



May 26, 2021

Chiquita Brooks-LaSure
CMS Administrator
200 Independence Ave SW
Washington, DC 20201

RE: Strategic Vision – Improving Care and Coverage for the Dual Eligible Population

Dear Administrator Brooks-LaSure:

Arnold Ventures is a philanthropy dedicated to evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide range of issues including prescription drug prices, health care prices, low-value care, and complex care.

First, we want to thank you and the new Administration for beginning to develop a thoughtful and inclusive plan for improving the health care system in the United States. We recognize the competing priorities your team is facing and appreciate the opportunity to provide input.

We write to you today about a population that has been particularly hard hit by COVID-19, the “dual eligible” population, or the 12 million people simultaneously enrolled in Medicare and Medicaid. Improving this population’s coverage and care is the focus of the Complex Care initiative at Arnold Ventures. The Centers for Medicare and Medicaid Services (CMS) found that dual eligible individuals are three times as likely as the average Medicare beneficiary to be hospitalized from COVID-19,¹ likely because the dual eligible population has a disproportionate level of characteristics deemed “high risk” by the CDC.² The pandemic has only underscored the need to improve the complicated system that provides coverage and care to this population.

This letter outlines a vision for CMS staff regarding near-term opportunities to address the needs of dual eligible individuals while also shifting long-term care services towards the community. We recognize that there are multiple strategies that could be used to improve the experience and outcomes of this population and welcome you to consider further discussions with our staff and grantees. We hope to be a valuable resource as CMS contemplates how best to address the challenges facing the dual eligible population today.

The Problem

¹ Centers for Medicare and Medicaid Services. [Preliminary Medicare COVID-19 Data Snapshot \(January 1-November 21, 2020\)](#). December 18, 2020.

² Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-eligible beneficiaries](#). July 17, 2020.

The dual eligible population make up approximately 15% of Medicare and Medicaid enrollees, yet account for more than 30% of public spending.³ With a high burden of medical conditions and functional limitations, dual eligible individuals are more likely have an inpatient stay, an emergency room visit, or live in a long-term care facility compared to Medicare-only beneficiaries.⁴ They are also more likely to self-report poor health.⁵ These high costs and worse outcomes are driven largely by two factors, (1) inefficiencies in delivering two interrelated health benefits—acute and long-term care—in an unintegrated manner while states and the federal government cost-shift; and (2) institutional bias within the Medicaid system.

The Solution

Our goal is to address these problems by integrating Medicare and Medicaid, or aligning acute and long-term care financing, benefits, and experience for those who are enrolled in both programs. This unified system must also be inclusive of and incentivize the use of the benefits people need in order to thrive outside of nursing homes in their own communities.

Efforts to Date

This vision is not new. Congress and CMS have been making strides towards integrating care for decades. A few highlights over the last ten years include:

- In recognition that a singular government office needed to be responsible for driving change for the dual eligible population, the Patient Protection and Affordable Care Act (ACA) created the Medicare and Medicaid Coordination Office (MMCO).⁶
- The creation of the Centers for Medicare and Medicaid Innovation (CMMI) led to a new demonstration for integrating the two programs, the Financial Alignment Initiative (FAI), representing great progress in providing an integrated coverage option to dual eligible individuals in select states.
- Through the Bipartisan Budget Act (BBA) of 2018, Congress made permanent the Dual Eligible Special Need Plan (D-SNP), a type of Medicare Advantage plan targeted to dual eligible individuals, and imposed new requirements to increase the plans' level of integration with Medicaid.
- Through 2019 regulation, CMS updated its Program of All-Inclusive Care for the Elderly (PACE) model to provide the programs with more flexibility to achieve greater scale.

These developments have made a range of coverage options, offering different levels of integration, available to dual eligible individuals today. States are left to determine which models to make available and to define what integration means within the confines of federal parameters. This has created a confusing landscape for policymakers and consumers alike. Many states do not make integrated models available, and even when they do, there are significant barriers to enrollment—people do not always understand the models, are not encouraged to select them, and may even be discouraged by

³ Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. [January 2018 Joint Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#). January 2018.

