

January 13, 2023

The Honorable Bill Cassidy, M.D.
United States Senate
Washington, D.C. 20510

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

The Honorable Tim Scott
United States Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
United States Senate
Washington, D.C. 20510

The Honorable John Cornyn
United States Senate
Washington, D.C. 20510

The Honorable Robert Menendez
United States Senate
Washington, D.C. 20510

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

Arnold Ventures welcomes the opportunity to respond to your request for information about improving the coverage and care experience for the approximately 12 million people who are dually eligible for Medicare and Medicaid. We thank you for your interest and stand ready to serve as a resource to members of Congress and their staff on this issue.

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, commercial sector prices, Medicare solvency, provider payment incentives, and complex care. Improving outcomes for people who are dually eligible for Medicare and Medicaid is the focus of our work on Arnold Ventures' Complex Care team today. We fund research, policy development, technical assistance to policymakers at the state and federal level, communications, and advocacy efforts to advance our goals.

Dual-eligible individuals are most often elderly or disabled and have complex health care needs. When trying to get care, they must navigate Medicare and Medicaid and face a mountain of red tape, waste, and a lack of coordination. The result—patients suffer worse health outcomes, and our system gets more and more costly. On average, total government spending for the dual-eligible population is almost double their non-dual-eligible counterparts.¹ We must act to simplify this system and create better coordination for people who are dual-eligible. They should no longer be forced to navigate between two separate programs. Meaningful reform could bring less bureaucracy, lower costs, and more patients getting the care they need to lead healthy, independent lives.

Likely voters also understand this issue and believe the system needs to change:²

¹ MedPAC and MACPAC. [Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#). February 2022.

² AV-funded polling data.

- People sympathize with this issue. 84% of likely voters say it would be “very difficult” to navigate the Medicare and Medicaid programs simultaneously.
- Support for reforms cuts across party lines. More than 70% of Democrats, nearly 70% of Independents, and more than 60% of Republicans support reforming complex care in a way that focuses on standardization and coordination.
- People support a complete overhaul of today’s system. 70% of likely voters believe the system needs to be replaced or completely reformed.

Solutions to these long-standing health policy problems exist and are within reach. Indeed, solutions build off the significant investments that Congress, multiple Administrations, and stakeholders have made over the course of many years. We use the following objectives to frame our recommended solutions:

1. **Ensure that all dual-eligible individuals have access to a model that fully integrates their Medicare and Medicaid coverage:** Full integration means that the financial, clinical, and administrative components of Medicare and Medicaid are unified in such a way that the two programs feel like one to the people enrolled. We believe that this should happen through entities held accountable for cost, quality, and experience. We look for policy solutions that would raise the standards for what counts as “fully integrated” and ensure that these models are available in every state, to all full benefit dual-eligible individuals.
2. **Increase enrollment in integrated models:** People cannot benefit from integrated models if they do not enroll in them. Thus, we look for policy solutions that help beneficiaries understand the value of integrated models and make informed choices, and we seek to address organizations that have a financial interest in curtailing enrollment in integrated models.
3. **Improve the mix of services available through integrated models:** The dual-eligible population is not homogenous, and dual-eligible individuals need to be able to access the services they want and need, including community-based services that allow them to remain outside of institutions when consistent with their wishes. We seek policy solutions that enable integrated models to deliver those services and be held accountable for improving outcomes for the people they serve.

In addition to the above, Arnold Venture’s work in the health care sector is driven by a belief that today’s system is too costly for people and taxpayers, so we strive for solutions that address this issue. A significant share of taxpayer dollars already goes towards caring for the dual-eligible population. At a minimum, we believe we can achieve better outcomes for the dollars being spent today, ensuring that no more is spent on average on a per-person basis. However, if savings were achieved through the development of a legislative solution, those resources could be used to fund eligibility or service expansions for low-income older adults and people with disabilities, for example. The following uses the objectives outlined above to directly respond to the majority of the questions posed in the request for information, reflecting the knowledge of our staff, partners, and grantees, spanning states, advocates, industry, and research.

