



January 13, 2023

The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Thomas R. Carper
United States Senate
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senate
703 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
United States Senate
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Robert Menendez
United States Senate
528 Hart Senate Office Building
Washington, DC 20510

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

On behalf of our nearly 38 million members and all older Americans nationwide, AARP appreciates the opportunity to provide comments in response to your request for information regarding “dual eligible” enrollees—that is, individuals enrolled in both Medicare and Medicaid—and possibilities to better coordinate and improve their care. AARP shares your interest in not only improving the data and knowledge base regarding the needs of dual eligibles, but in using this information to improve the quality and effectiveness of their care as well as the various payment and care models that have been tested to optimize their lives.

Your request provides important context and outlines crucial questions for considering how to better integrate Medicare and Medicaid coverage for dual eligibles. This is a high-need population with diverse life situations and preferences. Many dual eligibles need long-term services and supports (LTSS), which may be provided in a wide variety of settings, from skilled nursing facilities to home and community-based settings. Many have both complex physical and behavioral health conditions. As your request notes, dual eligibles also vary in age, with 38% under age 65.¹ Care for dual eligibles can be fragmented and disjointed. They may see multiple providers to address their health needs, and must navigate the rules and processes of both

¹ Medpac/MACPAC Data Book, February 2022

Medicare and Medicaid. Finally, providers and plans are too often paid in a way that rewards volume of services provided rather than quality and outcomes, to the detriment of those served.

Not surprisingly, given this context, dual eligibles have historically experienced poor health outcomes, and at the same time represent a disproportionate share of costs to both the Medicare and Medicaid programs. For these reasons, dual eligibles have long been a focus for stakeholders and policy makers. However, it is not clear that we have reached a point where we can point to a model as truly best serving this population. With this shared recognition of the current context for dually eligible individuals, we offer the following comments.

Increasing Care Coordination and Integration to Improve Care for Dual Eligibles

Dual eligibles receive care from a variety of providers in various settings. So far, efforts to improve care for dual eligibles have focused largely on better coordination across providers and settings. Current approaches to enhance care coordination include patient-centered medical homes and establishment of interdisciplinary care teams. These approaches should also address, to the maximum extent possible, social drivers of health and health-related social needs that can underlie disparities and health outcomes.

How dual eligibles experience the Medicare and Medicaid coverage systems varies greatly by how they access those services. They may obtain services for one or both programs on a fee-for-service (FFS) basis, or be enrolled in managed care plans for one or both programs. They may even be enrolled in managed care plans for Medicare and Medicaid and also receive additional Medicaid services on a fee-for-service basis (as is the case if a state “carves out” any services from its managed care program). Each of these frameworks presents its own challenges. Dual eligibles may have to deal with different coverage policies, which can present challenges such as determining if a service is covered and, if so, by which program. Enrollees must also determine the requirements for the service to be paid, and whether the policies between programs differ, all of which may impede access to care. If an enrollee seeks to file an appeal in an attempt to ensure a service is covered, the enrollee may face confusion with whether to file with Medicare, the state Medicaid agency, or the managed care organization (MCO).

One way to mitigate the issues associated with multiple payers and policies is to integrate the functions of program payment benefits administration and care coordination. For dual eligibles, the level of integration refers to the extent to which these functions are effectively performed by a single entity. Integration tends to rely on capitated models, in which a plan enters into a risk-based managed care arrangement aimed at improving clinical, service, financial and administrative coordination. Medicare-Medicaid Plans (MMPs) enter into three-way contracts with the Centers for Medicare and Medicaid Services (CMS) and the state Medicaid agency to receive a combined prospective payment to provide all Medicare and Medicaid benefits to their enrollees, including behavioral health and LTSS. Other examples of integrated models for dual eligibles include the Program of All-Inclusive Care for the Elderly (PACE) and certain Medicare Advantage dual eligible special needs plans (D-SNPs).

Shortcomings of the Current Systems

How dual eligibles currently obtain their Medicare and Medicaid services varies greatly. More than half of dual eligibles (55%) have their Medicare enrollment in FFS only, meaning their care is generally less likely to have care coordination.² Half of those in Medicare managed care plans are in D-SNPs. While these plans provide some coordination between the programs, the levels vary significantly.³ Among all dual eligibles, 37 percent had their Medicaid enrollment through a managed care plan with more comprehensive care coordination.⁴

The Financial Alignment Initiative demonstrations (FAI demos or demos) sought to test new approaches to address the needs of dual eligibles.⁵ Under these demos, a single managed care plan receives capitated payments to cover all Medicare and Medicaid managed care benefits under a contract with both the state and CMS. The demos are designed to address several of the issues outlined above by having one entity at financial risk for both sets of benefits, using case management and care coordination.

Many elements of the demonstrations have provided some improvements for dual eligibles. However, missing and inconclusive data leaves many questions unanswered. For example, under the demos, Medicare cost impacts have been mixed. Findings from enrollee [focus groups](#) and quality measure outcomes data such as HEDIS and [CAHPS](#) are also mixed.⁶ Finally and importantly, the FAI demos have suffered from high opt-out rates among beneficiaries.⁷ Beneficiaries' experiences should be further explored to understand why many beneficiaries did not see value in staying enrolled in these models.