⁴ Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-eligible beneficiaries](#). July 17, 2020.

⁵ Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. [January 2018 Joint Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#). January 2018.

⁶ The Patient Protection and Affordable Care Act, Section 2602. [The Federal Coordination Health Care Office \(“Medicare-Medicaid Coordination Office”\)](#). 2010.

providers. As a result, only one in ten dual eligible individuals is enrolled in a coverage option that is considered “fully” integrated today.⁷

CMS likely cannot achieve the broad vision of completely integrating Medicare and Medicaid independently—it will require an act of Congress—but we believe significant progress can be made under existing authority to better streamline the two programs and incent enrollment in integrated coverage options.

Building on Progress to Date

We have organized our strategic vision around six principles. **On the following page please find a summary of our vision and recommendations, including specific strategies, where appropriate.** A more detailed overview of each principle and recommendation, including background on the topics, can be found in the appendix (pages 5-11). We emphasize that this outline represents one path forward for CMS to contemplate and recognize there are other strategies that could be used to address the needs of the dual eligible population. No matter what vision is ultimately pursued, we look forward to working with CMS in the years ahead to improve care and coverage for the dual eligible population.

Please contact Arielle Mir at amir@arnoldventures.org with any questions. Thank you again for the opportunity to provide feedback on the strategic direction that CMS might take to pursue opportunities to further integrate Medicare and Medicaid for the dual eligible population.

Sincerely,

Arielle Mir

⁷ The Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office. [Fact Sheet: People Dually Eligible for Medicare and Medicaid](#). March 2020.

Principle	Identified Problem	Proposed Solution
1. Use the Lessons Learned from the Financial Alignment Initiative (FAI) Demonstration to Improve Upon the FIDE-SNP	The FIDE-SNP model lacks some of the key features needed for effective integration that have been piloted through Medicare-Medicaid Plans (MMPs) under the FAI demonstration.	We recommend that CMS use its authority to make key improvements to the FIDE-SNP and ask Congress for further authority, as necessary.
2. Streamline the Home and Community-Based Waiver Process & Use MLTSS to Rebalance and Expand Access to the FIDE-SNP Model	Due to the complexity of the State Plan and waiver processes, state MLTSS programs often fail to rebalance care away from institutions and towards home- and community-based services. Additionally, few states take advantage of the ability to use MLTSS to integrate care through the FIDE-SNP.	We recommend that CMS use its authority to streamline and simplify the existing State Plan and waiver process for home and community-based services and encourage states with MLTSS programs to build in incentives to rebalance care and implement FIDE-SNPs.
3. Financially Support States Willing to Implement the FIDE-SNP	There is inadequate availability of integrated models nationwide, as states often lack the resources and capacity to implement such models.	We recommend that CMS establish its own grant program to support states that are willing to implement a FIDE-SNP to expand access to integrated models and connect rebalancing efforts with implementing a FIDE-SNP.
4. Invest in Increasing Enrollment in Integrated Models	Only one in ten dual eligible individuals is enrolled in an integrated model, in part because of the lack of clear guidance on how to select a coverage plan and churn within the Medicaid program.	We recommend that CMS build on investments made by the Association for Community Living (ACL) to assist states and entities that provide direct-to-consumer support with further education and resources in order to make the value of integrated models clearer to consumers and to facilitate their enrollment in such models. We also recommend that CMS help beneficiaries stay enrolled in integrated models by reducing churn out of Medicaid.
5. Limit the Ability of Medicare Advantage and Centers for Medicare and Medicaid Innovation (CMMI) Models to “Pull” Dual Eligible Individuals out of Integrated Coverage Models	Alternative coverage options, including those that do not offer integrated coverage but market themselves similarly to dual eligible special needs plans, often called “look-alikes,” as well as some that are offered through CMMI, can confuse dual eligible consumers and reduce enrollment in integrated options.	We recommend that CMS expand upon its policy to decline to contract with or renew contracts with certain “look-alike” plans and carefully contemplate the potential impact that each new CMMI model could have on dual eligible enrollment in integrated models.
6. Consider Consolidating Authority for the Full-Benefit Dual Eligible Population’s Coverage Within the Medicare and Medicaid Coordination Office (MMCO)	The authority for the coverage programs used to integrate care for the dual eligible population is currently shared between multiple offices. In order to move integrated models forward, the office tasked with focusing on the dual eligible population, MMCO, must navigate this complicated landscape.	We recommend that CMS consider consolidating authority within MMCO for issues impacting the dual eligible population and have the office directly report to the Administrator, making it an equivalent office with Medicare and Medicaid.

