The Commonwealth Fund
Affordable, quality health care. For everyone.

1 East 75th Street
New York, NY 10021
212.606.3800
commonwealthfund.org

TO: **The Honorable Bill Cassidy, Thomas Carper, Tim Scott, Mark Warner, John Cornyn, and Robert Menendez**

FROM: **The Commonwealth Fund**

DATE: **January 13, 2023**

SUBJECT: **Response to Request for Information on Improving Coverage for Dually Eligible Enrollees**

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

Thank you for the opportunity to respond to your request for information on ways to improve coverage for dually eligible enrollees on behalf of the Commonwealth Fund. The Fund supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for underserved communities, including people of color, people with low income, and those who are uninsured.

Please find responses below to select questions from your request for information.

2. What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?

Increasing Adoption of Integrated Care for Dually Eligible People

Between May 2019 and October 2020, the Commonwealth Fund convened an eighteen-member Task Force on Payment and Delivery System Reform, charged with developing federal policies to improve quality, advance equity, and increase affordability of health care in the United States.

To reflect a wide array of expertise and perspectives, the Task Force was comprised of delivery system leaders, health insurance executives, patient advocates, current and former federal and state officials, and business leaders. These members drew on their real-world experience and the available evidence to put forth a consensus report detailing their recommendations.

With the intent of increasing health system accountability for health care quality, equity, and cost, the Task Force developed the following recommendations to increase adoption of integrated care for people dually eligible for Medicare and Medicaid:

- Congress should enable CMS and/or state Medicaid agencies to automatically enroll all full-benefit dually eligible beneficiaries into integrated plans (accompanied by the protections and supports listed below), with the following requirements:
    - That integrated care plans include Medicare-Medicaid plans, fully integrated or highly integrated dual-eligible special needs plans (FIDE/HIDE SNPs), or the Program for All-Inclusive Care for the Elderly (PACE).
    - That beneficiaries have the option to disenroll in accordance with existing Special Enrollment Period options and be regularly notified of the option.

    - That Congress provide additional federal funds to enhance states' capacity to develop expertise in Medicare and to implement integrated care models.
- The CMS Medicare-Medicaid Coordination Office should:
    - Closely monitor individual Medicare-Medicaid plan performance on quality and equity, with particular attention to the experience of different subpopulations of enrollees, such as those determined by race/ethnicity, age, gender, zip code, functional status, disability status, or chronic conditions.
    - Rigorously evaluate the aggregate effects of integrated products on quality of life, total health care spending, and equity of care.
    - Make upfront financial support and technical assistance available to states and plans for the implementation of integrated models.
    - Address financial and regulatory barriers that have hindered the spread and scale of models to date.
- CMS should require and fund all state Medicaid programs to enhance their capacity to improve care integration with the Medicare program by having:
    - Well-staffed help lines to assist dually eligible beneficiaries in understanding and navigating their benefits.
    - Dedicated ombudsperson programs for people who are dually eligible beneficiaries.
    - A dedicated Medicare person to coordinate the dual-eligible program and collaborate with CMS.
- Congress should provide general waiver authority to the HHS secretary to align administrative differences between the Medicare and Medicaid programs, while protecting essential program benefits and patient rights.

Source: Commonwealth Fund Task Force on Payment and Delivery System Reform, Six Policy Imperatives to Improve Quality, Advance Equity, and Increase Affordability (Commonwealth Fund, Nov. 2020). https://doi.org/10.26099/7mvb-m252

Assessing SNP Impact on Beneficiary Health

As part of a series of publications taking stock of the Medicare Advantage program, the Commonwealth Fund consulted with six experts to discuss opportunities to improve Special Needs Plans (SNPs)—a type of Medicare Advantage plan that enables insurers to offer customized approaches for high-need beneficiaries, including those who are dually eligible.

SNPs can serve as a good platform for tailoring care to people's needs, given their latitude in developing care models and incentives to manage medical risk. However, interviewed experts agreed that not enough is known about whether and how SNPs are customizing care, as well as the impact of SNPs on beneficiaries' health.

To that end, they recommended fine-tuning quality measures to detect differences in treatment and outcomes among different subgroups of beneficiaries (e.g., younger beneficiaries with disabilities vs. frail older adults). Moreover, rather than allowing Medicare Advantage carriers to combine the quality scores of different plan types (e.g., SNPs and non-SNPs) to establish star ratings, CMS could rate the performance of each type of SNP separately.

