



June 30, 2023

The Honorable Bill Cassidy  
United States Senate  
Washington, DC 20510

The Honorable Thomas R. Carper  
United States Senate  
Washington, DC 20510

The Honorable Tim Scott  
United States Senate  
Washington, DC 20510

The Honorable Mark Warner  
United States Senate  
Washington, DC 20510

The Honorable John Cornyn  
United States Senate  
Washington, DC 20510

The Honorable Robert Menendez  
United States Senate  
Washington, DC 20510

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

Thank you for your continued commitment to promoting care coordination, improving health outcomes and advancing equity for dually eligible individuals. The Alliance of Community Health Plans (ACHP) appreciates the opportunity to provide feedback on your dual eligible discussion draft that aims to improve care coordination for this vulnerable population.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care, delivering affordable, coordinated and comprehensive coverage options. Our member companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans in nearly 40 states and D.C. Anchored in their communities, ACHP member companies deeply understand the transformative impact of an integrated system of care, in which providers, payers and community leaders work together to enhance access to services and improve health outcomes. ACHP's member companies' model of care delivery fosters greater care coordination and effectively positions our members to serve the complex needs of dually eligible populations.

ACHP and our member companies strongly support efforts to advance legislation that achieves greater integration and care coordination for programs serving dually eligible individuals. Managed care plans, such as Dual Eligible Special Needs Plans (D-SNP), combine standard health benefits with additional coverage and services that address the unique health needs of their beneficiaries. The coordination of these benefits leads to health care that is both more efficient and higher quality.



The discussion draft is an important starting point at addressing existing areas of care delivery that can be improved. In summary, ACHP recommends the following changes to the discussion draft that will further advance care coordination.

- Consider the implications of introducing impact definitions for partial dually eligible individuals on existing network requirements and plan benefit designs.
- Include language that directs CMS to build on existing models that have an established foundation, while bolstering opportunities for innovation at the state or plan level.
- Support automatic and continuous enrollment that directs beneficiaries into high-quality plans.
- Direct CMS to evaluate the implications of state-by-state variances in Medicaid benefits for any new plan requirements for partial dually eligible individuals.
- Remove provisions that create a new risk adjustment model solely tailored to dually eligible beneficiaries.
- Prioritize existing outreach programs for dually eligible beneficiaries.
- Create consistency of provider directory requirements across government programs.
- Clarify the populations required to enroll into specialized D-SNP plans for institutional dually eligible individuals.
- Require CMS to clearly set parameters for proper care coordinator to patient staffing ratios.
- Remove the quarterly restrictions of new PACE Providers.

#### **Title I, Section 2201 – Definitions**

**ACHP recommends reconsidering definitions for partial dually eligible individuals on existing network requirements.** It is unclear how introducing new definitions regarding which populations are considered dually eligible will impact provisions in Section 2204 of the discussion draft and how this will affect the assignment of benefits between full dually eligible and partial dually eligible beneficiaries.

#### **Title I, Section 2202 – Dual Eligible Models**

**ACHP recommends directing CMS to build on existing models that have an established foundation, while bolstering opportunities for innovation at the state or plan level.** In the discussion draft, CMS would develop models for both fully and partially integrated plans. States would select a model to implement within one year of publication and plans would expect enrollment to begin in year four. As written, there are no requirements or criteria that CMS must consider when creating models for fully and partially integrated plans. States and managed care organizations (MCOs), in partnership with CMS, have worked to create models for dually eligible individuals that are working well. To foster meaningful innovation, ACHP recommends that the legislation direct CMS to use existing models as a baseline to drive efficiency and ensure that



states and plans can build upon current infrastructures to implement any changes with minimal disruption.

### **Title I, Section 2203 – Automatic Enrollment/Continuous Enrollment**

**ACHP strongly supports policies for automatic and continuous enrollment that directs beneficiaries into high-quality plans.** Mechanisms and processes for automatic and continuous enrollment need to be transparent and clearly communicated to the beneficiaries, and the role of the plan needs to be clearly defined. ACHP stands ready to serve as a partner in this effort, leveraging our long support of policies that enroll seniors entering the Medicare program in top-quality Medicare Advantage (MA) plans.