APPENDIX

1. Use the Lessons Learned from the Medicare-Medicaid Plans to Improve Upon FIDE-SNP

Identified Problem: In the BBA of 2018, Congress made the FIDE-SNP model permanent, and in doing so, created an enduring, scalable model for supporting the integration of Medicare and Medicaid. While this model represents a comprehensive integrated option, it lacks some of the key features needed for effective integration that have been piloted through Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative (FAI).

Background: The BBA of 2018 and associated regulations and guidance made improvements to better integrate Medicare and Medicaid under FIDE-SNPs, including aligning the two programs' appeals and grievance processes. However, it did not incorporate all the lessons learned from the MMPs, leaving a promising opportunity for the Administration, and Congress, as appropriate, to further improve the FIDE-SNP model by incorporating some of the key lessons from the MMPs. We have identified three key categories where improvements could be incorporated into the FIDE-SNP model: administrative alignment, passive or automatic enrollment, and limiting the model to full-benefit dual eligible individuals.

These categories represent changes that we believe could be feasible under existing CMS authority. Notably, we have not included the hallmark of the MMP demonstration—shared savings between the state and federal government—because we anticipate that incorporating that change into the FIDE-SNP would require an act of Congress.

Administrative Alignment: As previously noted, a FIDE-SNP is a plan that has a Medicare Advantage contract and an MLTSS contract with the state, which should serve to align the financial incentives at the plan level. However, outside of the new requirements related to the appeals and grievances process, there are two sets of administrative requirements that plans must navigate, which can also impact the way that consumers experience their coverage. For example, the Medicare and Medicaid open enrollment periods may differ because of timing considerations, the network adequacy requirements may look different between the two programs, and each program's marketing materials must go through different reviews which are often uncoordinated and promote inconsistent messaging to consumers. The FAI aligned the requirements and review processes in many states where they operated, thereby allowing dual enrollment in Medicare and Medicaid to feel more like enrollment in one plan for consumers. The only way that states can align the administrative requirements today through the FIDE-SNP model, is to understand all the Medicare requirements and then tailor their Medicaid requirements to align. While this can help states achieve a higher degree of administrative alignment, it has its shortcomings and not all administrative functions can be aligned.

Passive or Automatic Enrollment: One of the strategies tested under the FAI was allowing eligible people to become “passively” or automatically enrolled in the demonstration upon its introduction, or upon becoming dual eligible, with the option to opt-out of the model. Automatic enrollment into a managed care plan is a common Medicaid strategy. However, it represented a change in Medicare operations, as the Medicare program's default choice for enrollment on behalf of beneficiaries has traditionally been fee-for-service. The research points to passive enrollment as the most effective strategy for getting dual eligible individuals enrolled in the FAI.⁸

⁸ Mathematica Policy Research. [The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). December 4, 2018.

While similar enrollment strategies exist today for FIDE-SNPs, they are much more limited. These strategies are only available when an individual becomes newly eligible for Medicare, when an individual is enrolled in a Medicaid managed care plan (e.g., default enrollment), or when an individual's plan leaves the market. Most notably, there is no automatic enrollment when a state launches a FIDE-SNP or in other enrollment scenarios (e.g., someone in the Medicare program becomes eligible for Medicaid).

