January 13, 2023

The Honorable Bill Cassidy, M.D.
U.S. Senate
Washington, D.C. 20510

Dear Senator Cassidy:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit comments regarding shortfalls in the current system of care for dual eligibles, how to improve patient health outcomes and the role of federal or state governments in dual eligibles' care.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies –advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC is very supportive of efforts to improve coverage for dually eligible enrollees. These individuals typically have multiple chronic conditions, physical disabilities, mental illness, and cognitive impairments, and often need more medical care and social supports and services than healthier individuals. As a result, expenditures for care of dual eligibles account for a third of overall healthcare cost in Medicare and Medicaid. As Congress seeks more detailed information on data collection and policy recommendations to improve care and care coordination for dually eligible individuals, HLC offers responses to the questions below.

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?**

   HLC appreciates the opportunity to provide clarity on concepts central to improving care delivery for dually eligible beneficiaries. For HLC, integrated care means highly

coordinated health benefits representing a full continuum of services that are provided seamlessly and without care disruptions in transitions from one service to another. For example, this could entail Medicaid and Medicare programs working together-including coordination among federal government, state government, and private health plans to provide an integrated approach to providing access to benefits, administering processes, and coordinating services across a single network of contracted providers to support continuity of care for the dual eligible beneficiary. Care coordination is the integrated delivery of healthcare among a patient's primary care doctor, specialists, and other providers of healthcare services. For example, through care coordination, a patient's primary care physician gets information on their specialist visits and talks through the results of these visits directly with the patient. Lastly, aligned enrollment entails arrangements in which a dually eligible beneficiary receives both Medicare and Medicaid benefits through the same organization or closely related organizations that use the same network of contracted providers.

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?**

   In the current system of care for dual eligibles, beneficiaries can be managed by two distinct and different payers, which are abiding by either state or federal regulations related to care coordination. Oftentimes, this management is duplicative and causes confusion and frustration for the enrollee. There is also a lack of resources and expertise at the state level on Medicare program policies especially those meant to foster greater integration efforts and Dual Eligible Special Needs Plan (D-SNP) communications. To address this, we recommend the Centers for Medicare & Medicaid Services (CMS) offer more educational opportunities to support state partners in understanding requirements and policy changes and require all state Medicaid agencies to have a designated dual eligible subject matter expert.

   Lastly, there remain challenges with the exchange of data among health plans, states, and CMS to facilitate both enrollment and care delivery. For example, there is not a consistent use of eligibility categories across states and CMS, which can create issues with continuity of coverage, care coordination, and coordination among the health plan, the state, and beneficiaries. HLC recommends Congress work with CMS, states, and the private sector to identify opportunities for data consistency and information sharing for dual eligible care.

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).**

Congress initially enabled the D-SNP model by making it permanent under the Bipartisan Budget Act 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. Therefore, HLC believes the D-SNP model is the appropriate base on which to build increased access to integrated Medicare and Medicaid models. We recommend that Congress further indicate support for making the choice of a Fully Integrated Dual Eligible SNP available to all dually eligible individuals, but also recognize that states and health plans may face challenges in setting deadlines for fully meeting that goal. In addition, Congress should also recognize that Coordination Only and Highly Integrated Dually Eligible SNPs are important building blocks for plans and states who are at different stages in moving towards such a goal and thus should be allowed to play that key role as states work to build additional capacity for integration.

4. **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.**

   While a new unified system for dual eligibles may provide an opportunity to address shortcomings of the current system, we do not believe a "one size fits all" approach would best serve the diverse needs of the duals population. Given the diversity of the dual eligible beneficiaries and the varying capabilities of states to provide integrated coverage, a continuum of options is needed.

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

   HLC appreciates Congress acknowledging that any changes to the current system of care for dual eligibles must account for and reduce disruption. To minimize disruption and maximize enrollment, we recommend that passive enrollment of mandatory populations into a Fully Integrated Dual Eligible (FIDE) or Highly Integrated Dual Eligible (HIDE) Special Needs Plan be allowed for a seamless experience. Medicare and Medicaid enrollment dates and special enrollment periods should be aligned, and states should have access to enrollment information to better facilitate default and/or passive enrollment. These changes will help prevent disruption due to missed deadlines or network differences and promote continuity of care.

