addition to offering concrete, practical policy solutions. Please find our responses, on behalf of our 26-member health plans, to your questions below.

Respectfully,

Cheryl Phillips, MD

Cheryl Phillips, M.D. AGSF
President and CEO
Special Needs Plan Alliance
Washington, DC.
cphillips@snpalliance.org
www.snpalliance.org

CC:

Will Dede, MPP
Associate Director
Health Policy
C: (434) 363-5905
wdede@snpalliance.org

Pamela J. Parker, MPA
Consultant
Medicare Medicaid Integration
C: (612) 719-5845
Pparker2@comcast.net

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 Definition:
Integration of Medicare and Medicaid exists on a continuum based on a variety of factors. D-SNPs must have a contract with a state Medicaid agency that outlines the level of integration the state is willing to support. States have the option of not contracting with D-SNPs at all. Presently, there are three categories of D-SNPs (excluding the Financial Alignment Initiative's (FAI) Medicare-Medicaid Plans (MMPs) that are set to end in 2025) integrating Medicare and Medicaid, and are listed below from least integrated to most integrated:

- Coordination-only D-SNPs (CO D-SNPs)
- Highly Integrated D-SNPs (HIDE SNPs)
- Fully Integrated D-SNPs (FIDE SNPs)

The SNP Alliance supports a goal of what we call "Full Integration," which is best represented by the FIDE SNP model. We understand nuances and different factors may not allow for full integration everywhere and all at once, but it's the position of the SNP Alliance that working toward full integration is necessary. We define "full integration" as having the following nine components designed to simplify access to care for dually eligible beneficiaries:

1. **Fully aligned financing, policy direction, and oversight.** Medicare and Medicaid program policy and oversight functions are managed through a federal-state partnership with aligned federal/state authority, roles, responsibilities, and financing including joint contract management teams (CMTs) to facilitate state and federal and plan communications.
2. **Single set of benefits, services, and aligned networks.** Eligible beneficiaries access a fully integrated set of benefits and services that include medical, behavioral health (BH), and long-term services and supports (LTSS) across an aligned Medicare and Medicaid network of providers.
3. **Single source of access and integrated materials.** Eligible beneficiaries are enrolled in the same plan or under the same sponsor (parent company) for benefits and services. They receive a single set of integrated materials that describe a single set of benefits and services that can be accessed through a single source with one enrollment card and a single benefit determination. (Complicated administrative processes are behind the scenes and not readily visible to enrollees.)
4. **D-SNPs as program integrators.** D-SNPs are responsible for administering the full spectrum of Medicaid and Medicare benefits and services for defined subgroups within service areas.
5. **Strong consumer involvement, education, and protections.** Consumer advisory committees are established at state and plan levels to enable involvement in program design and operations. "Choice education" is available so that beneficiaries are fully informed of their plan options, rights, and opportunities, with ample time and support in making enrollment decisions and safeguards for high-risk/high-need beneficiaries. Appeals and grievance procedures for the spectrum of benefits and services are fully aligned.
6. **Risk-adjusted, capitated financing.** Plans are paid through population-based and risk-adjusted, capitated payment methods including all relevant federal and state funds that fully account for risk factors associated with targeted subgroups. All payer, plan, provider, and beneficiary stakeholders have aligned incentives.

7. **Interdisciplinary team approach for high-risk subgroups.** High-risk enrollees have a principal care provider and care coordinator with additional interdisciplinary care team (ICT) members to facilitate access to benefits and services as needs evolve over time and across care settings.
8. **Aligned care delivery systems and models of care (MOCs).** Plans operate under a MOC outlining how delivery of primary, specialist, acute, post-acute and pharmacy services are integrated with BH and/or LTSS, including in-home care around a tailored individual care plan (ICP) developed with the member that evolves with the member's needs. This is supported by integrated information system capabilities, coordinated care transitions and aligned policies and procedures that simplify beneficiary access.
9. **Integrated, appropriate, efficient performance evaluation.** A streamlined set of core quality measures that are meaningful for a complex dual population are used across the Medicare and Medicaid programs. Performance evaluation reporting is linked, and appropriate risk adjustment is applied to ensure accuracy and utility and inform quality improvement.

Care Coordination Definition: Care coordination is integral to serving this diverse population with complex care needs, and strong care coordination is necessary to advancing integration and reaching full integration. Unlike non-SNP Medicare Advantage (MA) plans, D-SNPs must establish a written MOC outlining how Medicare and Medicaid service delivery, individual care coordination, provider training, information sharing, and data collection will be provided and coordinated. The SNP Alliance offers five core components included in the MOCs as part of the definition of "care coordination" for dual eligible beneficiaries:

1. **Interdisciplinary Care Team (ICT):** Care coordination uses an interdisciplinary team approach that coordinates both Medicare and Medicaid service delivery and providers.
2. **Care Coordinator:** The full range of needs are assessed through a principal care provider and care coordinator across both Medicare and Medicaid including LTSS and BH, with additional interdisciplinary team members involved to facilitate access to benefits and services as needs evolve over time and across care settings.
3. **Assessment and Person-Centered Care Planning:** Patient needs from assessments are incorporated into person-centered care plans with involvement of the member, their families and representatives (where appropriate) and direct care givers.
4. **Individual Care Plans (ICP):** Primary, specialist, acute, post-acute and pharmacy service delivery is integrated with BH and/or LTSS and home care around a person-centered care plan that is **tailored to** and **evolves** with the members' needs.
5. **Information Sharing:** Information is shared across all needed medical and non-medical providers and supports, including the member's family, designated representatives, and other caregivers where appropriate.

   Additional information on care coordination models in integrated care is found here.

Aligned Enrollment Definition:
Aligned enrollment, where beneficiaries receive their Medicare and Medicaid services from the same entity (parent organization), is the goal of the SNP Alliance with its inclusion in our definition of "full integration." The comprehensive SNP Alliance definition of "aligned enrollment" is as follows:

- ***Aligned Enrollment:*** *Dual eligible beneficiaries enrolled in a D-SNP receive their Medicaid benefits from the* ***same plan or a Medicaid plan operated by D-SNP's MA organization, the D-SNP's parent organization, or another entity owned and controlled by the D-SNP's parent organization,*** *under arrangements designed to simplify access and Medicare and Medicaid service delivery for dually eligible beneficiaries.*

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?

While the D-SNP model and platform has been a success for integration of Medicare and Medicaid and should be built upon, there are eight primary areas that should be strengthened for further improvement and advancement of integration:

1. Insufficient and unclear Medicare-Medicaid Coordination Office (MMCO) authority.
2. Fully integrated care models (such as FIDE SNPs) are not consistently available throughout the country.
3. Need for states along with plans to develop, submit and implement a strategy for integration to CMS/MMCO based on CMS/MMCO creation of standards and oversight including a menu of flexibilities/pathways as options states can choose for building their integrated programs.
4. Need for additional incentives, funding and expertise for state administration, implementation, and management of integrated programs and for state/federal communications such as joint contract coordination or management teams.
5. Lack of consistent resources and requirements for coordination of and strengthening consumer involvement, protections, communications and choice education through Implementation Councils or consumer advisory committees, Ombudsman and State Health Insurance Assistance (SHIP) programs.
6. Lack of consistent tools for aligned enrollment.
7. Lack of shared savings applicable to D-SNPs for states.
8. Lack of aligned data reporting and measurement alignment.