The concept of automatically enrolling dual eligible individuals into a FIDE-SNP, however, is not a full solution. It must be coupled with significant education and outreach efforts and a long enough opt-out period to ensure that beneficiaries are not only able to transfer plans or coverage options post-enrollment but that they receive adequate notice about their automatic enrollment and are able to make an active and informed decision about to either become enrolled in the FIDE-SNP or opt-out. This point is critical as it allows dual eligible beneficiaries to feel that enrollment in the FIDE-SNP is a choice, rather than something that is being done to them.⁹

Full-Benefit Dual Eligible Individuals: There are two broad categories of dual eligible individuals. Full dual eligible individuals are those who are eligible for the full range of both Medicare and Medicaid benefits. The second category is partial dual eligible individuals, who are eligible for the full range of Medicare benefits and some Medicaid benefits but receive assistance in paying for premiums and cost-sharing.

The theory behind integrated models is that the Medicare and Medicaid programs—or the acute care and the long-term care benefits, respectively—are integrated so that the health plan has access to the full array of benefits to address the beneficiary's needs and health care outcomes holistically. For example, integrated plans may provide additional personal care assistance supports after a hospitalization to avoid the need for a sub-acute stay in a skilled nursing facility. However, this theory does not hold as true for partial benefit dual eligible individuals because of the limited role of Medicaid in providing benefits. For this reason, partial benefit dual eligible individuals were not permitted to enroll in the FAI. The Medicare Payment and Access Commission (MedPAC) suggested in 2018 that this policy be extended to D-SNPs so that they can focus on the population that is most likely to benefit from integration.¹⁰ Several states are already deploying this tactic, including Arizona, Massachusetts, Minnesota, and New Jersey.¹¹

Proposed Solution: *We recommend that CMS explore its authority under each of the key categories identified—administrative alignment, passive or automatic enrollment, and limiting FIDE-SNPs to full-benefit dual eligible individuals—and make improvements to the FIDE-SNP to the greatest extent feasible under existing law. Where CMS does not have the authority to implement lessons learned, we recommend it clearly outline those areas and request the authority from Congress.*

⁹ Medicare Payment Advisory Commission. [June 2018 Report to Congress, Chapter 9: Managed Care Plans for Dual-Eligible Beneficiaries](#). June 2018.

¹⁰ Medicare Payment Advisory Commission. [June 2018 Report to Congress, Chapter 9: Managed Care Plans for Dual-Eligible Beneficiaries](#). June 2018.

¹¹ Medicare Payment Advisory Commission. [June 2018 Report to Congress, Chapter 9: Managed Care Plans for Dual-Eligible Beneficiaries](#). June 2018.

2. Streamline Home and Community-Based Waiver Process & Use MLTSS to Rebalance and Expand Access to the FIDE-SNP Model

Identified Problem: FIDE-SNPs and MLTSS plans can only make long-term care services available to people enrolled in their plans who are covered by the state’s Medicaid program. We have heard from states and other stakeholders that the process states must go through to make a comprehensive array of home and community-based services available is complicated to navigate and promotes institutional bias. Furthermore, while states are increasingly implementing MLTSS programs, few of them are using those programs to incentivize more care delivery in the home and community or to make a FIDE-SNP available.

Background: States are only mandated to provide nursing home and some home health services for full-benefit dual eligible individuals.¹² States generally must provide this care to people eligible for federal Supplemental Security Income, which requires impairment in ability to work due to old age or disability, in addition to being very low-income. In 2018, the income threshold for this group was approximately 74 percent of the federal poverty limit, with an asset limit of \$2,000 for an individual and \$3,000 for a couple (eight states used their own eligibility criteria).¹³

Given that the federal benchmarks are relatively low, most states provide additional coverage. In fiscal year 2018, 94 percent of all HCBS spending was on services provided at the states’ option.¹⁴ States use a patchwork of State Plan and waiver authorities to get their services approved by the federal government.¹⁵ This process is complicated to navigate and creates confusion for consumers, researchers, and other stakeholders about what is covered and for whom.

Our grantee, the Bipartisan Policy Center, is currently working with stakeholders to develop specific recommendations for how Congress and the administration could streamline this process to get approval for their coverage expansions. Their recommendations will be made public in late 2021, but we would be happy to share interim findings if there is interest.

