S. HRG. 117–163

IMPROVING CARE EXPERIENCES FOR PEOPLE WITH BOTH MEDICARE AND MEDICAID

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

FEBRUARY 10, 2022

Serial No. 117–12

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.govinfo.gov
U.S. GOVERNMENT PUBLISHING OFFICE
46–921 PDF WASHINGTON : 2022

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IMPROVING CARE EXPERIENCES FOR PEOPLE WITH BOTH MEDICARE AND MEDICAID

THURSDAY, FEBRUARY 10, 2022

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., virtually via Webex and in Room SD-562, Dirksen Senate Office Building, Hon. Robert P. Casey, Chairman of the Committee, presiding.

Present: Senators Casey, Gillibrand, Warnock, Tim Scott, Collins, Braun, and Rick Scott.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

The CHAIRMAN. Good morning. The hearing will come to order. Today's hearing will focus on seniors and people with disabilities who depend on both Medicare and Medicaid as their lifeline.

Over 12 million Americans are eligible for both Medicare and Medicaid, including almost half a million in Pennsylvania. These Americans are expected to know which services Medicare covers, which services Medicaid covers, and which services are not covered at all. They might have one insurance card for their primary care doctor, one for their behavioral health, and one for prescription drugs, the list goes on and on. They might have a doctor who takes their Medicare insurance, but not their Medicaid insurance. Not only is this confusing and frustrating, it creates unnecessary hurdles for people trying to get the care that they need. All Americans deserve a health care system they can actually use, not one rife with stumbling blocks.

We will hear today from Jane Doyle, from northeastern Pennsylvania, not far from where I live. She lives in Monroe County, in the northeastern corner of our State. Jane will share her harrowing story of navigating the complexity of these benefits, not only for herself but also as a caregiver for her mother. She will also describe how she lives in fear that her doctors, who she trusts to keep her healthy, will no longer take her coverage.

We will also hear from Dennis Heaphy about how his coverage that combines Medicare and Medicaid and how that lets him remain independent, but it was quite a road to get to that independence. Certainly, there is work to be done. Jane's experience and Dennis's story make that clear. I am grateful that our Ranking Member, Senator Scott and I agree on this point.

Today, we are introducing the PACE Expanded Act. This bill would reduce administrative barriers that prevent the development and expansion of PACE programs. In Pennsylvania, we call them LIFE programs, but in most of the country, they go by that name, PACE. These programs enable people with Medicare and Medicaid to receive all their benefits through a single organization, providing primary care, long-term care and more in one place. PACE also enables people with a high level of need to stay in the community rather than receiving care in a nursing home, if that is their preference. Indeed, this is the preference for the majority of older adults, as well as people with disabilities.

That is why I am committed to expanding access to home and community-based services. Last year, the Senate passed the American Rescue Plan which included $12.7 billion in emergency funding for states for these services, these home and community-based services. States are using these resources to help more seniors and people with disabilities access care and to pay the heroic home care workers the hazard pay and the bonuses that they deserve. So this investment in the Rescue Plan of $12.7 billion dollars was a good first step, but we need to do more and invest more to ensure people with disabilities and seniors can receive care in their homes.

That is why I led 40 Democratic Senators in introducing the Better Care Better Jobs Act last year, that is Senate Bill 2210. This bill would make a permanent investment in home and community-based services. It would help states provide better care for seniors, people with disabilities and their families, and it would ensure there is a strong and supported workforce to provide those services. It would lead ultimately to better care. These are just a few of the many issues faced by people that have to navigate both Medicare and Medicaid. We will hear from several witnesses today who will highlight how we can continue to improve care for all of these Americans.

Now I will turn to Ranking Member Scott.

OPENING STATEMENT OF SENATOR TIM SCOTT, RANKING MEMBER

Senator TIM SCOTT. Thank you, Mr. Chairman, for working together on the PACE Expanded Act. Certainly, it is good for the country to see a bipartisan coalition working on behalf of the country, not on behalf of Democrats or Republicans, but on behalf of Americans.

One of the things I enjoy and appreciate about this committee is that we put seniors first, and not red ones or blue ones, Black ones or white ones, just seniors, and that should be a mission for our Nation and for all of those us in elected office certainly, to follow the example that you are leading by. I really appreciate your work on the PACE Expanded Act, and the one-stop-shop concept is something that is really important when you have so many layers of complexity in your life as you age. If we can eliminate any of it, it helps all of it become more digestible and easier to handle for the seniors, so thank you very much for your hard work on that issue.

One of the reasons why this legislation is so important is because we have nearly 12 million Americans and 150,000 South Carolinians who are dual eligible. They are eligible for both Medicaid and Medicare, and if you can imagine, as you described, seniors with chronic conditions have multiple caregivers, multiple places to go and if you think about Medicare, a national program run from the Federal Government, Medicaid is essentially a Federal program but run from the State government, and so getting those two to work together is not as easy as it should be. Anything that we can do in the direction of making that happen is going to be in the best interest of the seniors across this Nation and certainly the seniors in South Carolina that I know and love so much.

I will say that the Biden administration needs to consistently and continuously work on making sure that those agencies that serve our seniors, like the Social Security agency, is open.

I am thankful to see that after 15 of my colleagues and I wrote a letter to President Biden asking for field offices to reopen, that we are at least seeing that move in the direction of telework for those agencies. I think it is really important for us to have an opportunity to have our seniors have the place to go, whether virtually or in-person, when the pandemic subsides, for them to find the help they need from the agencies that they desperately wanted.

One of the focuses we have during this hearing, of course, is trying to figure out this jigsaw puzzle for the dual eligibles. I will say that the issues are quite challenging in many ways and as opposed to thinking about how to explain it, I just thought I would use examples of two folks who are dual eligible in South Carolina, who have benefited from having caregivers and case managers who understand and appreciate the complexity of the situation.

We have in South Carolina a program known as Healthy Connections Prime, that allows for three providers—Molina, Centene, and AmeriHealth—to serve about 15,000 people over 44 counties, to help that dual-eligible concept become a little easier.

Since the program started in 2015, we have seen improvements throughout the State. One member of the program was living in his car, homeless. His care manager noticed the signs that something was not going well. The care manager educated the young man about the plan benefits that assisted him and helped him find glasses, a place to stay, hearing aids, and dental work.

Another Molina member from Florence, South Carolina, had been gradually declining over the past several months. His daughter, who also serves as his caregiver, noticed he was having more and more difficulty even with his walker and needed more support. His care coordinator worked with his daughter and the gentleman's doctor on the needs, and soon thereafter a wheelchair was ordered, covered, and delivered. The member and the daughter reported that they were relieved and felt much safer at home, and they were able to get their appointments scheduled because of the support being provided.

To help states further improve coverage, I have introduced legislation to provide further assistance to State Medicaid agencies to help integrate coverage. It creates a $100 million grant for states to improve care coordination for their dually eligible population.

States can use the funds to hire personnel that have experience with the Medicare program or train existing personnel or help beneficiaries with the enrollment process. Initial studies have shown that integrated care improves health outcomes such as decreased rates of hospitalization and readmissions.

I look forward to hearing from our witnesses about what else we can do as Congress members, Senators, to improve the lives of our dual-eligible population.

The CHAIRMAN. Thank you, Ranking Member Scott. Before we move to our witnesses for introduction I want to note that we have been joined by Senator Collins, former Chair of this Committee, and Senator Rick Scott, who was here earlier. We are going to have Senators, as folks might know, moving in and out because of a busy day of other hearings and engagements but we will go as people arrive and are grateful to have everyone with us today.

Let me start with our first witness, Dr. Jose Figueroa. Dr. Figueroa is an Assistant Professor of Health Policy and Management at Harvard University's School of Public Health. Dr. Figueroa's research focuses on understanding the drivers of health care spending and poor clinical outcomes among older, at-risk populations with complex medical needs. He is also a practicing hospital medicine physician at Brigham and Women's Hospital in Boston, where he provides care to many Americans with Medicare and Medicaid. I want to thank Dr. Figueroa for being with us today to share his expertise with the Committee.

For our second witness I will turn to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman. I am pleased to welcome Eunice Medina. Eunice is a new South Carolinian but someone who has a deep background and understanding of this critical issue.

Eunice serves as the Chief of Staff and Deputy Director of Programs for the South Carolina Health and Human Services. The State department of HHS is the agency responsible for running our state's Medicaid program, which provides health coverage to more than 1 million South Carolinians. The department also operates the Health Connections Prime program, which coordinates care for South Carolinians who are dually eligible.

Ms. Medina's testimony today comes from her more than 18 years of experience working on this issue in both South Carolina and Florida, where she recently moved from. She has dedicated her career to working on behalf of older Americans and Americans with disabilities, those who are our most vulnerable and who need this assistance the most.

Ms. Medina is one of the thousands of public servants who work every single day to make the lives of South Carolinians better. Welcome to this hearing and welcome to South Carolina.

The CHAIRMAN. Thank you, Ranking Member Scott. Next I will introduce Dennis Heaphy. Dennis is a health justice advocate and researcher at the Massachusetts Disability Policy Consortium. Dennis is also a Commissioner on the Medicaid and CHIP Payment and Access Commission, known as MACPAC, the nonpartisan body that provides expert recommendations to Congress on ways to improve the Medicaid program.

Mr. Heaphy also happens to have both Medicare and Medicaid. He is on the front lines helping states create programs that serve the needs of people with Medicaid by meeting them where they are.

Thank you, Mr. Heaphy, for being with us today and sharing your expertise with the Committee.

Our fourth and final witness is Ms. Jane Doyle from Bartonsville, Pennsylvania, in Monroe County, as I mentioned in my opening statement. Jane has two children and three grandchildren. While they do not live close by, she is able to connect with them through daily phone calls. Jane describes herself as, "an artist at heart," and loves to paint.

Jane happens to receive Medicare and Medicaid because of multiple sclerosis. She also helps care for her mother who has Medicare and Medicaid as well.

Thank you, Jane, for being with us today and sharing your personal story with the Committee.

We will turn next to our witness statements, and we will start with Dr. Figueroa. Dr. Figueroa, you may begin.

STATEMENT OF JOSE FIGUEROA, MD, MPH, ASSISTANT PROFESSOR OF HEALTH POLICY AND MANAGEMENT, HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH, ASSOCIATE PHYSICIAN, BRIGHAM AND WOMEN'S HOSPITAL, BOSTON, MASSACHUSETTS

Dr. FIGUEROA. Thank you, Chairman Casey, Ranking Member Scott, and honorable members of the Committee. Thank you for the opportunity to testify today.

My name is Jose Figueroa and I am an Assistant Professor of Health Policy and Medicine at Harvard University. I am also a practicing physician in hospital medicine at the Brigham and Women's Hospital where I take care of critically ill hospitalized patients. For my research, I focus on how best to improve the quality of care delivered to the sickest and most vulnerable patients in our country, including the dual-eligible population, which are those, as mentioned, who qualify for both Medicare and Medicaid programs.

As a physician and a researcher, I can attest to the fact that navigating our health care system is inherently complex for anyone. These challenges, however, are far more difficult for the 12.3 million dual-eligible patients living with disability, with serious mental illness, with frailty, with multiple chronic conditions, and importantly, living in poverty, because of these vulnerabilities, dual-eligible people are much more likely to require hospital care, nursing home care, long-term care, home-based care, behavioral health, and unfortunately at increased risk for experiencing poor health outcomes.

A great failure of our health care system is that so much of dual-eligible patients' time is lost navigating the complex and confusing rules and regulations of two programs, which they must do in order to ensure they get the care they need. This is valuable time that they could instead be spending at home with their family and with their friends, and as a physician, one of the most frustrating realities for caring of dual-eligible patients is our inability to help them effectively throughout this process. Countless hours are spent by clinicians, care coordinators, social workers trying to determine what should be the safest discharge plan for our patients while at the same time trying to coordinate their care across multiple different providers, across multiple different clinics. This often results in prolonged hospital stays and deconditioning of our patients while they wait.

As stewards of our health care system we have an obligation to deliver better care for dual-eligible people. One important way of doing so is by promoting care models that offer true integration between both the Medicare and the Medicaid programs, financially and clinically across the entire care continuum. Integrated programs, when done right, have the potential to improve the efficiency, the affordability, and the quality of care that dual-eligible patients receive.

Today there are three major types of fully integrated care models. They include, as mentioned, the Program of All-Inclusive Care for the Elderly, known as the PACE program, Medicare Advantage Dual Eligible Special Needs Plans, or the D-SNPs, and state-level Medicare-Medicaid plans, or MMPs, under the CMS Financial Alignment Initiative.

In my submitted testimony I have outlined what the experience has been with these programs to date. The big takeaway is that while we have limited and, at times, mixed evidence on the success of these programs, there are some reassuringly positive signals that suggest integrated care, when done right, can improve the quality and the efficiency delivered to dual patients, and with more time and experience we expect these programs to get better.

However, to date, only 1 in 10 duals are enrolled in an integrated care model, and nearly 50 percent of dual-eligible patients across our country do not even have access to one.

In my written testimony I highlight recommendations of how we can make integrated care for duals better. For example, Congress should consider policy options that help states adopt and expand integrated care models, especially in the 14 states that currently do not have one program. In some states, clear guidance, technical assistance, and financial support may be necessary.

Integrated models must also offer meaningfully better value than the status quo and should cover all services patients need, from primary care, acute care, to long-term care and behavioral health services. The enrollment process into integrated care models must also be easy. Patients need adequate, unbiased support to ensure that they make an informed decision about what program is best to meet their unique needs and preferences.

Finally, we need better transparency on performance, better and timelier data, and we need to develop better quality measures that capture what truly matters to patients. If and when we do this, we can ensure a high quality and affordable care for the millions of people who are dually enrolled in the Medicare and Medicaid program across our country.

Thank you for your time.

The CHAIRMAN. Doctor, thank you very much. Next we will turn to Ms. Medina. You may begin.

STATEMENT OF EUNICE MEDINA, CHIEF OF STAFF, SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, COLUMBIA, SOUTH CAROLINA

Ms. MEDINA. Good morning. Thank you, Chairman Casey, Ranking Member Scott, and members of the Committee, for the opportunity to participate in today's discussion. As stated, my name is Eunice Medina and I currently serve as Chief of Staff and Deputy Director of Programs at the South Carolina Department of Health and Human Services.

Prior to joining South Carolina's Medicaid agency, I spent 17 years working with Florida's Medicaid population in various capacities. I spent more than a decade of my career working with seniors through the Florida Department of Elder Affairs where I managed multiple home and community-based waiver programs. In 2013, I assisted the Medicaid agency in transitioning those Medicaid beneficiaries into what is now known as Florida's statewide Medicaid Managed Care Program. The following year I joined the Florida Medicaid Agency where I worked to ensure health plans offering long-term care services were doing so in accordance to State and Federal requirements. I later ended up overseeing their 15 health and 3 dental plans serving approximately 3.5 million beneficiaries.

In June 2021, I joined South Carolina's Medicaid agency and have spent much of my first year analyzing how to best help the State by evaluating its Medicaid program and assisting the agency in developing a plan to improve quality of care and cost efficiency. South Carolina's population that is eligible for both Medicare and Medicaid, otherwise known as its dual population, have multiple options for receiving services.

According to December 2021 data, there are over 168,000 dual-eligible beneficiaries. Within that total over 59,000 are enrolled in a Dual Special Needs Plan; 15,000 or so are enrolled in our state's Financial Alignment Initiative program, our dual demonstration program; and over 22,000 are enrolled in one of our four fee-for-service home and community-based waiver programs, which serve the disabled over the age of 18 or the elderly. This group may include beneficiaries with a corresponding Medicare Advantage, Dual Special Needs Plan, or fee-for-service Medicare.

In 2015, our State chose to participate in the Federal dual demonstration program to evaluate opportunities for integrated care for seniors. Unlike other states, South Carolina chose to start off the program with a focus on those 65 years of age and older. This month marks our seventh-year anniversary since implementing this program, and I am happy to spend our anniversary discussing some lessons learned.

We have found that in cases where a beneficiary did not need home and community-based services, they typically utilized three services that Medicare only covers a limited amount of: home health, durable medical equipment, and behavioral health. Access to these services through our dual demonstration program has delayed the need for more costly home and community-based services. Another lesson was the importance of care coordination at the individual beneficiary level and the importance of fully assessing beneficiary needs.

We have a big decision to make as a State in deciding whether we want to take advantage of the alternative offered by the proposed rule that CMS issued on Jan. 7, 2022, or explore other options.

One reason to explore an option other than what is available through the dual demonstration or the recently released CMS proposed rule is the fact that Medicaid waiver programs are made up of more than just duals. When states are looking to integrate care, they may also need to consider the capacity of their Medicaid agency to manage the programs they have already committed to, which may include individuals that are eligible for full benefits under Medicaid, meet the nursing facility level-of-care, but are not eligible for Medicare. This is the approach Florida took.

Florida consolidated more than 10 waiver programs that served its Medicaid home and community-based service programs and nursing facility population over a 5-year period. Through this model, Florida currently serves more than 100,000 beneficiaries through seven comprehensive health plans, meaning that if someone is enrolled in one of these plans, they could receive both Medicaid medical and long-term care services. When possible, the Medicaid enrollment process considered whether a beneficiary had a Medicare product with a corresponding Medicaid plan.

Streamlining programs and focusing efforts and funding on an integrated program can help avoid confusion and administrative burden among dual beneficiaries and providers. Even still, Florida's model presents opportunities to further coordinate care and information, chief among them being the integration of Medicare data.

In conclusion, I truly believe each State faces its own challenges. For our State, we will be looking for solutions that continue to allow flexibility in how to design our programs, access to Medicare data, opportunities to align processes across all Medicare and Medicaid products, and time to responsibly shift to a model that embraces these flexibilities. Furthermore, resources that would allow states to strengthen their agency to support these massive internal and external changes would be most welcome.

Again, thank you for allowing me to participate in today's discussion on a topic I truly am passionate about and a population I have dedicated my career to serving.

The CHAIRMAN. Ms. Medina, thank you for your opening statement and we will turn next to Mr. Heaphy. You may begin.

[Pause.]

The CHAIRMAN. Mr. Heaphy, I think you might be muted.

Mr. HEAPHY. Apologies.

The CHAIRMAN. Great. Thank you.

STATEMENT OF DENNIS HEAPHY, MDIV, MED, MPH, POLICY ANALYST, DISABILITY POLICY CONSORTIUM, MALDEN, MASSACHUSETTS

Mr. HEAPHY. Chairman Casey, Ranking Member Scott, members of the Senate Special Committee on Aging, thank you for the opportunity to testify about my experience as a dually eligible enrollee in an integrated plan. To start, I want to give a special thanks to Senator Casey for his support of the disability community and his leadership on the COVID HCBS Relief Act. Senator Scott, several of my family members have moved to South Carolina and love the State.

I am here to speak to you from the perspective of a disability advocate and member of One Care integrated model in Massachusetts. One Care was established to improve the health and wellness of persons 21 to 64 with Medicaid and Medicare by better aligning both funding sources in a single health plan. One Care was designed to place increased weight on home and community-based services and diversionary behavioral health services and substance use disorder services, emphasizes independent living and recovery.

I became a member of One Care when it began in 2013, out of fear of losing my independence and my health in a fee for service system and/or in an algorithm-driven, short-term, medically focused plan.