To address the above issues in the D-SNP model, the SNP Alliance proposes the following nine policy solutions:

1. Congress should clarify congressional intent that MMCO has regulatory and administrative authority over serving dually eligible beneficiaries within CMS.
2. Congress should set a goal for states of making access to fully integrated plan options such as FIDE SNPs available for all dually eligible individuals who choose to enroll.
3. Congress should follow MACPAC recommendations and direct states to submit a state plan amendment, to be submitted to and managed by MMCO, outlining each state's strategy for integrated programs and timelines for implementation. This process should include authorities for MMCO to create a menu of pathways including templates for administrative and operational flexibilities for designing these integrated programs that states can choose and follow in alignment with their current integration status, along with minimum federal standards, oversight and readiness reviews and joint contract management/coordination teams.
4. Congress should provide incentives, funding and expertise for state development, implementation and management of integrated programs including state planning grants, increased FMAP and MMCO resources for oversight and use of joint contract coordination or management teams.
5. Congress should strengthen consumer involvement, protections, communications and choice education by assuring sufficient resources and requirements for state managed care Ombudsman programs, consumer advisory committee or implementation council involvement

and SHIPs in every state and by directing CMS and ACL to work together to create a coordinated approach to assist dually eligible populations with integrated programs access and services.

6. Congress should increase access to FIDE SNPs by allowing D-SNPs with state Medicaid contracts meeting FIDE SNP criteria (including aligned enrollment) serving dually eligible individuals in separate legal entities sponsored by the same parent company to operate as FIDE SNPs.
7. Congress should direct CMS to facilitate aligned enrollment through enrollment tools such as expansion of default enrollment and Medicaid auto-assignment to individuals' D-SNP choices.
8. Congress should direct CMS/MMCO to research and develop shared savings opportunities applicable to D-SNPs for states.
9. Congress should direct CMS to develop and improve core set of measures and tools to accurately capture measurement and data for the dually eligible population.

Please find discussion of the nine policy solutions below.

1. ***Congress should clarify congressional intent that MMCO has regulatory and administrative authority over serving dual eligible beneficiaries.***

   Congress has designated the MMCO to be in charge of integration policy for dually eligible individuals within CMS, subject to oversight from the Secretary. Through the 2018 BBA, Congress provided additional authority to CMS for MMCO responsibilities, but the extent of this authority has been unclear and internal barriers related to CMS silos continue to impede integration.

   Specifically, Congress should clarify its intent that MMCO has authority over programs serving dual eligible individuals and include language that allows MMCO to develop and issue any necessary regulation and guidance related to alignment of policy and operational processes CMS deems necessary for implementation under both Medicaid and Medicare. Congressional clarification of existing statutory authority, followed by CMS' use of this authority, would result in authority for MMCO to align regulations for D-SNPs and Medicaid managed care, and to have rulemaking space that specifically addresses both the Medicaid and Medicare statutory and regulatory requirements for D-SNPs.

   The 2018 BBA integration requirements amended the MMCO responsibilities by adding the following duty to 42 U.S.C. 1315 b(d):

   > (8) To be responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight under the Medicare program under title XVIII of such Act and the Medicaid program under title XIX of such Act regarding specialized MA plans for special needs individuals described in sub- section (b)(6)(B)(ii) of such section 1859.

   We have observed that CMS has not always interpreted this language to allow MMCO to clearly integrate Medicare and Medicaid regulation and policy involving D-SNPs and dually eligible beneficiaries. Many researchers and policy experts have noted the need for additional MMCO regulatory authority over provisions affecting dually eligible individuals under both Medicare and Medicaid in order to align operational and administrative detail to achieve further integration of Medicare DSNP and Medicaid contract provisions.

While MMCO has made important strides in integration policy during 2022, now that the FAI is ending, it is even more obvious that current authority remains siloed. There are administrative, operational, and regulatory misalignments between Medicare and Medicaid that need correction to make it feasible for both plans and states to reach higher levels of integration. These misalignments are often highly technical and not always immediately obvious. Many are related to systems and data sharing mechanisms that need change or improvement and result in administrative burdens and resource barriers to states and plans, some of which might be reduced or avoided with clearer direction and authority from the Secretary and CMS.

Some legislative proposals—that we have supported in general—include provisions for Medicaid state plan amendments for state integration strategies to be submitted to CMS. But these submissions are normally handled by Medicaid, and there is no mention of MMCO authority to oversee or be involved in those proposals. Other examples include unexpected barriers related to MA or Part D provisions that would prohibit joint state-federal review of certain activities or other technical changes that depart from broader MA processes to accommodate working with states and make program operations more efficient.

Additionally, with the pending closure of the FAI demonstration, there has been more concern among states, plans and stakeholders about the loss of some unique FAI features such as shared savings, passive enrollment mechanisms, and care management and quality measurement tailored to specific populations such as younger dual eligible with disabilities and frail elderly at end of life. The SNP Alliance represents both departing MMP plans involved in the FAI and D-SNPs. CMS has asked for input on how certain FAI features as outlined above can be accommodated in the D-SNP platform. We recommend that Congress provide MMCO with authorities to include or adapt some of those features for the D-SNP platform.

To address these issues further, the Association for Community Affiliated Plans (ACAP) has proposed legislation allowing waivers of certain administrative and operational provisions/processes (along with consumer protections) that could be considered as part of the authority clarifications which would permit some additional limited flexibilities for states. CMS could also build on expanded use of 1115A for additional permanent changes including incorporation of certain FAI features into DSNP platform.

2. ***Congress should support making access to fully integrated plan options such as FIDE SNPs available to all dually eligible individuals.***

Despite the long history, development and benefits of models that integrate Medicare and Medicaid, most dual eligible individuals are enrolled in separate Medicare and Medicaid coverage options that do not provide integrated care or care coordination for all services. As a result, these individuals may receive fragmented care, and incentives for their providers and payers to deliver the best care at the lowest cost can be misaligned. Although the number of dual eligible individuals in D-SNPs has grown significantly in recent years, a relatively small percentage, about 12% according to MMCO, are enrolled in programs that fully integrate Medicare and Medicaid.

The 2018 BBA established 3 categories of DSNPs as follows:

Coordination Only (CO D-SNPs). These D-SNPs are required to coordinate Medicare services with Medicaid, but do not have state contracts to provide significant Medicaid services to their

DSNP enrollees. CO-D-SNPs have grown from 218 in 2021 to 481 in 2023 of which 16 have fully aligned enrollments.

Highly Integrated (HIDE SNPs). These D-SNPs are required to have state contracts that provide either BH or MLTSS services or both. The number of HIDE SNPs has grown from 90 in 2023 to 228 in 2023, of which 189 have fully aligned enrollment.

Fully Integrated (FIDE SNPS): These D-SNPs must provide both BH and LTSS services and must also meet additional integration criteria so represent the highest standard of integration under the current regulatory system. The number of FIDE SNPs has grown from 40 in 2021 to 65 in 2023 of which 55 have fully aligned enrollments.

The Program for All Inclusive Care for the Elderly (PACE) is another integrated option which serves around 100,000 enrollees, but due to its design it is not expected to serve the large number of enrollees that D-SNPs already serve. A number of states have both PACE and FIDE SNP options. In addition, I-SNPs and C-SNPs also serve dually eligible enrollees and may offer services specifically tailored to beneficiaries who need skilled nursing facility, assisted living, BH services or specific illnesses such as HIV-AIDs so should be considered and preserved as options for dually eligible populations meeting enrollment criteria.

While there has been considerable growth in the total number of D-SNPs (774), which now serve nearly 4.5 million enrollees, enrollment growth in the HIDE and FIDE integrated programs has lagged (about 140,000 to just under 800,000 between 2021 and 2023). Though D-SNPs are available in most states and there is a large enrollment in Puerto Rico, some states (AK, NV, WY, SD, VT, NH) have little if any enrollment, and FIDE SNPS are available in only 12 states. Concern has grown over the continued lack of access to integrated models throughout the country and there is growing consensus among many policy experts that more changes are needed to ensure that all dually eligible beneficiaries have access to a fully integrated program such as a FIDE SNP.

