AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

January 12, 2023

Senator Bill Cassidy
520 Hart Senate Office Building
Washington, DC 20510

Senator Thomas Carper
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Senator John Cornyn
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Senator Robert Menendez
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Senator Tim Scott
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Washington DC, 20510

Senator Mark Warner
703 Hart Senate Office Building
Washington, DC 20510

Re: Congressional Request for Information on Ways to Improve Coverage for People Dually Eligible for Medicare and Medicaid

Dear Senators:

America's Physician Groups (APG) appreciates the opportunity to respond to your November 23, 2022 request of for information (RFI) on improving coverage for people who are dually eligible for Medicare and Medicaid. As you know, the more than 12 million dual-eligible beneficiaries in the United States are a diverse population that often includes people with multiple chronic conditions and complicated social needs. Providing better medical and social services for this population holds the potential to improve health outcomes even as cost savings could reduce the fiscal pressure on Medicare and Medicaid.

We welcome your inquiry into how these programs are currently operating to serve dual eligibles and how they could be improved. We appreciate your openness to stakeholder input and your ongoing commitment to improving healthcare for all Americans.

Below, APG will provide (I) a brief description of our organization, followed by (II) a summary of our key points, followed by (III) our more in-depth comments and recommendations, organized in response to the numbered questions included in the RFI. Together these statements reflect the voice of our membership and our commitment to working with you to ensure that all Americans, and particularly the most vulnerable, have consistently accessible, high-quality, person-centered healthcare.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). Our motto, "Taking Responsibility for America's Health," underscores our members' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis.

Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide. APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians). These professionals in turn provide care for nearly 90 million patients.

II. With respect to improving care and coverage for the dually eligible, APG recommends the following:

- **Dually eligible beneficiaries will receive optimal continuity of care and coordination if their coverage under both Medicare and Medicaid is stable. This is particularly true for people who are at risk of losing coverage under a Dual Eligible Special Needs Plan (D-SNP) if they lose their Medicaid coverage. APG recommends that, if dually eligible beneficiaries become ineligible for Medicaid for any reason, they should be automatically enrolled into MA plans offered by the same parent organization as their Dual Eligible Special Needs Plan (D-SNP), with an option to opt out of this plan reassignment if they actively choose to do so.**
- **There should be greater communication with beneficiaries and more education available to them on their options and benefits within programs.**
- **CMS should continue to establish and expand value-based care and alternative payment models within both the Medicare and Medicaid programs, such as the Financial Alignment Initiative (FAI) demonstration currently underway.**
- **Given the challenges in aligning enrollment and coordinating care between Medicare and Medicaid, APG welcomes exploration of options for improving how public payors support the physical and social needs of the patients they cover. However, APG cautions against implementing wholesale changes – for example, through a new, unified system – without first undertaking sufficient due diligence in designing a new system with input from stakeholders.**
- **Per-member per-month payments to providers should be increased based on linking payment to social determinant factors and the social complexities of dually eligible patients.**
- **Plans should be granted greater flexibilities to address provider shortages in both urban and rural areas – for example, by allowing more types of clinicians to provide services to beneficiaries (e.g., licensed professional behavioral health counselors (LPCs)).**

III. APG's Detailed Responses

Below, we repeat some of the questions that you framed in your initial request for information and supply APG's responses.

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?***

The three terms "integrated care," "care coordination," and "aligned enrollment" are similar and achievement of each is highly dependent on the presence of all three, particularly for people dually eligible for Medicare and Medicaid. "Integrated care" can be thought of as the cohesion of coverage and benefits such that providers and patients can easily navigate and access the continuum of services (e.g., from preventative to long term care) as needed or appropriate. "Care coordination" reflects managing the care delivery itself, across service settings, service providers, transitions, and records. "Aligned enrollment" includes having the patient enrolled in an MA or D-SNP plan and a Medicaid managed care plan, both administered by the same parent company. Even today, the majority of dual eligibles are in coverage situations – for example, in traditional forms of both fee-for-service Medicare and Medicaid – where there is a lack of coordination between Medicare and Medicaid benefits. In these situations, care is "unaligned," in that beneficiaries struggle to navigate between these two programs. As Smith et al have noted, "Because Medicare and Medicaid providers generally address different needs and lack incentives to coordinate with each other, dual enrollees risk missing needed services; receiving duplicative care; experiencing avoidable emergency department visits, hospitalizations, and readmissions; and exhibiting poor health outcomes."[1]

