ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

January 13, 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

RE: Senate Request for Information on Dual Eligibles

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

Thank you for your leadership in promoting care coordination, improving health outcomes, fostering integration and advancing equity in programs that serve dually eligible populations. The Alliance of Community Health Plans (ACHP) appreciates the opportunity to provide feedback on serving this important and 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. ACHP member companies collaborate with their provider partners to deliver higher-quality coverage and care to tens of millions of Americans in 37 states and D.C. Deeply rooted in their communities, ACHP member companies understand the value of an integrated system of care, in which providers, payers and community leaders work together to enhance access to services and improve health outcomes.

Dually eligible patients are a high-need, high-cost population. Approximately 70 percent of dually eligible patients have three or more chronic conditions, 41 percent live with a behavioral health disorder and 40 percent utilize advanced medical care and support. Further, Medicare Advantage and managed Medicaid plans have experienced a rise in enrollment among people of color, particularly among Black and Hispanic enrollees. With a growing and rapidly changing market, it is imperative to tailor care delivery to serve this population, further health equity and improve health outcomes.

ACHP member companies are leading efforts to address disparities. In our 2030 Roadmap to Reform, ACHP members pledged to reduce the prevalence of chronic disease and implement sustainable solutions

to improve health care affordability. With a keen focus on diabetes and heart disease, ACHP member plans and their provider partners pledge to measure and address specific drivers of chronic conditions in their communities. We look forward to providing additional insights into strategies demonstrated to address chronic illness that can inform interventions for dually eligible individuals whose experiences serve as the impetus for this effort.

The Request for Information (RFI) seeks feedback on key priorities to encourage greater integration between Medicare and Medicaid programs. In addition to identifying and providing insights on specific priorities, ACHP is recommending congressional actions to advance care for dual eligibles. The following priority areas are further detailed below.

- Defining care for dually eligible beneficiaries;
- Identifying barriers and limitations in the current system for dual eligibles;
- Identifying successful models of integration between Medicare and Medicaid programs;
- Recognizing the diversity of the dual eligible population; and
- Evaluating the impact of geography on coverage for dual eligibles.

Defining Care for Dually Eligible Beneficiaries. ACHP member companies identify integrated care, care coordination and aligned enrollment as critical elements of a cohesive process for the successful integration of Medicare and Medicaid. To continue to build and improve upon the current system for dual eligible individuals, it is vital that these three concepts work in concert to cultivate the best experience and health outcomes for dually eligible patients. In response to the RFI, we have detailed below the ways in which ACHP member companies distinguish these concepts.

Integrated Care

Integrated care is a patient-centric approach to health care delivery that relies heavily on the establishment of partnerships, data sharing mechanisms and simplified operational protocols to provide appropriate care and services in the right place, at the right time to consumers. In the context of dually eligible beneficiaries, this means providing care regardless of payer (Medicare or Medicaid). The information loop facilitated through integrated care best serves the patient, as members of the care team are afforded a more comprehensive perspective into the individual's health, regardless of how care was provided, or by which entity care was financed.

Care Coordination

Care coordination entails all activities required to assess, authorize, navigate, facilitate and communicate appropriate services and care delivery for patients. Care coordination ensures that patients receive critical services, such as the completion of routine health screenings, ensuring access to social services and supports and medication management.

Aligned Enrollment

Aligned enrollment is an arrangement in which a beneficiary is enrolled in a Dual Eligible Special Needs Plan (D-SNP) and an affiliated managed Medicaid plan offered by the same company.
Aligned enrollment is an essential component to providing integrated care and affords care coordinators with a complete assessment of a consumer's care needs.

Limitations within the Current System for Dual Eligibles. Often, consumers do not understand the difference between integrated and non-integrated health plan options. A fully dual eligible individual may have the option to enroll into an integrated managed care plan, but they are not automatically enrolled. Instead, they are automatically enrolled in a non-integrated plan in most states. By defaulting a dually eligible individual's enrollment to a Medicaid organization integrated with their selected Medicare D-SNP, with the option to opt-out, consumers would begin their care journey with whole person-centered coverage.

This strategy is validated by the legacy Minnesota Senior Health Options (MSHO) FIDE-SNP analysis, which revealed that when optional enrollment into the fully integrated plan is selected, very few enrollees "opt-out" and switch to the non-integrated plan. However, about 13 percent of the non-integrated enrollees *switch* to the integrated plan during their annual election period.

ACHP recommends Congress instruct CMS to provide guidance regarding defaulting enrollment into integrated plans as they become more available across states. Also, to the extent possible, we urge Congress to encourage CMS to review mandated Medicaid coverage requirements and update them to support greater coordination and integration of dual programs.

The lack of clearly defined requirements to include long-term services and supports (LTSS) and behavioral health services create disruption in care coordination. For example, in Pennsylvania, the state Medicaid program operates with a behavioral health carve-out, contracting with county-based agencies. The state agency has not indicated any intention of moving away from that model to transfer the behavioral health benefit to the managed Medicaid plans' responsibility. Unless there is a change to CMS' definition of FIDE-SNP that would not require providing behavioral health when the benefit is a state Medicaid carve-out, some plans stand to lose this designation.

ACHP recommends Congress direct CMS to review the mandated Medicare coverage requirements and include definitions of LTSS and behavioral health services.