One important factor reducing the potential for creating more FIDE or HIDE SNPs is that some state Medicaid agencies continue to carve BH and/or LTSS services out of their Medicaid managed care contracts. FIDE or HIDE status requires inclusion of both LTSS and BH (FIDE) or either LTSS and/or BH (HIDE). Therefore, D-SNPs operating in states with "carve out" policies cannot meet those higher levels of integration. Dually eligible beneficiaries are more likely to require a complex mix of services that span preventive, primary, acute, BH, and LTSS. Carving these key services out of the Medicaid managed care programs thwarts the purpose of integration by reducing the potential for improved coordination across providers and multiple settings of care, resulting in more complexity that enrollees then must navigate. **We recommend that Congress support requirements to move towards carving in of BH and LTSS to enable increased availability and access to integrated HIDE and FIDE SNP plan options.**

We also recommend that as Congress further indicates support for making the choice of a FIDE SNP available to all dually eligible beneficiaries, it recognizes that states and thus plans may face challenges in setting deadlines for fully meeting that goal. In addition to the PACE option, Congress should also recognize that CO and HIDE SNPs are important building blocks/steppingstones for plans and states who are at different stages of moving towards such a goal, and thus should be allowed to play that key role as states and plans work to build additional capacity for integration.

Please find additional information on these topics below:

State Contracting with D-SNPs: Introduction to D-SNPs and D-SNP Contracting Basics
Fixing the FIDE-SNP — Redefining 'Fully Integrated'
Guaranteeing Integrated Care for Dual Eligible Individuals
Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans

Special Needs Plans as Leaders: We also refer Congress to the independent report from RAND, commissioned by the U.S Department of Health and Human Services that highlighted four exemplary health plans serving the dually eligible population: Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies.

All three of the featured health plans are special needs plans that developed their care models and acumen in serving the dually eligible effectively over many years. This report offers insights into strategies for integrating care and achieving positive health outcomes. We highly recommend a thorough read when considering how to support these best practices through legislation, policy, payment, and regulation.

3. ***Congress should follow MACPAC recommendations to direct states to submit a state plan amendment to CMS/MMCO outlining their strategy for integrated programs and timelines for implementation***.

Integration of Medicare and Medicaid is highly dependent on partnerships between CMS, states and D-SNPs. D-SNPs cannot on their own accomplish integrated models without state cooperation and involvement. Therefore, **Congress should provide directives to CMS and states to develop integrated programs such as provided in recent MACPAC recommendations for State Plan Amendments (SPAs) to be submitted to CMS/MMCO for implementation of state strategies to advance integration.** These SPAs should be managed by MMCO with involvement of CMS Medicaid staff, but authorities should be clarified that MMCO is the administering entity at CMS for reasons described above.

As part of this proposal, Congress should direct CMS/MMCO and provide them with authorities needed to develop a defined set of pathways/menu of options with certain flexibilities that fit state needs depending on where states are in development, including implementation plans to move to the next level of integration within a timeframe with a goal of creating increased access to FIDE SNPs. Congress should also assure that the administrative structures needed to make integrated programs workable at both state and federal levels are in place. Outside of the FAI (which is ending) there are no clear joint oversight and communication structures available to each state Medicaid agency designed for working with Medicare on integrated managed care programs. Therefore, Congress should also direct CMS/MMCO to develop minimum federal standards, oversight processes, conduct readiness reviews, provide ongoing education and support to states for

managing integrated programs, and assist states in establishing contract management/coordination teams in each state.

Congress could build on current bi-partisan legislative proposals with some important modifications, including addressing the limited authority granted to MMCO in those proposed legislative proposals and provision of funding. In the end, States should be empowered to design and implement fully integrated programs such as the FIDE SNP model to make access to fully integrated models available to any dually eligible beneficiary who chooses to enroll.

4. **Congress should provide FMAP incentives, start-up grants, and access to expertise to states for administration of integrated programs and should provide adequate funding to CMS/MMCO to oversee these integrated programs.**

   Additional resources must be provided to both states and CMS/MMCO if we hope to expand access to integrated programs for dually eligible individuals throughout the country. States consistently cite barriers to integrated programs related to additional resources needed for development and ongoing maintenance of integrated programs, in particular the need for staff expertise and education around Medicare and additional systems changes involved in data collection and sharing. States will require start up grants in order to move to the next steps in integration. Additionally, Congress should provide ongoing incentives for states, such as increased FMAP for maintenance and systems activities needed for integrated programs to assure consistent program management, plan oversight, data sharing, state staff training and participation in ongoing communications with CMS.

   CMS/MMCO and states should also establish modified CMTs responsible for day-to-day oversight similar to that used in the FAI demonstration or the D-SNP based Administrative Alignment demonstration in Minnesota. States involved in the FAI cited the CMTs, which included representatives from states and MMCO, as an essential for ongoing communications between states, MMCO and plans and for avoiding conflicting policy directives to plans. However, while MMCO does work to educate and support state integration, they do not have resources to staff CMTs for all states. Therefore Congress should also provide resources necessary for CMS/MMCO to establish oversight and review processes and contract management/coordination teams with each state for day-to-day operations.

5. **Congress should strengthen consumer protections for consumer involvement, communications, choice education and protection by assuring sufficient resources and requirements for state managed care Ombudsman programs, consumer advisory committee or implementation council involvement for stakeholders at both state and plan levels, and for State Health Insurance Assistance Programs (SHIPs) as part of state integration strategies, and by directing CMS and the Administration for Community Living (ACL) to work together to create a coordinated approach to assist dually eligible individuals with access to integrated programs and services.**

   As stated earlier, Medicare and Medicaid programs are incredibly complicated, and most people have difficulty understanding them let alone those who face complex medical and Social Determinant of Health (SDOH) needs at the same time. A primary goal of integrated programs

should be to simplify access for the consumer as much as possible through stakeholder involvement in program development and design, consumer choice education through SHIP programs to reduce confusion over multiple competing plan choices and assistance with their rights as an enrollee through Ombudsman programs.

Stakeholder involvement has been key to the successful design and implementation of integrated programs at both plan and state levels. Stakeholder involvement through groups such as the Implementation Council was a critical element of the FAI, and CMS has issued new rules for D-SNPs to involve consumer advisory groups for D-SNPs. **Congress should assure that such consumer stakeholder involvement is a requirement for development of additional integrated programs at both state and plan levels and that resources are provided for them to continue.**

Congress should require that each state designate an Ombudsman program to address the needs of dually eligible enrollees of integrated programs and ensure that funding is available for such programs. Ombudsman programs work to resolve problems related to the health, safety, welfare, and rights of individuals. Traditionally States are required to have ombudsman programs for their LTSS populations, but they are not always coordinated with managed care ombudsman services or other services provided through SHIPs or ACL funding activities. LTSS Ombudsman programs promote policies and consumer protections to improve LTSS at the facility, local, state, and national levels and are required to focus on LTSS issues so may not have capacity to take on a focus on dually eligible enrollees in D-SNPs.