An alternative to these situations is alignment – that is, moving dual-eligible beneficiaries out of situations in which fee-for-service (FFS) Medicare provides primary coverage and Medicaid provides secondary coverage, and into situations where they belong to a MA-like plan, as well as managed Medicaid. Beneficiaries thus move from being in an uncoordinated model of care to a model with extensive coordination. For example, in the optimal case, dual eligibles may be enrolled in a type of MA plan such as a D-SNP that provides extra benefits beyond original Medicare and Medicaid, while they are also obtaining Medicaid services through a managed Medicaid plan. (Having Medicaid coverage is a requirement to enroll in a D-SNP). Overall, nearly half of Medicare enrollees are now in an MA plan, and roughly 70 percent of Medicaid beneficiaries are now enrolled in managed Medicaid thanks to the growth of these programs at the state level.[2] As of February 2022, D-SNPs were operating in 45 states and the District of Columbia with about 3.8 million dually eligible beneficiaries enrolled. [3,4]

Managed care in both Medicare and Medicaid has been successful in the care of dual eligibles to a large degree because of their reliance on delegated medical groups and independent practice associations (IPAs), which integrate care among clinical teams independent of enrollees' forms of coverage. Delegated medical groups are provider organizations that have demonstrated a capacity to assume the financial risk that is required to care for patient populations *and* assume additional functions from the primary payer, such as third-party claims payment, credentialling, utilization and network management, and population health. The focus on coordinating care places these organizations and their providers in closer contact with patients than health plans can be that contract with providers on a fee-for-service basis. This aspect is crucial in improving care for highly vulnerable patient populations like those under Medicaid.

Continuity of care and coordination is improved in circumstances when dual eligible populations are enrolled consistently over time in both a MA or D-SNP plan and managed Medicaid. However, this stability can sometimes be interrupted when, for whatever reason, a dually eligible enrollee becomes ineligible for Medicaid. When a D-SNP member no longer qualifies for Medicaid, there is a grace period during which members can still get care and services through their health plan; Medicare will still pay for most of the care and benefits covered with the D-SNP member responsible for any out-of-pocket costs. Eventually, however, the member is disenrolled from the D-SNP plan and must enroll in another Medicare Advantage Plan or traditional Medicare.

To avoid disruptions to the continuity and coordination of care for dual eligible populations, APG recommends that if dually eligible beneficiaries become ineligible for Medicaid, they should be enrolled into MA plans offered by the same parent organization as their D-SNP by default, with an option to opt-out of the reassignment. The opt-out should be communicated directly to the beneficiary at the time when they are informed of their loss of Medicaid eligibility.

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 Medicare and Medicaid?***

Dually eligible beneficiaries face numerous enrollment choices to access the full complement of Medicare and Medicaid services (e.g., MA or FFS, Medicaid Managed Care for behavioral health, dental, and long-term services and supports). This creates fractured care that is hard to coordinate between providers and presents barriers for duals and their families in navigating multiple systems. For example, many dually eligible beneficiaries have multiple insurance cards, which creates confusion when they seek care. Any simplifications could greatly improve patient experience and satisfaction, making tasks such as follow-up care and compliance an easier lift.

APG recommends fostering greater alignment between Medicaid managed care long-term services and MA D-SNPs, which would help improve conditions for dual-eligible beneficiaries. As MA enrollment increases among the Medicare population, including for duals, program alignment will be integral for providing better clinical and social services for duals. Care for dually eligible beneficiaries should be streamlined as much as possible. In terms of quality and cost metrics, a single, streamlined set of measures across Medicare and Medicaid—including quality and performance measures developed for complex populations—should be used to improve quality.