Finally, another barrier is state-by-state variances in the availability of integrated plans. In addition to differences in Medicaid eligibility requirements and Medicaid benefit coverage across states, the level of integration varies as well. These factors are contingent upon individual state capacity and interest in supporting D-SNPs and integration overall. Minnesota and Massachusetts have had significant success in their integration efforts, largely attributable to the support they have received from state officials. To build these models to scale across the country, states need ample guidance and resources to support their efforts to move in a more integrated direction.

ACHP recommends Congress consider legislation providing CMS with the authority and infrastructure to support state efforts in integrating Medicare and Medicaid programs.

Successful Models for Integrating Care for Dual Eligibles. ACHP member companies in Minnesota and Massachusetts have observed success in their respective fully integrated dual eligible special needs plan (FIDE-SNP) programs. States using integrated models have refined and continue to innovate their models to best suit their population.

In the 2016 legacy MSHO FIDE-SNP analysis, researchers compared over 121,000 full dual eligibles who were enrolled in the fully integrated MSHO health plan to those enrolled in the Minnesota Senior Care Plus (MSC+), a non-integrated plan. For MSC+ enrollees, Medicare services were paid by original Medicare over a three-year period. The goal was to determine if the delivery of Medicare and Medicaid services through a fully integrated managed care plan (MSHO) was associated with stronger community-based service use. The analysis concludes that the managed care program is associated with improved patterns of care which can improve health outcomes for dual eligible individuals.

Select findings from the analysis revealed that those enrolled in MSHO were 48 percent less likely to have a hospital stay; 2.7 times more likely to have a visit with a primary care physician, yet still have fewer visits overall than those on MSC+; and 13 percent more likely to have home and community-based services than those in MSC+. This is a key service that keeps enrollees in the community and out of hospitals and institutions.

Separately, Massachusetts's Senior Care Options plan, the state's proprietary FIDE-SNP, has consistently supported the expansion of service areas, benefits and care management capabilities to further enhance comprehensive care integration for dual populations.

ACHP recommends Congress refer to the MSHO and the Senior Care Options plan as highly impactful FIDE-SNPs for models of successful integration. There is not a singular resource that completes an analysis or review of all models to determine best practices and outcomes.

ACHP recommends that Congress enact legislation directing a study, by the Government Accountability Office, evaluating best practices and outcomes of the various programs currently in place to serve dual eligible populations.

Diversity of the Dual Eligible Population. To identify poor outcomes, fully integrated plans need the ability to capture and use enrollee data to make meaningful inferences. Based on these data analyses, fully integrated plans could implement performance improvement projects. The results from these projects could be tied to financial outcomes such as withholds or a condition of contracting with the state to serve these individuals. It is important that multiple projects be chosen to focus on the diverse population based on geography, race, utilization, among other factors.

Establishing federal standards for data collection would positively impact the critical work providers and payers are engaged in to advance health equity and meaningfully address health disparities. There is no national consensus on these data elements. Consequently, persistent disparities between systems lead to member abrasion.

ACHP recommends Congress require CMS to partner with states and plans to develop technical guidance and assistance to ensure consistent and standardized data collection and reporting. Additionally, ACHP recommends that Congress direct CMS to evaluate current Risk Adjustment methodologies to account for SDOH risks and the utilization of LTSS. The population demographics for traditional Medicare and FIDE-SNP programs are dissimilar enough to warrant adjusting this methodology to better represent the populations currently served.

Impact of Geography on Coverage for Dual Eligibles. Geography impacts a consumer's access to services, including provider availability. Those in rural or isolated areas are less likely to receive appropriate care quickly or conveniently due to a lack of providers and logistical challenges.

Dually Eligible individuals in rural areas require increased resources in the form of HCBS, LTSS, telehealth and transportation. To best serve these individuals, there are several strategies that must be considered (with the needs slightly differing based on geography). Those in rural areas need strong, stable internet to utilize telemedicine, as well as the technology (smartphone, tablet, computer). These services are furnished via mobile clinics, including medical, mental health and dental, and social services, such as food pantries, in rural and urban areas, particularly without provider availability.

Living in a rural environment increases the risk of poor outcomes. Continuing to evaluate and support the provision of telehealth services to supplement or replace in-person visits is integral to improving care delivery.

ACHP recommends Congress provide resources to support the health care workforce.

Social Risk Factors. The only way to provide more flexible benefits to dually eligible beneficiaries is through Special Supplemental Benefits for the Chronically Ill or Value-Based Insurance Design (VBID). The administrative burden of applying for and monitoring services under VBID often deters plans from participation.

ACHP recommends Congress direct CMS to increase supplemental benefit flexibilities for D-SNPs. SSBCI only considers chronic illness and does not account for social risk factors such as low-income indicators this entire population is subject to. CMS should consider a social-risk or income-based supplemental benefit flexibility for D-SNP plans to better support these vulnerable populations.

ACHP stands ready to work with you and your staff to forge sustainable and innovative solutions towards integrating care for dually eligible individuals. We look forward to continued engagement and partnership in this effort and look forward to scheduling meetings with our member companies to highlight how they have leveraged their provider-aligned, community health models to deliver superior care to their dually eligible members. Please contact me at djones@achp.org or 202-524-7753, with any questions or if we can provide further information.

Sincerely,

Dan Jones

Dan Jones
Senior Vice President, Federal Affairs
Alliance of Community Health Plans