



January 13, 2023

Senator Bill Cassidy
520 Hart Senate Office Building
1035 Longworth House Office Building
Washington, DC 20515

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

On behalf of the nation's Medicaid Directors, the National Association of Medicaid Directors (NAMD) is writing in response to your [request for information on dually eligible enrollees](#). We appreciate the opportunity to provide comments on federal approaches to drive improvements in care.

As discussed in your request for information (RFI), dually eligible members, or individuals who are enrolled in Medicare and Medicaid, have a complex set of needs. The current system of care for duals is fragmented, which leads to worse health outcomes for dually eligible members and inefficiencies in care delivery that drive increased health expenditures.

State and Territory Medicaid agencies are key partners in efforts to improve care for dually eligible members. Congressional efforts should focus on aligning financial incentives, building duals policy expertise at Medicaid agencies, and ensuring thoughtful transitions for members.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Sincerely,

A handwritten signature in black ink that reads "Allison Taylor".

Allison Taylor
NAMD Board President
Director of Medicaid
Indiana Family and Social
Services Administration

A handwritten signature in black ink that reads "Cynthia Beane, MSW, LCSW".

Cindy Beane
NAMD Board President-Elect
Commissioner
West Virginia Department of Health
and Human Resources

Core Principles

In addition to the specific areas discussed in your RFI, NAMD would like to highlight three major areas for federal action:

- **Congress should develop strategies to build Medicare expertise within Medicaid agencies.** Having Medicare experts on staff at Medicaid agencies is crucial to developing strong duals integration strategies, but agencies report that it is difficult to find employees with this expertise. Congress should consider strategies to increase Medicare expertise at Medicaid agencies, including additional technical assistance from CMS, training sessions for state staff working on duals issues, and targeted funding (including FMAP enhancements) for dedicated duals staff. Congress could also consider options for direct CMS and Medicaid agency staff collaboration in managing FIDE SNP models.
- **Medicaid agencies should share in savings that are generated through duals integration models.** Currently, only the Financial Alignment Initiative (FAI) generates savings that are shared between Medicaid agencies and the federal government; other models often generate savings in Medicare that are not shared with states and territories. Aligning financial incentives is crucial to ensuring sustainable and effective Medicaid strategies that impact outcomes for duals. Congress could allow Medicaid programs to get credit for Medicare savings in Medicaid cost calculations, such as 1115 budget neutrality calculations and 1915(c) HCBS waiver cost neutrality methodologies. Congress could also permit states to include overall profits and losses (i.e., a joint Medical Loss Ratio) in risk sharing methodologies. For example, in the FIDE SNP model, Congress could allow states to first consider whether a plan had overall (Medicare plus Medicaid) losses as a threshold step before making risk corridor payments for Medicaid managed care cost reconciliation.
- **If Congress pursues major policy changes, it is crucial to ensure thoughtful transitions for Medicaid agencies and Medicaid members.** Some Medicaid agencies have already made significant investments in certain integration models, and significant changes to duals policy may have negative impacts on members in these states and territories. Substantially changing the underlying duals system would be challenging and resource intensive. If Congress does pursue larger-scale reform, it will be crucial to ensure that agencies have the time and resources to transition members thoughtfully and without disrupting care. This issue is discussed in more detail below.

Responses to RFI Questions

Integrated Care, Care Coordination, and Aligned Enrollment (Question 1)

Although Medicaid agencies use different approaches to deliver care for dually eligible members, they report similar conceptualizations of integrated care, care coordination, and aligned enrollment.

Integrated care is the most advanced level of alignment across multiple payers or programs. In an integrated delivery system, the dually eligible member should experience seamless services and benefits as if they had a single plan, including integrated notices and a single appeals process. The member should not have to navigate multiple systems or notice any differences between services that are covered by Medicare vs. Medicaid.

Care coordination helps members navigate multiple payers and connect to needed benefits. The member may experience differences between Medicare and Medicaid-covered services, including different notices, authorization processes, and appeal processes, but should receive support from their plan(s) in navigating these differences. Care coordination can help facilitate integration but does not inherently mean the care is integrated.

Aligned enrollment refers to when a member's Medicare Advantage and Medicaid managed care plan are the same entity or have the same parent organization. This can facilitate streamlined information for members on benefits, unified appeals processes, and single prior authorization processes. As with care coordination, aligned enrollment can support integrated care, but does not necessarily mean care is integrated. CMS defines "exclusively aligned enrollment" as when a D-SNP is *only* allowed to enroll individuals who receive their Medicaid and Medicare benefits from the same entity or entities with the same parent organization. Per CMS' CY 2023 Medicare Advantage and Part D final rule, all FIDE SNPs must have exclusively aligned enrollment starting in 2025.

