

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 13, 2023

U.S. Senator Bill Cassidy, M.D.  
U.S. Senator Thomas Carper  
U.S. Senator Tim Scott  
U.S. Senator Mark Warner  
U.S. Senator John Cornyn  
U.S. Senator Robert Menendez  
United States Senate  
Washington, DC

*Sent Via Electronic Transmission to [dualeligibles@cassidy.senate.gov](mailto:dualeligibles@cassidy.senate.gov)*

Dear Senators:

Justice in Aging appreciates your interest in the important topic of better serving the health care needs of individuals eligible for both Medicare and Medicaid coverage. Thank you for the opportunity to comment on this legislative RFI.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and persons with limited English proficiency.

Our responses focus on those areas where, as advocates for dually eligible individuals, we see specific needs from their perspective.

## **Adequacy of Program Benefits**

While our comments below highlight critical consumer protections that should be incorporated into all integration efforts, we caution that a sole focus on integration fails to address the fact that, even when integrated, current Medicare and Medicaid benefits are inadequate to fully meet the needs of enrollees. For example, the bias in Medicaid law toward nursing facility care, combined with persistent underfunding of home and community-based services (HCBS), results in a lack of available community-based care options and, consequently, fuels the unnecessary institutionalization of older adults and people with disabilities. We urge Congress to make critical investments that will increase access to HCBS so that all individuals, regardless of their demographic characteristics, can access care that enables them to age with dignity in the location of their choice.

Oral health coverage is another example of an area with inadequate coverage of benefits fundamental to health. The Medicare program offers almost no coverage of dental services; coverage by state

## **WASHINGTON**

1444 Eye Street, NW, Suite 1100  
Washington, DC 20005  
202-289-6976

## **LOS ANGELES**

3660 Wilshire Boulevard, Suite 718  
Los Angeles, CA 90010  
213-639-0930

## **OAKLAND**

1330 Broadway, Suite 525  
Oakland, CA 94612  
510-663-1055

Medicaid programs varies widely. Although some states provide fairly robust oral health benefits, others offer almost nothing.

Integration efforts can only be effective if the underlying services are sufficient to meet the health care needs of dual eligible individuals.

**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?**

*Integrated Care*

In the context of care for dual eligible individuals, the term integrated care is usually used to describe the design of delivery systems that through various mechanisms such as common ownership, blended funding streams, data exchange, and combined consumer communication and appeals processes, seek to deliver Medicare and Medicaid benefits in a more unified way. In designing integrated models, it is important to always start with the beneficiary—what services are needed, where are the barriers, where are the inequities in both quality and access, what makes navigation difficult, what problems do individuals report, and what are the pressure points where experiences and outcomes are most affected?

*Care Coordination*

Care coordination is a critical pillar of any integrated model, but can also be provided outside of integrated settings. Care coordination aims to address enrollees’ medical and social needs, empower enrollees with the information needed to make decisions about their care, facilitate access to services, navigate care transitions, and prevent avoidable health events, including hospitalizations.<sup>1</sup> From the perspective of the dual eligible individual, care coordination is central to improving the health care experience.

*Aligned Enrollment*

The CMS Dual Eligible Special Needs Plan (D-SNP) regulations at 42 C.F.R. § 422.2, provide a useful definition of both aligned enrollment and exclusively aligned enrollment.<sup>2</sup> Advocates report that individuals enrolled in misaligned Medicare and Medicaid managed care plans find that care coordination across benefits is particularly difficult.

**Questions 2 and 4:**

***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?***

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<sup>1</sup> [Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative \(cms.gov\)](#).

<sup>2</sup> See also [Dual Eligible Special Needs Plans: What Advocates Need to Know \(justiceinaging.org\)](#).

***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?***

When examining opportunities to improve care outcomes for people dually eligible for Medicare and Medicaid via integrated models, we encourage policymakers to consider the common care concerns experienced by dual eligible individuals across delivery systems. These challenges, including inequitable access to services that perpetuate health disparities, negative implications of program misalignment, inadequate care management offerings, and benefit gaps between Medicare and Medicaid, contribute to poor care outcomes for enrollees. Within our response, we explore care concerns experienced by people dually eligible for Medicare and Medicaid and uplift the importance of consumer protections in any integrated offering.