1. How would you separately define integrated care, care coordination, and aligned enrollment in the context of care for dually eligible beneficiaries? How are these terms similar and how are they different?

Care coordination and aligned enrollment are essential components of integrated care, and integrated care is not feasible without them. Our definition of integrated care spans financing, benefits, administration, care coordination, accountability, and enrollment.

We believe integrated care should mean:

- *Financing:* At a minimum, Medicare and Medicaid dollars are pooled and take the other program's expenditures into account, while eliminating incentives to cost shift between the two programs.
- *Benefits:* All benefits, inclusive of all medical, behavioral, and long-term services and supports must be available through a single entity.
- *Streamlined Administration:* Medicare and Medicaid must feel like one program to those enrolled and to the providers that deliver care, including through the coverage enrollment process, the educational materials provided, utilization reviews (i.e., prior authorization and appeals processes), customer support call centers, etc.
- *Care Coordination:* Each person must have an identified point of contact that can assist with health care navigation, a promptly completed assessment, an individualized care plan, and an interdisciplinary team to support them in meeting their health care goals.
- *Accountability:* The entity delivering integrated care should be held accountable to a single streamlined set of outcomes measures that include incentives to help people live and stay in the community if it is consistent with their wishes.
- *Aligned Enrollment:* When a person is enrolled in an integrated model, they should receive the full range of Medicare and Medicaid support and services through a single entity—integrated care is not possible outside of the context of aligned enrollment.

2. What are the shortcomings of the current system of care for dual eligibles? What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?

We have identified three primary shortcomings of today's system that we believe need to be addressed:

1. Medicare and Medicaid are not truly integrated, even in the best integrated models operating today;
2. Integrated models need to be more person-centered and meaningfully held accountable for improving the care people receive; and
3. Too few people have access to integrated models, and it is too hard to enroll in integrated models today. We believe that every dual-eligible individual should have access to this improved-upon model and it should be easier to get and stay enrolled.

Efforts to solve these problems and integrate Medicare and Medicaid are not new. Several models intended for people who are dual-eligible are available in the market today. Each option is held to different standards and offers different levels of integration. States are left to determine which model(s) to make available, and to what standards to hold the entities that participate. This has created a confusing landscape for policymakers and beneficiaries 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 or are not encouraged to select them. As a result, only one in ten dual-eligible individuals is enrolled in a coverage option that is considered “fully” integrated today.³

One solution that can address many of the problems outlined above is for the federal government to create an aligned Medicare-Medicaid enrollment process and then designate one model as the primary mechanism to integrate the two programs for the dual-eligible population. We believe that entities that are capitated and held accountable for delivering the full range of Medicare-Medicaid benefits are best equipped for this role. To this end, Congress and multiple Administrations have made significant investments in the FIDE-SNP model. Rather than create a new model, our proposed approach would build on these investments. However, today’s FIDE-SNP model is inadequate. Our ideal solution would create the conditions under which an improved version of the FIDE-SNP would be available to all dual-eligible individuals.

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.

Policymakers and researchers have known for some time that the bifurcation of Medicare and Medicaid misaligns incentives, thereby driving up spending and resulting in worse outcomes for people who are eligible for both programs.⁴ This misalignment must be addressed and more recent evidence has supported *fully* integrated models as a solution to this problem.

Fully integrated models—like the Financial Alignment Initiative (FAI), the FIDE-SNP, and the Program for All-Inclusive Care for the Elderly (PACE)—are associated with reductions in hospitalizations, hospital readmissions, mortality, emergency department visits, and nursing facility use.^{5, 6} We have funded additional research to build on this evidence and early, unpublished findings appear similar. Preliminary results from a recent study we funded on the Massachusetts FAI demonstration found that the integrated model was associated with decreased hospitalizations, decreased rates of post-acute nursing stays, increased use of non-emergency medical transportation, and more broadly, higher quality of care (measured by a decrease in hospitalizations for ambulatory care sensitive conditions, which are a common measure of poor quality). Preliminary results from another study on Pennsylvania’s FIDE-SNP found that the integrated model was associated with increased HCBS use and decreased nursing facility use.