² Exhibit 11 of “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid,” Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), February 2022.

³ Some D-SNPs are only required to provide minimal coordination to assist an enrollee Medicaid coverage. See 42 CFR 422.562(a)(5). Other D-SNPs, fully integrated may cover and coordinate all Medicare and Medicaid managed care benefits for an enrollee. See 42 CFR 422.2

⁴ Exhibit 12 of “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid,” Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), February 2022.

⁵ Under this authority, other models have been tested for dual eligibles. For example, two states (Washington and Colorado) operated a Managed FFS (MFFS) model. The Washington model has been extended through December 31, 2023. Colorado's ended December 31, 2017. Minnesota established an alternative model focused on administrative alignment.

⁶ Information on the evaluation findings for each state demonstration can be found at <https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/financialalignmentinitiative/evaluations>

⁷ MACPAC, “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare Issue Brief, April 2022, available at: <https://www.macpac.gov/wp-content/uploads/2022/04/Financial-Alignment-Initiative-2022.pdf>, and Georgia Burke, “Why Did Certain Language Communities Steer Clear Of Medicare-Medicaid Integration Demonstrations?,” Health Affairs, July 19, 2022, available at: <https://www.healthaffairs.org/content/forefront/why-did-certain-language-communities-steer-clear-medicare-medicaid-integration>

CMS is now phasing out the FAI demos and is encouraging states to require integrated forms of D-SNPs; many successful elements of the FAI demos are being moved into D-SNP regulations.⁸ However, it is not clear whether the concerns noted above will be addressed by these changes. With respect to specific models to advance, we believe more complete data is necessary to ensure we have identified the best elements and approaches to implement those elements into a care delivery model for this complex population. We applaud Congress' efforts to look more broadly at how best to meet the health needs of dual eligibles.

Key Elements of a Care Delivery System

Though many questions posed in the request for information still need additional data and information to best answer, any model or system implemented to deliver services and care to dual eligibles should incorporate several important principles, including:

- Robust federal and state oversight of MCOs, including clear goals and quality improvement plans;
- Inclusion of beneficiary and family member perspectives in MCO oversight;
- Meaningful beneficiary protections, including opt-out provisions; and
- Sound quality measures.

To minimize disruption for beneficiaries, any future models should:

- Include provisions for continuity of care, allowing enrollees to continue with current courses of treatment or current providers for some period of time until a smooth transition can be completed.⁹
- Prior to enrollment in any new system or plan, ensure that all of the enrollees' electronic records and prior authorizations are transferred to the new system and honored by any entity responsible for overseeing the enrollee's benefits.
- Conduct testing of education and outreach materials with a diverse sample of potential enrollees.

In addition, AARP continues to advocate for certain principles and protections regarding managed care for dually eligible individuals:

- Quality and value: Any approach should seek to improve the quality and value of care for dual eligibles by organizing and delivering care in ways that coordinate and improve service delivery, eliminate unnecessary utilization and cost, and promote quality. This may require developing new measures to best capture useful information focused on this complex but diverse population.
- Guaranteed and informed choice: Beneficiaries should have the ability to make enrollment changes at any time, based on information that is easy to understand, culturally competent, and linguistically appropriate.

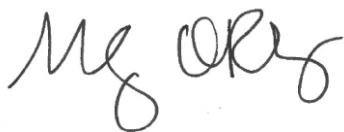
⁸ See 87 FR 27715, available at <https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and>

⁹ These continuity of care provisions were included in the FAI demonstrations.

- Consumer participation: States should ensure that a broad and diverse representation of stakeholders is actively and meaningfully engaged in the design, implementation, and operation of managed care programs for dual eligibles.
- Benefit coverage: State and federal governments must ensure that all benefits required under statute or regulations are covered in an integrated way such that the beneficiary does not need to navigate different entities for coverage of their Medicare and Medicaid services, including access to comprehensive LTSS (as applicable). State and federal governments should work collaboratively to align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.
- Oversight and enforcement: State and federal regulators must have sufficient resources, capacity, and seamless cooperation to monitor MCO compliance effectively and take timely corrective action where necessary.
- Performance assessment and evaluation: Any entity responsible for administering benefits should be assessed using standardized measures that are valid and reliable and that assess clinical effectiveness, safety, consumer and family experience, resource use, and efficiency across the continuum of care. Model evaluations should be conducted on an ongoing basis by national, independent evaluators, beginning where there is sufficient baseline data from existing managed care and FFS delivery systems for both Medicare and Medicaid.

We thank you for the opportunity to respond to this important request to help ensure a more comprehensive look at how best to meet the diverse health needs of dually eligible individuals. If you have any questions, please do not hesitate to contact me or Glen Fewkes (gfewkes@aarp.org) on our Government Affairs staff at 202-434-3766.

Sincerely,



Megan O'Reilly
Vice President, Health & Family
Government Affairs