#### *Advancing Health Equity*

Integration models must consider the demographic makeup of people dually eligible for Medicare and Medicaid and ensure that models tailor services to meet the diverse needs of enrollees. Compared to Medicare-only recipients, dually eligible individuals are more likely to be female, Black or Latino, have limited English proficiency (LEP), and experience social risk needs like homelessness and food insecurity.<sup>3</sup> This population also experiences greater healthcare needs and worse reported health outcomes than Medicare-only enrollees; dually eligible individuals incur higher burdens of chronic conditions and are more likely to require assistance with activities of daily living and utilize high-cost emergency services.<sup>4</sup>

#### *The Importance of Language Access and Culturally Competent Care*

Given the diversity of dually eligible individuals and the significant percentage of LEP members, integration models must prioritize the language access needs of members and opportunities to ensure culturally relevant care. Language assistance, including translation and interpretation support, is critical to ensure that LEP older adults can successfully navigate their benefits. Cultural competence, or the ability to interact effectively with persons of different cultures, is also a key component of effective communication with LEP individuals. Communications should be clear, timely, and available in multiple formats to ensure beneficiaries understand their benefits and consumer protections. Materials should also be subjected to consumer testing to ensure clarity.

#### *Care Coordination is Critical*

Successful integration, whatever the model, must always start with the individual. Design should always be from the perspective of the individual's needs and wants. A persistent issue among people dually eligible for Medicare and Medicaid is confusion about what benefits are available to them, what limitations exist regarding access to the benefits, and what their appeal rights are with respect to those benefits. Individuals need clear information to make informed enrollment decisions and, once enrolled,

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<sup>3</sup> [February 2022 MedPAC MACPAC Dually Eligible Data Book](#).

<sup>4</sup> Id.

to understand their rights to access particular services. Evaluations from the Financial Alignment Initiative (FAI) found that despite care management requirements, many enrollees could not access a care navigator, and additional studies reveal disparities in care management access by race, ethnicity, and primary language.<sup>5</sup> Integration models must expand access to the support offered to enrollees through care management services and be subject to more thorough oversight to address access concerns.

Successful care management hinges upon establishing and maintaining trust between the care navigator and the enrollee. To foster this trusting relationship, integrated plans may need a varied approach. For example, individuals with behavioral or mental health issues may work better with a care manager affiliated with their behavioral health providers. Individuals experiencing homelessness or housing instability and those reentering the community after incarceration may work best when a community health worker with lived experience offers navigational support. Care coordination must be responsive to the particular individual.

#### *Inequitable Access to Home and Community-Based Services*

Specific integration models are required to facilitate access to long-term services and supports (LTSS). However, existing limitations within the Medicare and Medicaid programs inhibit access to these services for dual enrollees, resulting in the utilization of more costly care.

Integration models operate within the limitations of existing Medicare and Medicaid benefits. As the HCBS example demonstrates, the current benefits offered by the two programs must be increased to meet the needs of enrollees. Therefore, even if these programs are integrated, the system will continue perpetuating the burden of poor health and costly care for duals. In addition to improving program alignment and administration of benefits, explicit efforts should be made to expand access to services to address gaps in the two programs, such as home and community-based services, oral health care, and quality provider networks.

#### *Network Adequacy Considerations*

In our work with on-the-ground advocates, when we hear of individuals wishing to drop their Medicare Advantage plan, it most frequently happens when they experience a significant change in health status and believe that the plan's network is not meeting their needs. Thus, at a time when they might benefit most from the care coordination services that a Medicare Advantage plan should be providing, they are dropping out. Though plans do not discourage high-cost individuals from enrolling initially, there is an adverse selection when inadequacies and limitations incentivize individuals to leave right when they become the most expensive to serve. Legislative efforts must ensure that network adequacy standards do not encourage this result and that its oversight is sufficiently rigorous to ensure its standards are followed. In addition, we encourage network adequacy to be evaluated from an equity and disparities perspective and consider benchmarks for plans on issues like disability access, providers that can offer services in non-English languages, providers in low-income neighborhoods, etc.