This evidence supports broader application of the FIDE-SNP so long as it is fully integrated. The research is less clear, however, on the design elements that must be incorporated within the FIDE-SNP to achieve better

³ The Centers for Medicare and Medicaid Services, Medicare-Medicaid Coordination Office. [Fact Sheet: People Dually Eligible for Medicare and Medicaid](#). March 2020.

⁴ MedPAC and MACPAC. [Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#). February 2022.

⁵ MACPAC. [Evaluations of Integrated Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps](#). August 2020.

⁶ Zhanlian Feng, et al. [Comparing Outcomes for Dual-eligible Beneficiaries in Integrated Care: Final Report](#). ASPE. October 2021.

outcomes. We are currently looking to fund additional research that empirically validates nascent research on which components of integrated models—such as robust care management—are responsible for driving improved outcomes. The desire to identify all of the evidence-based components should not delay efforts to move forward with implementing fully integrated models more broadly, however. We also believe that the answers to questions about spending, for example, may not be well suited to be answered through traditional academic research alone. For example, when the entities operating integrated models receive a capitation rate, a program's failure to operate in a budget-neutral way can be a function of where the capitation rate is set, rather than a failure of the program itself. We therefore encourage Congress to use the evidence that we do have, examine mechanisms to use capitated payments to ensure budget neutrality, apply the lessons and payment methodology to the FIDE-SNP model, and ensure that it is available to all dual-eligible individuals.

4. After reviewing these models, would you recommend building upon current systems in place (e.g. improving aligned enrollment and/or coordination of care between two separate Medicare and Medicaid plans) or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on their needs?

Our recommendation is to build on today's FIDE-SNP model as a chassis for scaling an integrated system of coverage and care for the dual-eligible population. Today's FIDE-SNP model is woefully inadequate, however, and many changes are necessary to improve it and ensure that it is available to all dual-eligible individuals. For example, Medicare and Medicaid expenses should be capped under the FIDE-SNP and the FIDE-SNP should be held accountable for delivering the full range of Medicare and Medicaid benefits, using the dollars between the two programs interchangeably as appropriate. The entities operating the FIDE-SNP must also be required to deliver a more patient-centered experience than is largely available today, which includes robust care coordination and access to an interdisciplinary care team (more details regarding these requirements are outlined in our response to question eight). Additionally, the FIDE-SNP should be made available to all dual-eligible individuals through additional incentives and requirements placed on states, deploying a federal fallback where states opt not to develop their own model as outlined by the Bipartisan Policy Center, or through some combination of two.⁷

While we believe that reforming today's FIDE-SNP system is most politically and practically feasible at this time, we would be supportive of starting from scratch with a new, unified system if it met our objectives and solved the problems outlined above.

If we were designing the Medicare and Medicaid programs for the first time today, we would ensure that the population that is dual-eligible is enrolled in one program or the other, rather than both simultaneously. In trying to unify the two programs, we are particularly concerned with ensuring that all dual-eligible individuals have access to an integrated solution and government health care spending. We want to ensure that any effort to consolidate the two programs adequately incentivizes states to participate while protecting the existing Medicare Trust Funds and preventing increased spending on a per capita basis above today's already high spending levels.

6. How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?

Making changes to today's system of coverage will impact beneficiaries, and we are glad that the Senators are thinking about any potential disruption proactively. When it launched, the Financial Alignment Initiative (FAI)

⁷ Bipartisan Policy Center. [Guaranteeing Integrated Care for Dual-Eligible Individuals](#). November 2021.

was a test case for rolling out wide-scale coverage changes to the dual-eligible population, with many lessons learned documented in the evaluation reports published by CMS. Since then, several states have transitioned away from the FAI and others have implemented FIDE-SNPs. To minimize disruption and ensure that dual-eligible individuals are adequately informed of their choices, these lessons should be incorporated into any future policy changes.