Source: Martha Hostetter and Sarah Klein, "Taking Stock of Medicare Advantage: Special Needs Plans," To the Point (blog), Commonwealth Fund, Mar. 31, 2022. https://doi.org/10.26099/z020-me79

Promoting Integrated Care in D-SNPs

Dual Eligible Special Needs Plans (D-SNPs) are one type of SNP that serves people who are dually eligible for Medicare (because of age and/or disability) and Medicaid (because of low income). D-SNPs comprise the vast majority of enrollment in SNPs.

D-SNPs are required to contract with the states in which they operate to outline how they will coordinate members' Medicare and Medicaid benefits. But most experts interviewed by the Fund viewed the requirements as minimal, noting that only a handful of states mandate greater integration. They called on states to adopt proposals put forth by the Medicaid and CHIP Payment and Access Commission and the Medicare Payment Advisory Commission.

For example, to better promote integrated care for dually eligible beneficiaries, all states could:

- partner with D-SNPs to align their communication materials, benefit networks, and vendors for services like durable medical equipment.
- prevent D-SNPs from enrolling "partial duals," or Medicare beneficiaries who receive some financial assistance from their state Medicaid programs to pay out-of-pocket costs in Medicare but don't qualify for other Medicaid benefits. This would enable plans to offer a uniform set of benefits and keep their focus on populations that would benefit from greater integration of Medicare and Medicaid services.
- partner with D-SNPs to develop supplemental benefit packages that complement those in Medicaid.

States that rely on Medicaid managed care could:

- Require D-SNP insurers to also offer Medicaid managed care plans and align enrollment so that people eligible for Medicare and Medicaid benefits receive them from a plan capable of coordinating them.

Some experts would go further, such as by preventing Medicare Advantage plans other than D-SNPs from enrolling people who are dually eligible. They note that many of the selling points on which Medicare Advantage plans market themselves, such as low or no premiums, are already part of the benefits that dually eligible beneficiaries are entitled to under Medicaid.

Experts observed that because most state governments don't have expertise in Medicare, they will need support or incentivization to promote integrated care. Otherwise, states that invest resources in promoting integration that improves patients' care and avoids hospitalizations would see the savings accrue to D-SNPs, not states. This is because Medicare is the primary payer for hospital and physician services for dually eligible patients, while Medicaid covers long-term care.

Source: Martha Hostetter and Sarah Klein, "Taking Stock of Medicare Advantage: Special Needs Plans," To the Point (blog), Commonwealth Fund, Mar. 31, 2022. https://doi.org/10.26099/z020-me79

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).

Financial Alignment Initiative

The Financial Alignment Initiative (FAI) was launched in 2011 by the Medicare-Medicaid Coordination Office (MMCO) to test new ways to align incentives between Medicare and Medicaid and to improve care for the dually eligible population. At the time, thirteen states chose to participate in the FAI. Ten participated in a capitated model, in which Medicare and Medicaid benefits are delivered through a single managed care plan. Three opted for a fee-for-service (FFS) model, which did not fully integrate payments or benefits but allowed states to share in savings that resulted from quality and cost initiatives.

In late 2019, The Commonwealth Fund supported Drs. Ann Hwang, Laura Keohane, and Leena Sharma to analyze results from the evaluation reports of five states that participated in a capitated model: California, Illinois, Massachusetts, Ohio, and Texas. The evaluations compare changes in Medicare spending and service use in the demonstrations to concurrent changes in comparison groups selected from other counties or states with similar health care market characteristics using a difference-in-differences approach, which assumes that the demonstration and comparison groups would have had similar changes in health care use and spending if the demonstration had not taken place.

Below are the findings across three outcome domains:

Beneficiary Experience: Despite the focus on care coordination in the demonstrations, only a minority of demonstration participants reported receiving care coordination. Across demonstration plans in 2015, the percentage of beneficiaries receiving care coordination ranged from 15 percent to 47 percent.

Across the demonstration, satisfaction surveys suggest that members tended to rate their plans highly, at levels comparable to other Medicare Advantage plans. However, beneficiaries can more readily leave demonstration plans compared with other Medicare Advantage plans if they are unsatisfied with care. This may result in higher satisfaction scores among those members who do choose to remain in the demonstrations.

Service Utilization: In Illinois and Ohio, inpatient use decreased more among dual-eligible beneficiaries who are eligible to participate in the demonstration than in the comparison group. In the first three years of the Massachusetts demonstration, inpatient use declined among the demonstration-eligible population but decreased even more among the comparison group. These findings raise questions about whether long-term analyses of demonstration plans will show reduced inpatient use relative to comparison groups.