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<sup>5</sup> [When the Process Is the Problem: Racial/Ethnic and Language Disparities in Care Management \(springer.com\)](https://www.springer.com)

## *Maintaining Consumer Choice*

People dually eligible for Medicare and Medicaid should maintain their ability to choose whether or not they enroll in an integrated option. Their dual eligibility status should not fundamentally alter their right to decide whether to receive services through Original fee-for-service Medicare or managed care. That said, we believe that, at a minimum, there need to be significantly stricter regulations on the marketing of non-integrated products to dual eligible individuals. See our further discussion in response to Question 7(b).

**3) *In your view, which models have worked particularly well at integrated 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.***

Models offer varying levels of integration, ranging from coordination-only plans to care provided by a single entity. All models to date have offered important learnings and all have had challenges. Importantly, we still have much to learn from existing models; evaluations of the FAI are still underway, and more comprehensive assessments of the D-SNP model are needed. We encourage policymakers to leverage lessons learned from existing integration models to achieve improved beneficiary outcomes.

### *Evaluations have been helpful but more are needed*

Evaluative findings of the FAI demonstrations have varied among states.<sup>6</sup> With D-SNPs, though enrollment has been growing rapidly and states are increasingly looking to D-SNPs as a primary vehicle for serving their dual eligible populations, evaluations have been limited in scope and have looked at performance in a narrow range of states.<sup>7</sup> We look forward to additional findings for the FAI. For D-SNPs, we hope that states will take up the option provided by CMS to separate out D-SNP contracts so that a clearer picture will emerge with respect to D-SNP performance.

### *The FAI has produced significant learnings*

Although we look forward to additional evaluations, the value of several consumer protections introduced in the FAI has already become apparent. Some successful and scalable aspects of the FAI, including care coordination across benefit programs, unified appeals processes, unified communications, and consumer advisory committees, are now regulatory requirements for at least some categories of D-SNPs. A neutral ombudsman program to both assist enrollees experiencing difficulties with membership in integrated entities and to identify systemic issues also was a highly successful element of the FAI demonstration programs but has yet to be included in D-SNP programs. We urge that all of these consumer protections be included in any integration models moving forward.

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<sup>6</sup> [Evaluations | CMS](#).

<sup>7</sup> [Evaluations of Integrated Care Models for Dually Eligible Beneficiaries Key Findings and Research Gaps \(macpac.gov\)](#).

### *Consumer Protection: Unified Appeals and Grievances*

As previously noted, insufficient integration of Medicare and Medicaid results in significant consumer confusion, duplication of benefits, inefficiencies in service delivery, and improper denials of benefits. To address these concerns, the FAI tested a unified appeal and grievance process at the plan level. For overlapping services covered by both Medicare and Medicaid, the plan must review the request under both program criteria at the initial review and the first internal appeal level. The plan must then issue a single decision outlining the reasons for approval or denial under Medicare and Medicaid coverage rules. Based on this initiative's success within the FAI, exclusively aligned D-SNPs must now have a unified appeal and grievance process at the plan level that incorporates Medicare and Medicaid.<sup>8</sup> We encourage integration models that simplify procedures so the member experiences one unified system instead of two separate programs. We also urge further work to develop a unified appeals process beyond the plan level, building on the model piloted in the New York State FAI program.<sup>9</sup>

### *Consumer Protection: Advisory Committees*

Opportunities to facilitate feedback from enrollees should be part of all integration models. The FAI tested advisory committees comprised of family members, caregivers, and beneficiaries to receive and incorporate beneficiary feedback throughout the model's implementation. These committees successfully identified and developed effective solutions to address systemic issues negatively impacting care quality. Based on their success with the FAI, D-SNPs are now required to establish and maintain one or more advisory committees in each operating state.<sup>10</sup>

Advisory committees should reflect the diversity of beneficiaries and intentionally encourage participation from women, people of color, and individuals with limited English proficiency. Defined requirements for participation, clear methods for timely solicitation and integration of committee feedback, and accessibility deliberations, including language and technology considerations, are just some of the essential concerns for a successful advisory committee. We strongly encourage that all integration models require formal solicitation of feedback from enrollees.