I believe in the potential of integrated care and serve as Chair of the Massachusetts consumer-led One Care Implementation Council, which is comprised of many stakeholders but largely consumers and our family members, working in partnership with the State to ensure One Care meets enrollees' needs. Truly whole person-centered care meets the person's medical, LTSS, recovery, and other needs, helping the person to live in meaningful life in a community.

In my case, it also means ensuring I have the home and community-based services I need, including personal care attendant services, durable medical equipment, including wheelchairs, assistive technology, and medical supplies. It means having a care plan I have created with my care team and a direct line of communication with my nurse practitioner or physician assistant who can respond directly to my needs to reduce my chances of having to go to the emergency department or being hospitalized.

I have experienced integrated care at its best. I had truly home-based care with my nurse practitioner coming to my home regularly. She has taught my personal care attendants, my PCAs, who help me my activities of daily living how to do wound care, catheter changes, and more. When I developed a bone infection that required surgery, many hospitalizations and over a year of recovery, rather than going into a skilled nursing facility rehab my care team supported my decision to do recovery at home. My care team provided more training to my personal care attendants and increased their number of hours.

Acupuncture was provided on a weekly to reduce pain and control my spasticity. My autoimmune specialist, even though an out-of-network provider, was regularly consulted. I received a ceiling lift to transfer me from my bed to a wheelchair, alternating air mattress, upgraded wheelchair and seating system, and more. Most health plans do not provide people like me these types of services or care.

Thankfully I usually do not need intensive services. What I need most are home and community-based services and supports, developed in a care planning process with people I know and trust. Frustratingly, even though designed to be fully integrated, a whole-person plan, One Care seems to be moving away from the original model. I went to the emergency department for the first time in years because I could not reach a medical person at my plan, but instead could only get to the after-hours answering service.

Not knowing what to do, I drove my wheelchair to the hospital a mile up the road. If I had been able to reach someone with medical knowledge I would not have gone to the emergency department.

Other One Care members are also identifying barriers to care, including lack of a care plan or a trusted care partner and reduced access to services.

The State is taking these concerns seriously and working with the Implementation Council, disability advocates, and the One Care plans themselves to address what appears to be a departure by the plans from the original intent of the model. I am confident that because of the relationship between consumers and the State we will be heard and we can make change.

Not every State is like Massachusetts, but every State needs consumer voice to succeed in developing an integrated care system.

Thank you again for the opportunity to speak with you today, and I look forward to answering your questions.

The CHAIRMAN. Mr. Heaphy, thank you for your opening statement. We will turn next to Ms. Doyle.

STATEMENT OF JANE DOYLE, GRANDMOTHER, BARTONSVILLE, PENNSYLVANIA

Ms. DOYLE. Good morning, Chairman Casey, Ranking Member Scott, and members of the Senate Special Committee on Aging. My name is Jane Doyle. I have lived in Bartonsville, Pennsylvania for the past 32 years. I have two children and three grandchildren living in the suburbs of Atlanta and Boston. I am honored to have this opportunity to testify to help make a positive change toward better health care for everyone.

I have experienced, for myself and my family, several different “kinds” of dual eligibility when I was first diagnosed with multiple sclerosis. I applied for Social Security disability benefits, so I also qualified for Medicare. I was still able to work part-time, and I also accessed Medicaid through a special program. It allows people to work and still earn higher incomes but otherwise qualify for Medicaid, to pay premiums for the Medicaid benefits. It was a relief to have affordable insurance that covered out-of-pocket costs, and I found it quite purposeful to continue to work.

Since 2017, due to further medical circumstances, I have been unable to work. I qualify for regular Medicaid. In 2020, Pennsylvania required Medicaid through managed health care. From the eight doctors I see, I do not believe any of them are enrolled in the new system, so far, I have been fairly lucky. Most of my doctors have continued to see me, but they must write off the balances after Medicare.

I recently received a balance bill from a new doctor who may not have even be aware that I they were not permitted to balance bill because of Medicaid. My doctors say that the new system is complicated and the rules are different across the three different networks.

I also worry that since many doctors do not take the managed care, and these programs try to cut costs, the quality of care I receive suffers. During the pandemic I had to undergo three operations, one of which resulted in irreversible nerve damage. This resulted in me needing neurosurgery, and I had to travel 100 miles to Philadelphia to get that care.

My mother is also dually eligible. She is enrolled in Medicare and began to need more help. She needed the kind of long-term care that Medicare does not cover. For some time, she paid for home health care out of her pocket, costing around $7,000 a month, but for 24 years as a widow, her money was running out at 87 years of age. Thankfully, in Pennsylvania, Medicaid does have a special program known as “waiver.” This provides home care. Our family viewed this a great alternative to a nursing home setting for our mother, but to qualify someone must first apply for Medicaid and then apply for the waiver.

This process was long and difficult. It involved several applications, documentation from both Medicaid and doctors, choosing a provider to oversee your case, and finding a participating home health care agency with enough staff to meet our mom’s needs.

Eventually, we did not have enough money to pay for one more day. I was fortunate to have stumbled across the Pennsylvania Health Law Project. They helped to expedite my mother’s case. As you can imagine, the stress of not knowing how we were going to care for our mother was insurmountable.

I have talked about the trouble my mother faced becoming dually eligible, the challenges I experience as a dually eligible person. I would like to tell you what would happen if I stop being dually eligible. If I lose Medicaid, I would not be able to buy Medigap insurance to cover my out-of-pocket costs because I have a pre-existing condition. For those of us with a pre-existing condition, Medigap is allowed to deny you insurance if you have Medicaid when you first sign up for Medicare. As a result, I am stuck. I cannot increase my income or savings because I will no longer have Medicaid and I will not be able to buy Medigap. I would face high costs with having Medicare with no other insurance.

This is a lot for one person to navigate. Fortunately, there are sources of help like the Pennsylvania Health Law Project and the kind folks at the Medicare Rights Center’s national helpline, which I have reached out to.

I ask you today to do whatever you can to ease the burdens of people like me and my mother, who have faced challenges. While these programs are important, they are not easy to use. To make these programs actually work, it needs to be much easier for people like myself and my mother to enroll and find the care.

Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

The CHAIRMAN. Ms. Doyle, thanks very much. I appreciate your testimony.

Now we will move to questions, and I will actually start with Jane Doyle for the first question. Jane, I wanted to again thank you for your testimony. These stories that are shared by you and other witnesses help all of us when we are trying to formulate policy, especially on complex issues like health care, and in this case the challenges that dual eligible Americans face with regard to Medicare and Medicaid.

In your testimony you talked about your mother receiving long-term care at home. You stated that your family, “viewed this is a great alternative to a nursing home for our mother as it would allow her to stay independent and involved with us,” it is so important for Americans to be able to receive care in the setting that they prefer. Every person should have the option to stay close and stay connected to family if that is their choice.

Can you tell us more about why home and community-based services were so important both to you and your mother and, of course, your family?

Ms. DOYLE. Well, in our particular situation it was my mother's personal choice, and we wanted to honor that. Although my mom was college educated, my mom was a homemaker and she was not really accustomed to a lot of outside socializing, and her home was her life, but the second piece to that question, in short, the quality of the care that we received from both home care and the family pitching in was far better than what we had experienced in short stints in rehabs following hospitalizations. Nursing homes that provide rehabilitation were grossly understaffed, even prior to the pandemic, and I can assure you, from a recent hospital visit, that understaffing is even worse.

It is hard to leave your loved one and go home at night not knowing if they are going to answer your loved one's call bell or simply place a cup of water within their reach.

The CHAIRMAN. Thank you very much. For my second question I will move to Dr. Figueroa. In your testimony you told us about your experience not only as a researcher but also as a provider for people who have both Medicare and Medicaid. Your testimony spoke to the importance of having various options for people when it comes to integrated care models.

One of the models you mentioned is the PACE program, or as I mentioned earlier, the LIFE program in Pennsylvania. We have 7,000 Pennsylvanians that rely on PACE for their care, many of whom would otherwise be receiving care in a nursing home. There are hundreds of thousands of others with Medicare and Medicaid in Pennsylvania that may not live near a PACE program and may not know that it is an option available to them.

As I mentioned, Ranking Member Scott and I have introduced the PACE Expanded Act to reduce barriers to access and availability of PACE programs. Could you share with the Committee how expanding a program like PACE might be better able to support individuals with both Medicare and Medicaid?

Dr. FIGUEROA. Thank you, Chairman Casey. Yes, I can. First, the PACE program, as you mentioned, is a program that provides all health care services for older adults who would otherwise be in a nursing home, and the primary objective of the PACE program is to keep patients at home as safely as possible, for as long as possible and the key to the PACE programs are three things. One is that they are fully integrated financially. Two, is that they have the multi-disciplinary team, as Ranking Member Scott mentioned, a one-stop shop that include nurses, doctors, therapists, social workers, case managers, all with one common goal, that they are fully accountable for the care of the patient across the entire care pathway and then three, is that they maximize again what matters most to patients, is keeping them at home, in their communities, with their loved ones, so some of the examples that they do a really good job on is that every time someone joins a PACE program they do really comprehensive patient assessments, full review of all of their medical needs, they get into communication with all prior physicians that have taken care of the person, and then they try to ascertain what really matters to the patient, what values do they really appreciate and what they want to really preserve.

The second thing is that they create a plan that is unique to each individual patient, based on those values. The third thing is that they then coordinate all of the care, as I mentioned, and it is usually in sort of in an adult daycare type program, where the multidiscipline team operates and then they are always communicating with family members and so I think expanding the PACE program is a good option, especially in areas where there are no integrated care models, so we can think about ways of expanding the program. For example, one, you can scale existing PACE programs by increasing current capacity of existing PACE sites. The second thing you can do is you can think about spreading the PACE program, which in order to do so you need to offer incentives to other areas and states where there are no integrated care programs or there is no experience among the local health care providers in participating in a PACE program.

As you might have mentioned, there is a big challenge for the health care workforce to actually be certified to deliver PACE-type care or nursing home care, and so that is an important challenge that needs to be overcome and then the last thing you can think about is changing the scope of the program, which means expanding to other patient populations who do not currently qualify, so for example, I would be really interested in seeing if the PACE program model would be beneficial for younger people with disabilities or younger people with serious mental illness. I think that might be potential avenues of exploration.

The CHAIRMAN. Okay, Doctor. Thank you very much. I will turn to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman. As you imagine, having the Chairman on your left and your former Chairwoman on your right, the best I could do is defer to her first. Then I will continue with my questions when it is my turn.

Senator COLLINS. First of all, thank you, Senator Scott. You are always so gracious to me and I very much appreciate it. I want to thank you both for holding this very important hearing.

Dr. Figueroa, I want to start with you. As we have learned today, listening to the testimony, and we know from our own experiences doing casework in our State offices, the dual eligible population is extremely diverse. Many people think of it as, to use just three common words, as old, poor, and sick. That really does not capture the diversity of those who are in the dual eligible population.

For example, a dual eligible might be an 80-year-old woman who requires assisted living services and has spent her remaining income on medical expenses. It could be a middle-aged woman with diabetes and pulmonary disease who requires a variety of specialists. It could be a young person with disabilities who lives at home and requires assistance with the activities of daily living. Moreover, some dual-eligible people are not actually costly, but the minority makes the duals overall one of the most expensive groups for both Medicare and Medicaid, so my point is that what is driving the cost is different for each subpopulation. As we seek reforms to improve the care and lower costs, where possible, how should we evaluate policies that might better integrate care, knowing that there is not one way? Could you give us some guidance on that?

Dr. FIGUEROA. Thank you, Senator Collins. Yes, I think you bring up a great point, and we should not expect, given the diversity of the population you just described, we should not expect that one strategy will work for everyone. A strategy that might work in urban areas might not work in rural areas and so what we need is we need better data to understand what works for what specific populations, and in order to get to that level of understanding we must do a better job at making how we care and the different programs and the different plans that care for dual-eligible patients, we need to understand their effectiveness. We need to understand how well they perform for these populations. We need to understand what patient experience is like. We need to ask more questions of patients to determine if they really think their care is meaningfully different under these programs, and at the moment we often have very lagged data that does not help us make decisions today for how to improve care tomorrow. If you look at a lot of evaluations out there, the evaluations are from like data in 2012, 2013, 2014, and we are trying to make decisions in 2022. That is very challenging for us, as clinicians, to understand which care model to refer patients too, and I am assuming for policymakers to figure out what policy solutions they should be implementing at the Federal level and at the State level.

If we can somehow make data better and more transparent and also be able to drill down on which programs work for the young duals with schizophrenia versus with the older, frail adult living in a nursing home, I think we can then adopt and expand the models that make more sense.

Senator COLLINS. Thank you, Doctor. The second issue I want to touch on with you briefly is the challenges posed by the workforce issues that we are dealing with. There was a recent survey of long-term care facilities in Maine that found that 94 percent of Maine providers were experiencing a staffing shortage, and more than half of the respondents replied that their situation was at a crisis level.

At the same time, we know that these interdisciplinary teams are an important component of integrating care for dual eligible. So could you comment on how the workforce challenges affect our ability to adopt and scale integrated care models for dual eligible? Is this an area that should be more of a focus for Congress?

Dr. FIGUEROA. Thank you, Senator. Yes, I agree that it should be an area of more focus of Congress. We, as you said, have staff shortages across the country, and I think the COVID pandemic really exposed that vulnerability in our health care system. For example, if you think of nursing homes, nursing homes have significant nursing staff shortages, and the nursing homes with those shortages were much more likely to be decimated by COVID–19, and so one thing that we can think about in terms of improving the workforce, one is we need to compensate the workforce in certain areas better. We need to provide appropriate living wages so that we have less turnover and we have more people, good people, wanting to work in the health care sector.

Another thing to think about is we need to think about training a diverse workforce. We cannot expect to have doctors in all areas of the country caring for the majority of patients. In some areas we need collaboration with doctors and other types of professionals. For example, you can think about expanding community health workers to fill certain needs, especially in low-income areas where shortages are a problem.

What kind of policies can we do to promote, for example, more community health workers practicing across the country, working side by side with clinicians and other health care providers. One thing we could consider is how we pay for community health workers, and we should think about appropriately paying community health workers and not just them providing volunteer services because they care about the community and the people that live in their communities, and so those things that I think Congress and states can consider.

Senator COLLINS. Thank you. Thank you again, Senator Scott.

Senator TIM SCOTT. Yes, ma'am.

The CHAIRMAN. Thank you, Senator Collins. I just want to acknowledge, as well, as I said we will have Senators coming in throughout the hearing. Senator Braun was with us and will be joined by other Senators very soon.

I want to turn to Ranking Member Scott for his questions.

Senator TIM SCOTT. Thank you, Mr. Chairman. Let me ask Ms. Medina, the Healthy Connections Prime demonstration was South Carolina's first major effort targeted toward improving care for dually eligible individuals. Ms. Medina, can you talk about the lessons learned during this demonstration project, and how do you envision its future, moving forward?

Ms. MEDINA. Thank you, Senator Scott. There has been great success here in South Carolina with our duals demonstration program. It really was here in South Carolina the first attempt serving our duals, both in the medical services and long-term care services together.

Having said that, we are at a point in the program —it is a demonstration, and so we have been working with our partners over at the Centers for Medicare and Medicaid Services to figure out what are our next steps. I think there are definitely opportunities to figure out what really works best in the State and what we can take from the experience with Healthy Connections into whatever we decide to design for the future.

Senator TIM SCOTT. Thank you. Let me ask you another question. I have just introduced legislation that would provide states with one-time grant resources to improve care for dually eligible beneficiaries. One possible use of this fund is for State Medicaid offices to expand their understanding of the Medicare program.

Is this something that you think states would benefit from, and would other witnesses like to weigh in if they think it is necessary.

Ms. MEDINA. For sure, I definitely think that when it comes to Medicaid agencies obviously the focus is heavy on the Medicaid population, Medicaid experience, and that institutional knowledge that goes with it. As dual integration has become such a hot topic, agencies are really looking internally to better understand the Medicare rules and processes, especially those states that have chosen to participate in the dual demonstration program or that are managing their duals special needs plans in their states.

I definitely think there is an opportunity that we would welcome to further increase our institutional knowledge around Medicare, so we can make the best decisions for our State.

Senator TIM SCOTT. Thank you. Would any other panelist like to weigh in on the question as it relates to the benefits of one-time resources, one-time grant money going to states to help to bridge the gap in understanding and appreciating the complexities of the two programs?

I will continue with Ms. Medina.

Mr. HEAPHY. I am sorry.

Senator TIM SCOTT. Go ahead.

Mr. HEAPHY. This is Dennis Heaphy. There is a potential opportunity for increasing capacity and competency of our State Medicaid offices to collect data that better aligns Medicaid and Medicare information so that states can actually start developing a data collection system that actually works, to understand—I guess that is all I would say, is to have better data collection systems.

Senator TIM SCOTT. Thank you, sir, for your comments.

With the balance of my time I would love to ask Ms. Medina one last question here. There is always a natural tension between the states and Federal Government about the amount of Federal involvement in administering large programs like Medicare. I believe that states are the best laboratories for treating their own unique populations.

Do you believe that you have the appropriate amount of flexibility to provide coverage to dually eligible individuals?

Ms. MEDINA. As a State Medicaid agency we definitely have to navigate really complex authorities when we want to design programs that best fit our agencies and our population. Absolutely, there are definitely delays sometimes in new processes or new guidance that they issue, but we continue to work with them to figure out what are the best pathways that we should take, especially when it comes to the various options states have in how to implement their programs and the corresponding authorities.

Senator TIM SCOTT. Thank you. Mr. Chairman, with my last 30 seconds as opposed to asking another question that someone will not have time to answer, I think I would like to just point out the importance of both having experts and people who are actually dealing with the dual challenges of this complex system. Thinking about Dennis' comments as it relates to having to take his wheelchair a mile to a hospital, to get care, or thinking about our other witness who has spoken so clearly about not only Jane Doyle, her situation, but her mother's situation.

There is something about hearing from experts who can help illuminate the necessity of direction, but it also, I think, incredibly informative and important to hear from witnesses who understand the real-life pain and challenges that come with a system built for them, but not really, and so I think having a good balance has been helpful for me today.

The CHAIRMAN. Very well said by the Ranking Member. Very complicated issues and very personal.

We will turn next to Senator Warnock, who is joining us virtually.

Senator WARNOCK. Thank you so very much, Mr. Chair. Medicaid is one of the most critical safety net programs in our country, and it was created to expand access to health care for low-income children or families or people with disability because the Affordable Care Act allows states to expand Medicaid, there are more than 10 million Americans who qualify for Medicaid due to a disability. Many of these same individuals also have Medicare, but there are currently more than 300,000 Georgians eligible for Medicaid due to a disability. However, that number would be higher if my home State of Georgia would finally expand Medicaid, expand this lifeline program to more low-income individuals, individuals who live in the coverage gap, 275,000 Georgians in the Medicaid coverage gap, 500,000 uninsured Georgians, 646,000 Georgians who would qualify for free and affordable health coverage if Georgia joined the other 38 states and the District of Columbia in expanding Medicaid.