Due to limited Medicaid data availability, the evaluations provide limited information on the use of long-term services and supports.

Cost Savings: Cost-savings calculations were only provided for Medicare services. Results should be interpreted in the context of low overall rates of Medicare per-beneficiary spending growth in the past decade. Relative to the comparison groups, the demonstration groups showed increases in Medicare spending in some states and decreases in others (Table 1). Spending variation pre-demonstration could reflect different populations across states: for example, Massachusetts' demonstration was limited to dual-eligibles under the age of 65, which could contribute to the lower baseline Medicare expenditures.

Hwang et al. note an important limitation of the analysis. When comparing changes in Medicare spending and service use in the demonstrations to changes in comparison groups in other counties or states, the evaluations used an intention-to-treat analysis. This means that the evaluation looked for changes among all individuals eligible for the demonstration, whether or not they actually participated. Even if demonstration enrollees benefited from participating in the program, the effect is difficult to detect due to lower-than-expected enrollment across all demonstrations among the eligible population.

Table 1: Pre-Demonstration Medicare Spending vs. Changes in Spending Between Demonstration and Control Groups, by State

	Adjusted mean monthly Medicare expenditures, pre-demonstration	Difference between demonstration and control groups, in mean monthly Medicare spending, post-demonstration
California demo (Apr. 2014–Dec. 2016)	$1,195	3.7% (p=0.0608)
Illinois demo (Mar. 2014–Dec. 2015)	$1,245	–2.2% (p=0.0045)
Massachusetts demo (Oct. 2013–Dec. 2016)	$907	0.54% (p=0.7213)
Ohio demo (May 2014–Dec. 2016)	$1,317	–2.6% (p=0.1228)
Texas demo (Mar. 2015–Dec. 2016)	$1,494	–5.17% (p=0.0537)

Data: Authors' analysis of RTI International evaluations of the Financial Alignment Initiative (FAI) in California, Illinois, Massachusetts, Ohio, and Texas.

Source: Ann Hwang, Laura M. Keohane, and Leena Sharma, Improving Care for Individuals Dually Eligible for Medicare and Medicaid: Preliminary Findings from Recent Evaluations of the Financial Alignment Initiative (Commonwealth Fund, Nov. 2019). https://doi.org/10.26099/0g1s-7n26

While the FAI results have been modest and mixed, these demonstrations offer valuable lessons for policymakers on future design considerations as they seek to advance integrated care for dual eligibles. Table 2 offers strategies that states deployed to overcome implementation challenges.

Table 2: Implementation Strategies for the Financial Alignment Initiative Demonstration

Implementation considerations	Examples of strategies used by states or plans
Communicating changes in enrollment and policies to beneficiaries; maximizing participation rates	Coordinated the rollout of the FAI with other concurrent changes (like introduction of Medicaid managed long-term services and supports) [Ohio]; maintained broad provider networks [Ohio]; conducted outreach to beneficiaries before they are enrolled [Texas]
Engaging beneficiaries; building consumer leadership; addressing	Created implementation council, led by consumers, with state and Centers for Medicare and Medicaid Services participation [Mass.]; trained consumer advisory board participants [Ohio];

beneficiaries' priorities; gathering timely feedback	invited transportation vendor to consumer advisory board meetings to respond to concerns about transportation reliability [Ill.]
Challenges with engaging nursing homes and establishing billing systems for nursing home claims	Implemented a comprehensive nursing home strategy using staggered enrollment in nursing facilities and engaging physicians serving residents to improve communication between the plan and nursing facilities and to increase buy-in from the facilities [Calif.]
Challenges in contacting plan members, establishing meaningful relationships, and creating effective care plans	Partnered with homeless shelters to provide cell phones to homeless enrollees to allow them to contact their care coordinators [Mass.]; used "promotoras" (community member who receives specialized training) for outreach [Texas]
Creating comprehensive, whole-person care	State and local foundation convened Medicare–Medicaid plans to share best practices [Calif.]; created community-based residential treatment programs as an alternative to inpatient psychiatric services [Mass.]; partnered with paramedics to expand home-based care [Mass.]