### *Consumer Protection: Ombudsman Program*

As part of the FAI initiative, all participating states established an ombudsman program to assist beneficiaries in resolving challenges hindering access to benefits. Some states incorporated ombudsman services into an existing long-term care ombudsman program,<sup>11</sup> while others utilized nonprofit organizations to provide this support.<sup>12</sup> Ombudsman programs have proven effective in addressing systemic issues, particularly as, over time, they develop strong working relationships with plans and state officials.

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<sup>8</sup> See 42 C.F.R. § 422.561(2)(ii)

<sup>9</sup> [Financial Alignment Initiative New York Integrated Appeals and Grievances Demonstration: First Brief Report \(cms.gov\)](https://www.cms.gov/financial-alignment-initiative-new-york-integrated-appeals-and-grievances-demonstration-first-brief-report).

<sup>10</sup> [eCFR :: 42 CFR 422.107 -- Requirements for dual eligible special needs plans](https://www.ecfr.gov/current/title-42/chapter-II/subchapter-B/part-107/section-42.107).

<sup>11</sup> One example is the Long-term Care Ombudsman in Virginia, see [LTCOP: Commonwealth Coordinated Care \(virginia.gov\)](https://www.ltcop.org/).

<sup>12</sup> One example is ICAN in New York, see [ICAN - Your FIDA Ombudsman \(ny.gov\)](https://www.ican.org/).

In our experience, we saw that ombudsman programs were often able to resolve issues that otherwise might have required lengthy appeals. The relationships that ombudsman programs built with state agencies, CMS, and plans brought value to all parties and significantly helped to improve program operation. Expanding ombudsman programs to all dual integration models can improve the beneficiary experience at the local and systemic levels.

The FAI provided dedicated funding for an ombudsman program and we believe it was money well spent. We urge Congress to require ombudsman programs with integrated models and provide adequate funding to support those programs.

**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 government vs. state government), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.***

Much has been learned from experience with integrated models to date and much more learning is happening as states expand models to serve broader communities and larger populations. Robust care coordination and expansion of many of the consumer protections introduced in the FAI and discussed elsewhere in these comments are critically important. Also important is the development of state expertise and dedication of state resources to ensure strong oversight of implementation.

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

Strong consumer protections can reduce disruption for beneficiaries during periods of change. The following actions can minimize disruption for beneficiaries during these periods:

- Members must be able to access culturally competent and accessible care navigators to educate them about the upcoming changes and assist in navigating consequential decisions about their care.
- Mailings are important tools to provide enrollees with information about upcoming changes that impact their care. To improve their effectiveness, notices should consider accessibility needs, such as language access requirements and the health literacy levels of recipients. Enrollees should receive multiple notices informing them of upcoming changes; these notices should also be delivered with enough time so that enrollees can make informed decisions about their care. In addition to receiving multiple mailings, members should receive outreach assistance from a care navigator to ensure enrollees understand the change's impact on their care.
- Allowing members' benefits to continue while they navigate plan changes can help reduce service disruptions. These temporary benefit continuation periods offer consumers additional time to navigate the transition process without losing access to their providers and ensure they have sufficient time to make necessary changes.

- Engaging providers in the model development process is critical to increasing participation from beneficiaries' preferred providers.<sup>13</sup> Within the FAI, data from California, New York, and other states demonstrated high opt-out rates from specific language and ethnic communities.<sup>14</sup> In part, high-opt out rates have been attributed to providers discouraging members from participating in the demonstration program. Involving the provider community throughout the planning process will increase their likelihood of participating in integrated models and improve network adequacy for enrollees.
- Continuous gathering of feedback from members and consumer advocates can help plans identify and address systemic issues that negatively impact care quality. Developing systems to facilitate feedback from consumers and related stakeholders throughout the model's development and implementation processes provides plans with the information needed to make decisions that will reduce disruption for enrollees.