Minimizing disruption will require a multi-pronged approach. The following recommendations were developed through a review of the literature and information gathered from individuals who are dual-eligible, their caregivers, and their advocates, and from our grantee partners (some of whose findings have yet to be made public).^{8, 9, 10}

- *Beneficiaries must receive adequate support to understand their coverage options.* To support informed decision-making about their coverage options, people need ample educational resources and support. They also need to be given adequate time to weigh their options and seek guidance. Education and enrollment information must be provided in a culturally component manner (including in the range of languages used by the population) and through multiple channels, including web-based, telephonic, and in-person non-biased counseling options. Educational resources must also be targeted to dual-eligible individuals' caregivers, providers, and social support networks, who often assist and facilitate enrollment choices.
- *Those newly enrolled in an integrated model should be able to keep their out of network providers for a period of six months to one year to ensure continuity of care.* Many dual-eligible individuals have established a network of providers and supports to help them manage their health and functional needs. We want integrated models to be an attractive coverage option for this group of people and do not want these networks to be undermined with the introduction of integrated models. Therefore, we recommend a period to allow beneficiaries, their providers, and the integrated model to adjust, post-initial enrollment in such a coverage option. Based on interviews with consumers, providers, and plans, a period of six months to one year provides sufficient time for the integrated model to identify any gaps between their members' providers and their own network, attempt to contract with the network, and if unsuccessful, provide the beneficiary with time to identify a new trusted support network. Ultimately though, dual-eligible individuals should have the option to opt for a different coverage option if the provider network offered by an integrated model is not aligned with their preferences.
- *Enrolling in and staying enrolled in coverage must be made simpler than it is today.* The harder we make it for people to enroll in coverage the more disruptive changes can feel. There needs to be a streamlined process for enrolling in Medicare and Medicaid coverage, including when and where you can access information about coverage choices. Automatically, or passively, enrolling people into integrated coverage models with the opportunity to opt out is an effective tool to simplify the process for people. However, automatic enrollment needs to be tied to adequate assistance as described above, lest it creates more confusion. Furthermore, strategies that allow people once enrolled to stay enrolled, like continuous eligibility and deeming, can simplify the process for beneficiaries and reduce disruptions in coverage (more on continuous eligibility and deeming can be found in the response to question 6).

⁸ Arnold Ventures. [Findings from Arnold Ventures' Request for Information on the Dual-Eligible Experience](#). January 2022.

⁹ Community Catalyst. [First Step Enrollment: Getting It Right for Medicare-Medicaid Enrollees](#). December 2021.

¹⁰ Debra Lipson, et al. [The Complex Art of Making it Simple: Factors Effecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). MACPAC. December 2018.

- *Proactively address detractors:* A major challenge in educating dual-eligible beneficiaries about integrated models is conveying the signal through the noise of marketing and outreach from unintegrated plans and the brokers who work for them. While policymakers have been aware of this challenge for some time, more needs to be done to prevent these organizations from targeting dual-eligible individuals. Early this year, CMS implemented a policy to curtail the D-SNP look-alikes, but this policy does not go nearly far enough to achieve meaningful change. The threshold CMS set for closing a “look-alike” Medicare Advantage plan requires that at least 80% of their membership be composed of dual-eligible individuals and it does not apply to other forms of special needs plans beyond D-SNPs. We believe the definition of a look-alike plan should be broader both in terms of the percentage of dual-eligible membership and the type of plan eligible, in order to minimize disruptions.
- *Adequate time horizon for implementation of the new model.* There needs to be time to ensure that beneficiaries can provide feedback regarding the design and implementation of any new integrated model. The entities operating the integrated models and the states and federal government providing oversight also need adequate time to ensure that the model is ready to be operational.

7. In your analyses of data on dual eligibles, did you consider continuity of enrollment status or consistency of full and partial dual eligible status during a year?