Beyond simplification, CMS’s waiver approval process offers an important opportunity to direct states to more effectively rebalance their programs. Increasingly, states are turning to managed care plans to provide long-term services and supports. Today, there are 25 states that use MLTSS, and that number is expected to grow. Yet just over half of the states that use MLTSS have included financial incentives to move care from institutional settings back into the home and community.¹⁶ And only 11 of the 25 states that offer MLTSS connect this care provision to a D-SNP contract in such a way that permits it to be considered a FIDE-SNP. Connecting these strategies—aligning acute and long-term care through integration and incentivizing more care to be delivered in the home—is critical.

Proposed Solution: *We recommend that CMS explore its legal authority to streamline and simplify the existing State Plan and waiver process for HCBS. Additionally, we recommend that CMS use the waiver authorization process to encourage states with MLTSS programs to build in incentives to rebalance care and implement FIDE-SNPs.*

¹² Kaiser Family Foundation. [Medicaid Home and Community-Based Services Enrollment and Spending](#). February 4, 2020.

¹³ Kaiser Family Foundation. [Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey](#). January 14, 2019.

¹⁴ Kaiser Family Foundation. [Medicaid Home and Community-Based Services Enrollment and Spending](#). February 4, 2020.

¹⁵ Kaiser Family Foundation. [Medicaid Home and Community-Based Services Enrollment and Spending](#). February 4, 2020.

¹⁶ Kaiser Family Foundation. [Key State Policy Choices About Medicaid Home and Community-Based Services](#). Appendix Table 13. February 4, 2020.

3. Financially Support States Willing to Implement the FIDE-SNP

Identified Problem: Through our conversations with states and their advisors, we have consistently heard that implementing integrated models is challenging and that states often lack the necessary expertise to develop an integration strategy. Medicaid agencies both often lack Medicare expertise and an understanding of necessary steps to develop and implement an integrated product. Furthermore, states often worry that implementing an integrated model will cost them money. It is for these reasons that approximately one-third of states have yet to make an integrated model available and only 11 states use the FIDE-SNP model to do so today.

Background: Some of the most significant strides towards achieving a widespread availability of fully integrated models came in reaction to state grants provided by the federal government under CMMI to promote engagement with the FAI. As a result of these investments, 40 percent of the one million people enrolled in a fully integrated coverage option today are enrolled in the FAI.¹⁷ States are well-positioned once again to take advantage of a grant opportunity to promote integration, this time in FIDE-SNPs.

COVID-19 has shone a spotlight on the dual eligible population for states. Nearly all states saw the disproportionate toll that the pandemic took on nursing homes and those who use long-term care services. As a result, many are invested in finding solutions to improve the long-term care delivery system. FIDE-SNPs represent one attractive option for states contemplating such a change.

In recognition of this increased interest, Arnold Ventures will be formally launching an opportunity in the early summer to provide states interested in implementing integrated models, especially those focused on rebalancing efforts, with financial support to carry out these strategies. While this initiative will certainly be valuable to states, the funding will pale in comparison to a potential federal assistance program, like what was provided under the Financial Alignment Initiative.

Proposed Solution: *We recommend that CMS establish its own grant program to support states that are willing to implement a FIDE-SNP to expand access to integrated models and connect rebalancing efforts with implementing a FIDE-SNP.*

4. Invest in Increasing Enrollment in Integrated Models

Identified Problem: Despite all the efforts to integrate care, only one in ten dual eligible individuals is currently enrolled in an integrated coverage option. One barrier to enrollment, which has become evident through research and conversations with consumer stakeholders, is how confusing the choice set is when dual eligible individuals look to enroll in coverage plans.¹⁸ Dual eligible individuals can be faced with as many as 43 different combinations of Medicare and Medicaid coverage, not even accounting for the number of organizations providing the coverage.¹⁹ Another barrier to enrollment is churn within the Medicaid program, which can cause individuals who do choose to enroll in integrated models to temporarily lose that coverage.