**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?***

Continuity of Medicaid enrollment reduces instances where enrollees experience a sudden loss of coverage that causes disruptions in their services. Overall, the income and assets of dual eligible individuals do not fluctuate annually, meaning that most remain financially eligible for Medicaid benefits. Even though they remain eligible, enrollees often experience disruptions in coverage due to administrative requirements during annual redeterminations; approximately one in three dually eligible beneficiaries lost their coverage for a month or more during their first year of enrollment, while one in five lost their coverage for three months or more.<sup>15</sup>

Denoted as “churn,” loss of coverage has devastating implications for beneficiaries. Loss of Medicaid coverage can result in members experiencing significant financial burdens from Medicare cost-sharing and loss of services, such as long-term services and supports, that are unavailable through Medicare.

To reduce care loss caused by administrative hurdles, the redetermination process must be as consumer-friendly as possible. Procedures should include pre-populated forms, required outreach and assistance from care navigators, and benefits continuation during temporary lapses in coverage, as the enrollee will likely regain eligibility once their redetermination paperwork is complete.

***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 only?***

We believe there is merit in MedPAC’s recommendation to limit D-SNP enrollment to full-benefit duals. Partial-benefit dual eligible individuals have Medicare but not full Medicaid benefits. The integration

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<sup>13</sup> [Why Did Certain Language Communities Steer Clear Of Medicare-Medicaid Integration Demonstrations? | Health Affairs.](#)

<sup>14</sup> [Financial Alignment Initiative New York Fully Integrated Duals Advantage \(FIDA\) Program First Evaluation Report \(cms.gov\)](#)

<sup>15</sup> [Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications \(hhs.gov\)](#)



benefits of a D-SNP are of little value when the enrollee does not have access to Medicaid benefits. Further, having full and partial dual eligible enrollees in the same plan creates challenges in enrollee communications. Integrated notices about benefits and integrated appeals procedures are not appropriate for partial duals. Thus, plans need to either have separate communications for their partial dual members or create confusing notices that describe options available to each group. Integrated appeals also are not relevant to partial dual eligible individuals.

Partial-benefit dual eligible individuals constitute a low-income population with extensive needs that should be addressed. Addressing those needs within a D-SNP that is primarily serving full benefit dual eligibles, however, muddies the waters and can dilute the value of the D-SNP model.

***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?***

We strongly oppose locking in dual eligible plan members for extended periods. These very high needs individuals simply do not have the resources to fill in if there are gaps in what their plan can provide.

We instead encourage policymakers to examine the factors that contribute to decisions by dual eligible individuals to switch plans. Oftentimes, conversations around plan switching “blame” the beneficiary for making this change, as opposed to examining opportunities for plans to make improvements that would prevent enrollees from having to leave their plan. SHIP counselors and other advocates report that individuals change plans primarily because they cannot access the services or providers they need in their existing plans. Requiring more expansive care navigation supports, for example, can help individuals better understand and access the benefits they need, likely decreasing instances of plan switching. We also hear from on-the-ground advocates that narrow provider networks are a major cause of switching plans when individuals face new health challenges.

We also note that concerns about individuals dropping plans can often be overblown. For example, a recent study in the Journal of the American Medical Association found that prior analysis of the impact of switching from Medicare Advantage to Original Medicare in the last year of life may have been overstated.<sup>16</sup>

In addition, we hear from advocates that, when individuals make plan changes that do not appear to be appropriate for them, misleading advertising or bad information by brokers and agents have often played a role. Addressing marketing practices directed at dual eligible individuals could also help to address the stability of enrollment. Currently, dual eligible individuals are subjected to a barrage of marketing and outreach from Medicare Advantage plans. This information is overwhelming and confusing for enrollees, and as a result, many dual eligible individuals enroll in plans that do not meet

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<sup>16</sup> [JAMA Health Forum – Health Policy, Health Care Reform, Health Affairs | JAMA Health Forum | JAMA Network](#)

their needs or expectations. We believe there is a need for CMS to significantly rein in Medicare Advantage marketing, particularly marketing to dual eligibles, and limit the profusion of plan choices.