Mr. Heaphy, in your testimony you highlighted that not every State has provided innovative ways to ensure people have access to health care services like yours has. Can you talk now about the implications of living in a State that has not expanded Medicaid/Medicare disabilities and you are no longer eligible for the program?

Mr. HEAPHY. I would not be here testifying. I would probably even be in a nursing home or isolated in my home or not alive, and I am not being hyperbolic about that. It is very challenging for anyone with a disability to be able to live, even with Medicaid services, and without eligibility it is even more devastating.

I think something that needs to be considered too is work requirements, that for someone like me, I love working. The importance of working to me is—it is important to me, and the opportunity to work in Massachusetts is great. However, a work requirement scares me, because it disproportionately impacts folks with substance use disorder, folks with mental health diagnoses, folks who may not be able to demonstrate the level of disability that is required to be eligible for Medicaid under the Medicaid requirements.

For me, access to Medicaid is the first step toward accessing health care, and the lack of ability to get Medicaid is really just—it is really just a human rights issue as well as a civil rights issue, so I would not be able to live in another State. I live in Massachusetts because of the health care system here. I have been offered jobs in other states and I have not been able to take those jobs because of the lack of supports provided. In Massachusetts I can actually increase the amount of money I make and still maintain my Medicaid benefits and so the ability to maintain Medicaid benefits over time, that supports my ability to work.

I think what is important is really to look at how to incentivize the ability of people to get Medicaid and work at the same time without penalizing people who cannot work. I do not know if that answered your question or not, but that is what came to mind as you were talking.

Senator WARNOCK. Sure. Absolutely it answers my question, and to your point, after just 10 months of Arkansas' Medicaid work requirement, for example, some 18,000 poor and disabled folks lost their health care coverage, after just 10 months with this work requirement. I live in a State that has an expanded Medicaid and what I am hearing from you is that you might not be alive if you were just in the wrong State and the wrong ZIP code.

I happen to think that health care is a human right, and if it is a human right it is not a human right in 38 states. It is a human right in all 50 states, where we have an Affordable Care Act law that has been on the books for 10 years.

Thank you so very much for your courage and for your witness today.

Mr. HEAPHY. Thank you.

The CHAIRMAN. Thank you, Senator Warnock. I will continue with my questions and may turn to the Ranking Member after that, and then I think we will have Senator Gillibrand after that.

I want to turn back to Jane Doyle. Jane, you highlighted how difficult it was to help your mother apply for and enroll in the care that she needs. In your testimony, you talked about, “several applications,” and having to attach, “hundreds of documents,” hundreds. You also describe your own experience applying for Medicaid at different points in your life while you had Medicare, while you were working and when you could no longer work.

At various points you turned to nonprofit organizations like the Pennsylvania Health Law Project and the Medicare Rights Center for help. I imagine there are so many people listening at home who can relate to your story. As Ranking Member Scott made reference to, it is so important to hear from people that are living through these challenges.

Jane, are there things that could have made the application and enrollment process easier for you and easier for your mother to navigate?

Ms. DOYLE. Thank you, Senator. Well, it was a little more clear for basic Medicaid for myself, but for my mom it was not. In short, I think the answer would be to make the whole process quicker, but that might be exactly realistic. A certain degree of prudence obviously certainly needs to ensure compliance of the programs.

I will say for what we call in Pennsylvania as nursing home-level care Medicaid, the big issue I had was the $7,000 asset mark, and so with the $7,000 asset mark for a person with very, very high needs, that money is spent very, very quickly. First, as I mentioned in my testimony, you have to qualify for Medicaid, and not everyone is already qualified for Medicaid, and then you go on to the next application of waiver, so these dual applications can take two to 3 months, and as you can imagine, $7,000, when $7,000 a month is going out for high needs, that is not going to last you that duration.

Possibly, that limit may be able to be increased to allow people the time needed to get through the process, may be one way. The other way may be integrating. We have talked a lot about that during this meeting, but possibly integrating that process of applying for Medicaid and waiver together, you know, may make that more efficient.

Also in my case, this may be local but it would really be great if they update, you know, local government update their websites and make sure they have the correct forms online so that people can access those and that you can upload those documents that we mentioned earlier. That would be far easier than having to photocopy a book to get down to the county assistance with your process.

The other thing that I will talk about, there are a lot of programs for help to reach out to, but I myself found myself making numerous phone calls before I found the correct source. I cannot imagine that, you know, elderly people with maybe fewer skills or a bit of confusion, I cannot imagine how they might get through the process. I would suggest perhaps more awareness, and designate maybe one agency that fields people to the right resource. You know, that might be helpful.

My first resource, which unfortunately was not all that helpful, was the local Office on Aging. I did not find them particularly resource knowledgeable, but I think elderly might tend to go there. That might be a good place to start for people to find out where they need to be guided for specific issues for this massive, massive system.

The CHAIRMAN. Jane, thank you very much, and thank you for giving us your perspective from the perspective you have, which is very practical.

I will turn to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Mr. Chairman, and I will also note that some of the comments that we have heard during the hearing about the importance of understanding and appreciating the path back to work for Medicaid and some of the challenges they face, especially for folks—in Dennis' situation, I think there is always going to be a carve-out or a second look at the concept of Welfare-to-Work. I do believe that Bill Clinton, President Clinton's approach to Welfare-to-Work, in his 1992 campaign, that he actually was able to pass through, was overall good for the country and good for people, and frankly, something I completely support.

I do believe that we should always take into consideration special exceptions when necessary, but the path forward certainly, I think, is a good one overall.

Dr. Figueroa, may I ask you a question about the challenges that you find dually eligible beneficiaries facing when receiving care? I think Chairman Casey did a really good job of really simplifying this web of challenges of paperwork and the streams of challenges that come along with those binders that you are trying to find your way through when you are looking for help in all the wrong places because the paperwork jigsaw puzzle seems to be missing a few pieces, but beyond that, can you talk about some of the other challenges that dually eligible beneficiaries face when receiving care?

Dr. FIGUEROA. Thank you, Ranking Member Scott. As you mentioned, the administrative web and complexity is a wall to access health care. It is a wall that people have to climb over to access health care. As we mentioned, these are very vulnerable people, living in poverty, some people with limited health literacy, some people with limited computer proficiency, and that wall is insurmountable for some, and these are the people that need care the most. These are the people that want to be at home, living with family and their friends, and these are the people that are, unfortunately, stuck behind this wall. This wall prevents them from, for example, if they need medical equipment to be at home and they have to call two different insurance programs, they sometimes have to wait to be denied by the Medicare program before they can ask the Medicaid program, you know, can you cover this medical equipment that my doctors and my therapists say that I need to be safe, so I can get around my home safely, so I do not have to fall at my home?

You know, the two different programs, sometimes as well, in getting payments for their hospital care and trying to figure out the sharing between the two different programs, also in terms of how long can they be in a nursing home and how many days is covered by the Medicare program before the Medicaid program kicks in.

It is all a wall that complicates the lives of not just patients and families but also to us, the clinicians and the health care providers and instead of us spending time taking care of the patients and improving their health, we are spending time on the phone trying to figure out how to get the care they need, and that is a problem in our country and I think we need to fix it and the way to do it is by integrating everything, creating one true program, having one pot of money where the people and the health care providers that are responsible for the patients can use it to ensure that they can cover everything that the person needs.

Senator TIM SCOTT. Thank you. Thank you very much.

Ms. Medina, dual-eligible program enrolls only a fraction of those who are eligible for these plans. How can states enroll more people in plans that work for them?

Ms. MEDINA. In South Carolina I hope to approach this in two ways, first by streamlining our programs. As I mentioned earlier, when you have so many options it is hard for beneficiaries to really understand which direction to go, so if you offer them one really good program or just a couple, I think that makes things easier for them.

I also hope to, here in South Carolina, to bolster our customer service approach. I think that the State Medicaid agencies are truly a safety net for beneficiaries and providers and we have a responsibility to be available to them when they encounter the roadblocks that we discussed today.

Senator TIM SCOTT. Thanks very much. Mr. Chairman?

The CHAIRMAN. Ranking Member Scott, thank you very much. I want to move to a question for Mr. Heaphy regarding home and community-based services. I mentioned earlier we have got legislation to provide more of those opportunities, and you, Mr. Heaphy, had mentioned in your testimony the importance of those services in keeping you independent and giving you a high quality of life.

I note, on page 3 of your written testimony, you said, “what I need most are home and community-based services and supports,” and you later noted that your personal care attendant often participates in conversations with you and members of your care team.

You testimony spoke to the importance of making sure that these services are available to all who are eligible, and the inequality in availability of these services across states, so that is why we have introduced the Better Care Better Jobs Act.

From your perspective, Mr. Heaphy, how would a robust investment in these services impact the lives of people with Medicare and Medicaid across the country?

Mr. HEAPHY. I think—so many things come to my mind, but first it is to recognize HCBS has a means of offsetting institutional bias for folks who have Medicaid and Medicare. Myself, I am someone who is nursing home eligible, and for me I would be in a nursing home, as I said before, if I did not have the HCBS services I receive.

I think it is important that people be able to remain in the community with folks they love, people in their family, rather than being isolated in an institution and away from the folks who provide their supports.

I also think it is important that states maintain a commitment to allowing people to remain in the least restrictive setting possible. There is mounting evidence that shows increased choice, satisfaction, and personal outcome achievements are associated with home or residential settings of smaller size. People with disabilities living in smaller settings are also more likely to achieve positive outcomes and to experience improved personal support related to quality of life than individuals living in larger settings.

I think probably the most important aspect of HCBS to consider is that it is important to look at the lifespan approach and recognize that the needs of children and families are very different than folks who are adults or older folks, and if HCBS is solely determined on medical necessity it does not take into consideration the developmental milestones of kids with disabilities. I think for those of us who learned how to drive, have a driver's license, and know how important that milestone was in our lives, to go independently and do things for ourselves, I think this is also true of children with disabilities, that they have the opportunity to have a wheelchair that they can actually use, one that meets their needs in terms of meeting a milestone as opposed to just a medical necessity requirement is really important. An expansion of understanding what determination of need is.

I think it is also important that day habilitation service is not being in default for folks with high LTSS needs, whether it be adults with developmental disabilities or a mental health diagnosis, that the promise of integrated care is to really provide tailored HCBS services that really meet the person's needs and provide them the greatest opportunities to live in the community. I have experienced that here myself, you know, as a dual eligible, and if I were not able to shape my LTSS services I think I would be in a very different situation.

I guess I would also say, which is really important, personal care attendants. They are so woefully underpaid and underappreciated. They are in the homes and they are doing work that nobody else wants to do, a lot of folks cannot do the work, and yet the amount of money they make is not there. My PCAs engage in what is considered the nursing level activities. That includes changing my catheter, doing wound care, and assisting with my bowel program and they are doing all this work and not receiving the money that they really need to live in the community.

An example would be in Massachusetts, which is very generous—PCAs make over $17 an hour. However, the living wage in Boston is actually over $19 an hour, and for someone who has a child, that is over $39 an hour for a person to actually have a living wage and so as HCBS is being though out and determined, that the wages of folks doing this direct community work needs to be considered.

The last thing I would say is that it is really important that the consumer-driven model be central to HCBS. I am a consumer employer and my PCAs work for me and not an agency, I am able to direct my care to them and they are part of my schedule. I am able to travel for work. I am able to do things in the community that I would not be able to do in an agency. There is definitely a place for the agency model. However, for folks like myself who really need that flexibility to engage with the community, we need that opportunity to live in the community using these PCAs, and with COVID, if not for my personal care attendants coming into my home, I would have been devastated, because of the relationship my PCAs and I have with each other, they were dedicated and came to my home during COVID, despite putting themselves at risk, and so I cannot say more than just making sure that these folks get reimbursed at adequate rates.

The CHAIRMAN. Mr. Heaphy, thanks so much for your personal testimony, based upon your own experience and being a voice for those workers who are among the folks that we hope to be helping with some investments in home and community-based services that are not available today.

Mr. HEAPHY. Can I just add one more thing, Senator? I am sorry.

The CHAIRMAN. Yes, quickly, because I want to turn to the Ranking Member.

Mr. HEAPHY. Sure. I think it would be really helpful to institute like the national core indicators across the country and also HCBS caps, because this would give us a better sense of the quality and access to HCBS and the outcomes. That is the only other thing I would say, is having that national snapshot of how states are doing and perform, where HCBS is going, is critical.

The CHAIRMAN. Well thanks very much. We are waiting for some other Senators who have had to juggle things. We hope they arrive, but in the interim, Ranking Member Scott, do you have additional questions?

Senator GILLIBRAND. Mr. Chairman, I just joined if you want to call on me.

The CHAIRMAN. Oh. Senator Gillibrand, right on the money.

Senator GILLIBRAND. Thank you. I have competing hearings.

A quick question for the whole panel. How should we be thinking about incorporating community health workers into integrated Medicare-Medicaid plans, and do you have any examples where this is already being done, particularly when it comes to navigator and ombudsman services?

Dr. FIGUEROA. I can go ahead and start, if you do not mind. Thank you, Senator Gillibrand. I think community health care workers play an important role as the liaison, as you know, between the health care system, social service organizations, and the patients in their community, and they are generally well-trusted people who understand the values of their community as well. It is potential workforce that should tap into, especially in areas where there is limited workforce and limited health care infrastructure, and the key, though, for a successful community health worker relationship with the patient is that they must be integrated with the care team. If they are only in the community and not necessarily integrated with the care team it is not going to be a successful relationship, unfortunately, and so really trying to promote integration is key.

I do know of one example in Massachusetts, for example, that under the 1115 demonstration Massachusetts made all of their Medicaid patients participate in ACOs, and in that there was a lot of funds that went into hiring community health workers, training community health workers, operating in areas, for example, in western Massachusetts, where there are not as much providers as eastern Massachusetts. To date, about 1 million people are in these Medicaid ACOs, and the evidence to date, in a recent survey, showed providers in ACOs think that community health workers are operating well with social service organizations and improving patient experience.

Senator GILLIBRAND. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Gillibrand.

We are going to move to our closing statements at this time. I want to thank, of course, Ranking Member Scott for hosting this hearing with me and the work that he has done on the legislation that we have introduced, so I want to thank him for that work.

I also want to thank our witnesses for their invaluable input, and as we noted earlier their personal experiences.

As we heard today, people with Medicare and Medicaid face many challenges in navigating the health care system generally, but in particular these challenges that our witnesses outlined today. This challenge that they face will impact their overall health and their quality of life, so we have work to do.

The people that testified today, whether it was Jane or Dennis or others, who shared their stories, these stories help us in Congress to formulate policy and propose legislation to make these programs work better. Their health care system should provide support for them rather than adding yet another headache and so much confusion.

Jane Doyle, for example, should not have to worry about getting a surprise bill in the mail after a doctor visit, wondering if she is on the hook for that bill or not. Dennis should not have to go to the emergency room because he cannot get hold of his plan's care team, who were supposed to be there to help him.

We need to make sure that the care delivery models available to people with Medicare and Medicaid meet their needs and meet their preferences. That is why we must pass the PACE Expanded Act that Senator Scott and I have introduced, to increase the availability of these programs, and it is why we should make a permanent investment in home and community-based services to help seniors and people with disabilities remain with their families in their communities, so we are grateful for the testimony of our witnesses, and now I will turn to Ranking Member Scott for his closing statement.

Senator TIM SCOTT. Thank you, Mr. Chairman, for holding, once again, a really important hearing for so many Americans who are looking for more information, and frankly, more reasons to be hopeful as they deal with declining health and other challenges that too often come with aging.

Today we learned about the challenges of caring for dual eligibles. There are numerous gaps in policy and knowledge that contribute to these challenges. As the son of a caregiver—my mother, as I have said a number of times, has been a nurse's assistant for her entire career. Last week I was visiting her at the hospital and this week is her 49th year at the hospital, and she loves her patients. She loves what she does because she really loves the thought of making a difference, and in today's world I think we need more people dedicated to a mission. Whatever that mission is for you, we should all be thankful that people have the mission of providing care for those who cannot care for themselves.

The Supporting Care for Dual-Eligible Individuals Act will help fill some of those gaps. This legislation will help states provide the care this population so desperately needs, and the testimonies today only reinforce, if not amplifies the importance of that truth.

I will make two other points that I think are really important. Number one, Dennis and so many others have done a really good job of helping us to understand and appreciate the importance of home health care. While you can sometimes get into a senior facility or, as my mother working in a hospital, so many people prefer their care to be given in the environment that is best for them, and that environment so often is at home.

I think all that we can do to help people receive the care they need in the place of their preference is really an important part of health, because peace of mind and health are so often synonymous. Not only is there the mental health component but there is the physical health being delivered in your home, where you are comfortable, where you know where things are cannot be overstated, to be honest with you, and I think that very often providing home health care is actually better overall in a system that has limited resources, and it does not seem that we do, but when we are spending over $550 billion or so for Medicare and nearly $400 billion for Medicaid, and over $400 billion for veterans benefits as well, we run into the challenge of limited resources. I think we can take our resources further by focusing on a delivery system that is so often at home.

The final comment I would make is that as we think through the unbelievable challenges of the pandemic, one of the more important points is the delivery system of virtual health care. To have patients, as we spoke about today, being able to see their doctors from their homes, when possible, really helpful. I hope we continue, as a Nation, to move in the direction of providing virtual health care as a priority and as a priority delivery system, because I believe that not only will it help us take care of our patients, but it will also help us spend the limited pot of resources in the most effective way possible, providing amazing assistance of care for those who desperately need it.

Thank you again, Mr. Chairman, for this hearing, and I look forward to the next one.

The CHAIRMAN. Thank you, Ranking Member Scott. Thanks very much.

I want to thank you again and thank all the witnesses again for their expertise and their time today. If any Senators have additional questions for the witnesses or statements to be added the hearing record will be kept open for 7 days, until next Thursday, February 17.

Thank you all for participating. We are adjourned.

[Whereupon, at 11 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

Testimony of Jose F. Figueroa, M.D., MPH

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Assistant Professor of Medicine, Harvard Medical School
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Submitted to the
United States Senate Special Committee on Aging
February 10th, 2022

Introduction

Chairman Casey, Ranking Member Scott, and honorable members of the Special Committee on Aging, thank you for the opportunity to testify today.

My name is Jose Figueroa, and I am an Assistant Professor of Health Policy and Medicine at Harvard University. I am also a practicing physician in Hospital Medicine at the Brigham and Women's Hospital, where I take care of critically ill, hospitalized patients. For my research, I focus on how to improve the quality of care delivered to the sickest and most vulnerable patients in our country, including the dual-eligible population, which are people who qualify for both the Medicare and Medicaid program.

As a physician and researcher, I can attest to the fact that navigating our health care system is inherently complex for anyone. These challenges, however, are far more difficult for the 12.3 million dual-eligible patients living with disability, serious mental illness, frailty, multiple chronic conditions, and importantly, living in poverty.[1] Because of these vulnerabilities, dual-eligible patients are much more likely to require hospital care, nursing home care, long-term care, and home-based care, and are unfortunately at increased risk for experiencing poor health outcomes.[2,3]

One of the greatest failures of our healthcare system is that so much of dual-eligible patients' time is lost navigating the complex and confusing rules and regulations of the two programs, which they must do to ensure they get the care and services they need. This is valuable time that they would rather be spending at home, with their family and friends, and enjoying the things they love doing most.