Source: Ann Hwang, Laura M. Keohane, and Leena Sharma, Improving Care for Individuals Dually Eligible for Medicare and Medicaid: Preliminary Findings from Recent Evaluations of the Financial Alignment Initiative (Commonwealth Fund, Nov. 2019). https://doi.org/10.26099/0g1s-7n26

Data: Authors' analysis of RTI International evaluations of the Financial Alignment Initiative (FAI) in California, Illinois, Massachusetts, Ohio, and Texas.

To improve upon the FAI in future efforts to advance integration, policymakers should consider:

- Focusing on plans' ability to deliver on care coordination services, which will require sufficient workforce, appropriate training and resources, and close monitoring of performance.
- Developing and deploying a robust quality strategy that encompasses person-centered outcomes such as quality of life and community integration. Efforts at integration should achieve more than simply preventing negative outcomes like avoidable nursing home stays or hospitalizations.
- Providing technical assistance and funding support to state officials and state-based stakeholders to support successful adoption. Interim findings from the five states indicated that states and other stakeholders faced significant logistical and operational challenges (e.g., interfacing with separate Medicaid and Medicare systems for eligibility and payment, submitting claims to managed care plans for the first time, overcoming a steep learning curve in understanding Medicare practices and procedures).

Source: Ann Hwang, Laura M. Keohane, and Leena Sharma, Improving Care for Individuals Dually Eligible for Medicare and Medicaid: Preliminary Findings from Recent Evaluations of the Financial Alignment Initiative (Commonwealth Fund, Nov. 2019). https://doi.org/10.26099/0g1s-7n26

Implementing New Systems of Integration for Dually Eligible Enrollees (INSIDE)

The Commonwealth Fund and the SCAN Foundation supported the Center for Health Care Strategies (CHCS) to establish a learning collaborative called *INSIDE.* This three-phase project supported and connected states, federal officials, health plans, and provider partners to advance models that integrate

Medicare and Medicaid. CHCS provided participating states with a platform for shared learning, as well as opportunities for peer-to-peer exchange and dialogue between states and federal officials.

INSIDE III (2017) worked with 10 pioneering states—Arizona, Illinois, Massachusetts, Minnesota, New Jersey, Ohio, Rhode Island, South Carolina, Tennessee, and Virginia—advancing Medicare-Medicaid integration through financial alignment demonstration programs and/or contracts with Dual Eligible Special Needs Plans. See Table 3 for more details on each state's program at the time of this analysis.

Table 3: Overview of INSIDE State Programs

State	Integration Model	Program Launch	Aligned Enrollment[a]	Target Population
Arizona	D-SNP	2004	69,693[b]	All full benefit duals
Illinois	Capitated Financial Alignment Initiative (FAI)	March 2014	52,285	Age ≥ 21
Massachusetts	Capitated FAI and D-SNP	March 2004 (D-SNP); October 2013 (FAI)	65,365[c]	Age ≥ 65 (D-SNP); 21-64 (FAI)
Minnesota	D-SNP	1997[d]	40,499[e]	All full benefit duals
New Jersey	D-SNP	January 2012	26,142[f]	All full benefit duals
Ohio	Capitated FAI	May 2014	78,285	Age ≥ 18
Rhode Island	Capitated FAI	July 2016	14,451	Age ≥ 21
South Carolina	Capitated FAI	February 2015	5,241	Age ≥ 65
Tennessee	D-SNP	January 2013	38,718	All full benefit duals
Virginia[g]	Capitated FAI transitioned to D-SNP	April 2014 (FAI); August 2017 (D-SNP)	23,763 (FAI)	Age ≥ 21

[a] FAI enrollment is as of November 2017. Time points for D-SNP enrollment vary by state, but all are as of Fall 2017.
[b] Arizona's aligned enrollment of 69,693 includes 9,874 FIDE SNP enrollees, 53,829 aligned D-SNP/MLTSS enrollees, and 990 Mercy Maricopa Integrated Care enrollees.
[c] Massachusetts' aligned enrollment of 65,446 includes 18,513 Financial Alignment Initiative demonstration enrollees and 46,852 Senior Care Options FIDE SNP enrollees.
[d] Minnesota's program launch date corresponds to the start of its Minnesota Senior Health Options program in 1997 under a past Medicare-Medicaid alignment waiver that later transitioned to a D-SNP-based program in 2004.
[e] Minnesota's aligned enrollment of 40,499 includes 38,370 Minnesota Senior Health Options enrollees and 2,129 Special Needs Basic Care enrollees.
[f] All of New Jersey's aligned enrollment is in FIDE SNPs.
[g] Virginia began a transition from a capitated Financial Alignment Initiative demonstration to an aligned D-SNP/MLTSS program on August 1, 2017 that will be fully implemented statewide by January 1, 2018.