Temporary loss of Medicaid coverage, or “churn”, is quite common within the dual-eligible population, with nearly 30% of new full-benefit dual-eligible beneficiaries losing coverage for at least one month within their first year of coverage.¹¹ Almost one-third of these lapses in coverage are relatively short (1-3 months) and are mainly due to administrative issues, not changes to individuals’ program eligibility.¹² These gaps in coverage can lead to care delays and increased costs for dual-eligible individuals.

Continuous eligibility policies reduce churn by guaranteeing program coverage for beneficiaries within a set time period, regardless of changes in their circumstances. Some states have also required plans to offer a “deeming” period, keeping people enrolled for a short grace period if the plan believes they are still eligible for the program while their Medicaid eligibility is formally reassessed by the state. Continuous eligibility and deeming can serve to minimize disruptions for people who are dual-eligible—they also can reduce administrative burden on states, entities that serve this population, and their providers over the longer term. We are supportive of efforts to streamline and simplify the eligibility process more broadly, including efforts to reduce churn.

While we believe they are beneficial to enrollees, it is important to note that these strategies can carry a significant cost to federal and state budgets. These investments may be worth making, and we believe that the associated costs can and should be offset through cuts elsewhere to the Medicare or Medicaid programs, including cuts to Medicare Advantage plans’ payments, which evidence shows are too high relative to fee-for-service today or cuts to provider taxes eligible for federal match reimbursement in Medicaid. Our staff and our grantees have additional ideas about offsets that we would be happy to discuss with the Congressional staff as interested.

- a. Are there different coverage strategies that should be employed for "partial" dual eligibles vs. "full" dual eligibles when it comes to improving outcomes, such as MedPAC's recommendation on limiting D-SNP enrollment to "full" dual eligibles?**

¹¹ Zhanlian Feng, et al. [Loss of Medicare-Medicaid Dual-Eligible Status: Frequency, Contributing Factors and Implications](#). ASPE. May 2019.

¹² Ibid.

The value of integrating Medicare and Medicaid is to align the financial, clinical, and administrative components of the two programs. Because partial-benefit dual-eligible individuals only have the cost-sharing components of their coverage covered by Medicaid and are not eligible for the full range of benefits, we question the value that these plans bring to this population. We therefore currently believe that integrated models should be limited to the full-benefit dual-eligible population only. However, to our knowledge, this question has never been answered empirically. A team of researchers at Mathematica is currently conducting an analysis to help answer this question with Arnold Ventures' support. It is estimated to be completed later this year.

- b. Studies indicate that frequent plan switching can have a negative impact on beneficiary health outcomes, especially for dual eligibles who are enrolled in aligned managed Medicare and Medicaid products. CMS and States have taken different policy approaches to reduce excessive switching. Which of those policies have the best data on improving cost-effectiveness, clinical outcomes, and/or beneficiary satisfaction? Which of these approaches can be expanded to apply more widely across States?**

While strategies applied directly to the beneficiary—like limiting their ability to switch plans throughout the year—may limit rates of plan switching, they do not clarify or address the problems with Medicare Advantage plans that incentivize people with significant health care needs to disenroll from these options. Evidence suggests that people disenroll from Medicare Advantage plans when they are high-cost and have a high level of need, or when they begin to near the end of life. This phenomenon is not limited to dual-eligible individuals.^{13, 14} The reason why disenrollment rates are higher amongst these populations is not well understood today, and the evidence regarding the efficacy of available solutions is also limited. We hope to fund additional research on this topic in the future.

Given that Medicare Advantage plans seem to hold a significant degree of responsibility for the switching, we recommend policy solutions that focus on placing additional requirements on these entities, as well as increased education for beneficiaries, all of which can be applied widely across states. More specific ideas include:

- *Ensure that integrated models are held accountable for having a robust provider network and delivering the care the people need.* People often disenroll from plans because the providers they need to see are not available on the network or medical management reviews make the services they need difficult to access. The federal government and states should provide oversight to entities operating integrated models, including ensuring that their provider networks are adequate and reviewing service denials and appeals to ensure that people are getting access to the services for which they are eligible.
- *Invest in educating and reducing the administrative burden for providers serving the dual-eligible population.* People also disenroll from integrated models at the recommendation of their providers. More needs to be done to educate providers about the value of integrated care and to reduce the providers' administrative burden for their patients in integrated

¹³ Meyers, D. et al. [Limited Medigap Consumer Protections Are Associated With Higher Reenrollment in Medicare Advantage Plans](#). May 2019.