¹⁷ Integrated Care Resource Center. [Monthly Enrollment in Medicare-Medicaid Plans by Plan and by State, October 2019 to October 2020](#). October 2020.

¹⁸ Mathematica Policy Research. [The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). December 4, 2018.

¹⁹ Allison Rizer. [Making Sense of Medicare-Medicaid Integration Models](#). ATI Advisory. June 11, 2020.

Background: Arnold Ventures funded Community Catalyst to conduct focus groups with consumers about their decision to enroll in MMPs. We learned that dual eligible individuals need more assistance to understand their coverage options, as states where MMPs had the highest enrollment rates tended to provide the most robust education. Furthermore, the focus groups suggest that the way that coverage options are presented today does not necessarily entice dual eligible individuals to select the integrated coverage option.²⁰ Dual eligible individuals may not understand what “integrated” care means for them. Communicating that integration leads to benefit coordination could be helpful, as individuals in the focus group expressed interest in having someone coordinate their benefits—a task that is currently left mainly to beneficiaries themselves or their caregivers. Dual eligible individuals also reported that they do not know where to turn when making enrollment decisions.

Some infrastructure exists today to facilitate enrollment decisions, but it is likely under-resourced and could be better organized. The Administration of Community Living (ACL) supports some of these efforts and recently awarded the National Council on Aging, Inc. a contract for the National Center for Benefits Outreach and Enrollment, which is used to educate organizations like Area Agencies on Aging that are responsible for providing direct-to-consumer support.²¹ As part of this funding, ACL is piloting an expansion of a tool that was developed for California—My Care, My Choice²²—to provide a technology solution to help navigators and the people they serve to better understand integrated coverage options. Further, in order to make those enrollment decisions last, more attention must be placed on policies that help ensure that beneficiaries who are enrolled in integrated models stay enrolled in such models.

Proposed Solution: *CMS should build on investments made by ACL, assisting states and entities that provide direct-to-consumer support with further education and resources to make the value of integrated models clearer to consumers and facilitate their enrollment in such models. CMS should also help dual eligible beneficiaries stay enrolled in integrated models by taking steps to reduce churn within the Medicaid program.*

5. Limit the Ability of Medicare Advantage and CMMI Models to “Pull” Dual Eligible Individuals out of Integrated Coverage Options

5.A. Further Limit D-SNP Look-Alikes

Identified Problem: Some non-D-SNP Medicare Advantage plans target dual eligible individuals, yet these plans are not integrated and do not have a contract with the state to provide care for this population. These plans confuse consumers and hinder efforts to increase enrollment in true integrated coverage options.

Background: Serving dual eligible individuals is assumed to be profitable for Medicare Advantage companies because of D-SNPs’ wide availability. However, states can, and do, limit the number of D-SNPs available by declining to contract with them. Plans that do not receive a contract may seek to target the dual eligible population anyway by developing a “look-alike” plan. These plans design their coverage in such a way that targets dual eligible individuals without providing any integration with the Medicaid program.

²⁰ The outcomes of this research will be released in the early summer of 2021. If you are interested in learning more, please do not hesitate to reach out and we can connect you with the relevant researchers.

²¹ Administration for Community Living. [National Center for Benefits Outreach and Enrollment Awarded](#). September 3, 2020.

²² MyCare MyChoice. [Find My Care](#).

The Medicare Payment Advisory Commission (MedPAC) outlined this phenomenon in Chapter 12 of their June 2019 report, “Promoting Enrollment in Dual-Eligible Special Needs Plans.”²³ CMS responded in their annual rulemaking by defining “look-alikes” as non-special needs plans with 80 percent or more enrollment of dual eligible individuals. CMS will not (1) enter into new contracts with plans that expect their enrollment to exceed this threshold for contract year 2022; and (2) renew contracts with plans that exceed this threshold for contract year 2023, unless the plan has been active for less than one year and has fewer than 200 beneficiaries. This policy is limited to states where a D-SNP or some other integrated model (e.g., the MMP) exists.²⁴ While this represents significant progress, we believe that the rule change did not go far enough.