We recommend, at a minimum, imposing clear requirements when an agent/broker initiates an enrollment that involves disenrolling a dual eligible individual from an integrated product like a D-SNP, Medicare-Medicaid Plan (MMP), or Program of All-Inclusive Care for the Elderly (PACE) plan. The broker/agent should be required to explain to the dual eligible individual what they are disenrolling from, that they will be enrolling into a non-integrated product, and the potential implications for their care. CMS should set specific requirements around oral and written communication and verification calls, focusing especially on ensuring that the individual understands how the plan does and does not coordinate Medicaid benefits. Measures such as these would assist dual eligible individuals and, rather than restricting their right to change plans, would empower them to make decisions based on good information.

Finally, we are fully supportive of CMS efforts to curb D-SNP “look-alike” plans, which are explicitly designed to attract dual eligibles but are not subject to D-SNP rules or to state oversight through State Medicaid Agency Contracts (SMACs). We appreciate the current look-alike regulations but expect that it may be necessary to tighten the rules further in the future.

**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 subgroup of beneficiaries? How should these subgroups be defined and how should the data be disaggregated? Please provide examples of methodology and the evidence-based rationale for each example.***

The demographic diversity of people dually eligible for Medicare and Medicaid, combined with heightened social risk needs experienced by these marginalized groups, contributes to unique vulnerabilities that fuel poor health for dual eligible individuals. For example, many dual eligible enrollees experience risk factors such as financial and housing instability, higher rates of chronic conditions, and required assistance with activities of daily living, which result in heightened exposure and more adverse outcomes from COVID-19. At the beginning of the pandemic, dual eligible individuals were over four times as likely to be hospitalized from COVID-19 compared to their Medicare-only counterparts.<sup>17</sup> American Indian/Alaska Native, Black and Latino dual eligibles, and those with end-stage renal disease were hospitalized at the greatest rates.<sup>18</sup>

Better data is a critical first step to identify the needs of specific groups and address disparities.

Intersectional identities can compound the impact of race disparities among older adults and people with disabilities, and result in particular minority populations incurring higher disease burdens. Currently, insufficient data obscures a collective understanding of health disparities and prevents analysis of the compounding impact of intersectional identities on care outcomes. To identify and develop strategies to address health disparities, standardized, accurate, and accessible Medicare and

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<sup>17</sup> [COVID19 Data Snapshot Public Release \(cms.gov\)](#)

<sup>18</sup> *Id.*

Medicaid utilization data, stratified by demographic elements such as race, ethnicity, gender identity, sexual orientation, disability status, geography, language preference, and age, are needed.

#### *Separate reporting by D-SNPs*

As a first step, recent CMS rulemaking now permits states to require separate contracts for D-SNPs.<sup>19</sup> Separating D-SNPs from other Medicare Advantage contracts will allow for a more robust performance measurement. We strongly support separate contracts for all integrated models to evaluate care outcomes for enrollees and believe they should be mandatory instead of optional.

#### *Demographic data collection*

Beyond separate contracts, collecting accurate demographic data is one of the greatest needs to understand health disparities. The Transformed Medicaid Statistical Information System (T-MSIS) is a state data reporting system containing Medicaid expenditure data, beneficiary demographic information, and enrollment data. Due to variations in state-based reporting, the completeness and accuracy of T-MSIS data vary significantly; in 2018, 20 states had either “high concern” or “unusable” data related to race/ethnicity information.<sup>20</sup> Variations in the quality of this information hinder comparisons and analysis of care quality needs at the provider, state, and federal levels. T-MSIS offers significant promise as a standardized location where states can report their Medicaid expenditure and demographic data. That said, for this information to be usable, more oversight from CMS is needed to ensure the accuracy and completeness of this data.