As stewards of our health care system, we have an obligation to deliver better care to the dual-eligible population. With the remainder of my testimony, I hope to give you my perspective, as a front-line physician and health policy and services researcher, on the important needs of the dual-eligible populations, the complex challenges they currently face, and opportunities for promoting care models that offer true integration of care between the Medicare and Medicaid programs.

Who Are Dual-Eligible Beneficiaries?

Demographics, Health Status, and Social Determinants of Dual-Eligible Patients

There is an estimated 12.3 million people who were dually eligible for Medicare and Medicaid in 2020, which account for an estimated 20% of Medicare beneficiaries and 15% of Medicaid beneficiaries.[1] People become dual-eligible because they share entitlement to both Medicaid and Medicare coverage, but the reasons for that entitlement varies across states. A major challenge in designing programs for dual-eligible patients is the fact they are quite diverse. Among the population, there are people with disabilities, complex multi-morbidities (like heart failure, end-stage renal disease, and diabetes), physical and cognitive impairments, behavioral health conditions, and serious mental illness, meaning their care needs are also diverse.[4] Because of this increased burden of disease and impairment, dual-eligible beneficiaries are more likely to self-report being of poor health and more likely to experience limitations on performing activities of daily living compared to the Medicare-only population (with nearly 1 in 2 dual-eligible people reporting one or more ADL limitations).[4]

Of particular concern is the high prevalence of serious mental illness among dual-eligible beneficiaries, including schizophrenia/related psychotic disorders, bipolar disorder, and major depressive disorder.[5] Nearly 1 in 3 dual-eligible beneficiaries suffer from serious mental illness, which make it challenging for clinicians and other providers to manage both their physical and behavioral health needs.[6] Fragmented behavioral health services and physical health services delivered by different providers leads to barriers to access to care, and ultimately, leads to worse health outcomes.[7,8]

Dual-eligible patients are also disproportionately racial and ethnic minorities compared to the Medicare-only population (21% vs. 9%, respectively, are Black; 17% vs. 6%, respectively are Hispanic).[4] The presence of issues related to social determinants of health (e.g. financial insecurity, homelessness, food insecurity, low health literacy, and limited access to adequate transportation) are also much higher among dual-eligible patients, which places them at greater risk for experiencing poor quality of care, limited health care access, and ultimately, worse health outcomes.[9]

Healthcare Utilization & Spending Among Dual-Eligible Beneficiaries

Dual-eligible beneficiaries have higher rates of service utilization, including hospitalizations, emergency room visits, and community- and facility-based long-term care services, than Medicare- or Medicaid-only beneficiaries.[3] Likewise, they account for a disproportionate share of spending in both programs (34% of total spending in Medicare and 30% in Medicaid).[4] Of particular importance are the differences in the types of services dual-eligible patients need depending on their specific circumstances. For example, when we examined persistently high-cost dual-eligible patients (i.e. those in the top 10% of total spending across both Medicare and Medicaid over a 3-year period between 2010 to 2012), we found that young dual-eligible beneficiaries with disability spent over $160,000 per year; of which nearly 70% of costs were related to long-term care services, while very little was related to potentially avoidable hospitalizations (<1% of total spending).[10] Other work has identified that older dual-eligible beneficiaries require more intense use of nursing facilities and acute hospital care than younger dual-eligible patients.[11]

Challenges Faced by Dual-Eligible Beneficiaries

Medicare and Medicaid have a complicated division of coverage that makes navigating each program especially difficult for dual-eligible beneficiaries. Medicare provides coverage for primary care, preventive care, acute hospital, post-acute rehabilitative care, and prescription drugs for those with a Part D drug plan. Medicaid supplements this coverage by assisting with Medicare premiums and other cost-sharing.[12] In addition, Medicaid programs cover long-term services and supports and certain behavioral health services. However, the specific coverage rules vary not only state to state but also among private insurers. In some states, beneficiaries must enroll in multiple Medicaid plans to receive full coverage of health care services, further complicating their ability to seek care.[2]

These patchwork solutions exist largely because Medicare and Medicaid were not initially designed to work together for the benefit of dual-eligible patients. As a result, the lack of integration between the two programs leads to a disjointed and confusing experience for patients, their family members and caregivers, and clinicians and other health providers. In 2020, the Medicaid Payment and Access Commission (MACPAC) highlighted a series of important challenges.[3] They include misalignments between Medicare and Medicaid coverage rules, insufficient care coordination across the patient's care continuum, and maligned incentives that may lead to cost-shifting between programs.

As a physician, one of the most frustrating components of caring for dual-eligible patients is our inability to effectively help patients throughout this process given that we also lack full understanding of the rules and regulations of their plans. Countless hours are spent by clinicians, care coordinators and social workers in our hospital trying to determine what the safest discharge plan should be for our patients. This can result in prolonged hospital stays and even deconditioning of our frail dual-eligible patients given limited capacity to perform necessary rehabilitative care in the hospital. The responsibility of coordinating care is thus often left to the patient themselves or their family members.

Experiences with Current Integrated Care Models for Dual-Eligible Patients

There is an urgent need for greater integration across the payment, delivery, and administration of health care services between the Medicare and Medicaid programs for dual-eligible patients. Better integration offers the opportunity to improve health outcomes and control rising healthcare costs through more efficient, affordable, and effective healthcare. However, to date, rollout for existing integrated care plans has been limited. Only an estimated 1 in 10 dual-eligible patients are enrolled in an integrated plan,[12] with 14 states and the District of Columbia lacking any integrated option.[13] Importantly, nearly 50% of dual-eligible beneficiaries do not even have access to an integrated model.

Given the complexity and heterogeneity of the dual-eligible patient population, it is unlikely that one care model will be effective across all patients living in our diverse country, especially since local healthcare capacity, community resources, and provider density vary significantly. For example, we should not expect that a program that is successful for urban adults with a physical disability will also be successful for older patients with cognitive impairment living in a rural area. Ultimately, dual-eligible beneficiaries will benefit from the expansion of different care models that can meet their local needs.

Integrated financing is important to ensure there are aligned financial incentives between Medicare and Medicaid. However, at its core, these models must revolve around a framework that is individualized and meets the local and diverse needs of patients. Today, there are three primary models that integrate Medicare and Medicaid services: The Program of All-Inclusive Care for the Elderly (PACE), the Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs), which can align with Medicaid managed long-term services and supports (MLTSS) programs, and the Financial Alignment Initiative (FAI) integrated care models. Below, I summarize some of the key findings about these models.

The Program of All-Inclusive Care for the Elderly (PACE)

The PACE program was first established in the 1970s and then permanently authorized by Congress in 1997. PACE is a highly integrated managed care program that provides comprehensive health care services to older adults who meet the criteria for a nursing home level of care though are able to live safely in the community with the appropriate support.[3] The PACE program provides all Medicare- and Medicaid-covered services, for which they receive capitated monthly payments from both programs. PACE is centered around adult day health centers, where participants travel to receive a range of integrated and coordinated services. The care team is composed of an interdisciplinary workforce, which includes physicians, nurses, physical and occupational therapists, a center manager, home care coordinator, dieticians, social workers, and others.[3]

Currently, there are 144 PACE programs operating 272 PACE centers across 30 states, serving about 55,000 beneficiaries,[14] 90% of whom are dual-eligible patients (accounting for <1% of all dual-eligible patients).[15] Evaluations of the PACE program have yielded mixed results, though it is important to recognize that there is substantial heterogeneity across different PACE sites. Prior work has found that PACE is associated with lower risk of hospitalization,[16-20] but findings on other outcomes (nursing home use,[16,19,21] spending,[21-23] mortality[21,24,25]) are mixed. One important aspect of the program is that patients can remain in the community as they age, arguably one of the strongest reasons why beneficiaries choose the PACE program. It also removes many complex insurance barriers that dual-eligible patients face, since it is one integrated program.

However, there are important limitations of the PACE program. First, eligibility criteria limit individuals who can potentially participate. For example, younger dual-eligible patients are not eligible (since age criteria starts at the age of 55 years). Eligibility criteria for providers is also stringent given that they require nursing home level certification. As such, PACE programs are not available across all states, often due to lack of resources and support, state regulations, and other limitations.[26,27] Individuals who are currently eligible but not enrolled in PACE programs could benefit from PACE expansion.[27] In the past, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations regarding the PACE program, which include broadening eligibility and developing a better quality framework for assessing the effectiveness of PACE.[28,29]

Medicare Advantage (MA) Dual-Eligible Special Needs Plans

MA Dual-Eligible Special Need Plans (D-SNPs) are private, managed care plans that receive monthly capitated payments to care for dual-eligible patients. D-SNPs were first introduced in 2003 under the Medicare Prescription Drug, Improvement and Modernization Act and later made permanent under the Bipartisan Budget Act of 2018.[3] As of February 2021, about 3 million dual-eligible beneficiaries were enrolled in D-SNPs across 43 states and the District of Columbia.[30] D-SNPs are required to contract with state Medicaid agencies. There are multiple types of D-SNPs, including fully integrated D-SNPs (FIDE-SNPs) and highly integrated D-SNPs. The FIDE-SNPs are intended to provide the greatest degree of integration with Medicaid.

There have been limited evaluations of D-SNPs that assess the value that these programs generate for dual-eligible patients. This is primarily because national data on plan performance is limited. The narrow evaluations that exist found evidence of decreased hospitalizations, readmissions, nursing facility admissions,[31-33] and per-person Medicare spending, with no effect on Medicaid per-person spending found.[34] Currently, MA Star Ratings, which rate plans on performance across various quality measures, are reported at the contract level across many plans and include non-dual patients, which make it impossible for dual-eligible beneficiaries to properly assess which plans are of higher quality in their local area. Recently, CMS proposed changes to make MA Star Ratings more specific to D-SNP performance.[35] This proposal offers an opportunity for transparency that may better drive quality improvement efforts for dual-eligible patients.

Of note, the number of dual-eligible beneficiaries enrolling in MA Plans is growing. One area of particular concern is D-SNP “look-alike” plans, which are MA plans that appear to aggressively enroll dual-eligible patients through their supplemental benefits and cost-sharing structure but are not actually integrated D-SNPs.[8] There are concerns that these plans may interfere with the goal of fully integrating care for dual-eligible patients, and CMS has considered action to limit the growth of these plans. Another concern is the increasing role of private equity in caring for dual-eligible patients.[36] It is absolutely essential that appropriate regulation and policies are in place to ensure that private-equity backed plans are meeting the needs of dual-eligible patients through better value of care and are not causing harm.

Medicare-Medicaid Financial Alignment Initiative (FAI) Models

The Financial Alignment Initiative (FAI) was launched by the CMS Medicare-Medicaid Coordination Office (MMCO) in 2011. This demonstration project allowed for states to financially align Medicare and Medicaid programs through three models: 1) a capitated model that establishes Medicare-Medicaid Plans (MMPs), 2) a managed-fee-for-service (MFFS) model (implemented in Washington and Colorado), or 3) an alternative model developed by the state and approved by CMS (implemented in Minnesota). The first demonstrations began in 2013, and in total, 13 states originally participated, though only 11 states continue with their programs today (Virginia and Colorado’s demonstrations have ended).

Most states have chosen to participate in the capitated MMP model, which offers the highest level of integration in comparison to other integrated care models. Under this model, CMS, the state government, and participating health plans agree on a blended capitated monthly rate for all Medicare and Medicaid benefits for dual-eligible beneficiaries. However, there is limited market penetration in MMPs, as only an estimated 29% of eligible beneficiaries enrolled in qualified plans across 9 states in 2017.[37]

There have been preliminary evaluations of state FAI models that have yielded mix results.[37] In some states, MMP enrollment was associated with reduced hospitalizations, nursing home admissions, and lower emergency department use.[38] Most evaluations have only focused on Medicare utilization and spending, omitting an analysis on Medicaid outcomes due to issues in data availability. However, long-term data on its effectiveness and final evaluations are still pending.

Strategies for Improving Dual-Eligible Integrated Care Models

Truly integrated and coordinated programs have the potential to transform care for dual-eligible beneficiaries for the better, including better quality of care, better patient experience, and potentially lower costs. While much of the evidence to date is mixed, it is important to note that the data reveals many positive signals that show the promise of integrated care programs. In addition, there are ample opportunities to continue improving existing integrated models, which can be supported by better data availability on performance and understanding important tradeoffs of existing programs.

Below, I summarize recommendations of how we may improve integrated care models for dual-eligible beneficiaries, which are supported by several reports and evaluations.[13,39-43] They include the following:

1. Every dual-eligible individual should have access to an integrated care model. Congress can consider options to help states progress towards adoption or expansion of integrated models. In some states, clear guidance, technical assistance, and financial support may be necessary.
2. Integrated care models for duals must provide better value for patients than alternative, default models in their local area. They should also meaningfully feel like one program that covers services across the entire patient care continuum (from primary care and specialty care to long-term care and behavioral health services). If not, integrated care plans will continue to struggle with enrollment.
3. The enrollment process into care models must be easy, with readily accessible information that patients need to help make informed decisions about what type of model is best for themselves.
4. Beneficiaries must receive adequate support to help understand the tradeoffs of their coverage options that is free from biased marketing agents and brokers who may have financial incentives to enroll patients into particular plans. Clinicians, case managers, and social workers caring for duals will also benefit from this support.
5. Better and timelier data is necessary to help us understand how well integrated care models are performing relative to other alternatives. Additionally, there is significant heterogeneity even among specific integrated models (i.e., across D-SNPs, across state MMPs, and across PACE programs). It is challenging for policymakers, clinicians, patients and their families to make decisions about which programs are best to meet their needs without this information. Congress has an opportunity to help ensure that reliable and relevant data is made available in a timely manner for all to benefit.
6. Given heterogeneity of the dual-eligible population, integrated care models must be flexible and take advantage of 21st century technology, including virtual health, for patients who prefer being taking care of at home. However, issues of proficiency with technology, broadband accessibility, disabilities, and cognitive impairment that limit participation must be addressed.
7. Better patient-specific quality metrics that capture quality of life, patient-reported outcomes, and patient satisfaction with their integrated care plans should be developed and adopted. The use of claims-based measures of utilization (e.g. hospitalizations, ED visits, home care visits) as quality measures are limited because they sometimes signal appropriate patient care and not necessarily reflect poor quality of care.

In summary, it is important for Congress to continue promoting policies that make integrated care models for dual-eligible beneficiaries more widely available and structure incentives that promote even greater integration among existing models. In doing so, we can ensure high quality and affordable care for the millions of people who are dually enrolled in the Medicare and Medicaid programs.

References

1. Medicaid Payment and Access Commission. Dually Eligible Beneficiaries. https://www.macpac.gov/topics/dually-eligible-beneficiaries/
2. Wadhera RK, Wang Y, Figueroa JF, Dominici F, Yeh RW, Joynt Maddox KE. Mortality and Hospitalizations for Dually Enrolled and Nondually Enrolled Medicare Beneficiaries Aged 65 Years or Older, 2004 to 2017. *JAMA*. 03 10 2020;323(10):961-969. doi:10.1001/jama.2020.1021
3. Medicaid Payment and Access Commission. *Integrating Care for Dually Eligible Beneficiaries: Background and Context*. June 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-1-Integrating-Care-for-Dually-Eligible-Beneficiaries-Background-and-Context.pdf
4. Medicare Payment Advisory Commission, Medicaid Payment and Access Commission. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*. February 2022. https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf
5. Center for Health Care Strategies. *Coordinating Physical and Behavioral Health Services for Dually Eligible Members with Serious Mental Illness*. Dec 2019. https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/
6. Figueroa JF, Phelan J, Orav EJ, Patel V, Jha AK. Association of Mental Health Disorders With Health Care Spending in the Medicare Population. *JAMA Netw Open*. 03 02 2020;3(3):e201210. doi:10.1001/jamanetworkopen.2020.1210
7. Medicaid Payment and Access Commission. *Integration of Behavioral and Physical Health Services in Medicaid*. March 2016. https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf
8. Melek SP, Norris DT, Paulus J. *Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry*. Apr 2014. https://www.coloradocoalition.org/sites/default/files/2017-01/milliaman-apa-economicimpactofintegratedmedicalbehavioralhealthcare2014.pdf
9. Sorbero ME, Kranz AM, Bouskill KE, Ross R, Palimaru AI, Meyer A. *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans*. 2018. https://aspe.hhs.gov/sites/default/files/private/pdf/259896/MAStudy_Phase2_RR2634-final.pdf
10. Figueroa JF, Lyon Z, Zhou X, Grabowski DC, Jha AK. Persistence and Drivers of High-Cost Status Among Dual-Eligible Medicare and Medicaid Beneficiaries: An Observational Study. *Ann Intern Med*. 10 16 2018;169(8):528-534. doi:10.7326/M18-0085
11. Bynum JPW, Austin A, Carmichael D, Meara E. High-Cost Dual Eligibles' Service Use Demonstrates The Need For Supportive And Palliative Models Of Care. *Health Aff (Millwood)*. 07 01 2017;36(7):1309-1317. doi:10.1377/hlthaff.2017.0157
12. Medicare-Medicaid Coordination Office. *FY19 Report to Congress*. 2020. https://www.cms.gov/files/document/mmco-report-congress.pdf
13. Bipartisan Policy Center. Guaranteeing Integrated Care for Dual Eligible Individuals. November 2021. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/11/BPC-Duals-Report-Final.pdf
14. The National PACE Association. PACEFinder: Find a PACE Program in Your Neighborhood. https://www.npaonline.org/pace-you/pacefinder-find-pace-program-your-neighborhood
15. The National PACE Association. *PACE by the Numbers*. 2019. https://www.npaonline.org/sites/default/files/3186_pace_infographic_update_121819_combined_v1.pdf
16. Segelman M, Cai X, van Reenen C, Temkin-Greener H. Transitioning From Community-Based to Institutional Long-term Care: Comparing 1915(c) Waiver and PACE Enrollees. *Gerontologist*. 04 01 2017;57(2):300-308. doi:10.1093/geront/gnv106
17. Meret-Hanke LA. Effects of the Program of All-inclusive Care for the Elderly on hospital use. *Gerontologist*. Dec 2011;51(6):774-85. doi:10.1093/geront/gnr040
18. Jones D, Duda N, Schmitz B, et al. *Study of Access and Quality of Care in For-Profit PACE*. 2013. https://innovation.cms.gov/files/reports/pace-access-qualityreport.pdf
19. Beauchamp J, Cheh V, Schmitz R, Kemper P, Hall P. *The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality*. 2008. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Beauchamp_2008.pdf
20. Segelman M, Szydlowski J, Kinosian B, et al. Hospitalizations in the Program of All-Inclusive Care for the Elderly. *J Am Geriatr Soc*. Feb 2014;62(2):320-4. doi:10.1111/jgs.12637
21. Ghosh A, Schmitz R, Brown R. *Effect of PACE on costs, nursing home admissions, and mortality: 2006–2011*. 2015. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/57606/PACEeffect.pdf
22. Wieland D, Kinosian B, Stallard E, Boland R. Does Medicaid pay more to a program of all-inclusive care for the elderly (PACE) than for fee-for-service long-term care? *J Gerontol A Biol Sci Med Sci*. Jan 2013;68(1):47-55. doi:10.1093/gerona/gls137
23. Foster L, Schmitz R, Kemper P. *The effects of PACE on Medicare and Medicaid expenditures*. 2007. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Foster_PACE_2009.pdf
24. Wieland D, Boland R, Baskins J, Kinosian B. Five-year survival in a Program of All-inclusive Care for Elderly compared with alternative institutional and home- and community-based care. *J Gerontol A Biol Sci Med Sci*. Jul 2010;65(7):721-6. doi:10.1093/gerona/glq040
25. Mukamel DB, Peterson DR, Temkin-Greener H, et al. Program characteristics and enrollees' outcomes in the Program of All-Inclusive Care for the Elderly (PACE). *Milbank Q*. Sep 2007;85(3):499-531. doi:10.1111/j.1468-0009.2007.00497.x