Managed care Ombudsman programs serving dually eligible enrollees were a requirement of the FAI demonstration but with that demonstration ending there is no clear provision that they are still required. We believe they should be required as part of any proposal for state integration strategies. While MMPs and some non-FAI states have developed these programs to serve dually eligible members or have combined them with MLTSS managed care ombudsman programs other states have not made funding for these services available. States are currently allowed to receive Medicaid administrative funding for managed care Ombudsman programs but still have to make a significant investment for their share, thus such programs are not consistently or universally available for enrollees of integrated programs. **Congress should ensure that ongoing federal funding with enhanced FMAP is available for administration of robust Ombudsman programs with expertise and capacity to serve dually eligible D-SNP enrollees.**

Equally important is the role that SHIPs can and do play in educating potential enrollees of their Medicare choices and how those may interface with their Medicaid services. Choice education is critical to consumer understanding of the multitude of plan options available to them and SHIPs can provide an independent consumer oriented source of advice beyond brokers who are beholden to either Medicare or Medicaid. However most SHIPs rely on volunteers and may lack resources and training to provide adequate services to fully meet their responsibility for education of dually eligible individuals about the increasingly confusing myriad of choices they face under both Medicare and Medicaid. **Congress should enhance SHIP funding to assure adequate resources for meeting their responsibilities in assisting dually eligible individuals with these complex choices.**

Finally, Congress should direct MMCO and the ACL to work together to coordinate existing and new resources for stakeholder involvement, consumer protections and choice counseling, and to maximize their capacity to address issues specific to dually eligible individuals.

Additional information on these issues is found at the link to the toolkit here.

6. ***Allow D-SNPs with state Medicaid contracts meeting FIDE-SNP criteria serving dually eligible individuals through plans in separate legal entities sponsored by the same parent company to operate as FIDE SNPs when they provide enrollees an integrated consumer experience as outlined in their state Medicaid contract.***

   Language in current FIDE-SNP statutes regarding sponsorship of integrated programs, including FIDE-SNP statutes limiting enrollment to the "same plan" for Medicaid and Medicare is confusing and should be eliminated. The definition of "same plan" is confusing because most FIDE SNPs must have two separate contracts, one with CMS for Medicare and one with a state for Medicaid in order to operate, and most states procure separately for Medicaid services rather than contracting directly with a D-SNP. While D-SNPs Medicare and Medicaid contracts may for various reasons be separated into two different legal entities under the same plan sponsor, that does not dictate their administrative, operational or financial integration features. It is still possible to align administrative, operational and financial activities to integrate care delivery under two legal entities operating under the same parent organization. Medicaid contracts with states establish and dictate FIDE SNP integration status. Therefore, state Medicaid contract requirements can override any paperwork designating separate legal entities, making such a distinction moot. In fact, some FIDE SNP programs operating under the "same plan" definition are actually less integrated (for example, have less aligned enrollment or fewer integrated operational functions) than some HIDE SNPs that are operating two legal entities under the same "parent organization" with higher levels of alignment of enrollments and operations. Since states can and do require additional provisions for a certain level of integrated experience for the enrollees regardless of legal entity status, this "same plan" requirement is ultimately not relevant to the enrollee's experience of coordination of care provided through the D-SNP.

   Specifically, Congress should revise the FIDE SNP definition to remove the requirement for "same plan" under FIDE-SNP statutes and to allow D-SNPs with state Medicaid contracts meeting FIDE SNP criteria serving dually eligible individuals in separate legal entities sponsored by the same parent company to operate as FIDE SNPs when they are able to provide the same level of integrated enrollee experience as a FIDE SNP as outlined in their state contract.

7. ***Direct CMS to facilitate improved aligned enrollment via the default enrollment tool and current Medicaid authorities for assignment to Medicaid plans affiliated with their D-SNP choices.*** Congress should strengthen tools allowed for alignment of enrollment into the same plan sponsor for both Medicare and Medicaid. Most dually eligible individuals are currently not in the same plan sponsor for both Medicaid and Medicare. For example, many are in fee-for-service (FFS) for Medicaid and in a separate Medicare plan or vice versa. A significant number are enrolled plans offered by two different plans/plan sponsors, one for Medicare and one for Medicaid so that

enrollment is not aligned. Unaligned enrollment is also often the result of state procurement policies so may be beyond the D-SNPs control to change.

Unaligned enrollment is confusing to enrollees and incents cost shifting among providers and plans as well as impeding coordination of care. Without aligning enrollment of dually eligible individuals into the same plan sponsor for both Medicare and Medicaid, it is difficult to achieve the full potential of integrated programs. Aside from changes in state procurement policies designed for better alignment and improvements in consumer choice education, the main tools that facilitate aligned enrollment are default enrollment and auto assignment of Medicaid members to Medicaid plans affiliated with their D-SNP choice.

Aligned enrollment, particularly for dual eligible beneficiaries who access Medicaid-only services such as LTSS, allows a single organization to view the whole person across multiple settings and provider types in order to coordinate and manage care regardless of whether a benefit is covered through Medicare or Medicaid. Aligned enrollment may have a positive impact on the experiences of dual eligible beneficiaries. For example, Minnesota compared older adult dually eligible beneficiaries enrolled in a Medicaid-only-program-without-D-SNP with those enrolled in an aligned Medicare-Medicaid program. Results showed that aligned duals had significantly lower rates of hospital and emergency department visits, as well as significantly higher rates of primary care and home and community-based services (HCBS) utilization. Other studies have indicated more mixed results, but few studies exist using a matched control group in the same Medicaid plan.

Current default enrollment provisions allow D-SNPs approved by CMS and state Medicaid agencies to enroll newly Medicare-eligible individuals into an aligned D-SNP if they are already enrolled in an affiliated Medicaid managed care plan through the same parent company. Dually eligible individuals are allowed to opt out of this process, but the process can minimize member confusion around selecting and enrolling in a Medicare plan and ensures that the individual receives efficient care coordination. This also allows the parent entity to support members through the entire transition period, starting from the original notice 60 days before enrollment through exploring and using their benefits. Default enrollment typically results in a low opt-out rate and low rapid disenrollment rate, which creates stability in a state's market. All members who are default enrolled are provided with a Special Enrollment Period (SEP) to protect member choice. That way, individuals can switch to a Fee-for-Service (FFS) model or another Medicare Advantage product if they do not wish to be enrolled in the aligned DSNP.

However, default enrollment only covers a small group of new dually eligible individuals. It is limited to newly dual eligible enrollees who are already enrolled in a Medicaid plan, and most are people with disabilities under age 65 on Medicaid who have completed the waiting period for Medicare. The vast majority of dually eligible individuals are those over age 65 who are already on Medicare and subsequently become eligible for Medicaid and do not have the option of default enrollment.

Currently states also have authority under Medicaid to enroll dually eligible individuals into a Medicaid plan matching their Medicare D-SNP choice including affiliated/coordinated products under the same parent organization. However, states may not choose to use this authority and may

not consider the need for aligned enrollment when conducting their procurements for Medicaid plans.

Consistent with this Medicaid authority, Congress should direct CMS to reinterpret what qualifies as a "situation necessary to promote integrated care and continuity of care" and require states or provide them with greater discretion to facilitate enrollment of dually-eligible individuals into D-SNPs with aligned Medicaid contracts. This authority should include extension of default enrollment processes to new Medicaid dually eligible individuals over age 65 by assignment to a corresponding Medicaid plan under the same plan or plan sponsor as their D-SNP while retaining the consumer's right to opt out or change D-SNPs as part of the process.

It is important to note that alignment strategies should be carefully designed to avoid inadvertently decreasing the number of dual individuals who choose to enroll in D-SNPs. 58% of full duals do not use LTSS and Medicare covers nearly all their services so they may not see the value of aligned enrollment. Dual eligible beneficiaries are a heterogeneous population, and "integration" and alignment should consider their individual choices.

8. ***Develop shared savings opportunities to increase incentives for states through D-SNPs***

Incentives for shared savings under the FAI MMPs have been important to states to allow them to move forward with investments in integration. However, this FAI feature was dependent on special demonstration status. As the FAI is phased out, CMS has asked for input on how to incorporate shared savings for states into the D-SNP model, but policy experts point out that this may require additional authority.

