

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

July 7, 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 DUALS_Cassidy@cassidy.senate.gov

Dear Senators:

Justice in Aging appreciates the opportunity to comment on draft legislation to establish integrated care programs for people dually eligible for Medicare and Medicaid. Better serving the health care needs of individuals eligible for both Medicare and Medicaid coverage is an important topic and one that Justice in Aging cares about deeply.

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.

As advocates for low-income older adults, we are committed to improving the integration of care for individuals dually eligible for Medicare and Medicaid. Over the last decade, we have worked with federal and state policymakers through the Financial Alignment Initiative (FAI) to design and implement integrated models with strong consumer protections that improve access to care and reduce health disparities. The FAI is informed by years of stakeholder feedback, evaluation, and testing. It is imperative that any and all integrated care initiatives, including your legislation to create a new integrated care program, incorporate the lessons learned from previous and existing integrated models (including the FAI, D-SNPs, and PACE) and improve on them. Our comments reflect this foundational principle.

We have highlighted below several of our concerns and questions about the current draft legislation from the perspective of consumer advocates and our experience with the FAI and other integrated models. This is not an exhaustive evaluation of the draft legislation. Please refer to our response to the [January 2023 Request for Information](#), for a more detailed summary of Justice in Aging's recommendations on the topic of how to better serve individuals dually eligible for Medicare and Medicaid.

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Advancing Equity and Centering the Beneficiary

Fundamentally, any legislative proposal establishing a new program must articulate core goals. We believe that the current draft would benefit from the addition of a section that clearly sets out the goals and values that would govern regulations and implementation of the statutory changes. We urge that the legislation at a minimum include goals and principles of improving access to care, long-term services and supports (LTSS), and health outcomes for dual eligible individuals; person-centeredness, including empowering individuals to participate in their health care; advancing health equity; supporting individual needs and preferences; providing culturally appropriate care; addressing social determinants of health; and providing care in the most integrated setting. We also urge the working group, as it continues to craft legislation, to put particular focus on strengthening elements that advance equity and improve beneficiary protections.

Advance Equity

An integrated care proposal must consider the demographic makeup of people dually eligible for Medicare and Medicaid and tailor services to meet the diverse needs of enrollees and reduce health disparities among 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.¹ This population also experiences greater health care 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.² We propose several ways to advance equity in any integrated care product and that should be incorporated into legislation or any integrated proposal:

- **Expand Plan Benefits in Existing Programs.** Today there is wide variation from state to state in the availability and robustness of essential benefits for individuals dually eligible for Medicare and Medicaid. 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 high rates of institutionalization of older adults and people with disabilities that varies considerably from state to state. Oral health is another example of an area with inadequate coverage of benefits fundamental to health. Integrating inadequate benefits is of limited value. An integrated care proposal must increase the adequacy of the underlying services that the program is intended to integrate and reduce disparities from region to region by standardizing benefits.
- **Reduce Disparities by Listening to Enrollees.** Targeted strategies are required to reduce disparities. Integrated policies must be informed by the needs of marginalized sub-populations by listening to what they have to say at every stage from program design to provision of services. Focus groups during the FAI, for example, provided actionable feedback that led health plans to make specific meaningful changes. An integrated care proposal must ensure that advisory councils and focus groups genuinely reflect the diversity of the dual eligible population.

¹ [February 2022 MedPAC MACPAC Dually Eligible Data Book](#); [February 2023 MedPAC MACPAC Dually Eligible Data Book](#).

² Id.

This requires accommodation for disability, language assistance, and other aids to facilitate broader participation.

- **Increase Culturally Competent Care Coordination.** Care coordination is central in efforts to integrate care, reduce disparities, and improve the health care experience. In addition to requirements that a care coordinator connect and coordinate acute, subacute, social, primary, specialty, and LTSS services, as outlined in the draft legislation, care coordination should also explicitly require coordination for home and community-based services (HCBS), and any carved out services such as oral health and behavioral health. Given the diversity of dually eligible individuals and the significant percentage of enrollees with limited English proficiency (LEP), an integrated care proposal must prioritize the language access needs of members and opportunities to ensure culturally relevant care coordination.
- **Collect and Report Demographic Data.** Collecting accurate demographic data is one of the greatest needs to understand health disparities. This information is needed to identify disparities in care quality and deploy targeted resources to improve health outcomes. An integrated care proposal must require health plans to collect and report robust demographic data on plan enrollees. It is also essential that the quality measures include measures to reduce disparities and that quality withholds for plan performance incorporate equity measures.

Improve Consumer Protections

The value of consumer protections was made apparent in the FAI model. 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 and must be incorporated into any integrated care proposal. We appreciate their inclusion in the draft legislation.