26. Gross DL, Temkin-Greener H, Kunitz S, Mukamel DB. The growing pains of integrated health care for the elderly: lessons from the expansion of PACE. *Milbank Q*. 2004;82(2):257-82. doi:10.1111/j.0887-378X.2004.00310.x
27. Karon S, Knowles M, Kordomenos K, Segelman M. *Expanding the PACE Model of Care to High-Need, High-Cost Populations*. October 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/expanding-pace-model-high-need-high-cost#5
28. Jacobson GA. Promoting Integrated and Coordinated Care for Medicare Beneficiaries. Senate Ways & Means Committee, Subcommittee on HealthJune 7, 2017.
29. Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*. June 2012. https://www.medpac.gov/document/report-to-the-congress-medicare-and-the-health-care-delivery-system-june-2012/
30. Medicaid Payment and Access Commission. Medicare Advantage Dual Eligible Special Needs Plans. https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/
31. Bihrle Johnson M, McCarthy D. The Visiting Nurse Service of New York's Choice Health Plans: Continuous care management for dually eligible Medicare and Medicaid beneficiaries. The Commonwealth Fund; 2013. commonwealthfund.org/sites/default/files/documents/___media_files_publications_case_study_2013_jan_1659_mccarthy_care_transitions_vnsny_case_study_v2.pdf
32. JEN Associates, Inc. *Massachusetts Senior Care Option 2005–2010 impact on enrollees: Nursing home entry utilization.* . 2013:JEN Associates, Inc. https://www.mass.gov/files/documents/2016/07/rg/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.pdf
33. Avalere Health LLC. *Dual eligible population analysis for SCAN Health Plan: Hospitalizations and readmissions*. 2012. https://docs.house.gov/meetings/IF/IF14/20170726/106325/HHRG-115-IF14-20170726-SD007.pdf
34. Zhang Y, Diana ML. Effects of Early Dual-Eligible Special Needs Plans on Health Expenditure. *Health Serv Res*. 08 2018;53(4):2165-2184. doi:10.1111/1475-6773.12778
35. Centers for Medicare and Medicaid Services. CY 2023 Medicare Advantage and Part D Proposed Rule (CMS-4192-P). Jan 2022. https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-advantage-and-part-d-proposed-rule-cms-4192-p
36. Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2021:chap Chapter 3: Congressional request: Private equity and Medicare. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf
37. Medicaid Payment and Access Commission. *Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps*. Aug 2020. https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf
38. Centers for Medicare and Medicaid Services. State-specific Evaluation Reports. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations
39. Medicaid Payment and Access Commission. Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options. *Report to Congress on Medicaid and CHIP*. June 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-2-Integrating-Care-for-Dually-Eligible-Beneficiaries-Policy-Issues-and-Options.pdf
40. Arnold Ventures Complex Care Team. *Findings from Arnold Ventures' Request For Information on the Dual-Eligible Experience*. January 2022. https://www.arnoldventures.org/stories/findings-about-the-dual-eligible-consumer-experience
41. Hwang A, Keohane LM, Sharma L. Improving Care for Individuals Dually Eligible for Medicare and Medicaid. The Commonwealth Fund; Nov 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/oct/improving-care-individuals-dually-eligible-medicare-medicaid-fai
42. Medicaid Payment and Access Commission. *Improving Integration for Dually Eligible Beneficiaries: State Contracts with D-SNPs*. June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf
43. Medicaid Payment and Access Commission. *Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations*. March 2021. https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-4-Establishing-a-Unified-Program-for-Dually-Eligible-Beneficiaries-Design-Considerations.pdf

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Written Testimony of Eunice Medina

Chief of Staff, South Carolina Department of Health and Human Services

U.S. Senate Special Committee on Aging

February 10, 2022

Good morning. Thank you, Chairman Casey, Ranking Member Scott, and members of the Committee, for the opportunity to participate in today's discussion. As stated, my name is Eunice Medina and I currently serve as chief of staff and deputy director of programs at the South Carolina Department of Health and Human Services (SCDHHS).

Prior to joining South Carolina's Medicaid agency, I spent 17 years working with Florida's Medicaid population in various capacities. I spent more than a decade of my career working with seniors through the Florida Department of Elder Affairs where I managed multiple home and community-based waiver programs. In 2013, I assisted the Medicaid agency in transitioning those Medicaid beneficiaries into what is now known as Florida's Statewide Medicaid Managed Care Program. The following year I joined the Florida Medicaid Agency where I worked to ensure health plans offering long-term care services were doing so in accordance to state and federal requirements. I later ended up overseeing their 15 health and 3 dental plans serving approximately 3.5 million beneficiaries.

In June 2021, I joined South Carolina's Medicaid agency and have spent much of my first year analyzing how to best help the state by evaluating its Medicaid program and assisting the agency in developing a plan to improve quality of care and cost efficiency. South Carolina's population that is eligible for both Medicare and Medicaid, otherwise known as its "dual population," have multiple options for receiving services. According to December 2021 data, there are 168,800 dual-eligible beneficiaries. Within that total there are:

- 59,733 who are enrolled in a Dual Special Needs Plan (D-SNP)
- 15,055 who are enrolled in our state's Financial Alignment Initiative (FAI) program, our dual demonstration program called Healthy Connections Prime; and
- 22,895 who are enrolled in one of our four fee-for-service home and community-based waiver programs, which serve the disabled over the age of 18 or the elderly. This group may include beneficiaries with a corresponding Medicare Advantage, Dual Special Needs Plan, or fee-for-service Medicare.

In 2015, our state chose to participate in the federal dual demonstration program to evaluate opportunities for integrated care for seniors. Unlike other states, South Carolina chose to start off the program with a focus on those 65 years of age and older. This month marks our 7th year anniversary since implementing this program and I am happy to spend our anniversary discussing some lessons learned. We have found that in cases where a beneficiary didn't need home and community-based services (HCBS), they typically utilized three services that Medicare only covers a limited amount of, if at all: home health, durable medical equipment, and behavioral health. Access to these services through our dual demonstration program has delayed the need for more costly home and community-based services. Another lesson was the importance of care coordination at the individual beneficiary level and the importance of fully assessing beneficiary needs.

We have a big decision to make as a state in deciding whether we want to take advantage of the alternative offered by the proposed rule that CMS issued on Jan. 7, 2022, or explore other options.

One reason to explore an option other than what is available through the dual demonstration or the recently released CMS proposed rule, is the fact that Medicaid waiver programs are made up of more than just duals. When states are looking to integrate care, they may also need to consider the capacity of their Medicaid agency to manage the programs they have already committed to, which may include individuals that are eligible for full benefits under Medicaid, meet the nursing facility level-of-care but are not eligible for Medicare. This is the approach Florida took.

Florida consolidated more than 10 waiver programs that served its Medicaid HCBS and nursing facility population over a five-year period. Through this model, Florida currently serves more than 100,000 beneficiaries through seven comprehensive health plans, meaning that if someone is enrolled in one of these plans, they could receive both Medicaid medical and long-term care services. When possible, the Medicaid enrollment process considered whether a beneficiary had a Medicare product with a corresponding Medicaid plan. Streamlining programs and focusing efforts and funding on an integrated program can help avoid confusion and administrative burden among dual beneficiaries and providers. Even still, Florida's model presents opportunities to further coordinate care and information, chief among them being the integration of Medicare data.

In conclusion, I truly believe each state faces its own challenges. For our state, we'll be looking for solutions that continue to allow flexibility in how to design our programs, access to Medicare data, opportunities to align processes across all Medicare and Medicaid products, and time to responsibly shift to a model that embraces these flexibilities. Furthermore, resources that would allow states to strengthen their agency to support these massive internal and external changes would be most welcome. Again, thank you for allowing me to participate in today's discussion on a topic I truly am passionate about and a population I have dedicated my career to serving.

Dennis Heaphy
Policy Analyst, Disability Policy Consortium
Testimony before the
United States Senate Special Committee on Aging
February 10, 2022

Chairman Casey, Ranking Member Scott, Members of the Senate Special Committee on Aging, thank you for the opportunity to testify about my experiences as a dually eligible enrollee in an integrated plan. To start, I want to give a special thanks to Senator Casey for his support of the disability community and his leadership on the COVID HCBS Relief Act. I also want to thank Senator Warren for her ongoing partnership with dually eligible individuals and the larger disability community in Massachusetts.

The Importance of Consumer Involvement in Integrated Care

I am a person with complex medical needs due to a spinal injury and an unrelated autoimmune condition. In 1985, I became disabled at 23 years old. I am now 60 years old. For the last nine years, I have been a member of the One Care integrated model in Massachusetts since it started in 2013. This model was established to address the needs of people with both Medicare and Medicaid ages 21-64 through a single health plan, to step away from the traditional and medical model of care delivery, and to advance independent living.

To be clear, my life and thousands of others depend on integrated care, whole-person care, and a non-medical model, which is why I am professionally engaged in the direction of integrated care in Massachusetts, and with advocates nationally. I am the Chair of the Massachusetts consumer led One Care Implementation Council (IC), which came about through disability advocacy. The IC is comprised of many stakeholders but largely consumers and their families, who work in partnership with the Medicaid agency to ensure One Care meets enrollees' needs. The positive impact of the IC on the One Care model cannot be overstated.

Integrated Care and Whole Person Care at Its Best

As a disability rights advocate, I know firsthand what works and what does not work in providing whole-person health care for persons with complex needs. Integrated care, when done well, helps us to live meaningful lives in the community. What does a meaningful life in the community mean? It means understanding and promoting the basic principles of independent living. It means having a care team that not only looks at my medical needs, but also my life goals, my ability to engage with family and friends and participate in the community. In my case, it also means ensuring I have the right wheelchair, medical supplies and environmental controls to work independently from home. It means having a direct line of communication with a member of my care team with decision-making authority. It means having a nurse practitioner or physician assistant whom I trust and can act in real time. That can mean writing a prescription or coming to my home to change my urine catheter so that I can avoid the emergency department.

I have seen integrated care at its best. Several years after my spinal cord injury, I became a member of a Medicaid managed care plan in Massachusetts that provided everything I needed. Everything was done in my home. That included care for a cold or the flu, wound care, urine tests, blood tests, and wheelchair seating and positioning. Even x-rays were sometimes taken in my home. My nurse practitioner knew my family and taught my personal care attendant (PCA), who helps with my activities of daily living, how to do wound care, catheter changes, and more. She and I would discuss my overall health and life goals, often including my PCA.

As a result of consumer advocacy, the One Care model was based on this authentic form of person-centered care. Soon after One Care started, I developed a bone infection that required surgery, many hospitalizations and over a year of recovery. My Medicaid plan, now also my Medicare plan and part of One Care, was able to leverage Medicare dollars to reduce my hospital days and enable me to do my rehabilitation in my home. Following this intensive period, my care team and I decided to increase my personal care hours and to place much more emphasis on prevention. Acupuncture was provided on a weekly basis to reduce pain and control my spasticity. My autoimmune specialist, even though an out-of-network provider, was regularly consulted. I was provided a ceiling lift to transfer me from my bed to a wheelchair, alternating air mattress, upgraded wheelchair, and seating system. This may not sound like anything special, but many health plans that serve people like me do not provide this type of care.

I cannot tell you how grateful I am for the PCAs I had at the time, all of whom, by the way, were underpaid. If not for them, in addition to my care team respecting my choice to stay at home, I would have gone into a skilled nursing facility for rehab where I was at high risk for a series of complications such as secondary infections and skin breakdown. I am not exaggerating when I say that this integrated care model not only kept me out of a long-term nursing facility, One Care also kept me alive. Thankfully I don’t usually need intensive services. What I need most are home and community-based services and supports, which are determined in my care planning process with people I know and trust. This is what lets me stay healthy and independent. Many are not as fortunate as I have been and are required to abide by plans that use a one-size-fits-all approach based on algorithms with no regard to their unique needs and goals.

Designing and implementing an integrated program and making sure that it continues to meet enrollees’ needs are two different things. Even in One Care, things have started changing. It is increasingly challenging for me and others to know how to navigate the lines of communication, to know which care team members are responsible for what, or even the composition of the care team. I went to the emergency department for the first time in years because I could not reach anyone in my care plan other than the on-call service. This is at 10 AM. So, not knowing what to do, I drove my wheelchair to the hospital a mile up the road. My fear was the potential spread of a bacterial skin infection known as cellulitis. In my situation, cellulitis can spread rapidly, resulting in 10 plus days in the hospital on antibiotics if not treated readily. Thankfully, I just had a broken toe. If I had been able to reach someone from my care team to send them a picture or have them stop by, I would not have felt like I needed to be my own doctor. And being my own doctor is not a job I want.

Other One Care members are also raising complaints. Complaints include not having a care plan, not having a clear point person or care team of their choosing and not having access to needed services. I am not exaggerating when I say that, if I have more hoops to jump through to access care, or if my home support services get squeezed, I am a goner.

In response to the level of recent complaints raised by One Care enrollees and advocates, the state is working with the Implementation Council, disability advocates and the One Care plans to get the demonstration back on track. I am confident that, because of this relationship between consumers and the state, we will be heard, and we can make change. **Not every state is like Massachusetts.** And One Care might not work in every state. But every state would benefit from giving consumers a voice in the process to evolve integrated care around person-centered goals.

Thank you again for the opportunity to speak with you today, and I look forward to answering your questions.

Jane Doyle
Testimony before the
United States Senate Special Committee on Aging
February 10, 2022

Good morning, Chairman Casey, Ranking Member Scott, and Members of the Senate Special Committee on Aging. My name is Jane Doyle. I have lived in Bartonsville, Pennsylvania for the past 32 years. I have two children and three grandchildren living in the suburbs of Atlanta and Boston. I am honored to have this opportunity to testify to help make a positive change towards better health care for everyone.

I have experienced, for myself and my family, several different "kinds" of dual eligibility. When I was first diagnosed with Multiple Sclerosis over 20 years ago, I applied for Social Security disability benefits. Because I qualified for these benefits, I also qualified for Medicare. I was still able to work part-time, and I also accessed Medicaid through the Medical Assistance for Workers with Disability program. This program allows working people with slightly higher incomes, but otherwise qualify for Medicaid, to pay premiums for Medicaid benefits. It was a relief to have affordable insurance that covered my out-of-pocket costs, and I found it quite purposeful to continue to work.

Since 2017, due to further medical circumstances, I have been unable to work. I qualified for regular Medicaid. In 2020, Pennsylvania required Medicaid through managed care. From the eight doctors I see, I don't believe any of them are enrolled in the new system. So far, I have been fairly fortunate. Most of my doctors continue to see me, but they write off all balances after Medicare. I recently received a balance bill from a doctor I just started to see. He may not even be aware that I am not supposed to receive these bills because I have Medicaid, and that could be a potential hardship ahead. My doctors have shared that the new system is complicated, requires more documentation, and the rules are different across the three different networks.

I also worry that since many doctors don't take the managed care, and these programs try to cut costs, the quality of care I receive suffers. During the pandemic I had to undergo three operations, one of which resulted in irreversible nerve damage. This resulted in me needing neurosurgery, and I had to travel 100 miles to Philadelphia to get that care.

My mother is also dually eligible. She was enrolled in Medicare, and then began to need more help to live safely at home. She needed the kind of long-term care that Medicare doesn't cover. For some time, she paid for home health care out of her pocket, costing around $7,000 a month. But, after 24 years as a widow, her money was running out at 87 years old. Thankfully, in Pennsylvania, Medicaid does have a special program known as "waiver" that provides home care. Our family viewed this a great alternative to a nursing home for our mother, as it would allow her to stay independent and involved with us. But to qualify, someone must first apply for Medicaid and then apply for the waiver. This process was long and difficult.

It involved several applications, documentation from both Medicaid and doctors, choosing a provider to oversee your case, and finding a participating home health care agency with enough staff to meet my mother's needs. We had to complete hundreds of documents for my mother's application. Eventually, we didn't have enough money to pay for one more day of care. I was fortunate to have stumbled across the Pennsylvania Health Law Project. They helped to expedite my mother's case. It came just in time. As you can imagine, the stress of not knowing how we were going to care for our mother was insurmountable.

I have talked about the trouble my mother faced becoming dually eligible, the challenges I experience as a dually eligible person. I would like to tell you what would happen if I stop being dually eligible. If I lose Medicaid, I would not be able to buy Medigap insurance to cover my out-of-pocket costs because I have a pre-existing condition. For those of us with pre-existing conditions, Medigap is allowed to deny you insurance if you have Medicaid when you first sign up for Medicare. As a result, I am stuck. I can't increase my income or savings because I will no longer qualify for Medicaid. Since I can't buy a Medigap, I would face high costs from having Medicare with no other insurance.

This is a lot for one person to navigate. Fortunately, there are sources of help like the Pennsylvania Health Law Project and the kind folks at the Medicare Rights Center's national helpline that I have reached out to when it has gotten to be too much.

I ask you to do whatever you can to ease the burdens people like me and my mother have faced. While these programs are important, they are not easy to use. To make these programs actually work, it needs to be much easier for people like my mother to enroll and for people like me to find care. Thank you again for the opportunity to speak with you today. I look forward to answering your questions.

Questions for the Record

U.S. Senate Special Committee on Aging
"Improving Care Experiences for People with both Medicare and Medicaid"
February 10, 2022

Questions for the Record
Dr. Jose Figueroa

Senator Richard Blumenthal

The COVID-19 pandemic has exacerbated and exposed inequalities in our existing health system that have plagued some populations for years—this includes our dually-eligible population who often lack transportation to medical appointments, or are unable to get out of their homes to get a doctor's office. In some ways, the integration of telehealth into our health system as a result of the pandemic has been a blessing—however, barriers remain for patients, and doctors, as we continue to embrace this technology. That is why I cosponsored the CONNECT for Health Act of 2021, which expands coverage of telehealth services under Medicare by allowing CMS to waive certain restrictions on the type of technology that is allowable to use.

Question:

How can expanded coverage for telehealth services, like those provided in the CONNECT Act, support dually eligible beneficiaries?

Response:

There is broad consensus that telehealth services were essential for ensuring continuity of care for Medicare and Medicaid beneficiaries during the COVID-19 pandemic. Utilization of telehealth services was particularly important among low-income and disabled populations.[1] The CONNECT Act aims to expand and facilitate access to telehealth services by loosening restrictions in place prior to the public health emergency.