We recognize that states are concerned that their investments in MLTSS programs may enhance Medicare savings by reducing Medicare utilization, creating a disincentive for state involvement. The FAI included provisions for shared savings that were important to some states and is now being lost with the closure of that demonstration. In its 2023 MA rule, CMS suggested exploring a virtual integrated MLR concept which we think could be used to identify corridors for shared savings with states. This approach, plus further clarification of actuarial soundness policies, recognition that integration of funds can occur at the plan level, use of integrated benefit determinations, clarification of Medicaid payer of last resort requirements along with provider encounter data requirements would strengthen integrated models while avoiding more significant disruption of bids and financing for both plans and states. Attention should also be given to opportunities for simplification of billing and service authorizations for consumers and providers through use of integrated benefit determinations which allow for quick approvals of care based on the appropriate payer source without waiting for denials, a key benefit of having an integrated plan that can administer both benefit sets.

Development of shared savings opportunities applicable to D-SNPs such as offered in the FAI model should be a priority and Congress should ensure that CMS has authority and resources to develop and test models such as the virtual integrated MLR concept and clarification of TPL and encounter data requirements, along with requirements for integrated benefit determinations.

The SNP Alliance supports continuing to utilize current State (Medicaid) and federal (Medicare) risk adjustment and rate setting processes while allowing integration of Medicare and Medicaid funds at the plan level. Continuing the current approach would be less disruptive for members, providers, states, plans and CMS, than proposals to completely overhaul financing for integrated programs, and would preserve supplemental benefit arrangements designed for dually eligible populations. Where payment and benefit determination responsibilities for both Medicare and Medicaid services across the service spectrum of preventive, primary, acute, BH and LTSS reside in the same sponsor/parent entity, we believe financial incentives can be well aligned. The addition of opportunities for shared savings through some redesigning of the existing MLR features could help improve alignment for these financial incentives and replace what some states have lost through the discontinuation of the FAI.

9. ***Congress should direct CMS to designate a core set of measures that are meaningful for the dual eligible population and support states to align plan quality measurement and reporting, quality improvement plan requirements, and benchmarks for performance.***

The SNP Alliance supports quality measurement to evaluate and improve care for Medicare and Medicaid beneficiaries. However, the current measures and methods for performance evaluation within the Medicare and Medicaid programs are not aligned for the duals and scoring results do not provide an accurate picture of performance or the quality of service. The measures and methods are not well matched to complex and diverse populations.

Social determinant of health (SDOH) risk factors prevail in special needs populations and dual populations, and include poverty, housing instability, low education level, poor neighborhood conditions, inadequate food or transportation, and social isolation. These risks interact with existing mental or physical health and chronic conditions, disabilities, and functional limitations which are characteristic of special needs populations. Such risk factors affect how a person lives. They impact the treatment, procedures, care, and support—what can be done, when, and how. Clinicians, therapists, nurses, social workers, and others working with these populations explain that, even when provision of care meets the highest standards or clinical guidelines, optimal health outcomes can be difficult to achieve.

The SNP Alliance has three recommendations:

1. ***Create A Core Quality Measure Set for Duals: Alignment across Medicare & Medicaid -*** Identify a core set of aligned Medicare and Medicaid measures (and methods, timeframe, and reporting) to be used under both programs for the dually eligible, with attention to measures that are meaningful. This will ease the burden on individuals, providers, and plans and provide information that is more relevant, consistent, and actionable for all involved.
2. ***Re-test the HOS and CAHPs instruments and methods*** for surveying dually eligible beneficiaries, to ensure that they have been appropriately tested among dual populations and are valid, reliable, accurate and equitable and can be used for quality improvement. Publish results and make changes as needed to these instruments, methods of data collection, and how to interpret results.

3. ***Improve Case Mix and Predictive Models:*** In question #8 of this RFI we provide greater detail about characteristics of the duals and how to segment this heterogeneous population into more meaningful sub-groups. Use this information to improve case mix indexes and predictive models that are specific to duals and these more uniform sub-groups. This then helps guide improvement needed in policy, practice, payment, measurement, and benchmarking.

3. In your view, which models have worked particularly well at integrating care for dual eligibles, whether on the state level, federal level, or both? Please provide data, such as comparative analyses, including details on outcome measures and control group definitions, to support your response. (Examples of models include but are not limited to: Fully Integrated Dual Eligible Special Needs Plans, Highly Integrated Dual Eligible Special Needs Plans, Financial Alignment Initiative demonstrations, or States that have taken steps to better align the Medicaid and Medicare programs).

After a 25 year history of integrating D-SNP and Medicaid contracts including "legacy plans" in MN, MA and WI, substantial history of state contracting with D-SNPs in NY, TX, AZ, TN, ID and NM over the past 12-15 years, 23 states with MLTSS programs most of which include some delivery or coordination of Medicaid with DSNPs, and 10 years of history with the FAI demonstration, **CMS has adopted regulations that pave the way to more certainty for the future of D-SNPs as the base for integrated programs**. Congress initially enabled this model by making D-SNPs permanent under the BBA of 2018, and since then D-SNP enrollment has grown considerably. Currently 47 states have contracts with 774 D-SNP plans that are already serving 4.5 million dually eligible individuals, which is nearly one in four of the dually eligible population (12/22). **Therefore, we believe there is no doubt that the D-SNP model is the appropriate base on which to build increased access to integrated Medicare and Medicaid models.**

As noted in #2 above, there are key legislative and regulatory modifications necessary to facilitate the partnerships between DSNPs and states and enable them to reach their full integration levels and capacities. However, **many studies including CMS' own evaluations point to the value that has been and can be achieved under DSNP models as indicated by the sources below**:

- Analysis of MN Integrated DSNP/MLTSS program (MSHO)
- Minnesota Managed Care Longitudinal Data Analysis | ASPE (hhs.gov) (this is comparison study)
- Inventory of Evaluations of Integrated Care Programs for Dually Eligible Beneficiaries
- MACPAC Response to CMS 2022 Medicare Advantage RFI
- What's Next? Retaining the Successes of the Medicare-Medicaid Plan (MMP) Model
- Comparing Care for Dual-Eligibles Across Coverage Models: Empirical Evidence From Oregon
- Value Assessment of the Senior Care Options (SCO) Program
- MEDPAC: Care Coordination Programs for Dual Eligible Beneficiaries (2012)
- MEDPAC: Managed Care Plans for Dual Eligible Beneficiaries (2018)
- MEDPAC: Promoting Integration in Dual Eligible Special Needs Plans (2019)

Special Needs Plans as Leaders: We also refer Congress to the independent report from RAND, commissioned by the U.S Department of Health and Human Services that highlighted three exemplary health plans serving the dually eligible population: Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies. All three of the featured health plans are special needs plans that developed their care models and acumen in serving the dually eligible effectively over many years. This report offers insights into

strategies for integrating care and achieving positive health outcomes. We highly recommend a thorough read when considering how to support these best practices through legislation, policy, payment, and regulation.

4. After reviewing these models, would you recommend building upon current systems in place (e.g. improving aligned enrollment and/or coordination of care between two separate Medicare and Medicaid plans) or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on their needs.

The SNP Alliance has extensive experience with both the MMP model and the D-SNP platform, including Coordination-Only D-SNPs, HIDE-SNPs and FIDE-SNPs, as well as with state initiatives involving Medicare, Medicaid, and MLTSS programs. Our members have been pioneers in implementing all of these platforms for integration of Medicare and Medicaid, and in working to improve care for dually eligible individuals.

The SNP Alliance strongly supports building on the current D-SNP infrastructure and upon the regulatory direction CMS established in its 2023 MA rule which clarified that the D-SNP model is CMS' primary vehicle for state partnerships for integration of Medicare and Medicaid. **We recommend that Congress continue to provide support and additional authority for D-SNP-based integration models and to encourage states to continue to move toward FIDE SNP development.** To this end, the SNP Alliance also supports improving aligned enrollment and coordination of care between aligned Medicare and Medicaid D-SNP plans operating under the same parent company.