Additional beneficiary protections are essential in any integrated proposal, including the following:

- **Medicaid Eligibility Must Not Be Conditioned on Enrollment in an Integrated Care Plan.** We unequivocally oppose any proposal to make Medicaid eligibility conditional on enrollment into an integrated care product. The Patient Protection and Affordable Care Act established the Medicare and Medicaid Coordination Office (MMCO) to improve access to both Medicare and Medicaid services, not take benefits away from Medicare beneficiaries or pressure them into enrolling in an integrated product. The legislation as currently drafted could be interpreted to require dually eligible individuals to enroll in an integrated plan to access any Medicaid benefits. We understand that this requirement was not the author's intent and urge changes to clarify that Medicaid eligibility would not be conditioned on integrated plan enrollment.
- **Prohibit Passive Enrollment.** We oppose passive enrollment. Person-centered programs should start with the person making the decision to enroll. An integrated care product should provide adequate support and information to assist in an enrollment choice rather than taking the choice away. As the FAI has demonstrated, passive enrollment has resulted in significant distrust

of health plans and disruption in care for enrollees and did not result in expected levels of participation.³

- **Prohibit Lock-Ins.** We oppose lock-ins and urge that dually eligible individuals in an integrated product have a Special Enrollment Period allowing a change at any time with an effective date at the start of the following month. Oftentimes, conversations around plan switching blame the enrollee 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. An integrated care product should instead require more expansive care navigation supports to help individuals better understand and access the benefits they need, likely decreasing instances of plan switching.

Further, in our experience, most disenrollments from integrated products have been driven by aggressive marketing by agents or brokers of other non-integrated Medicare Advantage plans that may not serve dually enrolled individuals well. The solution to that problem lies with regulation of marketing to dually eligible individuals, not lock-ins. These very high needs individuals simply do not have the resources to fill in if there are gaps in what their plan provides.

- **Include Continuous Enrollment.** We support the use of continuous enrollment in an integrated care product to minimize disenrollment due to the failure to return Medicaid forms or minimal changes in income and assets throughout the year. An integrated care proposal should incorporate other forms of streamlining eligibility verifications and minimizing erroneous disenrollments and align and build upon the final Medicaid Streamlining Rule.⁴
- **Provide Broad Continuity of Care.** We appreciate the provision in the draft for continuity of care for individuals whose primary care provider is not in the network of an integrated plan. Effective care continuity, however, must be significantly broader and include all other providers on which the individual relies. Specialists, home health agencies, physical therapy providers and others may be highly important to an individual and continuity of any of those providers can be critical to successful transition to an integrated product.
- **Fully Fund an Ombuds.** An integrated care proposal must include an ombuds that is fully funded with minimum staffing ratios, as outlined in the draft legislation. In addition, an integrated care proposal must make clear that the ombuds' responsibilities include addressing 1) individual issues; 2) systemic monitoring and reporting; and 3) consumer education and empowerment.
- **Expand Implementation Council.** We have seen the value of an Implementation Council in the FAI and strongly support including an Implementation Council in any integrated product design. An Implementation Council should always have the majority of its members dually eligible individuals and their family members and reflect the diversity of the dually eligible population. An Implementation Council should be put in place as soon as a state begins its process of designing an integrated care program and should remain in place permanently to address and

³ Grabowski, D.C., et al., [Passive Enrollment of Dual-Eligible Beneficiaries in Medicare and Medicaid Managed Care Has Not Met Expectations](#) (May 2017).

⁴ [87 FR 54760](#)

respond to issues of design and provision of services. Massachusetts' FAI Implementation Council provides best practices for fostering meaningful participation and input from beneficiaries to inform integrated offerings.

- **Require Ongoing Evaluation.** In addition to data collection and reporting, an integrated care proposal should require ongoing evaluation of the integrated product's policies and their impact on enrollee experience and wellbeing. Analysis should also consider how integrated products are identifying disparities and addressing inequities
- **Provide Adequate Implementation Timeframes and Systems Testing.** The FAI experience has shown that many of the initial problems for enrollees resulted from data interface deficiencies. An integrated care proposal should require rigorous testing to ensure integrated plans can handle all functions effectively with adequate implementation timeframes to carry out this testing. It should be noted that in the FAI, integration of systems took far longer than anticipated and required more extensive financial investments from states and plans than estimated. Timelines for implementation should reflect the fact that states are at different stages in integrating their systems and programs.
- **Protect enrollees from disruptions in care.** Besides the specific technical issues of systems integration and data testing, there are broader preparedness issues for any new program for dual eligible individuals. In design, implementation, and timetables, it is critically important to take into account the complexity of the current landscape. The differences in current levels of integration and in availability of health care resources both among states and within portions of states are significant. In the FAI, several states limited the regions within the state where they implemented the demonstration, recognizing particularly the differing levels of preparedness between urban and rural counties. Additionally, the provider landscape that has evolved over time, particularly for essential Medicaid services that help individuals to live safely and thrive in community settings, is unique in every state and, to some extent, in every community. States have faced challenges when trying to integrate carved out services into their Medicaid managed care plan models. Clear eyed realism about state readiness as well as having preparations in place to address unexpected disruptions are both imperative so that individuals are not put at risk during a transition.