Finally, Congressional policies should focus on better educating and informing dually eligible individuals about their care and coverage options and supporting value-based care models that excel at these activities, for example, our recommendation presented above regarding ineligible dually eligible beneficiaries being informed of their loss of eligibility and reassignment/opt-out option being communicated to them in a timely and direct manner. APG believes that communication between health plans and patients will improve under the default MA enrollment option. Communication with and education of beneficiaries focused on helping them better navigate their coverage and benefits are most effective in an integrated care and proactive coordination of benefits model. For example, the evaluation of Cal MediConnect, which is an example of CMS' capitated Financial Alignment Initiative (FAI) demonstration model with a three-party contract, found increased enrollee confidence in navigating their health care, on knowing how to manage their health conditions, how to get their

questions about their health needs answered, and who to call if they have a health need or question, as well as increased overall enrollee satisfaction.[5]

3. ***In your view, which models have worked particularly well at integrating care for dual eligibles, whether on the state level or federal level or both? Please provide data, such as comparative analyses, including details on outcome measures and control group definitions, to support your response.***

APG supports the continued expansion and establishment of value-based care and alternative payment models within both the Medicare and Medicaid programs. Value-based care models emphasize improved patient care at lower costs relative to fee-for-service based health care, and encourage providers to offer coordinated, personalized, relationship-driven care that supports patients in making informed decisions about their health.

APG recommends to the attention of Senators and their staff the Financial Alignment Initiative (FAI) demonstration that has been approved by CMS in 13 states. The FAI features two value-based models: 1) a capitated model with a three-way contract among the state, CMS, and a health plan, with the plan receiving a prospective blended payment to provide comprehensive, coordinated care; and 2) a managed fee-for-service model, negotiated between CMS and a state, in which the state can benefit from savings if costs are reduced for both Medicare and Medicaid. The FAI is designed to provide dual-eligible beneficiaries with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. Expanding this demonstration nationally will spur increased investment in the infrastructure that is required for implementation of coordinated, integrated care.

4. ***After reviewing these models, would you recommend building on 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?***

Given the challenges in aligning enrollment and coordinating care between Medicare and Medicaid, APG welcomes exploration of options for improving how public payors support the physical and social needs of the patients they cover. APG recognizes that efforts to build on elements of the current system– the Medicare Savings Program, D-SNPs, Medicare-Medicaid Plans (MMPs), the Program for All-Inclusive Care for the Elderly (PACE), and others – have failed to fully overcome all obstacles. APG members would welcome the opportunity to learn more about the contours and features of a "new, unified system."

However, APG, however, cautions against implementing wholesale changes without first undertaking sufficient due diligence in designing a new system with input from stakeholders. APG members have extensive expertise in serving dual-eligible beneficiaries and would happily share their insights about the advantages and disadvantages of potential features of a new system with you and your staff.

Even if a new, unified system were ultimately more successful than the current one, the transition could be disruptive, costly, and potentially long, and some unintended consequences potentially negative. Given the inherent risks in switching to a new system, building on the systems that are currently in place, such as the FAI demonstration and value-based and alternative care models like Medicaid ACOs may best serve both providers and their patients.

5. ***If you believe a new, unified system is necessary, what are key improvements we should prioritize? What would such a system look like? Please provide details on financing, administration (e.g. federal vs. state), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.***

As implied above, it is not clear to APG that an entirely new system is the only or best option. Any features considered for inclusion in a new system should be considered as possibilities either for a new system or as key improvements to existing systems. For either a new system or refinements to existing systems, the most essential key improvement is to link each patient with a provider group that accepts delegated risk from payors and takes responsibility for the quality and total cost of care for the patients they serve. Additional improvements should be designed to support this core approach.

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 aggregated? Please provide examples of methodology and the evidence-based rationale for each example.***

The best action is to ensure that people who are dually eligible for Medicare and Medicaid have access to innovative, value-based care models. Studies have shown that duals are a sicker population than their non-dually eligible counterparts (e.g., more likely to be hospitalized or die after adjusting for comorbidities) while having lower access to high-quality care. For example, 40 percent of dual-eligible beneficiaries in California are under the age of 65 and are either disabled or have severe renal disease. Many of these patients account for twice the standard per member, per month (PMPM) payment compared to a non-dual MA beneficiary. For example, HealthCare LA IPA, an IPA in California, found that of their 650,000 Medicaid patients in Los Angeles County, those with mental health conditions and/or substance abuse disorders had emergency room utilization that was three times higher than patients who were not diagnosed with these conditions.

