

June 21, 2021

Shalanda Young  
Acting Director, Office of Management and Budget  
725 17<sup>th</sup> St NW,  
Washington, DC 20503

*Sent via Federal eRulemaking Portal*

RE: Request for Information – Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government

Dear Director Young,

Arnold Ventures is a philanthropy dedicated to investing in 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 both costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide array 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 making this important commitment to assessing the equity of federal policies and programs. We at Arnold Ventures share a commitment to advancing health equity and applaud what we understand will be an arduous effort to expose and redress systemic disparities facing underserved populations and individuals. We anticipate that your findings will lead to the development of a thoughtful and inclusive plan for promoting a more equitable health care system in the United States and look forward to learning from these findings.

This response letter touches on Areas 1 and 2 of the Request for Information. Area 1 requests input on equity assessments and strategies, and specifically, on promising methods for identifying systemic inequities to be addressed by agency policy. When it comes to systemic inequities, the experience of the “dual eligible” population, or the 12 million people simultaneously enrolled in Medicare and Medicaid comes to mind. Improving this population’s coverage and care is the focus of the Complex Care initiative at Arnold Ventures.

Given the bifurcation between Medicare and Medicaid, dual eligible individuals must navigate two complicated and separate sets of systems and providers in order to receive care. A challenge for anyone, accessing appropriate care models is made more difficult—but also more critical—by the fact that dual eligible individuals are more likely than the average Medicare beneficiary to have multiple chronic conditions and functional limitations, live in nursing facilities, experience food and housing insecurity, and identify as members of racial and ethnic minorities.<sup>1</sup> It is no wonder, therefore, that this population was among the hardest hit by the COVID-19 pandemic. Dual eligible individuals were more than three times as likely as the average Medicare

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<sup>1</sup> The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-eligible beneficiaries](#). July 17, 2020.

beneficiary to be hospitalized from COVID-19.<sup>2</sup> This dramatic toll only underscores the need to improve the fragmented care and coverage system that serves this population.

Arnold Ventures has elected to focus on the needs of dual eligible individuals because of the significant challenges facing this underserved and often stigmatized population. Despite their high level of need, dual eligible individuals experience disproportionately low outcomes—16% of this group reports that they are in poor health compared with 5% of Medicare-only beneficiaries.<sup>3</sup> An enormous opportunity exists for collaboration between OMB and organizations like Arnold Ventures to address the inequities experienced by the dual eligible population and make meaningful changes to their healthcare experience and health outcomes.

Area 2 requests input on tactics for addressing known burdens or barriers to accessing benefit programs. The obstacles experienced by the dual eligible population are numerous. Certain obstacles, however, if addressed, could meaningfully alleviate some of the burdens experienced by this group. The following sections describe obstacles facing the dual eligible population that are ripe for improvement and outline broad recommendations for policy change.

**Enrollment Education.** Models that integrate Medicare and Medicaid are generally understood to provide better care and improve the experience for dual eligible beneficiaries. However, today only one in ten dual eligible individuals is enrolled in an integrated coverage option.<sup>4</sup> This low enrollment rate is often attributed to the high number of choices available to this population and the lack of clear, patient-specific guidance for potential beneficiaries.<sup>5</sup> Dual eligible individuals can be faced with as many as 43 different combinations of Medicare and Medicaid coverage.<sup>6</sup> This figure does not even include the number of organizations providing the care, nor does it include so-called “look-alike” plans, or the myriad of non-integrated coverage options that market themselves as aligned to attract dual eligible beneficiaries.<sup>7</sup>

Arnold Ventures funded Community Catalyst to conduct focus groups with dual eligible beneficiaries regarding enrollment in integrated health plans. This research found several barriers to enrollment, including the need for more assistance to understand the gamut of coverage options, the benefits of integrated models, and the path to enrollment.<sup>8</sup> While some infrastructure exists today to facilitate enrollment decisions, it is fragmented, leading beneficiaries to have duplicative conversations that exacerbate, rather than reduce confusion.<sup>9</sup> Further, integrated

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<sup>2</sup> The Centers for Medicare and Medicaid Services. [Preliminary Medicare COVID-19 Data Snapshot](#). January 1-November 21, 2020. Accessed: June 1, 2021.

<sup>3</sup> The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-eligible beneficiaries](#). July 17, 2020.