Source: Alexandra Kruse, Stephanie Gibbs, and Leah Smith, "Advancing Medicare and Medicaid Integration: Key Program Features and Factors Driving State Investment," https://www.chcs.org/resource/advancing-medicare-medicaid-integration-key-program-features-factors-driving-state-investment/

CHCS prepared a brief that describes five key features of effective integrated care programs, regardless of the model, informed by these ten states' experiences:

1) **Strong partnerships with engaged stakeholders.** Broad stakeholder engagement—especially early in the program design and implementation process—is key to success.

States found that strong support was needed from their executive and legislative branches, as well as from beneficiary advocates and provider leaders to help make the case and maintain support for integrated care, particularly as stakeholders wait for program results. Federal partners also played a role in identifying and resolving Medicare and Medicaid misalignments, improving administrative coordination, and encouraging information sharing.

2) **Transparency and responsiveness.** After the initial launch, states noted the need for continued robust stakeholder engagement to demonstrate program transparency and responsiveness, as well as solicit valued beneficiary and provider feedback. Formal feedback loops supported states with short-term strategies for refining program requirements to meet program goals and stakeholder expectations, as well as longer-term strategies for demonstrating program success.

3) **Comprehensive care delivery.** States worked with their stakeholders to design and refine their programs' care management models to ensure person-centeredness and promote provider buy-in—while simultaneously ensuring flexibility at health plan or provider levels. States agreed that care management models should fundamentally provide for care coordination and system navigation needs, but how care is coordinated and the structure of care planning teams and processes varies by state. In some instances, this may vary at the beneficiary level when states give health plans the flexibility to adjust processes based on individual needs and preferences.

   States identified the following care management model elements as key to meeting beneficiaries' needs: (1) addressing the full continuum of care needs including behavioral health and LTSS, as well as social determinants of health for high-need or vulnerable subpopulations; (2) designing interdisciplinary care teams that encourage beneficiary and provider participation; (3) ensuring that cultural preferences and access to care issues are addressed; (4) evaluating the model and adjusting as necessary in partnership with stakeholders; and (5) providing person-centered, hands-on navigation support to beneficiaries. This person-centered support requires considerable upfront investments by plans or providers for things like comprehensive assessment completion and data sharing capacity. These investments may impact initial cost savings but are essential from states' perspective.

4) **Integrated financing, risk-adjustment, and rate sufficiency.** Successful models contain the right incentives for states, plans, and providers to deliver coordinated, flexible, and potentially lower cost care to dually eligible beneficiaries. Having one entity (e.g., integrated health plan) responsible for the provision and coordination of Medicare and Medicaid benefits creates an incentive for care delivery at the right setting at the right time.

   These incentives can be built into program financing and payment, but their effectiveness depends on the degree to which payment methodologies account for the complexity of the population being served, and whether federal and state partners can jointly establish and refine capitated health plan payments. To enable an integrated approach to rate setting and assessment of payment accuracy, states would welcome more transparency on Medicare

Advantage rate development—including sharing health plan risk scores and payment information where relevant.

5) **Sufficient resources for oversight and monitoring.** States, federal partners, and health plans need to provide considerable investment to develop comprehensive quality oversight and monitoring strategies. Resources were needed for factors like state agency staffing, information systems, technology, and contractor support. Moreover, developing Medicare expertise within the state Medicaid agency is essential for supporting both program design and ongoing monitoring and oversight of the program and health plans.

States identified the following federal-level factors as influential on states' decisions to invest in integrated care programs:

- **Flexibility** to align Medicare and Medicaid processes, requirements, and oversight.
- **Permanency** and **sustainability** of integration models, including pathways to identify effective beneficiary enrollment and retention strategies.
- Whether federally-driven integration options provide **financial incentives** to states to share in the Medicare savings that may accrue from better coordinated care.

Sources: Center for Health Care Strategies, "Implementing New Systems of Integration for Dually Eligible Enrollees (INSIDE)," May 2013 – December 2017. https://www.chcs.org/project/implementing-new-systems-of-integration-for-dual-eligibles-inside/

Alexandra Kruse, Stephanie Gibbs, and Leah Smith, "Advancing Medicare and Medicaid Integration: Key Program Features and Factors Driving State Investment," https://www.chcs.org/resource/advancing-medicare-medicaid-integration-key-program-features-factors-driving-state-investment/