When it comes to caring for dual-eligible patients, telehealth services offer an important tool to help manage their care. However, a recent report from the Office of the Assistant Secretary for Planning and Evaluation found that while telehealth service use was greater among dual-eligible beneficiaries, they actually experienced a larger decrease in overall health care utilization during the pandemic. [2] This suggests that while telehealth facilitates care for these patients, we must also address other potential financial and non-financial barriers that dual-eligible beneficiaries face. For example, telehealth services may be coupled with other efforts, such as access to transportation when in-person visits are essential, as well as appropriate home health care support for appropriate patients. Integrated care plans may help optimize these services. Finally, we should also ensure equitable access to telehealth services. Current data suggests that older populations and people of color are less likely to have access to internet services or own computers or smartphones.[1] Thus, when designing telehealth initiatives, we should ensure that these services benefit everyone, especially the vulnerable dual-eligible population.

Question:

How can we ensure that dually-eligible beneficiaries are able to access the telehealth services that are now available to them? Does broadband access play a role here?

Response:

There are several issues that affect dual-eligible beneficiaries' ability to access telehealth services. First, while a majority of older Americans have expressed interest in telehealth,[3] about a quarter of Medicare beneficiaries do not even know whether their doctors provide telehealth services.[1] Therefore, expansion of telehealth coverage must also be accompanied by campaigns that raise awareness of their availability. Second, issues of internet access are a major barrier. Dual-eligible beneficiaries are more likely to lack internet access than other people.[4] Many also lack access to devices like computers and smartphones necessary to engage in two-way audio/video-based telehealth services.[1] Populations living in rural areas have even greater barriers to accessing telehealth services.[5] Thus, educating dual-eligible beneficiaries about telehealth use, addressing prevalent concerns about confidentiality and quality of care,[3] improving access to computers and high-speed internet, and allowing use of audio-only telephone visits in appropriate scenarios may improve uptake of telehealth services among this population.

Finally, it is important to note that many beneficiaries have conditions like cognitive, hearing, or vision impairment that make telehealth communication difficult,[6] so these limitations need to be addressed. Ensuring these patients continue to access high quality care, including care in-person when necessary, should be an ongoing priority.

Question:

What else can we do to adequately address the needs of dually eligible beneficiaries?

Response:

Ensuring access to integrated care models for dual-eligible beneficiaries is a key strategy to meet their complex set of needs. Given the aligned incentives, many integrated care plans have prioritized outreach to dual-eligible enrollees to ensure they are aware of their telehealth features of their plan. Some also connect them with resources for subsidized internet access.[7] Promoting care models that engage beneficiaries in this manner helps ensure that dual eligible beneficiaries can access telehealth services.

During your testimony you mentioned that social determinants of health play a large role on the health outcomes of dually-eligible beneficiaries. Financial insecurity, limited access to adequate transportation, or low health literacy etc. are all much higher among dually eligible beneficiaries, which can lead to more negative health outcomes. I have supported legislation like the Improving Social Determinants of Health Act of 2021, that would require the Centers for Disease Control and Prevention (CDC) to establish a program to improve health outcomes and reduced health inequities.

Question:

How would a program to improve the social determinants of health impact the population of dually eligible beneficiaries?

Response:

Dual-eligible beneficiaries are low-income by virtue that they qualify for Medicaid eligibility. These patients have substantial needs related to the social determinants of health, including issues related to financial insecurity, housing insecurity, food insecurity, educational attainment, language barriers, rurality, and transportation issues.[8] Oftentimes, these beneficiaries are also living in communities with limited or inadequate social and community supports to help them meet their needs.[8] Taken together, these challenges create substantial barriers to accessing care and make it difficult for them to follow protocols recommended by their healthcare providers. As a result, these beneficiaries have higher rates of potentially avoidable hospitalizations and emergency department visits and are at increased risk for experiencing worsening progression of their underlying chronic conditions.[9,10] Therefore, interventions that address these social needs may help to improve their access to care and, in turn, lead to better health outcomes.

Question:

How might addressing the social determinants of health impact the rate of service utilization by dually eligible beneficiaries?

Response:

Addressing social determinants of health can have meaningful impacts on downstream healthcare utilization. For example, there is strong evidence that addressing housing insecurity among those who are homeless or at risk of becoming homeless, can lead to lower healthcare utilization of expensive services like hospitalizations and emergency room visits.[11-17] Interventions that address food insecurity by providing access to healthy foods can also lower healthcare utilization. For example, studies have shown that home-delivered, medically tailored meals for those with chronic conditions and with nutritional risk can lead to fewer hospitalizations and 30-day hospital readmissions.[18-19] Programs like the Supplemental Nutrition Assistance Program

(SNAP) have also been shown to have significant reductions in healthcare utilization among low-income people with chronic conditions.[20-21] There's also moderate evidence that providing transportation services, legal services, and care management to low-income people like dual eligible beneficiaries can help curb potential unnecessary care and increase access to outpatient services.[22-26]

Senator Jacky Rosen

Protecting Medicare Beneficiaries From Fraud: One of my Nevada constituents recently reached out to my office to share her family's traumatic experience dealing with a deceptive Medicare broker. This constituent's family member, who has dementia, experienced a fall and was admitted to a hospital in Las Vegas where she was successfully treated. Her treatment plan subsequently called for her to be transferred to a local rehabilitation facility. Shockingly, the patient – a Nevada resident, injured and receiving treatment in Nevada – was informed by hospital staff that she was actually on a Medicare policy in Utah, and none of the local rehabilitation facilities would take the plan she was on, even though she lives in Nevada and has never lived in Utah. Fortunately, my staff was able to help the constituent cancel the Utah plan and reactivate her Nevada plan within 48 hours, but it appears this may be a growing problem, with some Medicare plan agents purposely misleading vulnerable seniors.

Question:

Given that people with both Medicare and Medicaid coverage often choose to enroll in separate plans, what should the federal government be doing to prevent this type of deceptive practice and protect our seniors who rely on Medicare for their health coverage? Should Congress look at potentially strengthening federal laws to ensure seniors are only offered plans that actually serve the state in which they live?

Response:

Preventing fraudulent activity targeting dual-eligible beneficiaries should be a priority for Congress. The majority of care that dual-eligible beneficiaries receive is local. If there are any insurance brokers out their enrolling dual-eligible beneficiaries into plans that do not cover providers that they can easily access, we should be concerned that these practices will negatively impact the health of these populations. Congress should therefore look at strengthening any regulation that protects dual-eligible beneficiaries.

One other area of concern is the D-SNP "look-alike" plans, which are MA plans that appear to aggressively enroll dual-eligible patients through their supplemental benefits and cost-sharing structure but are not actually integrated DSNPs.[27] There are concerns that these plans may interfere with the goal of fully integrating care for dual-eligible patients, and CMS has considered action to limit the growth of these plans.

<u>Improving Seniors Access to Telehealth:</u> Throughout the pandemic, we have seen the importance of telehealth in delivering timely, accessible care, particularly to those in rural communities and many traditionally underserved populations. That's why last year I introduced bipartisan legislation with Senator Sullivan that would provide states with additional FMAP funding for telehealth services, incentivizing states to continue offering telehealth services under Medicaid.

Question:

Can you talk about the importance of ensuring robust telehealth coverage both now and beyond the pandemic, especially for Medicaid recipients who may receive care via telehealth and then later in life transition to become dual enrollees with Medicare coverage? How will this coverage help ensure continuity of care for these beneficiaries?

Response:

As noted above in my response to Senator Blumenthal's Question #1, ensuring access to telehealth services should be an important strategy for improving access and the quality of care delivered to dual-eligible beneficiaries. During the pandemic, there is broad consensus that telehealth services helped ensure continuity of care for these patients. However, as previously noted, there are several barriers that limit low-income populations from effectively participating in telehealth services. Funding to help break down these barriers and ensure equitable access to telehealth services will be important.

Question:

What other models should Congress consider to ensure seniors' access to telehealth, such as audio-only or telehealth combined with at-home visits, which may be necessary for seniors who are less proficient with technology?

Response:

Integrated dual-eligible care models offer an important strategy to ensure access to telehealth services. Prior work has found that integrated care plans prioritized outreach to enrollees during the COVID-19 pandemic to ensure they knew about the different ways they could use telehealth services and provided resources for subsidized internet access.[7] Integrated plans also have an incentive to combine telehealth services (like audio-only telehealth) coupled with in-home visits to ensure that they can effectively care for their dual-eligible patients with limited proficiency with technology or potential disability/impairment that limits their participation in telehealth services.[28]

Family Caregivers' Access to Hospitalized Seniors: Especially over the last two years, we have seen the devastating impact that social isolation has had on our seniors, particularly on mental health. CMS revised nursing home visitation guidelines in November, but hospital visitation guidelines remain very restrictive. Patients needing a caregiver due to disability are rightly provided this access, but patients with sudden onset or exacerbation of mental health or cognitive conditions – such as delirium, depression, anxiety, or something similar – may still be isolated away from the very family members who can improve the situation. As AARP has noted, it is important that we find a better balance for both reducing infection risk and protecting the mental health of patients, especially our most vulnerable seniors.

Question:

Considering that we now have readily accessible COVID-19 vaccines, booster shots, and N95 style masks, would you recommend updated visitor guidance for hospitalized seniors experiencing cognitive or mental health distress? What other recommendations do you have for additional steps the federal government can do to protect the mental health of seniors, especially dual enrollees?

Response:

This is an important issue that needs urgent attention. Yes, I do recommend revisiting and updating visitor guidance for hospitalized seniors experiencing cognitive and/or mental health distress. As noted, hospitals can ensure safe visitation for these vulnerable populations through appropriate personal protective equipment use (including N95 masks) and ensuring visitors are vaccinated and boosted as well.

As for additional steps for protecting the mental health of dual-eligible seniors, I refer again to the importance of ensuring integrated care. Integrated care models can offer a wide range of services that include behavioral health counselors, social workers, and peer counselors. It is also important to ensure dual-eligible beneficiaries have sufficient access to behavioral health specialists. Prior work has suggested that access to behavioral health specialists is often limited in dual-eligible plans.[29]

Senator Mark Kelly

I'd like to ask about default enrollment. Arizona has been highlighted for its early use of default enrollment for dually eligible beneficiaries. When someone enrolled in Arizona's Medicaid program is slated to become eligible for Medicare, that person receives proactive outreach to be enrolled in the Dual Eligible Special Needs Plan that corresponds with their Medicaid plan. This allows the beneficiary to receive complete, uninterrupted care.

Question:

This is a strategy that the Medicaid Advisory Commission has advocated for, noting its success in increasing enrollment. Why don't more states offer direct enrollment? From the federal level, how can we better help states with this process?

Response:

One of the main reasons why states do not offer direct enrollment into integrated plans is because this requires considerable upfront investments by states to ensure it is done appropriately and effectively.

Today, many states have insufficient Medicare expertise among state staff and lack the infrastructure and appropriate IT support necessary to implement direct enrollment.[30] MACPAC reports that using a default enrollment system may require some states to change their current IT systems to support enrollees who are eligible for Medicare and Medicaid.[30] Even if states are interested in default enrollment, actual implementation may take a significant amount of time and resources, and states will likely need to hire additional staff to ensure they can maintain it.

To help overcome these challenges, Congress can provide additional financial and non-financial resources to help states enhance their infrastructure and capacity to implement default enrollment and integrated care plans. Federal support could be used to enhance Medicare expertise, staff capacity, and information technology systems.

Question:

The past few years have been difficult. Mental health has suffered across the board, whether it's from losing a loved one, losing a job, or just general uncertainty about the state of the pandemic. More people are requesting mental health services. More people are facing substance abuse challenges. As a clinician and as a researcher, could you speak to why it's so important to integrate behavioral health care with physical health care?

Response:

Ensuring access to mental and behavioral health services is essential in the care of vulnerable, dual-eligible beneficiaries with substance abuse and mental health disorders. Prior work has found that fragmented, non-integrated behavioral health services and physical health services delivered by different providers introduces many barriers to access to care, and ultimately, leads to worse health outcomes for these patients. Therefore, it is important to consider enrolling more of these patients into integrated care models, which offer a wide range of services that may include behavioral health counselors, social workers, and peer counselors, in addition to other providers that care for their other chronic conditions like cardiovascular disease and diabetes.

Senator Mike Braun

Question:

Less than ten percent of duals are enrolled in any form of care that integrates Medicare and Medicaid services, leaving this population to navigate disconnected delivery and payment systems, as well as administrative barriers that delay the overall processing of data. This creates confusion for both duals and providers. How can we improve the integration of care services across Medicare and Medicaid programs to reduce confusion for duals and providers?

Response:

Ensuring access to truly integrated and coordinated Medicare and Medicaid programs for dual-eligible beneficiaries is essential for improving quality of care and patient experience. In my written testimony, I highlight several recommendations of how we can enhance integrated care. They include the following: 1) ensuring that all dual-eligible beneficiaries have access to an integrated care model; 2) providing guidance, technical assistance, and financial support to states to support integrated care models; 3) ensuring that the enrollment process is easy for duals and that they have sufficient, unbiased support from knowledgeable people about what plan is best to meet their unique needs and preferences; 4) building better patient-centered quality metrics that capture quality of life, patient-reported outcomes, and patient experience with integrated care models; and 5) better timelier data is needed to understand how well integrated care models are performing relative to other alternatives, among others.

Question:

Are there opportunities here to better ensure that funding is directed towards simplifying systems across Medicare and Medicaid programs?

Response:

To date, states are operating with limited resources that affect how well they can support dual-eligible beneficiaries and integrated care plans. Recently, MACPAC recommended additional federal funding to enhance capacity of states to integrate care by training state staff on Medicare expertise and financing upfront investments necessary to build integrated care programs and infrastructure.[27] MACPAC also suggested that additional funding could come from enhanced FMAP payments or grant-based programs (modeled after the Financial Alignment Initiative).

Question:

According to a May 2021 report from the U.S. Government Accountability Office, in 2020, the federal government increased funding for Medicare and Medicaid, spending over $1.5 trillion on health care services in response to the COVID-19 pandemic. CMS also issued federal waivers to expand beneficiary care access at this time. As a result, GAO identified several risks to program integrity for Medicare and Medicaid due to the suspension of program safeguards, increasing chances of fraud, waste, and abuse. In your research on understanding the drivers of health care spending and poor clinical outcomes among older, at-risk populations, has increased spending and waivers complicated matters in improving care experiences for duals?

Response:

This is an important question that requires more research to understand the full effects of the increased federal funding on our health care system and patient care. To date, there is evidence that these additional resources and waivers helped ensure access and continuity of care for vulnerable populations during the pandemic, increased hospital capacity, reduced administrative burden, expanded telehealth coverage, and ensured patients remained enrolled in health plans (e.g., maintenance of eligibility in the Medicaid program).[31] However, the full effects of these actions are not yet known, and so Congress should consider investing in efforts that help comprehensively evaluate this important issue.

Question:

Has it made it more difficult for core health services to receive the support they need?

Response:

To my knowledge, there is not substantial evidence that the waivers passed during the pandemic have had meaningful disruptions to core health services. However, as noted above, we need to fully investigate the impact of the broad set of actions taken during the pandemic, and importantly, how stopping or rolling back some of these actions will affect dual-eligible beneficiaries and other vulnerable patients.

References

1. Koma W, Cubanski J, Neuman T. Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. KFF, 2021. https://www.kff.org/medicare/issue-brief/medicare-andtelehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/
2. Samson LW, Tarazi W, Turrini G, Sheingold S. Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location. Office of the Assistant Secretary for Planning and Evaluation, 2021. https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealthreport.pdf
3. AARP Research. Views on Telehealth. AARP, 2020. https://www.aarp.org/content/dam/aarp/research/surveys_statistics/health/2020/views-ontelehealth.doi.10.26419-2Fres.00388.001.pdf

4. Rizer A. Left Behind in the Era of Internet: Yet Another Challenge Facing Dual Eligible Beneficiaries. ATI Advisory, 2020. https://atiadvisory.com/left-behind-in-the-era-of-internet-yet-another-challenge-facing-dualeligible-beneficiaries/
5. National Public Radio, the Robert Wood Johnson Foundation, and the Harvard T.H. Chan School of Public Health. Life in Rural America: Part II. 2019. https://media.npr.org/documents/2019/may/NPR-RWJFHARVARD_Rural_Poll_Part_2.pdf
6. Arnold Ventures Complex Care Team. Telehealth: Good in Theory, Potentially Problematic in Practice. Arnold Ventures, 2020. https://www.arnoldventures.org/stories/telehealth-good-in-theory-potentially-problematic-inpractice/
7. Janoski BE, Betlach T, Sopher MH. Integrated Care Programs for Dually Eligible Individuals in the Era of COVID-19: Response Efforts and Policy Reommendations. Center for Health Care Strategies, 2020. https://www.chcs.org/resource/integrated-care-programs-for-dually-eligible-individuals-in-the-era-of-covid-19report/
8. Sorbero ME, Kranz AM, Bouskill KR, Ross R, Palimaru AI, Meyer A. Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies. RAND Corporation, 2018. https://aspe.hhs.gov/sites/default/files/private/pdf/259896/MAStudy_Phase2_RR2634-final.pdf
9. Office of the Assistant Secretary for Planning and Evaluation (ASPE). Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. 2016. https://aspe.hhs.gov/sites/default/files/private/pdf/253971/ASPESESRTCfull.pdf
10. National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. The National Academies Press, 2016.
11. The Commonwealth Fund. Review of Evidence for Health-Related Social Needs Interventions. 2019. https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-119.pdf
12. Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. JAMA. 2009 May 6;301(17):1771-8. doi: 10.1001/jama.2009.561. PMID: 19417194.
13. Gusmano MK, Rodwin VG, Weisz D. Medicare Beneficiaries Living In Housing With Supportive Services Experienced Lower Hospital Use Than Others. Health Affairs. 2018 37(10). https://doi.org/10.1377/hlthaff.2018.0070
14. America Hospital Association (AHA). Social Determinants of Health Series: Housing and the Role of Hospitals. 2017. https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/housing-role-of-hospitals.pdf
15. Bamberger JD, Dobbins S. Long-term Cost Effectiveness of Placing Homeless Seniors in permanent Supportive Housing. Federal Reserve Bank of San Francisco. 2014. https://www.frbsf.org/communitydevelopment/publications/working-

papers/2014/july/long-term-cost-effectiveness-homeless-seniors-permanentsupportive-housing/