MedPAC found that most plans where at least 50 percent of its members were dually eligible were targeting this population, and “most [were] being offered in situations...that [enabled] plan sponsors to circumvent restrictions on offering a D-SNP.” Further, in the majority of states where look-alikes exist, the 80 percent threshold is not sufficient to resolve the enrollment issue. While at the time of the MedPAC analysis, look-alike plans’ enrollment had reached the 80 percent threshold in only 13 states, 35 states have plans in their market that meet the 50 percent threshold.²⁵ We reference the 50 percent threshold because that was what MedPAC used to conduct its analysis, however, we are skeptical of any Medicare Advantage plan that has a significant number of dual eligible enrollees. We believe this population is best served in integrated coverage options, and that CMS should use its authority to clearly and fully promote enrollment in integrated plans.

Proposed Solution: *We recommend that CMS reduce the threshold for declining to contract or renew contracts with D-SNP look-alikes from 80 to at least 50 percent, further monitor the enrollment patterns of full-benefit dual eligible individuals, including in other types of special needs plans (i.e., chronic care special needs plans and institutional special needs plans) and report these patterns publicly, in either regulation or the call letter.*

5.B. Address CMMI Model Overlaps with Integration Goals

Identified Problem: Similar to certain Medicare Advantage plans, some CMMI models can target dual eligible individuals and thwart efforts to increase enrollment in integrated care. Additionally, if not designed carefully new models intended to further promote integration can create perverse incentives between existing integrated care models.

Background: CMMI has been a powerful actor for meaningfully advancing efforts to integrate Medicare and Medicaid thus far. The grants to states to implement integrated solutions and the Financial Alignment Initiative were carried out through its authority. However, we believe now is the time to take the lessons learned from the Financial Alignment Initiative and apply them to a more permanent program—the FIDE-SNP—using CMMI in a more limited way to test new flexibilities or innovations as previously outlined.

Proposed Solution: *CMS should carefully contemplate each new model it proposes and the potential impact it could have on enrollment in integrated models.*

²³ Medicare Payment Advisory Commission. [June 2019 Report to Congress, Chapter 12: Promoting Integration in Dual-Eligible Special Needs Plans](#). June 2019.

²⁴ Federal Register, Vol. 85, No. 106. [Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program](#). June 2, 2020.

²⁵ Medicare Payment Advisory Commission. [June 2019 Report to Congress, Chapter 12: Promoting Integration in Dual-Eligible Special Needs Plans](#). June 2019.

6. Consider Consolidating Authority for the Dual Eligible Population Within Medicare and Medicaid Coordination Office.

Identified Problem: The authority for the coverage programs used to integrate care for the dual eligible population is currently shared between multiple offices. In order to move integrated models forward, the office tasked with focusing on the dual eligible population, the Medicare and Medicaid Coordination Office (MMCO), must navigate this complex landscape.

Background: The MMCO, which was established under the ACA, must work through various channels to accomplish policy change, namely the Medicaid center, the Medicare center, and CMMI's demonstration authority. This bifurcated approach to administering the programs that ensure care for the dual eligible population reflects the fundamental differences that have plagued efforts to integrate the two programs to date. If CMS is interested in pursuing the strategy outlined above, it may want to consider outlining its strategy publicly and consolidating additional authority for the dual eligible population within MMCO.

Proposed Solution: *CMS could consider consolidating authority within MMCO for issues impacting the dual eligible population and have the office directly report to the Administrator, making it an equivalent office with Medicare and Medicaid. Potential functions that the MMCO could be responsible for include:*

- *Regulatory responsibility for models targeted at the dual eligible population (i.e., D-SNPs, HIDE-SNPs, FIDE-SNPs, and PACE)*
- *Collaborate and provide meaningful input on all matters impacting the dual eligible population including:*
 - *Medicare Advantage*
 - *Medicaid MCO and HCBS rules*
 - *Rebalancing efforts (e.g., HCBS streamlining)*
 - *CMMI Models*

The MMCO may require additional resources to carry out these responsibilities.