Shortcomings of the Current System of Care for Dual Eligibles (Question 2)

Integrating care across Medicare and Medicaid is inherently challenging. Medicare and Medicaid are governed by different sets of complex federal regulations, and Medicaid agencies note regulatory and statutory conflicts between Medicare and Medicaid that act as barriers to duals integration. Although CMS has worked to address some of these challenges, we encourage continued collaboration with Medicaid agencies to develop aligned rules that support more advanced models of integration. To support this work, Congress could empower the CMS Medicare-Medicaid Coordination Office (MMCO) to develop aligned rules where Medicare and Medicaid regulation or statute conflicts.

Congress should also consider data collection and technical assistance strategies. NAMD recognizes the need for clear information on the level of integration achievable in various Medicare models (Original Medicare, Medicare ACOs, MA Plans, D-SNPs, etc.)

and strategies Medicaid programs can use to serve dual eligibles in each of these models. These integration models should be studied using a whole member perspective, instead of looking at specific sets of services and investments. More broadly, developing and maintaining high-quality integration programs is time, staff, and resource intensive. States and territories report the need for additional health analytics expertise to integrate Medicare and Medicaid data sources, a crucial first step to monitoring health outcomes and expenditures. Congress should consider additional funding to support this work, and CMS should make Medicare data more readily available to Medicaid agencies to support integration.

Misaligned financial incentives also lead to challenges in promoting effective integration. When Medicaid and Medicare benefits are provided by different plans and payers, there is little incentive for one payer to invest resources if the other payer would financially benefit from the resulting reduced utilization or lower healthcare costs. Aligned enrollment helps address this issue at the plan level, but there are not currently good mechanisms for sharing savings across payers. Medicaid agencies also note an ongoing need for more Medicare expertise at Medicaid managed care organizations to promote integration. More broadly, Congress should contemplate mechanisms for shared savings and shared accountability across Medicare and Medicaid, including combined Medical Loss Ratio requirements for health plans serving dual eligible members and shared savings mechanisms (e.g., through 1115 waivers).

Finally, Medicaid agencies highlight challenges ensuring adequate provider networks in duals models. Some providers accept Medicare but not Medicaid or are not interested in participating in duals integration models. Additionally, some rural hospitals may struggle to support integrated models under current reimbursement structures, as Medicare fee-for-service may reimburse at higher rates. Congress could consider policies to give states more leverage – or use Medicare contracting as leverage – to encourage provider participation and model adoption.

Models for Integrating Care (Question 3)

Different models for integrating dual eligible care (D-SNPs, FIDE SNPs, HIDE SNPs, FAI, PACE, etc.) have different benefits and limitations. States and territories face unique local circumstances, including diverse member demographics and care needs, managed care markets across Medicaid and Medicare Advantage, statutory environments, and provider landscapes. Therefore, different states and territories may find different models better suited for local needs.

Medicaid agencies did, however, note advantages and disadvantages of certain models. The FAI model, which is being phased out by 2025 under the CY 2023 Medicare Advantage and Part D final rule, had mechanisms for shared savings between Medicare and Medicaid, promoted effective collaboration through direct three-way contracting between Medicare, Medicaid, and the managed care organization for agencies opting for the managed care demonstration, and achieved advanced care

integration in some states. However, the success of the FAI model varied based on model design, provider network participation, and other variables.

Medicaid agencies have different perspectives on the FIDE SNP model. Some agencies report that FIDE SNPs have been largely successful; other agencies note that, while FIDE SNPs represent significant improvements over typical D-SNPs, they often fail to deliver truly integrated benefits and member services. Other agencies note that safeguards like MLR corridors and contracting language can be helpful for ensuring the success of FIDE SNPs and preventing inappropriate institutionalization when community options are available. Per the CY2023 Medicare Advantage and Part D rule, FIDE SNPs will be required to transition to exclusively aligned enrollment by 2025. Although exclusively aligned enrollment can support integration, Medicaid agencies note that this change will require significant time and investment, including systems changes and contracts to integrate grievance and appeals processes. Congress should ensure that Medicaid agencies have the resources needed to support this work.

Unified Systems and Care Disruption (Questions 4, 5, and 6)

NAMD does not have a position on whether Congress should build upon existing models or pursue a new unified system for duals integration. However, if Congress does pursue a unified system, it should build on the successes of the FAI, which is currently being phased out. The FAI allowed for shared savings between Medicare and Medicaid and three-way contracts between managed care, Medicare, and Medicaid programs. Other models for integration, such as D-SNPs, do not have these features. Any new systems should also ensure a single care coordination/case management team and a unified contracting cycle, and provide mechanisms to directly address statutory and regulatory conflicts between Medicare and Medicaid. Congress should also consider how any national strategies for integration can support the needs of partial benefit dual eligibles.