16. Hunter SV, Harvey M, Briscombe B, Cefalu M. Evaluation of Housing for Health Permanent Supportive Housing Program. RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1694.html
17. Linkins KW, Brya JJ, Chandler DW. Frequent Users of Health Services Initiative: Final Evaluation Report. The Lewin Group, 2008. https://www.chcf.org/wp-content/uploads/2017/12/PDF-FUHSIEvaluationReport.pdf
18. Martin SL, Connelly N, Parsons C, Blackstone K. Simply delivered meals: a tale of collaboration. The American Journal of Managed Care. 2018 24(6):301-304. PMID: 29939505.
19. Gurvey J, Rand K, Daugherty S, Dinger C, Schmeling J, Laverty N. Examining health care costs among MANNA clients and a comparison group. J Prim Care Community Health. 2013 Oct;4(4):311-7. doi:10.1177/2150131913490737.
20. Berkowitz A, Terranova J, Hill C, Ajayi T, Linsky T, Tishler LW, DeWalt DA. Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries. Health Affairs. 2018 37(4). https://doi.org/10.1377/hlthaff.2017.0999
21. Samuel LJ, Szanton SL, Cahill R, Wolff JL, Ong P, Zielinskie G, Betley C. Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland. Population Health Management. 2018 21(2). https://doi.org/10.1089/pop.2017.0055
22. Thomas LV, Wedel KR, Christopher JE. Access to Transportation and Health Care Visits for Medicaid Enrollees With Diabetes. J Rural Health. 2018 Mar;34(2):162-172. doi: 10.1111/jrh.12239.
23. O'Sullivan MM, Brandfield J, Hoskote SS, Segal SN, Chug L, Modrykamien A, Eden E. Environmental improvements brought by the legal interventions in the homes of poorly controlled inner-city adult asthmatic patients: a proof-of-concept study. J Asthma. 2012 Nov;49(9):911-7. doi: 10.3109/02770903.2012.724131.
24. 24. Martin J, Martin A, Schultz C, Sandel M. Embedding Civil Legal Aid Services in Care for High-Utilizing Patients Using Medical-Legal Partnership. Health Affairs Forefront. 2015. 10.1377/forefront.20150422.047143
25. Berkowitz SA, Parashuram S, Rowan K, Andon L, Bass EB, Bellantoni M, Brotman DJ, Deutschendorf A, Dunbar L, Durso SC, Everett A, Giuriceo KD, Hebert L, Hickman D, Hough DE, Howell EE, Huang X, Lepley D, Leung C, Lu Y, Lyketsos CG, Murphy SME, Novak T, Purnell L, Sylvester C, Wu AW, Zollinger R, Koenig K, Ahn R, Rothman PB, Brown PMC; Johns Hopkins Community Health Partnership (J-CHiP) Team. Association of a Care Coordination Model With Health Care Costs and Utilization: The Johns Hopkins Community Health Partnership (J-CHiP). JAMA Netw Open. 2018 Nov 2;1(7):e184273. doi: 10.1001/jamanetworkopen.2018.4273.
26. Center for Health Care Strategies. Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Viriginia Care Transitions Partnership. 2017. https://www.chcs.org/media/EVCTPCase-Study_101217.pdf

27. Medicaid and CHIP Payment and Access Comission (MACPAC). Report to Congress on Medicaid and CHIP: Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options. June 2020. https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-2-Integrating-Care-for-Dually-EligibleBeneficiaries-Policy-Issues-and-Options.pdf
28. Van Houtven CH, Dawson WD. Medicare and Home Health: Taking Stock in the COVID-19 Era. The Commonwealth Fund, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/medicarehome-health-taking-stock-covid-19-era#26
29. Brill R, Gleason B, Curbera J, Fisher CF, Robinson A. Listening to Dually Eligible Individuals: PersonCentered Enrollment Strategies for Integrated Care. Center for Consumer Engagement in Health Innovation, 2021. https://www.healthinnovation.org/Person-Centered-Enrollment-Strategies-for-Integrated-Care.pdf
30. Medicaid and CHIP Payment and Access Comission (MACPAC). Report to Congress on Medicaid and CHIP: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans. June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf
31. US Government Accountability Office. Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation. May 2021. https://www.gao.gov/assets/gao-21-575t.pdf

U.S. Senate Special Committee on Aging
"Improving Care Experiences for People with both Medicare and Medicaid"
February 10, 2022

Questions for the Record
Ms. Eunice Medina

Senator Jacky Rosen

FAMILY CAREGIVERS' ACCESS TO HOSPITALIZED SENIORS: Especially over the last two years, we have seen the devastating impact that social isolation has had on our seniors, particularly on mental health. CMS revised nursing home visitation guidelines in November, but hospital visitation guidelines remain very restrictive. Patients needing a caregiver due to disability are rightly provided this access, but patients with sudden onset or exacerbation of mental health or cognitive conditions – such as delirium, depression, anxiety, or something similar – may still be isolated away from the very family members who can improve the situation. As AARP has noted, it is important that we find a better balance for both reducing infection risk and protecting the mental health of patients, especially our most vulnerable seniors.

Question:

Considering that we now have readily accessible COVID-19 vaccines, booster shots, and N95 style masks, would you recommend updated visitor guidance for hospitalized seniors experiencing cognitive or mental health distress? What other recommendations do you have for additional steps the federal government can do to protect the mental health of seniors, especially dual enrollees?

Response:

Throughout the unprecedented COVID-19 public health emergency, hospitals have made countless policy changes to protect the health of their patients, staff, and the communities they serve. As vaccination rates increase and more effective treatment options become available, hospital leaders should focus on revising visitation policies that more appropriately balance compassion and caution. Policies that increase isolation of seniors with cognitive conditions should be avoided whenever possible as they can create serious unintended consequences for mental and physical health outcomes.

The federal government can play a crucial role in supporting states' efforts to mitigate the effect isolation can have on hospitalized seniors, especially those with acute mental health or cognitive issues. Specifically, the federal government can assist by:

- Prioritizing vaccination availability for seniors and other vulnerable populations;

- Increasing access to virtual visitation methods through funding opportunities, equipment allocations, or relaxation of regulations that discourage the use of electronic visitation for families; and,
- Ensuring free, rapid COVID-19 testing is available to anyone who requests it at visitor registration areas.

Consideration should also be given towards increasing training opportunities for care coordinators on the effects of isolation and the importance of social contact for seniors in hospital settings.

Senator Mark Kelly

Through the passage of the Families First Coronavirus Response Act, states are receiving an increase in federal Medicaid matching funds as long as they provide continuous coverage for individuals on Medicaid. This continuous coverage has been instrumental in keeping people connected to the health care they need. In Arizona, Medicaid enrollment has increased by nearly 24 percent in 22 months.

But we know the Public Health Emergency is going to end at some point. The continuous enrollment is going to end. I'd like to say on the record that when this time comes, it is going to be more important than ever that we work to make enhanced premium tax credits permanent so people can access affordable health care on the insurance marketplace.

Question:

Thinking about the end of the Public Health Emergency and the end of continuous enrollment—how is your agency preparing for this? How are you coordinating outreach among providers, plans, and the state? Are there special considerations that will be needed for dually eligible beneficiaries when making these preparations?

Response:

Our agency began preparing for the end of the public health emergency (PHE) and the end of the continuous enrollment requirement during the initial months of the PHE. Our planning continues and is adjusted as federal guidance is updated. The agency's goals for the end of continuous coverage include promoting continuity of coverage for eligible individuals, minimizing administrative burdens on members, and limiting delays in review processing.

As part of this preparation, the agency is implementing outreach strategies to encourage members to provide us with current contact information as well as to complete and return eligibility review forms when received; hiring additional staff to support application and review processing; and preparing systems, policies, procedures, and staff training for the resumption of review processing. A communications plan is also being implemented to include multiple modes of providing important information to stakeholders, such as beneficiaries, as well as providers and managed care plans so that they may conduct their own outreach efforts.

Senator Mike Braun

Question:

Lack of care coordination between state services and the federal government in integrated care models can lead to fragmented care for individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all. For example, Medicare and Medicaid have separate rules for coverage of medical equipment and home health services, as well as different ways of processing grievances and appeals. There is also little incentive for coordination between the two to reduce spending in their own programs. Given these issues, how can we incentivize better care coordination between state services and the federal government to maximize our investments in both programs to address the complex needs of duals more efficiently and effectively?

Response:

Given the experience gained under our Financial Alignment Initiative (FAI) demonstration, the agency recognizes that visibility into multiple care management systems is an integral part of the success of managing services not traditionally housed within one enterprise. This also allows for the successful involvement of health plans and supporting staff to see what services are in place, allotted hours (if applicable), and knowing if members are receiving care through a doctor, pharmacy, or a different place of service. Today, this initiative is supported within an administrative capitation payment to the partnered health plans performing this work.

Question:

As states consider strategies to incorporate health services into existing care delivery systems, they must develop data processing and financing mechanisms to avoid duplication of services, payments, and coverage for beneficiaries. To what degree in your work in health and human services have you seen instances of duplicative care occur and how often?

Response:

Under the current FAI, duplication is limited and mitigated by the health plans as they cover both Medicare and Medicaid services, including the claims adjudication process. Aside from the FAI, our claims system is designed to search for other potential payment sources and claims for services rendered by providers to reduce the potential for duplicated payments.

Question:

What are the main barriers to eliminating duplicative care across Medicare and Medicaid programs for duals?

Response:

The main barrier for eliminating duplication is a lack of enhanced visibility across adjudication systems. Under the current FAI, this barrier is circumvented through a central entity that is responsible for both Medicare and Medicaid care and payments. Absent a model like the FAI, these processes remain siloed.

Senator Rick Scott

When I was Governor of Florida, we made a series of reforms to our Medicaid program and transitioned from a fee for service to a statewide managed care program. This transition was a win-win for everyone. It allowed us to consolidate many of our waivers and streamline the program. It required Medicaid plans to compete against each other for beneficiaries. It gave beneficiaries all their traditional Medicaid benefits and additional benefits such as home delivery of meals, hearing services, or non-medical transport. To help dual-eligible populations, we tried to create plan alignment between state Medicaid plans, and Medicare Advantage & D-SNP plans. That way a dual eligible individual would be serviced by Medicaid and Medicare by the same plan.

Every state Medicaid program is different with different populations and needs. I think it's fair to say every State Medicaid Director faces issues with CMS when trying to reform the system. As a former Governor, I have always advocated for flexibility in the system.

Question:

What type of flexibility should Medicaid Directors have with CMS?

Response:

As it pertains to South Carolina and in my role as Chief of Staff and Deputy Director of Programs, I continue to advocate for more time and flexibility to plan and implement how we will decide to move forward with our program serving dual-eligible beneficiaries.

Question:

What are your thoughts on flexibility that can come from a managed care or capitation program? Is paying a state or a plan to manage the health of a beneficiary with appropriate safeguards a good idea?

Response:

Through my work in both Florida's and South Carolina's Medicaid agencies, I've observed a demonstrated commitment to the managed care delivery system. I truly believe providing beneficiaries with the best and most cost-effective services begins with state agencies ensuring safeguards are in place for both beneficiaries and providers.

Question:

Do you think that these managed care plans place greater emphasis on disease management and healthcare over sick care?

Response:

It is important that state agencies take the lead on ensuring managed care plan priorities align with those of the state. This can be accomplished by ensuring procurements/contracts, financial incentives, and monitoring activities connect to the state's goals and initiatives, including the desired approach to preventative care.

Question:

We always talk about the challenge of care coordination between Medicaid and Medicare. How did you do it in Florida, and how are you doing it in South Carolina? How can we make it better?

Response:

As you describe in your opening statement, alignment begins with connecting the individual across insurance lines, at a minimum through enrollment. Thereafter, further integration can be attained by developing streamlined approaches to the beneficiary experience (e.g., beneficiary communications). In South Carolina, we have achieved a more comprehensive model of care in our demonstration by setting up a single system of care for both Medicare and Medicaid (incl. long-term care) services. The goal moving forward is to identify the lessons learned from the demonstration and apply those lessons to a model that moves South Carolina past the demonstration phase.

Question:

Should there be an easier process to renew and modify existing Medicaid state waivers?

Response:

On a federal and state level, there are absolutely opportunities to improve how we ensure Medicaid authorities are in place. As innovation increases across states on Medicaid program design, new authorities or modified approaches can easily be identified; however, anything that streamlines the process to one approach is welcomed as states must currently navigate different rules and guidelines depending on the type of federal authorities required to address the various populations in Medicaid.

U.S. Senate Special Committee on Aging

"Improving Care Experiences for People with both Medicare and Medicaid"

February 10, 2022

Questions for the Record

Mr. Dennis Heaphy

Senator Richard Blumenthal

In your testimony, you discussed the importance of receiving care in your home. I believe caregivers, like your personal care assistant, play critical roles in ensuring the safety of those under their responsibility. These workers, as you've said, are often overlooked and underpaid. I have been happy to support efforts to expand access to Home and Community Based Services.

Question:

Can you expand on some of the changes you have seen to your One Care plan, a Home and Community Based Service in Massachusetts, that have made it challenging for you and others to receive care?

Response:

The OC model was unique. Created in collaboration with disability advocates with Massachusetts Medicaid office, commonly referred to as MassHealth, and CMS, OC was to offer transparent, highly personalized care to meet the needs of this high-cost high need population that is very distrustful of the medical system, and managed care in particular. There was a commitment by the original plans and their leadership to operationalizing Independent Living Rights and Recovery Principles in plan policies, practices, and procedures. Unfortunately, there seems to have been a shift away from this commitment, if not in word, in how these tenants are being operationalized.

One Care (OC) seems to be suffering from a lot of the ills prevalent in Medicare Advantage plans was created to be a population appropriate person-centered care plan, but it has devolved into a non-population specific, what some people characterize as a "one-size-fits-all" plan with "perks."

- A key element of OC is supposed to be high-level care planning and care coordination to meet the needs of the population. Unfortunately care planning and care coordination systems put in place seem to be dissolving. Increasingly members report not having a care plan were not having received a care plan that they have made with their care team, and even worse, cannot identify members of their care team. Plans have inserted an external care coordinator to be the primary connection between the individual and their care team. So, rather than having direct access to a person who knows them, and has been part of the care planning process, enrollees are required to communicate with a plan representative who is supposed to be the liaison between the person and their care team. This leads to longer turnaround times for enrollees to access services who seem to act more as a gatekeeper rather than a facilitator of services which leads to reduced trust, and what seems to advocates, as a system based on conflict of interest.

- At the start of OC there was integration between the UM team and the care team meeting to reduced modifications or denials of authorization requests. Siloing of utilization management from care team members and individualized care plans is a primary driver of these changes because standardized UM practices do not contextualize the unique intersecting needs of persons with complex medical, mobility, behavioral health and social determinant needs of the population, but instead taking unidimensional approach to authorization relies on Medicare and Medicaid codes.

- Under OC contract requirements, plans are supposed to make decisions based on which payer, Medicare or Medicaid provides coverage for a particular service and, if covered by both payers, to provide the service using the payer code with the most flexible and/or generous service allowable. However, it seems plans are taking a reductionistic approach to authorizations, by primarily using Medicare as the primary payer without going to MassHealth benefits when making medical determination decisions. This leads to both denials and modifications in durable medical equipment and short-term use durable medical such as wheelchairs and urinary supplies etc. Additionally, plans are supposed to go beyond medical necessity guidelines within Medicaid and Medicare and use covered flexibilities built into the One Care contract that are built into the capitation rates to enable plans to cover items that may not be covered under the strictest interpretation of medical necessity, for example payment of small fees to enable an enrollee to participate in a local sporting activity or adult learning opportunity.

- Prior authorization processes have become lengthy with increased numbers of administrative denials and modifications of authorized HCBS services. Due to lack of consistency in plan collection of data on authorization, authorization modifications and denials, it is all but impossible for advocates, researchers, let alone MassHealth more CMS, to provide the appropriate level of oversight and tracking of reductions in access to HCBS for fall under the umbrella of "modified authorizations".

Examples:

1. Nonmedical transportation is an essential benefit of OC. When OC began nonmedical transportation requests were rarely denied. However, whether because of (pre-COVID) transportation vendor capacity or recontracting practices payment to vendors leading to reduction in vendor networks, transportation requests are increasingly being modified and timeframes for making requests becoming more restrictive. Frequency of transportation

requests by members are being reduced by plans A person cannot plan the transportation for a wedding a month in advance.

2. Durable medical equipment authorization requests are increasingly being modified.

<u>We need greater transparency to ensure</u>

- Transparency of individual MA plans authorizations, authorization modifications, and denials are public facing regardless of whether a complaint or appeal has been filed.
- Per-Person, not just total spending on HCBS and LTSS aligns with enrollee population risk scores.
- Medical Loss Ratio (MLR) administrative allowables are actuarily sound and expenditures align with the stated purpose of the allowables over time by tracking trends and spending and increased utilization of HCBS, LTSS and diversionary services.
- Vendor network adequacy definitions and robustness align with the population needs, and that MA plan contracting, and payment practices are adequate and appropriate to support the HCBS and LTSS needs of members.
- MA plan by services from community vendors with leadership and staffing representative of the populations they serve e.g. Independent Living Centers, Recovery Learning Communities, community-based certify recovery coach organizations, minority run committee health worker nonprofits etc.

Senator Mark Kelly

A proposed rule that CMS released in January would make a fair amount of changes to make Dual Eligible Special Needs Plans more integrated and streamlined for the consumer. This includes changes like limiting plan offerings within a contract so people better understand the quality of what they're enrolling in, and integrated materials for the beneficiary to make notifications less confusing. It also proposes requiring each plan to have an advisory committee of beneficiaries in each state, and for each Special Needs Plan to assess physical, psychosocial, and functional needs. It's clear from your testimony that consumer voices make a difference in how care is provided.

Question:

Could you speak to how these changes would benefit beneficiaries across the country?

Response:

See the attached document which was sent to CMS in response to the proposed rule changes. The was submitted by the One Care Implementation Council, and while not speaking for the Council, provides a very strong picture of how disability advocates of Massachusetts understand the role consumer engagement in managed-care governance and oversight.

Attached Documents:

March 7, 2022

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS–4192–P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Dear Sir/Madam,

The One Care Implementation Council (IC) executive committee is writing to invite CMS leadership to one of the Council's regular scheduled meetings or, set up a time for a separate meeting based on the availability of CMS leadership to discuss the potential impact of the proposed rule changes on One Care. We know CMS leadership is very busy, but also know how much CMS leadership values the voice of the persons with disabilities directly impacted by its policies. We believe such a meeting is important to our ongoing partnership with CMS and MassHealth as we seek to advance aligned, integrated whole person-centered care for dually- eligibles 21-64. In the interim, we are pleased to respond to the CMS Request for Information on proposed D-SNP rule changes.

As you are aware, the IC along with the ombudsman program, was established as part of the One Care three-way contract at the start of One Care as a result of advocacy by Disability Advocate Advancing a Healthcare Rights (DAAHR). The Council plays a key role in monitoring access to healthcare and compliance with the Americans with Disabilities Act (ADA) and provides support and input to the Executive Office of Health and Human Services (EOHHS) in Massachusetts. The Council is grateful for the forward-thinking innovations developed by MassHealth leadership and our ability to support those innovations that improve the health and quality of life for persons who rely on MassHealth for their healthcare.

The IC executive team, while not speaking for the entire Council membership, feels that it is important to weigh in on the important changes proposed by CMS. While intended to strengthen the D-SNP model in markets across different states, the proposed rule changes fall short. In fact, the proposed changes have the potential to harm or at a minimum perpetuate inequities affecting the most vulnerable and costly dually eligible individuals in the country.

This letter is not exhaustive, but seeks to highlight recommendations and concerns already cited in RFI responses from Disability Advocates Advancing Our Healthcare Rights (DAAHR), Community Catalyst, and the joint letter submitted by national advocates including Justice in Aging and the Disability Rights Education & Defense Fund.

The IC exec team appreciate all that One Care has accomplished but are keenly sensitive to the work that still needs to be done to advance totally aligned and integrated care to high-risk, high need populations that experience health inequities due to bias and discrimination. So, we are profoundly troubled that CMS proposes to downgrade the One Care program from a Medicare/Medicaid Plan (MMP) to a Medicare Advantage Dual Eligible Special Needs Plan (DSNP). We are particularly concerned about the harm that One Care enrollees will suffer, if CMS removes the current protections embedded into the Financial Alignment Initiative (FAI) demonstration structure and practices.