Structural Concerns

We have several concerns about the basic structure of the integration proposal in the draft legislation, including the following:

Simplify to Ensure Meaningful Choice

It is not clear to us whether the current draft legislation is proposing an entirely new integrated program or whether it contemplates D-SNPs as a model option that MMCO could propose and that states could adopt. We do not support any integrated proposal that would add another integrated enrollment choice with additional plan options that does not include measures that tame the current market and offer dually eligible individuals a genuine opportunity for choice among high-quality integrated options with robust benefit packages. Today, integrated plans are competing with non-integrated plans and dually eligible people face too many plan choices.

Justice in Aging strongly supports active beneficiary choice. For that reason, as discussed above, we do not support passive enrollment in D-SNPs or in future integrated products and we do not support lock-ins for dually eligible individuals. *Meaningful* choice, however, requires plans that are designed to meet the needs of dually eligible enrollees, that the number of options be reasonable, and that differences among options are real and can be understood and reasonably compared. Meaningful choice is not currently available in the Medicare market, which is characterized by too many options that are hard to differentiate and aggressive marketing that focuses on benefits that may be quite limited or, for dually eligible individuals, duplicative of services to which they are already entitled. For example, in Alexandria, Virginia a dually eligible person has 44 available Medicare Advantage plans to choose from. Of those, six health plan sponsors offer 14 D-SNPs. One company alone offers four D-SNP options with identical costs and benefits under slightly different plan names. This kind of “choice overload” smothers the opportunity for meaningful choice.⁵

We support integration policies that improve the level of integration and availability of benefits for enrollees beyond what is currently available and place effective limits on marketing of other products to dually eligible individuals. There are many levers available, including:

- **Standardize and limit D-SNP plan offerings.** An integrated care proposal should require more standardization of plan benefits, limits on issuer plan offerings, and other elements adopted in the Marketplace to reduce plan choices and complexity.
- **Limit D-SNP Lookalikes.** As included in the draft legislation, an integrated care program should further limit sponsors’ ability to offer D-SNP lookalikes by reducing the enrollment threshold of dually eligible individuals to 50%.
- **Regulate Brokers.** An integrated care program must address broker commissions and incentives. 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 their needs or expectations. In addition, advocates report 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. An integrated care program should significantly rein in Medicare Advantage marketing, particularly marketing to dual eligibles. We recommend a broker commission policy that does not incentivize brokers from enrolling dually eligible people into non-integrated products and imposes clear requirements when an agent/broker initiates an enrollment that involves disenrolling a dual eligible individual from an integrated product about the implications for their care when they disenroll.
- **Prohibit Non-Integrated Products from Enrolling Individuals who have Full Medicaid.** If integration policies are fulfilling their purpose, integrated products should be providing superior access to care, coordination, and benefits through robust provider networks than would be available through enrollment in non-integrated plans. Meaningful choice is accomplished by

⁵ The phenomenon of choice overload has been widely studied by behavioral economists. See, e.g., <https://insidebe.com/articles/choice-overload/> for an introduction to the topic.

having access to a number of high-quality *integrated* options from which to choose coupled with the choice of remaining enrolled in Original Medicare.

Integrated Option for Partial Duals

We question the value, and even the concept, of an “integrated” option for partial duals. Because individuals with Medicare Savings Program (MSP) eligibility do not have access to any Medicaid services, there are no Medicaid benefits to integrate and thus the ability of states to exercise meaningful oversight of plans is limited. In observing D-SNPs currently serving partial duals, we have seen very little state engagement in their design and very minimal benefit to the partial duals plan members.

Also, as a technical drafting matter, we note the definition of “Medicare Savings Program eligible individual” in the draft includes individuals who only qualify for the Part D Low Income Subsidy and do not qualify for any MSP. That definition is inconsistent with the definition in all other parts of the Social Security Act and creates confusion because those individuals have no relationship to state Medicaid programs and do not even receive Medicare premium assistance from their states. We recommend deleting individuals who only qualify for the Low-Income Subsidy from the definition.

Creation of a New Title XXII

We have serious concerns about the complexity around the establishment of a new Title XXII. While we understand the concept of having a title specifically dedicated to programs uniquely designed for dually eligible individuals, we believe that much more analysis and more specific statutory text would be needed to ensure that all consumer protections in the Medicare and Medicaid programs, including those derived from Titles XVIII and XIX, implementing regulations, guidance, court rulings and state authorities, would carry over to programs under the new title. Avoiding harm and unintended consequences must be a priority of any program innovation.

Further, if D-SNPs are to be considered as integration options under this legislation, the fact that D-SNPs are currently regulated under Title XVIII would need to be addressed.

Conclusion

We share with the working group the desire to improve delivery of services to the dually eligible population and to work to improve equity for the many individuals in marginalized communities who rely on Medicare and Medicaid. Justice in Aging appreciates the ongoing opportunities to provide feedback on the group’s work. If any questions arise concerning this submission, please contact Amber Christ, at achrist@justiceinaging.org and Natalie Kean at nkean@justiceinaging.org.

Sincerely,



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