¹⁴ Riley, G. [Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-For-Service](#). January 2012.

models so that these providers want to recommend their patients enroll---and stay enrolled---in these models.

- *Address plans that target the dual-eligible population that are not integrated (e.g., D-SNP look-alikes).* Many Medicare Advantage plans and their brokers directly target the dual-eligible population for enrollment—these plans are sometimes referred to as “D-SNP look-alike” plans. We believe that this targeting can contribute to additional plan switching. Congress and CMS should prevent this practice by requiring Medicare Advantage plans whose membership is comprised of a significant share of full-benefit dual-eligible individuals, for example, 50 percent of people enrolled in the plan are full-benefit dual-eligible, to become an integrated plan or face penalty.

8. What is the best way to ensure that this system takes into account the diversity of the dually eligible population and is sufficiently targeted to ensure improved outcomes across each sub-group of beneficiaries? How should these sub-groups be defined and how should the data be disaggregated? Please provide examples of methodology and the evidence-based rationale for each example.

In our funding of research and our discussions with consumer advocates, we have generally identified the following sub-populations of full-benefit dual-eligible individuals:

- People of various races/ethnicities,
- People with behavioral health conditions,
- People with serious mental illness,
- People with physical disabilities,
- People over the age of 65 living in institutions,
- People over the age of 65 living in the community, and
- People with intellectual and developmental disabilities.

These categories are not mutually exclusive, however, and there is a significant degree of overlap among them. For example, nearly half of the dual-eligible population is non-White, and a significant portion lives in institutions.¹⁵ It is important that any solutions that integrate care for the dual-eligible population recognize this diversity and account for it in the evaluation of these models.

We believe that this accountability must begin with making the entities that operate integrated models responsible for delivering the full range of Medicare and Medicaid benefits, including physical, behavioral health, and long-term services and supports. Carve-outs of any of these major benefit categories can serve to detach improvements on clinical outcomes from the financial outcomes, causing cost-shifting.

However, it is not enough to make the full range of benefits available under one at-risk entity. Ensuring that there is integration at the care delivery level is equally vital. This can be achieved through meaningful care coordination, which is supported by the evidence more broadly and our conversations with dual-eligible individuals, their caregivers, and providers.^{16,17}

¹⁵ MedPAC and MACPAC. [Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid](#). February 2022.

¹⁶ Brown, R. [The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses](#). The National Coalition on Care Coordination. March 2009.

¹⁷ Powers, B. et al. [Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients](#). American Journal of Managed Care. February 2020.

Effective care coordination can help avoid unnecessary hospitalizations and ensure that people have access to community-based supports. In turn, it can also serve as a motivator to keep people enrolled in integrated models. Furthermore, we believe that when care coordination is done well, it allows a single entity to provide tailored care to a diverse population with a wide range of needs, like the dual-eligible population. The essential components of care coordination must be explicitly defined and the entities providing integrated care should be held accountable for delivering a specified level of care.