Medicaid agencies will always play a large role in coordinating care for dually eligible members. Dually eligible members may have a variety of needs, including behavioral health care, aging and disability services, and health related social needs, that require coordination with Medicaid agencies and other agencies operating Medicaid-funded programs and benefits. If Congress does pursue a unified federal system, it will be important to ensure the system is developed in collaboration with agencies in a manner that recognizes their expertise and operating structures, as well as the diversity of populations that they serve.

Finally, Congress should be cognizant of care disruptions for current members. Without extremely thoughtful transition plans, significant changes to duals policy may have negative impacts on dually eligible members. Medicaid agencies which have launched integration initiatives under current authorities report that implementing new duals models requires thoughtful transition planning, significant systems changes, and robust communications campaigns. Any legislative changes should include significant

implementation time and sufficient resources. NAMD also encourages phased delivery system changes (by geographic area, population, or another criteria) to give Medicaid agencies an opportunity to course-correct if any issues arise.

Plan Switching (Question 7.b)

NAMD does not have robust comments on plan switching. However, one Medicaid agency notes that one of their carriers designed a performance improvement project to identify reasons for member attrition. Members overwhelmingly reported that issues with the plan – including problems with care coordination and difficulties contacting member service – were their primary reason for plan switching. Congress could provide Medicaid agencies with additional resources to support robust choice counseling for dually eligible members; choice counseling is especially important for this population since their needs are different from, and often more complex than, other Medicare enrollees.

Diversity of the Dual Eligible Population (Question 8)

NAMD's members note a variety of strategies for addressing the diversity of the dual eligible population. One agency notes ongoing efforts to disaggregate quality and outcome measures by demographic variables, including race, ethnicity, language, gender, and sexual orientation. The agency is using this data to develop targeted goals for reducing disparities, with clear accountability mechanisms for health plans to make progress towards these goals.

In addition to the demographic characteristics listed in the report, dually eligible members also experience varying functional needs and interact with different state agencies (aging and disability, behavioral health, etc.). Any Congressional strategies should consider these differences. One Medicaid agency notes their work with dually eligible members with disabilities under the age of 65, and the importance of focused strategies for independence and community integration, assessing risk factors, and quality measurements for this population compared to the over 65 population. This agency specifically focused their FAI model on the under 65 group and found this to be a successful strategy.

Congress should recognize the heterogeneous nature of duals populations and build on these types of approaches, with an emphasis on flexibility for Medicaid agencies to design and implement models that meet the diversity of their members' needs. We note that Congress could give D-SNPs additional flexibility to meet the unique needs of their members (e.g., through supplemental benefits). Aligning metrics across Medicare and Medicaid could also support improved monitoring of health outcomes, including disparities.

Role of Geography (Question 11)

Geography has significant impacts on duals integration strategies. Some states and territories are so small that they are not attractive to health plans, which limits the feasibility of duals integration strategies that are dependent on managed care. Even in larger states and territories, NAMD's members note that managed care organizations may not operate in all regions. This can present a barrier to aligned enrollment; if a Medicare Advantage or Medicaid managed care plan does not cover a certain region of the state or territory, aligned enrollment may not be an option for all members.

This dynamic dovetails with provider network adequacy challenges. Rural and geographically isolated areas, such as islands or frontier regions, struggle to attract adequate provider bases, and these providers may not choose to enroll in Medicaid or in integration models. This challenge may be compounded by Medicare reimbursement models for rural and frontier hospitals that do not incentivize participation in integrated care models. This can lead to access challenges for members; one state notes that approximately one third of their counties do not have a licensed psychologist, social worker, or addiction counselor. This lack of providers can also make plans more reluctant to enter rural and frontier areas, limiting access to duals integration models.

To address these challenges, the federal government should continue to support Medicaid and Medicare telehealth flexibilities beyond the end of the COVID-19 public health emergency. One Medicaid agency notes that audio-only telehealth has been particularly helpful in addressing rural workforce shortages; another notes that telehealth has been critical to ensuring access to behavioral health care. NAMD members also applaud the Affordable Connectivity Program and other federal efforts to improve access to broadband across the nation as a step towards promoting equitable access to high-quality telehealth services.

Finally, NAMD's members note the importance of duals integration models that are responsive to local need. One state notes that, particularly in rural communities, members feel more comfortable working with care coordinators who are familiar with their region and the services available there. To address this challenge, the state requires care coordinators employed by the state's vendors to reside in-state and preferably in the communities they serve.