As noted earlier, **we think there is no doubt that the D-SNP model is the best model available to increase the scale of and thus access to integrated programs.** Currently 47 states have contracts with 774 DSNP plans that are already serving 4.5 million dually eligible individuals (12/22). As evidenced by current enrollment choices dually eligible individuals are making to enroll in DSNPs where enrollment has grown rapidly, there is much to build upon and some states (e.g. Indiana) are finding new ways to leverage their Coordination-Only D-SNP involvement as steppingstones toward more integrated models. State financial support and involvement is critical to any expansion of access to integrated programs and policies need to consider the additional time and resources needed to assist them. As noted earlier we also believe some tweaks in authorities as well as some additional features such as those included in the FAI are needed to more quickly and substantially improve state involvement and increase access to integrated programs.

Please see our criteria for evaluation of legislative proposals for integration here.

5. If you believe a new unified system is necessary, what are key improvements we should prioritize? What would such a system look like? Please provide details on financing, administration (e.g. federal government vs. state government), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.

The SNP Alliance opposes proposals that would start from scratch with new financing and enrollment models and believes that such an approach would cause great disruption for individual dually eligible beneficiaries, providers, D-SNPs, states and CMS, setting back the goals of increased access to integrated programs**.** Under the current system where Congress has provided for joint state and federal partnerships for states and D-SNPs to integrate financing and operational details at the plan level, many

states and plans have crafted relationships that have made significant investments in the infrastructures necessary to develop and manage integrated DSNP based programs. States and plans with this history of investment do not want to see these partnerships and investments disturbed or wasted.

As evidenced by the current enrollment choices dually eligible individuals are making to enroll in D-SNPs (where enrollment has grown rapidly), there is much in place to continue to build upon to improve access to integrated programs across the country. **Disrupting enrollment for over 4 million vulnerable dually eligible members who have already chosen D-SNP enrollment is likely to be harmful to current enrollees and to disrupt their care and benefits, including their supplemental benefits.**

Further, any new unified financing system would need a very complex financing mechanism to recognize the diversity of state experience with managed care and integrated care. While states with limited experience may initially be able to generate savings in a new system, a state with more experience (and investments in HCBS and positive rebalancing outcomes) may have already done the work to generate savings, and with less savings to be made moving forward they would face significant disadvantages and unfair consequences. **It would also be hard to replicate or continue current integration efforts and accomplishments which would be destabilized under a radically new financing system.**

While improvements in current state and D-SNP partnerships may mean having patience for more incremental change through stronger contracting provisions, additional provisions for Congressional support and resources for states, authorities for leadership under MMCO, continued consumer protections, and addressing technical and operational misalignments, we have no doubt that it can be accomplished more quickly and efficiently than starting over from scratch with a new platform. We also support the use of current state authorities for mandatory Medicaid and default enrollment processes as well as improvements in those current enrollment tools to achieve higher levels of aligned enrollment. Further, as noted above we believe that these authorities can be further tweaked to address technical and operational misalignments that would increase the feasibility and number of fully integrated programs.

6. How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?

A recent Mathematica study found that under the FAI, dually eligible beneficiaries were more likely to enroll, and remain enrolled, in integrated Medicare-Medicaid plans when the process of enrolling is easy, the benefits of doing so are tangibly and quickly demonstrated, and integrated care plans are cast as a preferred option over non-integrated care arrangements. Our recommendations throughout this document are focusing on a number of improvements needed to achieve more simplification of administrative processes for the dually eligible enrollee. While there may be some additional complexity for CMS, plans and states necessary to achieve this, it is important that the **enrollee experience** a smoother, less frustrating and less complex system of care. Aligned enrollment, one card, one enrollment process, and one care coordinator across services along with integrated benefit determinations are all part of this simplification goal.

State procurement strategies for Medicaid managed care are critical to aligning enrollment between Medicare and Medicaid. One way to avoid disruption to current beneficiaries is to encourage or require states to build on and/or consider aligning their enrollment with existing D-SNPs that are already serving

dually eligible members when they are designing their Medicaid procurement strategies. This would avoid further disruption involved in aligning enrollment at the start of the state's process.

Additionally, plans and states must work together on best practices for sharing information during any changes in enrollment and/or reenrollment processes, both of which can be complex and are often easily misunderstood by members. Various forms of member communication must be available, including cell phones, websites, letters, as well as direct access to state representatives to update addresses and other information for Medicaid. Beneficiaries' plans' care managers and Customer Service representatives can also work with members frequently to convey this message. Contracting with a third party to reach out to members when their enrollment needs to be updated is another best practice that could address disruptions. As noted earlier, Ombudsman and SHIP programs are also critical to this function.

Processes for sharing member information with D-SNPs also needs to be a priority. This information then must be transferred to from the state to the D-SNP/MCO so all records are in sync for both programs. Currently DSNPs are also required to verify any address changes directly with the member but this may result in duplication of effort and discrepancies between Medicare and Medicaid information depending on how the state and the D-SNP are able to coordinate the exchange.

Sharing and updating this information is much more difficult if individuals are not enrolled in the same plan/parent company. There also is no standard process for D-SNPs to know what Medicaid plan their members are in, or vice versa when enrollment is not aligned, as is the case for many Coordination Only D-SNPs. Some states share data files while others do not. These are examples of misalignment of technical administrative processes that with proper authority could be tweaked to simplify administration and gain efficiencies.

7. In your analyses of data on dual eligibles, did you consider continuity of enrollment status or consistency of full and partial dual eligible status during a year?

a) Are there different coverage strategies that should be employed for "partial" dual eligibles vs. "full" dual eligibles when it comes to improving outcomes, such as MedPAC's recommendation on limiting D-SNP enrollment to "full" dual eligibles only?

The SNPA strongly opposes barring partially dual D-SNP individuals from enrolling in D-SNPs. Partial dually eligible individuals are dramatically more similar to fully dual individuals than to non-dually eligible individuals in terms of their level of chronic illnesses, cognitive impairments, BH diagnoses, ED and hospitalization rates, SDOH characteristics and income levels among other comparisons as indicated in this Profile of Medicare-Medicaid Dual Beneficiaries. Partial duals also may move back and forth to full dual status based on financial eligibility. MedPAC estimates that about 6% of partial duals gain full Medicaid eligibility after a year and 10% gain full eligibility after three years. [1]

Partially dual D-SNP members receive significant benefits from the specifically tailored Models of Care designed for dual individuals which are not available in regular MA. While they do not receive Medicaid services, their Medicare needs are often complex and may be

[1] June 2019 Report to the Congress: Medicare and the Health Care Delivery System – MedPAC

exacerbated by the lack of access to Medicaid benefits so may require levels of care coordination and navigation for Medicare services not normally provided under non-SNP MA Medicare. The care coordination and additional clinical initiatives and features provided through the MOC can improve management of their chronic conditions. Partially dual individuals also find value in benefit packages that offer supplemental benefits designed for this subgroup of partially dual individuals. To prohibit enrollment of partial duals into DSNPs would deprive them of access to these important features as well as to networks and other regulatory protections designed for the needs of dually eligible individuals. In addition, this approach could exacerbate the use of DSNP "lookalike" products by leaving a gap that is filled by a lookalike plan, especially for partial duals who qualify as QMB. Lookalike plans do not offer the coordination requirements, or the tailored Model of Care required of D-SNPs.