We believe the essential components of this coordination include:

- *A single person responsible for helping each beneficiary navigate their coverage and care.* This “care navigator” is responsible for being the patient’s advocate within the entity that is providing the integrated model. They must ensure that each person has a completed comprehensive assessment and care plan and must assist the beneficiary with meeting the goals they have outlined and with accessing the full range of benefits that they are eligible for. Then, the navigator must support the beneficiary or their provider with questions associated with prior authorization and denials. Their job performance should also be tied to beneficiary satisfaction measures.
- *Each person should receive a comprehensive individualized care plan.* This should encompass an assessment and a plan that addresses the totality of an individual’s needs and goals, spanning medical, functional, behavioral, social, and caregiving. More specifically, the plan should explicitly contemplate a strategy to ensure that so people can live in the community when it is consistent with their wishes. The beneficiary or their authorized caregiver must agree to the care plan before it is employed. The plan should be completed upon enrollment into an integrated model and revisited at least on an annual basis and after all major health care events, including hospitalizations and emergency room visits.
- *Each person must have an interdisciplinary care team (ICT) that consists of the necessary expertise to execute an individual’s care plan.* At a minimum, all ICTs must include the person’s identified care navigator and a nurse, assuming the care navigator is not a nurse. The composition of the team should be commensurate with each individual’s needs, evolving over time as necessary, and the team must be responsible for the execution and maintenance of the individual’s care plan. For example, people whose needs and goals include behavioral health should have a behavioral health specialist on the team. Of course, if those goals are met and an individual approves, the behavioral specialist can be dismissed from the team. The individual or their caregiver must be included in the selection of the care team and in the team’s decision-making, with equal decision-making power at a minimum.

9. Does your data identify subgroups of individuals for whom having coverage from two payors is inefficient or is associated with worse clinical outcomes, as seen in academic literature?

We believe that all people who are dually eligible for Medicare and Medicaid should have the option to enroll in an integrated model that makes their full range of medical, behavioral, and long-term services and supports available, no matter which sub-group(s) they fall into. Thinking about acute care as separate from behavioral health or long-term care services and supports is ultimately not whole-person care.

The evidence points to several clear drivers of poor outcomes that should be a focus of an integrated model, but more work needs to be done to build the evidence on this issue, which we hope to pursue over the course of the coming year:

- *Nursing homes are an important component of any solution to integrated care.* The literature most clearly points to nursing homes as a driver of worse clinical outcomes and spending as a result of bifurcated Medicare and Medicaid financing.¹⁸ It will be important that any integrated model targets this population and the facilitates that serve them to improve outcomes.
- *Increasing access to certain community-based services to help people remain in the community when it is consistent with their wishes.* There is also work that suggests that the greatest opportunity for reducing spending amongst the dual-eligible population might be associated with those that have significant long-term care services and supports needs.¹⁹ Finding opportunities to make those services more efficient might lead to better outcomes including cost savings.
- *Access to meaningful care navigation and coordination that is tailored to an individual's needs.* The hallmark of some of the most successful fully integrated models—and models that serve patients with a complex array of needs—is meaningful care coordination. In response to question eight, we outline the key components of this care navigation and care coordination support that should be made available to every dual-eligible individual that enrolls in an integrated model to ensure their coverage is tailored to their unique needs.

10. There are individuals who can, or must, expend their assets on medical care until they financially qualify as dually eligible. Such spending can get these individuals access to long-term care under Medicaid, which Medicare would not cover. Another pathway to eligibility involves Medicaid beneficiaries who develop End-Stage Renal Disease (ESRD) and become Medicare eligible.¹⁴

- a. Is there data that demonstrates the cost-effectiveness of providing select supplemental benefits to Medicare Advantage beneficiaries that may help them avoid becoming Medicaid eligible through high spending on medical care?**

We are not aware of any publicly available data or evidence that shows that access to specific supplemental benefits prevents or delays people from becoming full-benefit dual-eligible. Despite the widespread availability of supplemental benefits through the Medicare Advantage program, we know surprisingly little about the extent to which beneficiaries, including people who are or become dual-eligible, receive these services. Information on the utilization of these benefits and their impacts on health outcomes is important for understanding how to best leverage these additional taxpayer-funded benefits, including preventing people from becoming full-benefit dual-eligible. We recommend that Congress or CMS create a standardized data collection methodology for supplemental benefits and require plans to operate it. Without it, this question will continue to be a challenge to answer through independent evaluations. Alongside data collection, Congress and CMS could contemplate standardizing some supplemental benefits. The outcomes associated with each of the standardized benefits could then be examined across multiple payers, including whether the introduction of the benefit has any impact on the number of people becoming full-benefit dual-eligible.