### **Title I, Section 2204 – Plan Requirements**

**ACHP recommends directing CMS to evaluate the implications of state-by-state variances in Medicaid benefits for any new plan requirements for partial dually eligible individuals.** The discussion draft mandates health plans that offer fully integrated plans for full-benefit individuals must also provide a partially integrated plan that includes the provider network of the fully integrated plan option. We acknowledge that partial dual eligible individuals require support and integration of benefits. However, there is significant variation at the state level regarding partial dual eligibility and state Medicaid plan benefits.

Further, in some states, enrollment of partial duals in D-SNPs is not permitted and no partial benefit D-SNPs exists. It is unclear what value a partial benefit D-SNP would be to the enrollee or the plans required to provide them. Additionally, it is important that CMS clarify the role of care coordination for this population who are not eligible for Medicaid benefits.

### **Title II, Section 201 – New Risk Adjustment Model**

**ACHP opposes the creation of a new risk adjustment model solely tailored to dually eligible beneficiaries.** Any model must maintain measure consistency across all MA plans in order to reduce administrative burdens, particularly for providers. ACHP's recently launched *MA for Tomorrow* proposal calls for improving the current risk adjustment model in MA by recalibrating the model on encounter data, scaling coding intensity adjustments to address outliers and targeting audits to the most aggressive risk adjustment behaviors. We look forward to providing additional insights as our *MA for Tomorrow* efforts advance in earnest and are eager to support the development of a risk adjustment model that better represents and accounts for acuties of duals.

### **Title II, Section 204 – State and Local Grants for Outreach**

**ACHP recommends prioritizing support for existing outreach programs for dually eligible beneficiaries.** Certain states may already operate programs to encourage cooperation and coordination from integrated plans to conduct outreach to dually eligible individuals. Supporting



existing programs in states that are currently deploying outreach efforts would leverage the system more efficiently, strengthen community partnerships and bolster referral loops.

#### **Title II, Section 209 – Provider Directory Update**

**ACHP requests consistency regarding provider directory requirements across government programs.** CMS currently has two proposed rules related to access to Medicaid covered services, including ensuring accurate provider directory information and a quality rating system. It is imperative that CMS remain consistent with the changes being proposed through these rules and the measures determined for dual eligible models across its programs. The more consistent the measures between Medicaid-only managed care plans and those plans serving dual eligibles, the lower the burden for both states and managed care plans, as well as members and providers, who are collecting and reporting this information.

#### **Title II, Section 210 – Additional CMS Responsibilities for Integrated Care**

**ACHP recommends clarifying the populations required to enroll into specialized D-SNP plans for institutional dually eligible individuals.** CMS has proposed rules related to access to Medicaid services which include metrics for quality rating systems. Consistent measures between Medicaid-only managed care plans and those plans serving dually eligible individuals will lower the burden for both states and managed care plans, as well as members and providers, who are collecting and reporting information on quality measures. Additional clarity is needed to determine if this section refers to Long-Term Care beneficiaries enrolled in a D-SNP plan that would need to be enrolled into a specialized D-SNP plan for institutional dually eligible individuals.

#### **Title II, Section 212 – Maximum Staffing Ratios for Care Coordinators**

**ACHP recommends CMS be directed to set parameters for proper care coordinator to patient staffing ratios.** It is vital that capitation rates are appropriately balanced for any staffing ratios without placing additional burdens on the plan that may impact care coordination. ACHP member companies are committed to meeting regulatory requirements and meeting enrollee needs and request clarity on staffing ratios required to ensure appropriate care coordination.

#### **Title III, Section 404 – Removal of Quarterly Restrictions of New Program of All-Inclusive Care for the Elderly (PACE) Providers**

**ACHP supports the removal of quarterly restrictions of new PACE Providers.** This would decrease PACE CMS regulatory timelines significantly and would support operationalizing provisions in this legislation that call for establishing a PACE program in each state.

#### **Title III, Sections 405 – Cost Protection for PACE Providers**

**ACHP requests clarification on the definitions of PACE providers.** The language in the discussion draft is vague and requires further clarification regarding which types of providers



would qualify as a new PACE provider. ACHP supports designations of existing PACE providers who expand to new states as new providers.

ACHP appreciates the opportunity to comment and provide recommendations on these important proposals to improve care for dually eligible individuals. ACHP and our member companies are committed to working closely with you and your staff as this draft legislation continues to take shape. Please contact Tricia Guay, ACHP's Director of Legislative Affairs, at [tguay@achp.org](mailto:tguay@achp.org) or (202) 524-7752, with any questions or if we can provide further information.

Sincerely,

Dan Jones  
SVP, Federal Affairs  
Alliance of Community Health Plans