While integration of member materials and other information is more challenging for alignment of some administrative provisions when partially dual individuals are included in integrated programs because of differences in Medicaid benefits, CMS has provided the option to set up separate PBPs (which can be under the same legal entity) designed for partial dual individuals to avoid some of those complications. Further, states may find value in facilitating partial dual Plan Benefit Packages (PBPs) which, along with care coordination and tailored supplemental benefits may be helpful in providing additional resources to mitigate deterioration and need for Medicaid eligibility. Finally, where some states contract only with FIDE SNPs, enrollment of partial duals in a separate PBP may also be useful to states interested in the additional care coordination provided to partial duals through a D-SNP.

b) Studies indicate that frequent plan switching can have a negative impact on beneficiary health outcomes, especially for dual eligibles who are enrolled in aligned managed Medicare and Medicaid products. CMS and States have taken different policy approaches to reduce excessive switching. Which of those policies have the best data on improving cost-effectiveness, clinical outcomes, and/or beneficiary satisfaction? Which of these approaches can be expanded to apply more widely across States?

Members often change plans when they have exhausted a special supplemental benefit i.e. dental, transportation, food cards, etc. Continuity is complicated when this happens because of the recent change to a quarterly plan change Special Enrollment Period (SEP) for dually eligible members. Previously D-SNP enrollees were allowed to change plans monthly. Plan changes among older D-SNP members are generally lower than those for regular MA and for those under 65. Returning to a special monthly SEP for dually eligible members may be more attractive for members under 65 but could continue enrollment churn for those 65 and older, albeit likely at a low level. Tracking these frequent SEP changes can be a huge administrative burden for plans, states and enrollees.

Medicaid programs often mandate annual enrollment periods and are often not as generous in allowing SEPs for plan changes compared to Medicare which then disrupts enrollment alignment because the member is choosing the two enrollments separately without

coordination between them. Programs with the most success have adopted the MMP approach, which sets up a process for allowing monthly enrollment changes into both Medicare and Medicaid simultaneously and does not allow members to choose conflicting (non-aligned plans). However the MMP model will no longer be available. In the absence of that approach, we would recommend that any program design allow dual eligibles in Medicare FFS to enroll into an integrated D-SNP on a monthly basis, but limit switching between D-SNP products outside of current enrollment timelines (which would continue to allow for quarterly SEPs).

8. What is the best way to ensure that this system takes into account the diversity of the dually eligible population and is sufficiently targeted to ensure improved outcomes across each sub-group of beneficiaries? How should these sub-groups be defined and how should the data be disaggregated? Please provide examples of methodology and the evidence-based rationale for each example.

Step 1 – **DATA** - The first step is to obtain, as much as possible, information on key characteristics of the duals. We suggest characteristics be considered when looking into the diversity of the dually-eligible population. Based on our analysis and observations over the last decade, we offer suggestions on the way to analyze/examine the diversity of the duals, with these following characteristics. We've attempted to list these indicators in the order which might offer best opportunity for analysis and yield useable segments or sub-groups:

- ***Age***, with three categories suggested. The age categories are suggested because there is evidence that those under age 65, and those over age 85 tend have specific medical, BH, social risk, functional status/frailty characteristics which are important to attend to in developing an effective care and services approach. Thus we suggest that be the first sub-group segmentation:
    - 18-64
    - 65-84
    - 85+
- ***Reason for initial Medicare eligibility*** (Disability or Age) – Again, the reason for initial Medicare eligibility has been shown to be important related to the needs and characteristics of the beneficiary. For example, if the person suffered severe physical trauma at age 50 resulting in permanent disability and therefore enrolled into Medicare, even though this person may age into the 65+ category, they will have had a decade of needing to adapt to their functional status limitations, medical conditions, and need for treatment/therapy. Thus, this person at age 65 is akin to younger people with disabilities in some ways—while also now addressing the degenerative and cumulative effects of aging.
- ***Primary Language other than English*** – The primary language is very important around issues of access, health literacy, cultural/language acceptability of services, and other key aspects of service to appropriately reach and serve the full population of dually-eligible in the U.S. Rather than trying to segment the duals into many languages, we would recommend that the duals be separated into at least two groups: (1) Primary language other than English, and (2) English.
- ***Race/Ethnicity, Gender identity, Sexual orientation*** – These gender, race, and orientation characteristics are important for population data review toward having the necessary data segmentation within the dual population –to guide interventions, and to see how disparities may be changing. This is needed both for policy and practice efforts toward advancing health equity goals and reducing disparities that have been observed historically and continue to be observed in many communities. One challenge will be that these characteristics are not always known and not always in existing data sets.

- ***Social risk vulnerabilities*** – We recommend six key social risk factors which impact access, service, health, and health outcomes : (1) poverty/low-income status, (2) social isolation/lives alone, (3) housing instability, (4) food insecurity, (5) lack of access to reliable transportation, and (6) lack of access to smart phone and/or Wi-Fi or broadband technology. Research shows that these social risk factors are interdependent and related, beginning with poverty/low-income status which usually drives many of these other factors. Special needs plans may be particularly helpful to Congress in better understanding how social risk factors influence health and health outcomes, as they conduct a required annual health risk assessment (HRA) that includes social risk factors –of every enrolled beneficiary as long as that person agrees to the HRA process.
- ***Functional status & Frailty*** -A focus on function is critical for effective care management and support, particularly for those with disabilities and who are frail and/or of advanced age. Segmenting a subgroup of duals who have a high level of functional impairment and 3 or more substantial limitations in activities of daily living offers an opportunity to tailor interventions and focus on interventions known to improve ADL and IADL functional status –working with the person and his/her/their home environment.
- ***Residential and care setting*** (home, nursing facility, other institutional setting) – with a particular focus on those living in an institutional setting—for these individuals, health outcomes are often heavily influenced by characteristics of the setting, particularly staffing and capacity/quality of clinical, social, and diagnostic/therapeutic services as well as nutrition and pharmaceutical services.

Other factors which are also important in better understanding and segmenting the dually eligible population into meaningful sub-groups to drive intervention, policy, and program improvement include:

- ***Dual status*** (full or partial) with State identifier – Dual eligibility status (whether full or partial benefit) depends, in part, on each state's benefit and eligibility criteria. Therefore if full/partial status is an indicator for segmenting the dual population for national review and analyses, it may be useful to couple the full/partial status indicator with a State identifier.
- ***Area deprivation index*** (socioeconomic indicator of neighborhood where the person lives)
- ***Urban/suburban/rural***
- ***Mental/BH conditions and level of severity***
- ***Multiple chronic physical/medical conditions and level of severity***

Step 2 – FULL GROUP – One data is gathered and organized, then a fuller analysis of the duals can be done through examining these characteristics (each individually and as a group) to more fully appreciate how diverse/heterogeneous the population is.

Step 3 – SEGMENTATION - Then begins the process to segment into meaningful subgroups, where members of each sub-group have similar characteristics so that members are more alike than different within that group. Various methods for sub-group segmentation should be tried and results examined using statistical methods. This would help determine the within group variance.

Step 4 VARIABLE ASSOCIATION - The methods should show what factors (variables/data elements) have a close association, such as low-income status and living in a poor neighborhood—so that one indicator can be used instead of two without losing impact. This helps reduce the complexity of the method and the number of data points needed to effectively and accurately separate into meaningful sub-groups.)

Step 5 – MEANINGFUL SUB-GROUPS – Statistical methods will be used to create meaningful sub-groups but there will be, without a doubt, overlaps in the groups which is to be expected. Stakeholder input will help address how much overlap indicates that two groups should be merged into one, or if maintaining separate groups is meaningful and important for addressing care needs and measuring outcomes.