<sup>4</sup> Centers for Medicare and Medicaid Services. [Fact Sheet: People Dually Eligible for Medicare and Medicaid](#) March 2020. Accessed June 1, 2021.

<sup>5</sup> Mathematica Policy Research. [The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). December 4, 2018.

<sup>6</sup> ATI Advisory. [Making Sense of Medicare-Medicaid Integration Models](#). June 11, 2020

<sup>7</sup> Medicare Payment Advisory Commission. [June 2019 Report to Congress, Chapter 12: Promoting Integration in Dual-Eligible Special Needs Plans](#). June 2019.

<sup>8</sup> The outcomes of this research will be released in the 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.

<sup>9</sup> Mathematica Policy Research. [The Complex Art of Making it Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries](#). December 4, 2018.

enrollment supports often draw from existing Medicare and Medicaid navigation resources, meaning enrollment brokers often lack experience in both Medicare and Medicaid navigation. Brokers' incentives may also be misaligned with consumers', due to compensation policies that reward enrollment in non-integrated models. Dual eligible individuals need an unbiased and specialized source of information on integrated care options to support their enrollment in integrated plans.

**Medicaid Churn.** Due to periodic eligibility redeterminations, the average Medicaid beneficiary is only covered for ten months of the year. While coverage length is slightly higher for those with disabilities (10.8 months on average) and older adults (10.3 months on average), both populations that tend to be dually eligible, Medicaid coverage gaps, also known as churn, are nearly unavoidable.<sup>10</sup> As a result, even for dual eligible individuals who are able to understand and enroll in integrated models, staying enrolled is difficult. Churn, and the subsequent disruptions and delays in care, have severe implications for dual eligible individuals, who as discussed above, tend to have higher levels of care needs and are often medically vulnerable. Moreover, the administrative burden associated with churn further complicates the enrollment experience for dual beneficiaries and may lead to lower enrollment rates in integrated models over time. Federal policy must be used to reduce churn within the Medicaid program and ensure that once individuals enroll in integrated models they are able to stay enrolled.

**Medicaid's Institutional Bias.** Federal mandates for Medicaid long-term services and supports (LTSS) coverage require states to provide nursing home level care, however, states are only required to cover a narrow array of home- and community-based services (HCBS). More comprehensive HCBS coverage is at the states' discretion. Adopting additional coverage requires navigating a complicated patchwork of State Plan Amendments and waivers, which often discourages states from expanding HCBS and complicates access to services for consumers and their advocates.<sup>11</sup> This so-called institutional bias in Medicaid disadvantages dual eligible individuals who, like a majority of American adults, tend to prefer to receive long-term care in their homes or communities, rather than in nursing homes.<sup>12</sup> In order to rebalance care away from nursing homes and towards home- and community-based settings, the federal HCBS State Plan Amendment and waiver process should be simplified and streamlined. Additionally, states should be encouraged to incentivize rebalancing, including by providing plans with bonus payments for keeping people in the community, as appropriate.

Policy reform across these three areas could help reduce inequities experienced by the dual eligible population by ensuring that individuals enroll and stay enrolled in health care plans specifically designed to integrate their physical, social, and behavioral health needs and that once enrolled in such plans, they receive care in settings that meet their needs and desires, such as their homes and communities.

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<sup>10</sup> ASPE. [Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic](#). April 12, 2021.

<sup>11</sup> Kaiser Family Foundation. [Medicaid Home and Community-Based Services Enrollment and Spending](#). February 4, 2020

<sup>12</sup> AARP. [2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus](#). July 2019.

We recognize that within OMB's effort to advance equity and support for underserved populations, there are many strategies that the office can take to identify systemic inequities (Area 1) and to address known barriers or burdens to accessing benefit programs (Area 2). Focusing on the needs of the dual eligible population and considering policies that reduce the obstacles that they face in accessing health care coverage represents one path forward. Regardless of the vision that OMB ultimately pursues, we are extremely supportive of this important undertaking and hope to serve as a resource as the office pursues this equity assessment and formulates plans to respond to its findings.

Please contact Arielle Mir at [amir@arnoldventures.org](mailto:amir@arnoldventures.org) with any questions. Thank you again for your work and your consideration of the feedback provided above.

Sincerely, Arielle Mir