11. How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?

¹⁸ Grabowski, D. [Medicare and Medicaid: Conflicting Incentives for Long-Term Care](#). Milbank Q. December 2007.

¹⁹ Figueroa, J et al. [Persistence and Drivers of High-Cost Status Among Dual-Eligible Medicare and Medicaid Beneficiaries](#). Ann Intern Med. October 2018.

Geography plays a significant role in access to integrated coverage for dual-eligible individuals and more than half of this population cannot even access a fully integrated model in their geographic area today.²⁰ States currently dictate whether and where these models are available and the degree to which they are integrated. Thus, the lack of access to integrated care is a direct result of states not making investments into developing these models. Yet the development of an integrated model requires a significant investment of time and resources on states' part, and states are not properly equipped and incentivized to stand up these models today.

Chief among states' justifications for not standing up these models is that they do not typically see a return on investment accruing to the state. Medicare is responsible for acute care services and spending, while state Medicaid programs are responsible for long-term care services and supports and many behavioral health services. The overriding belief amongst states is that investments in long-term care, behavioral health, and additional coordination services accrue only as benefits to the Medicare program in the form of reduced hospitalizations and emergency department visits. Furthermore, states are required to understand Medicare and wrap around it, while the Medicare program has very little flexibility.

We recommend the following strategies to ensure access and support states' continued involvement in these models:²¹

- *Employ a mechanism to ensure access to integrated care nationwide:* It is difficult to see how we attain nationwide access while continuing to have states dictate the availability of integrated models unless the incentive structure for states significantly changes. There is a range of policy options that can be deployed to this end. We could further encourage states to implement integrated models through mechanisms like shared savings or ensure that there is access through a mechanism like a federal fallback²² or a requirement that all states implement an integrated model.
- *Focus on one model and create more flexibility within the Medicare program around it:* We believe that states need fewer models to select from in order to integrate care, but more flexibility in how they implement the selected model. Today, there is little flexibility on the Medicare Advantage processes under the FIDE-SNP, including the Medicare materials sent to enrollees, for example, which can undermine their efforts to integrate care. Additional flexibility, more akin to the Financial Alignment Initiative demonstration, including waiving Medicare administrative rules where appropriate and in the interest of integration, would allow states and CMS to develop one set of requirements for these plans.
- *Medicaid and Medicare rate setting should be coordinated for integrated models:* Today, Medicare and Medicaid rates are set in isolation, rarely do the Medicare costs and experience get accounted for in establishing Medicaid rates or vice versa. We believe that this needs to change, setting a holistic rate that the states and federal government each contribute. We have funded work to better understand the process to align Medicare and Medicaid rate setting, and results will be available later this year.
- *Provide states with adequate financial resources, education, and time to implement integrated models:* States will need resources to implement integrated models nationwide, this includes financial resources to upgrade their systems and account for Medicare experience and technical assistance support.

²⁰ ATI Advisory. [A Profile of Medicare-Medicaid Dual-Beneficiaries](#). June 2022.

²¹ Nancy Archibald. [States Want to Integrate Medicare and Medicaid, But They Need Federal Resources and Flexibilities](#). Health Affairs. May 2022.

²² Bipartisan Policy Center. [Guaranteeing Integrated Care for Dual Eligible Individuals](#). November 2021.

Additionally, these models must have an adequate implementation time horizon to ensure that they are established thoughtfully and with input from dual-eligible beneficiaries and their advocates.

Conclusion

Again, we really appreciate the Senator's commitment to improving the coverage and care that dual-eligible individuals receive and the opportunity to respond to this request for information. We would welcome the opportunity to talk through these ideas further as there is interest. Please contact Mark Miller, Ph.D., Arnold Ventures' Executive Vice President of Health Care, at mmiller@arnoldventures.org, or Arielle Mir at amir@arnoldventures.org with any questions.

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