Step 6 – STAKEHOLDER INPUT - Once suggested sub-groups are developed through the statistical methods with tests of face validity, stakeholder input from each sub-group then helps drive next steps. Having meaningful subgroups helps with improving case-mix and predictive models for improving outreach and engagement, designing effective strategies, implementing evidence-based interventions, adapting care management approaches, coalescing collaborative efforts, and making needed changes in policy and programs toward better addressing care/support needs of the dually eligible population and better monitoring performance and providing incentives for quality improvement. In addition, Congress needs to consider the issue of data privacy, and the importance of educating consumers about why data is being collected and shared across their providers—communication is critical to coordinate and integrate care. Beneficiaries should be provided with assurances on how data is used, what their permissions cover, and how their information will be protected.

EXAMPLE: FIDE-SNP CASE MIX

One example of how to use this additional information would be around improving methods of applying a frailty adjustment to payment to increase resources to plans and care systems that have a significant portion of their enrolled dual population with functional status limitations, medical and chronic condition complexity, and frailty characteristics. Currently FIDE-SNPs may apply for a frailty factor adjustment, but this determination is based on use of an instrument (Medicare Health Outcomes Survey), that does not adequately capture the characteristics of each person—which therefore limits case mix segmentation. In addition, the adjustment methodology requires application by the SNP to their total enrollment and uses the level of care definitions and assessment tools outlined by the state in which they reside. Thus duals in one state may be defined as needing the highest level of care whereas in another state they would not be thus defined. Furthermore the adjustment is based on the total enrollment average and compared to much smaller PACE programs. Therefore duals in a FIDE-SNP who have a nursing home level of care where the FIDE-SNP also has enrolled others who do not have as high a level would be inadvertently penalized (not receive the frailty adjustment) as compared to individuals who did not enroll in that FIDE-SNP but chose to enroll in a PACE program. This is unequal treatment and diminishes the resources available to the person, even though they are functionally equivalent.

More comprehensive and inclusive data on the dual beneficiary population could inform the development of better case-mix methods and encourage movement toward a more standardized definition of care levels for functional status and frailty adjustment.

9. Does your data identify subgroups of individuals for whom having coverage from two payors is inefficient or is associated with worse clinical outcomes, as seen in academic literature?

> The SNP Alliance does not have these data. While in theory having additional health care insurance may provide additional coverage and fewer gaps for members, the challenge is that it can be difficult to truly coordinate. All insurers have different requirements for authorizations and for secondary insurance it can be difficult to know if a medical denial letter or Explanation of Benefits (EOB) will suffice for the next payer. Thus coverage from two different payers can

result in delays to members receiving needed care and it may be those delays that impact clinical outcomes negatively.

In addition, besides also being confusing for dually eligible enrollees, having two different payers or two different plans may incent cost shifting between both plans and providers as they try to avoid liability for any overlapping or substitutable services, for example, especially between Medicare covered acute or post-acute care and Medicaid covered LTSS services.

10. There are individuals who can, or must, expend their assets on medical care until they financially qualify as dually eligible. Such spending can get these individuals access to long-term care under Medicaid, which Medicare would not cover. Another pathway to eligibility involves Medicaid beneficiaries who develop End-Stage Renal Disease (ESRD) and become Medicare eligible.

a) Is there data that demonstrates the cost-effectiveness of providing select supplemental benefits to Medicare Advantage beneficiaries that may help them avoid becoming Medicaid eligible through high spending on medical care?

While we don't have specific data on this issue, we support use of supplemental benefit flexibilities to address member social needs. However we must note that the scope of what plans can provide through finite funding from bid savings is relatively limited, especially after the benefits like dental, vision, hearing benefits that plans have to offer to be competitive are included. Therefore, in general, supplemental benefits are not likely to be robust enough to offset major declines in functioning or act as a substitute for Medicaid benefits. However, there still may be some value in certain supplemental benefits being designed for partial duals who have no access to Medicaid benefits.

b) For Medicaid beneficiaries with risk factors for developing ESRD, such as chronic kidney disease, diabetes mellitus, hypertension, etc., which targeted care strategies have been proven to be effective at delaying development of ESRD and, in so doing, of Medicare eligibility until they turn 65 years old? Please share data on the costs vs. benefits of these interventions.

Some SNP Alliance plan members are exploring data on these risk factors for best management practices. They believe that increased education around routine screenings is important given that one can be symptomless for conditions such as Chronic Kidney Disease (CKD). Overall education about the inter-related body systems and the impact that chronic conditions have is critical. For example, CKD does not get the attention that heart disease has historically had, so overall screenings and understanding the impact of other chronic conditions could be the key to earlier interventions.

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?

It is important for those in rural areas to have access to transportation, telehealth, in-home services, supplemental benefits and mobile services. As detailed further in this response, there is a shortage of direct care workers, as well as transportation in rural areas. Transportation is even more scarce in rural

areas where there is little or no public transportation and limited volunteer drivers. For this reason, having access to care remotely or in-home is key.

Along with many others, the SNP Alliance is increasingly concerned about the serious staff shortages being experienced in health care, and in particular how this is impacting in-home MLTSS and long-term care settings in both rural and urban areas with deep poverty levels where such shortages are often most extreme. More transparency into unmet needs and how workforce shortages are impacting rural areas and what flexibilities could be useful is badly needed. This workforce crisis disproportionately impacts vulnerable dually eligible individuals. Direct care workers in those areas and settings are among the lowest in wages and generally lack health care benefits themselves, largely due to limits on Medicaid payments from CMS and states. Providers and plans alike are constrained in recruiting these workers by these same limits. At the same time, transportation and mileage costs are more acute in rural areas. The resultant workforce shortages are leading to decreased access to direct care at home, assisted living, nursing home and group home settings, some of which find themselves in competition with hospitals who may have higher wages, and have shut down beds or wings or shifted costs and care to families, who are often poor or elderly themselves.

While there are some technological solutions that can be of help and we are very thankful for Congress' work thus far to continue tele-health options, there is nothing that can replace the need to direct care staff to help individuals with basic functional tasks such as bathing, dressing, feeding and toileting. It is difficult to maintain any network adequacy standards for home and community- based services. Further, it is going to be increasingly challenging to hold providers and health plans accountable for care improvements when the direct care workforce is depleted.

It is impossible to separate this direct care workforce shortage from immigration policy. Many states (and other countries such as Canada) have relied on immigrants to maintain their workforces, particularly those in health care settings. Current immigrants are making up larger portions of health care workers in hospitals and larger health care facilities in the U.S. and it has become increasingly difficult to recruit new workers for MLTSS in home settings. Immigration policy in the US has stalled and arrival and training for new immigrants is no longer a significant source of additional workforce.

Specific to urban areas or areas with large non-English speaking populations, it is vital that enrollees have access to interpreter services and culturally congruent care coordination. When enrollees are able to speak to someone in the language in which they are most comfortable and can see themselves represented in their care coordinator, the ability to provide care coordination and offer access to whole-person care is made much easier.

We encourage Congress to make a major effort to address these workforce issues, which are only going to get worse in the next few years with the aging of the population and declining sources of new workers. Congress should base this effort on the many current taskforces and related efforts to research workforce issues in health care. As part of this effort, Congress should consider the impact of immigration policies on the direct care workforce, as well as the need to consider wage and benefit increases under Medicaid payments tied to recruitment of direct care workers, incentives for serving for certain populations and geographic areas, geographic differences in terms of market competition for workers in manufacturing vs health care and other factors suggested by providers, researchers, state and federal agencies and policy experts.

Conclusion

The SNP Alliance not only appreciates your interest in the dual eligible population, but very much recognizes and values the impact this RFI will have in continuing the work of advancing integration of Medicare and Medicaid for a population that is in much need of access to integrated plans. As noted above, we stand ready to partner with you to advance integration and improve the lives and health outcomes of the dual eligible population.