Additionally, while T-MSIS captures information on healthcare utilization, it does not include information on beneficiaries' psychological, social, and environmental needs. For example, CMS now requires health risk assessments for Medicare Advantage D-SNP plans to include housing, food, and transportation screenings. Collecting and reporting this information in coordination with claims data could help better determine how well D-SNPs meet the social needs of people dually eligible for Medicare and Medicaid.<sup>21</sup> Coordinated reporting of claims data and information on beneficiaries' social determinants of health could positively assist analysts in better identifying how well delivery models meet the needs of beneficiaries.

As previously noted, state reporting of expenditure information varies widely in accuracy and completeness. Once standardized and accurate data becomes available, Medicaid expenditure data must be disaggregated by the delivery system, including integrated models, and beneficiary demographic characteristics. This level of granular information will identify disparities in access and facilitate the deployment of targeted strategies to meet the needs of older adults and people with disabilities.

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<sup>19</sup> 42 C.F.R. § 422.107(e)(1)(i).

<sup>20</sup> [Medicaid Administrative Data: Challenges with Race, Ethnicity, and Other Demographic Variables | KFF.](#)

<sup>21</sup> [Integrating Medicare And Medicaid Data To Improve Care Quality And Advance Health Equity Among Dual-Eligible Beneficiaries | Health Affairs.](#)

## *Listening to Dual Eligibles*

Besides collecting aggregate data, finding out the needs of marginalized sub-populations requires listening to what they have to say. For example, some of the most helpful portions of the evaluations of the FAI demonstrations came from focus group participants. Plans in the FAI also reported that feedback from the Consumer Advisory Councils in the FAI led to specific actionable changes. When seeking direct consumer input, efforts must be made to ensure that advisory councils and focus groups genuinely reflect the diversity of the dual eligible population. This requires accommodation for disability, language assistance, and other aids to facilitate broader participation.

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

Dual eligible individuals who use durable medical equipment (DME) have experienced significant challenges with benefit coordination. When benefits overlap as they do with DME, dual eligible individuals can get caught in situations where it becomes difficult to access needed equipment. Navigating Medicare's more restrictive coverage of DME, which is limited to equipment needed in the home, with Medicaid's broader coverage of DME to enable community integration, can be a nightmare for both beneficiaries and suppliers.<sup>22</sup> These structural and regulatory impediments to timely access to needed equipment and services must be addressed across delivery systems, whether or not individuals are in an integrated model.

### ***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?***

It is estimated that 2.6 million people dually eligible for Medicare and Medicaid live in rural areas. Given that over 12 million people are dually eligible for Medicare and Medicaid, nearly one out of every five dual eligible individuals lives in a rural location.<sup>23</sup> As previously noted, the demographic characteristics of people dually eligible for Medicare and Medicaid, such as rural living, contribute to care complexities that require sufficient flexibility to address the unmet needs of this population.

People dually eligible for Medicare and Medicaid experience significant network inadequacies that diminish their overall health. Members residing in rural areas experience heightened unmet needs, as limited resources and network inadequacies prevent sufficient care access. For example, integrated offerings are often unavailable for duals residing in rural areas.

Since much of the FAI was located in urban areas and D-SNP availability is also more heavily represented in urban settings, policymakers must consider the limited amount of information on how successful these models are at meeting the needs of duals living in rural areas. We suggest that integration models carefully explore a community-driven response to care, as recipients themselves and local providers are experts on both care needs and resources available in the community to provide that care.

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<sup>22</sup> [Understanding Durable Medical Equipment | National Center on Law and Elder Rights](#)

<sup>23</sup> [Advancing Health Equity And Integrated Care For Rural Dual Eligibles | Health Affairs.](#)

## Conclusion

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Georgia Burke, Director of Medicare Advocacy, at [gburke@justiceinaging.org](mailto:gburke@justiceinaging.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" being more prominent than the last name "Goldberg".

Jennifer Goldberg  
Deputy Director