Value-based models allow providers to develop patient-centered care plans that address patients' distinctive concerns as well as their health-related social needs driven by the social determinants of health. Data show that these models of care can provide thus provide higher-quality care to multiple subgroups of patients while lowering costs. HealthCare LA IPA achieves this through the use of its

extensive network of 34 health centers that specialize in the local language and culture of each individual neighborhood they serve, ensuring that patients are linked with the organizations and providers they trust, even through changes in coverage, while emphasizing care coordination. HCLA is bringing the Samaritan program to Los Angeles, linking early 200 unhoused patients to resources that provide them with the financial and social support to find stable housing. When implemented in San Francisco, Samaritan was successful in reducing total health costs amongst participating patients by 11 percent and decreasing emergency department visits by more than 50 percent.

Longstanding inequities and unmet mental and physical care conditions can only begin to be addressed if they are appropriately measured and reflected in payment mechanisms such as those that characterize value-based models. Healthcare organizations that choose to serve disadvantaged patients must provide treatment for a larger number of more severe conditions. To support this choice, payment systems, especially those that include benchmarking targets, must include sufficient risk adjustment to support providers' ability to effectively treat these patients and avoid overwhelming disincentives for providing care for these populations. Linking the social complexity of patients to payment is paramount in positively transforming the care that dual-eligible beneficiaries receive.

APG recommends that Congress should direct Medicare, Medicaid, and any new system that might be introduced for dually eligible beneficiaries to increase the PMPM payment based on social determinants of health to better capture the complexity of dually eligible patients.

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

APG is not aware of coverage and care management strategies that are more effective in urban vs. rural areas, or vice versa. We would note that access to care, particularly within Medicaid, is a common concern that plays out across both types of geographies. Rural communities are more likely to suffer from an overall lack of providers, including hospitals, while urban centers are more likely to face insufficient payment rates that dissuade many physician-providers from treating Medicaid patients. In San Francisco, for instance, there are a large number of providers but very few of them accept the state's Medicaid program, MediCal, because of the very large pay discrepancy that exists between it and other payers. The same dynamic is being played out across urban hubs nationwide.

Congress should implement additional flexibilities in Medicare, Medicaid, and any new system that might be introduced for dually eligible beneficiaries to address provider shortages in both urban and rural areas, such as making telehealth flexibilities permanent, paying specialists to consult with primary care providers, and allowing more types of clinicians to provide services to beneficiaries (e.g., licensed professional counselors (LPCs)).

II. Conclusion

Thank you for your consideration of our comments. APG appreciates your efforts to better support patients and providers in the Medicare and Medicaid programs. Removing existing barriers to coordination of care, aligning enrollment, and providing incentives to integrate care will lead to improved health outcomes and quality of care for people who are dually eligible for Medicare and Medicaid. On behalf of our members, we look forward to continuing to collaborate with you on these

issues. Please feel free to contact Garrett Eberhardt, Executive Director, Medicaid Policy (geberhardt@apg.org) or Jennifer Podulka, Vice President, Federal Policy, (jpodulka@apg.org) if you have any questions or if APG can provide any assistance as you consider these issues.

Sincerely,

Susan Dentzer
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America's Physician Groups
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[1] Smith LB, Waidmann T, Caswell K, "Assessment of the Literature on Integrated Care Models for People Dually Enrolled in Medicare and Medicaid Approaches Used and Priorities for Future Research." Urban Institute issue brief, September 2021.

[2] See https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/ and https://www.kff.org/statedata/collection/medicaid-managed-care-tracker/

[3] See https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/#:~:text=As%20of%20February%202022%2C%20D,beneficiaries%20enrolled%20(CMS%202022).

[4] See https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldataspecial-needs/snp-comprehensive-report-2022-02

[5] See https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/2020-CalMediConnectEvaluationOutcomeReport.pdf