6. **In your analysis of data on dual eligibles, did you consider continuity of enrollment of full and partial dual eligible status during a year?**

   HLC supports maintaining and expanding the use of D-SNPs to better coordinate care for partial dual eligible beneficiaries. This is important given that variation in state approaches to defining and review of eligibility create challenges for continuity

of care for beneficiaries. Partial dually eligible beneficiaries have similar needs as full benefit dually eligibles, but do not qualify for full Medicaid benefits. Many of these partial dually eligible beneficiaries transition in and out of full dual eligible status. This has implications for a large number of beneficiaries since the size of the partial dual population is increasing. Additionally, due to state data systems and tracking processes it is difficult to identify and support beneficiaries with partial dual eligibility. For example, the frequency of eligibility review for partial duals can effect enrollment and status changes can happen frequently impacting benefits and/or enrollment in D-SNPs. HLC recommends limiting reviews of eligibility for partial dual status to one time per 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?**

   HLC believes D-SNPs can provide important services to support care for partial dual eligibles and may help to stabilize coverage. Continuity of enrollment in health coverage is especially important for both full and partial dual eligibles to ensure continuity of care, engagement with preventive services, and continued management of chronic conditions to avoid poor health outcomes. Congress should consider the creation of D-SNP specific plan options for partial dual eligibles that provide Medicare benefits but also include appropriate, supplemental benefits to address enrollee social determinants of health (SDOH) needs.

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?**

   Frequent plan switching can cause disruptions in care and cause issues with coordinated benefits. We recommend Congress evaluate whether changes are needed to the Special Enrollment Period that allows dually eligible beneficiaries to switch their Medicare coverage as often as quarterly in order to reduce negative impacts.

7. **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?

HLC supports the use of supplemental benefits in Medicare Advantage as they continue to help improve beneficiaries' health outcomes, assist in providing high-quality care, and strengthen beneficiaries' connections to their community. Social isolation has been proven as a factor that increases the risk of people getting sick and accruing higher medical spending. [1] Nutrition and transportation services are two of the most utilized supplemental benefits which support beneficiaries' overall health and their access to medical appointments and needed care. For example, if a beneficiary does not have access to nutritious food options, existing conditions such as diabetes could become exacerbated. If they lack access to food altogether, they may have more difficulty focusing on other medical needs, such as medication adherence. Similarly, lack of transportation is a major barrier to accessing care and adhering to medication regimens. Research shows that lack of transportation can reduce use of preventive and primary care, while increasing utilization of the emergency department.

In addition, we believe Supplemental Benefits for Chronically Ill (SSBCI) can support beneficiaries' overall health and reduce high medical spending. Currently, benefits can only address SDOH if they maintain or improve health function, and social need alone cannot be used to determine SSBCI eligibility. To further strengthen the use of supplemental benefits to prevent beneficiaries from increased need for Medicaid long-term care, Congress should work to provide health plans with the ability to use social need as the sole factor in determining eligibility for supplemental benefits, as well as provide more flexibility in targeting supplemental benefits to address social risk factors. H.R. 4074, the "Addressing Social Determinants in MA Act" introduced in the last Congress, would enable health plans to offer certain supplemental benefits that are currently only available to beneficiaries who are chronically ill to beneficiaries who have socioeconomic risk factors or are considered as low-income. This is an approach that could improve care outcomes and delay the need for long-term care.

8. 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 certainly plays a pivotal role in dual coverage. In both rural and urban areas dual eligibles are faced with challenges accessing reliable broadband

[1] *Chronic Care Act Prompts Some Medicare Advantage Plans to Incorporate Social Services (Jan. 9, 2020)* https://www.commonwealthfund.org/publications/2020/jan/chronic-care-act-prompts-some-medicare-advantage-plans-incorporate-social

services, unequal distribution of medical services, and lack of transportation to medical facilities. To address challenges based on geography, HLC recommends flexibilities in certain program requirements for D-SNPs serving beneficiaries who live in these areas. We believe there should be a greater focus on policies that support delivery system changes that increase access to care and services such as flexibilities for network adequacy and the use of telehealth and e-visits.

We also recommend the Center for Medicare and Medicaid Innovation test a comprehensive approach to advancing health equity in rural areas and increasing access to more integrated D-SNPs in these areas. This model should encourage public-private partnerships that engage the community and increase provider collaboration. The model should also increase supplemental benefit flexibility to allow health plans to expand these offerings to individuals with needs related to SDOH.

Thank you for your commitment to improve care for dual eligibles. HLC looks forward to working with you on our shared priorities. If you have any questions, please do not hesitate to contact Debbie Witchey at dwitchey@hlc.org or 202-449-3435 with any questions.

Sincerely,

Mary R. Grealy
President

cc:
Senator Tom Carper
Senator John Cornyn
Senator Robert Menendez
Senator Tim Scott
Senator Mark Warner