We believe the proposed rule changes do not go far enough to address existing deficits in DSNPs and are deeply concerned the proposed rule puts the interests of the D-SNP industry ahead of dually eligible individuals by undermining the consumer role in all aspects of oversight, innovations, and partnerships. The proposed rule threatens the One Care program's unique features including the consumer-led IC and singular ombudsman services provided to One Care members by a disability organization contracted through MassHealth,

The FAI and the One Care Program

CMS created the FAI and approved the One Care program as a model to incentivize One Care plans to rebalance spending, to prioritize spending away from medical services towards home-and-community based services (HCBS), other long-term services and supports (LTSS) and diversionary services, fully aligned with the disability rights and recovery movements. The One Care program has been successful in operationalizing the independent living (IL) philosophy and recovery principles through integration of peers (LTSS Coordinators) and certified peer specialists (CPSs)/certified recovery coaches (CRCs).

The One Care program has, and ongoing collaboration with the disability community, made strides for the disability community that can only happen under a program that fully integrates Medicare and Medicaid services and fully aligns Medicare and Medicaid financing. Converting to a D-SNP platform will turn the clock backwards for Massachusetts and other states with FAIs. D-SNPs are medical plans, and they are far less integrated than the One Care program. The proposed rule change omits any CMS plan to incentivize D-SNP plans, to create a fully integrated program that can parallel the care integration and financial alignment achieved under the One Care program, and most importantly, to provide states to funds to build and strengthen their infrastructure to ensure the rights of persons with disabilities.

We are deeply troubled that CMS proposes to leverage the key learnings from the FAI demonstrations including the One Care program, while dismantling the innovators of healthcare transformation such as the FAI. The proposed rule changes will de facto lower the standards for plans and for disability rights. A prime example is the shift away from regular three-way recontracting requirements. The IC has leveraged these regular recontracting periods to work with MassHealth to strengthen readiness review requirements, quality measure requirements, contract requirements, and oversight requirements. Removing this key element of the demonstration will give more power to the plan and greatly diminish the voice of those most affected by plan policies, practices, and procedures.

Finally, we are concerned that the federal government lacks the capacity to provide the adequate oversight needed to protect the independent living rights and recovery focused rights of dually eligible individuals in D-SNPs nationally without sharing responsibilities with states. We believe that without a commitment to increase funding to states, the rules changes proposed are really a cost shifting strategy that will exacerbate existing disparities in access to services across states. So, the rules should include FMAP funding to incentivize true integration rather than just placing thousands of more people into MA plan that have not proven to improve care.

To move forward with the proposed rule changes, CMS should:

1. Include rebalancing requirements and diversionary requirements, specific to each state.
2. Establish joint-rate setting for states like Massachusetts that wish to maintain MMPs 3. Maintain funding for the Massachusetts One Care Implementation Council and MyOmbudsman.

Increases Cost Shifting onto the States

As written, the proposed rule creates a high risk of increased cost shifting away from the federal government onto the states. Across the states, there are major inequities in state Medicaid program resources, capacity, and will to advance meaningful whole, person-centered care. Without a joint contracting requirement for D-SNPs, inequities across the states have the potential to increase. States that that have successfully improved care coordination and integration through the aligned Medicare and Medicaid payment streams are at high risk for lower quality.

Reduces Transparency in Plan Expenses and Medical Loss Ratio

We are also concerned that the break in federal and state financial alignment will erode transparency in medical spending and the integrity of the medical loss ratio (MLR). The break in financial alignment runs the risk that plans will pad allowable administrative costs. The break will also create two separate MLRs. Under the proposed rule changes, CMS proposes to consider an integrated MLR or an option for states to adjust capitation rates downward to capture medical savings. Both options serve as poor substitutes for a more certain path. For the sake of transparency and whole, person-centered care, CMS must allow states to continue the FAI to pool Medicare Medicaid resources and assume an active role in monitoring transparency and in setting MLRs. States must be able to track plan spending including allowable administrative costs in a transparent manner to ensure that funds are being used for their stated purpose and in compliance with actuarily sound principles and to establish the MLRs for the FAIs.

Erodes an Upstream Commitment

Maintaining the aligned Medicare and Medicaid financing under the One Care program is also critical to the evolution of independent living principles and recovery movement. Under the One Care program, plans are able to leverage the aligned financing under the One Care program to invest upstream in housing supports and in programs like the Massachusetts Housing and Shelter Alliance (MHSA), Marie's House, a residential facility for persons with mental health diagnoses, and coverage of the food-as-medicine program. Such innovations will not be possible in the future without the aligned financing model.

IC Background

Prior to the start of the FAI demonstration, DAAHR and the MassHealth leadership collaborated to establish the IC. The IC plays a key role in monitoring access to healthcare and compliance with the ADA, tracking quality of services, providing support and input to the EOHHS in Massachusetts, and promoting accountability and transparency.
The roles and responsibilities of IC members include advising EOHHS on the One Care program, the Duals Demonstration 2.0, and related matters affecting dually eligible populations; soliciting input from stakeholders on those topics; examining One Care plan quality; reviewing issues raised through the grievances and appeals process and MyOmbudsman reports on One Care; examining access to services (medical, behavioral health, and long-term services and supports) in One Care; and participating in the development of public education and outreach campaigns related to One Care, the Duals Demonstration 2.0, and related dual eligible matters.

The IC Executive Team has been engaged with MassHealth to strengthen plan readiness requirements, tighten contract language, and provide input on One Care plan selection. (The One Care program currently has 3 plans.) The IC brings in external experts on topics including care planning and care coordination, quality measurement development, food-as-medicine, experts seeking solutions to homelessness with attention to persons who are chronically homeless due to substance use disorder or mental health diagnoses, and care integration for persons with mental health diagnoses.

The IC has up to 21 members with at least 51% of members being persons covered under MassHealth or a family member. The IC Executive Team is led by MassHealth members. MassHealth selects IC members with input from the IC Executive Team. The IC meets monthly and receives administrative and other support from a contracted vendor, UMass. MassHealth pays stipends to Council members with disabilities for their time and effort, and provides free transportation.

The existence of an "Implementation Council" or "advisory committee" is not itself a demonstration of enrollee input. The IC derives its credibility from the disability community. While Council members are currently chosen by the MassHealth MCO oversight team, disability experts who comprise the Council's majority, have the support of the disability community and are held accountable for their activities on the IC by the disability community. The IC works closely with a variety of stakeholders ranging from providers to the Department of Public Health and Department of Mental Health. We remain engaged with One Care members through virtual town hall meetings. These meetings have been invaluable in bringing to light the strengths and weaknesses of One Care.

We are disappointed at the lack of engagement by One Care plan consumer advisory committee (CAC) members with the IC. Plan CAC members' selection processes is opaque as is the actual level of "guidance" provided to CAC members by their respective plans. Despite efforts by the IC, there is no direct communication between CAC members and the IC.

Enrollee Participation in Plan Governance Recommendations

We request that CMS clarify the consumer advisory committee requirement and fortify the role of consumers to ensure their engagement with D-SNPs leads to improvements in plan care delivery. In addition to individual D-SNP consumer advisory committees, we suggest that CMS require each state to establish a central D-SNP implementation Council using the One Care model. With **reservations**, we also support taking elements of the national § 431.12 Medical care advisory committee Medical care advisory committee language contained in Chapter IVcenters For Medicare And Medicaid Services, Department Of Health And Human Services. Our **reservations** are based in the requirement of the Chapter IV is a highly medicalized model that requires physicians to be part of the committee. **In contrast with the Consumer Advisory Committees, the One Care IC is led by consumers and prioritizes rebalancing spending operationalizing the IL philosophy and recovery principles.**

We further request that the proposed CMS rule changes strengthen the One Care IC by requiring all consumer representatives be recommended by community-based organizations (CBOs) whose leadership and staff reflect the populations they serve and provide representatives with experience in providing services that strengthen a person's independent living and recovery goals.

Health Equity

The IC is committed to advancing health equity as a primary goal of the One Care program. IC has been pressing for increased investment in value-based purchasing interventions that will reduce health disparities and advance health equity. The Council has successfully worked with MassHealth to build health equity requirements into One Care 2.0 contracts. One Care plan accountability to reducing health disparities and advancing health equity for people subject to racism, xenophobia, linguistic isolation or facing bias due to LGBTQIA status or transgender identity or bias due to a history of mental health diagnosis or trauma or substance use disorder.

In addition to persons within this broad population, persons with mental health and/or substance use disorder (SUD) should be included as a health equity priority population. This is important on many levels. First and foremost, however, this is a human rights issue to eliminate violations (restraints, incarceration etc.) experienced by people with mental health diagnosis and/or SUD, and disparities in access to these behavioral health services by minority populations.

The Council supports recommendations on health equity contained in the response by DAAHR, Justice in Aging, and Community Catalyst. We also want to highlight the importance of community health workers (CHWs) whose services are contracted by plans rather by plans creating an internal CHW system. This duplication of systems has the potential to lead to conflicts of interest for CHWs who, rather than working for the community, will have to be aligned with the priorities of the plan which may not be in the best interest of the member.

This allegiance to the plan over the community is also true for peer services. Peers should primarily be contracted from CBOs such as Recovery Learning Communities. Plans should develop value-based purchasing models that focus on outcomes rather than on FFS payment rewards.

<u>To move the needle on outcomes, CMS should require all D-SNPs to:</u>

1. Shift from FFS payment structures to value-based purchasing methods. States such as Minnesota have built into the contracting requirements health plan health equity projects that can be measured for quality.[1]
2. Have a public facing living Culturally and Linguistically Appropriate Services (CLAS) plan on file that outlines how the entity will incorporate the principles and practices outlined in the Massachusetts Department of Public Health CLAS Guide.[2]
3. Provide a roadmap to advance health equity that includes specific actions they will take to advance health equity and reduce health disparities.
4. Have a budget that includes a line item with cost estimates for providing reasonable accommodations to employees and populations they serve.[3]

Quality Measurement

CMS should build health equity quality measures into all D-SNP contract requirements. <u>NCQA</u> <u>Measuring Quality Improving Healthcare</u> has noted that high-quality care is equitable care, no quality without equity and equity is to be built into all NCQA programs.[4] The Institute for Healthcare Improvement, Improving Health Equity: Assessment Tool for Healthcare Organizations, is one of a number of instruments available for states to use to advance health equity. Improving health equity data collection must include the six HHS questions on disability: "The six-item disability standard represents a minimum standard.........Additional questions on disability may be added to any survey as long as the minimum standard is included."[5]

CMS should follow the lead of the National Institute for Health (NIH), which is taking active steps to increase the integration and prioritization of health outcome goals in adults with disabilities and multiple chronic conditions to drive attainment of health equity, particularly among working age adults within ethnic and minority populations. The shifting priorities of NIH is based on data showing that the number of persons with multiple chronic conditions is increasing among persons living below the poverty limit and experience higher degrees of morbidity and mortality due to higher incidences of multiple chronic conditions in ethnic minority populations.[6]

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[1] http://www.ihi.org/communities/blogs/how-to-know-where-to-go-on-health-equity

[2] "Making CLAS Happen: Six Areas for Action," Mass.gov, accessed February 2, 2022, https://www.mass.gov/lists/making-clas-happen-six-areas-for-action.

[3] "Disability Inclusion Toolkit," Ford Foundation, accessed February 2, 2022, https://www.fordfoundation.org/media/5800/ford-disability-inclusion-toolkit-1.pdf; "Reasonable Accommodations and Budgeting for Inclusion," Mobility International USA, accessed February 2, 2022, https://www.miusa.org/resource/tipsheet/budgeting; Irene Bowen, Ada One. "Renewing the Commitment: An ADA Compliance Guide for Nonprofits," The Chicago Community Trust, accessed February 2, 2022, https://cct.org/wp-content/uploads/2015/08/2015ADAComplianceGuide.pdf.

[4] https://www.ncqa.org/about-ncqa/health-equity/NCQA

[5] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=54https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html.

[6] "Health Care Models for Persons with Multiple Chronic Conditions from Populations that Experience Health Disparities: Advancing Health Care towards Health Equity," National Institute of Health Grant, accessed February 2, 2022, https://grants.nih.gov/grants/guide/pa-files/PAR-22-092.html. Establishing adequate quality measures for HCBS should be a priority.[1] It is essential that data collected include racial, ethnicity, linguistic diversity and LGBTQ + and geographic diversity. Consistent with the Long-Term Services and Supports State Scorecard 2020 edition,[2] MassHealth should deploy both NCI-AD and HCBS CAHPS surveys.[3] Many states deploy both measurement instruments.[4]

It is important to deploy both instruments, because the NCI-AD:

1. Focuses on member outcomes of care while HCBS CAHPS focuses on member experience.[5]
2. Covers more domains than CAHPS-HCBS services.
3. Provide on-going technical assistance, includes stakeholder engagement in education and standardizes surveyor training.

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[1] Debra J Lipson. "Person-Reported Outcome Measures for Home and Community-Based Services," HCBS Quality Measures Issue Brief (Nov 2019). https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-qualitymeasures-brief-2-person-reported-outcome.pdf

[2] "Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers," AARP Public Policy Institute, accessed February 2, 2022, http://www.longtermscorecard.org/~/media/Microsite/Files/2020/LTSS%202020%20Reference%20Edition%20PDF%20923.pdf.

[3] "About," National Core Indicators for Aging and Disabilities, accessed February 2, 2022, https://nci-ad.org/; "Overview: CAHPS Home and Community Based Services Survey," Medicaid.gov, accessed February 2, 2022, https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/cahps-home-andcommunity-based-services-survey/index.html.

[4] "State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports," Medicaid.gov, accessed February 2, 2022, https://www.medicaid.gov/state-overviews/scorecard/state-use-patientsurveys-ltss-beneficiaries/index.html.

[5] "Comparison of NCI-AD Adult Consumer Survey and HCBS CAHPS Survey," National Core Indicators of Aging and Disabilities, accessed February 2, 2022, https://nci-ad.org/images/uploads/FINAL_NCIAD_and_HCBS_CAHPS_Comparison_2021.pdf

Standardize Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments

We applaud CMS to require SNPs to collect social determinant of health (SDOH) data, however SDOH data collection is not enough. It is equally, if not more important, that health plans collect data that addresses the intersectional social determinant and the HCBS needs of persons with disabilities.

To illustrate through examples:

1. A person's food insecurity may be caused by the inability to access transportation because the individual does not have the wheelchair needed to go to the supermarket or the person's inability to access a food pantry located in the basement of a religious institution such as a church or synagogue.
2. A person may be facing energy instability because of high heating and cooling costs resulting from the person's inability to regulate their internal body temperature.

3. A person's housing search might be exacerbated not only by past felony, but also a mental health or substance use history or physical disability needing accessible housing unit.

Integrated Member Materials

1. Members should receive unified communication and materials that speak cohesively about full program scope from the member perspective.
2. Ensure state protections for linguistic and cultural competence and accessibility and communication access accommodations beyond Medicare marketing requirements.
3. Provide states with clear discretion and authority to ensure state-specific policy and requirements are included in integrated materials.

Ombudsman Services

We believe that CMS must continue to fund MyOmbudsman program. MyOmbudsman has proven to be a vital lifeline for One Care members with the most acute needs. Seven states currently operate ombudsman programs, assisting thousands of dually eligible individuals, the vast majority of whom are disabled or elderly. Demonstration enrollees, particularly those under 65, typically have highly complex medical conditions and require access to a wide variety of providers, equipment, and services to live healthy and independent lives.

However, while several state ombudsman programs are run by non-profits, MyOmbudsman is unique in being an Ombudsman program run by people with disabilities. MyOmbudsman's overseeing organization, the Disability Policy Consortium (and one of the members of DAAHR) is a disability rights organization with a workforce that is 75% disabled and an entirely disabled leadership team. The program also trains all its employees in disability history and culture to ensure that all staff have a unique level of cultural competency on disability issues. As a result, the staff ombudsman has the lived experience to understand what members are going through, to build the trust with members that is vital for dealing with issues that are frequently intimate and emotionally intense, and the knowledge of disability necessary to both make the often-complex healthcare process accessible to members and to propose effective accommodations to meet member's needs.

Because of its successes serving One Care enrollees, MyOmbudsman has expanded twice, first in 2018 to serve members of MassHealth's ACOs and MCOs, and in January of this year to cover all MassHealth members regardless of plan. However, it would be a serious mistake to imagine that the program could keep going without federal support. Federal funding from CMS accounts for over one third of the program's budget, and this represents an undercount of the extent to which the program is serving demonstration members. As of 2021, a majority of MyOmbudsman's cases were working with MyOmbudsman's One Care members. This means that MassHealth is arguably already cross subsidizing the program's ability to serve the demonstration program.

The loss of federal funding would seriously imperil the continued existence of the program. The success of MyOmbudsman has been built in significant part on the fact that the three-way contract requires plans to cooperate with MyOmbudsman. From the proposed rule, it is not obvious that this relationship would continue under a D-SNP structure – D-SNP autonomy from MyOmbudsman could substantially undermine the program's ability to be effective.

Destabilizing the FAI will also lead to the loss of federal funding to support the federally required State Health Insurance Assistance Program (SHIP), known in Massachusetts as Serving Health Insurance Needs of Everyone (SHINE). SHINE has assumed an increased level of responsibility under the FAI in response to the population's complex needs. SHINE has been an invaluable partner to disability advocates and dually eligible individuals by providing people with access to an impartial source of information about their options.

Implications for Consumers

We have valid reasons for opposing the elimination of the FAI. One Care plans will be downgraded from MMPs to FIDE-SNPs, emulating the structure of the Massachusetts FIDESNP Senior Care Options (SCO) plan.

The One Care program was designed to assist achieve independent living and recovery goals in the community by providing whole person-centered care to the high costing, high risk 21-64 age populations. SCO, designed for assisting frail elders remain safe in their homes. One Care provides transportation services that support independent living and recovery, SCO does not. One Care plans are required to provide flexible service opportunities to members. SCO does not.

Equally concerning for the IC, however, is the diminished voice of the consumer under the SCO model. The SCO consumer advisory committee, while meeting the expectations of the proposed rule change for consumer engagement, is far less robust than the One Care IC (IC). MassHealth creates the SCO committee agenda with minimal engagement or participation of SCO enrollees. In contrast, One Care enrollees/consumers drive the IC agenda. The One Care IC is instrumental in advancing improved network adequacy requirements, readiness requirements and contract requirements.

Without the three-way contract and aligned funding stream, MassHealth will not have the resources needed to support the IC at current, robust levels and to evolve the care delivery system for dually eligible individuals to respond to their needs and advance their independent living and recovery goals. Perhaps one of the most important levers that consumers have been to use under the MNP demonstration has been the contract renewal process. **Through the contract renewal process disability advocates have been able to strengthen the readiness review process, strengthen contract requirements, strengthen oversight and increase consumer voice.**

Clear Definitions Needed Increase Trust in MA Plans

The recommended rule changes do not include actions to be taken by CMS and states to increase trust in Medicare Advantage (MA) plans among dually eligible individuals 21-64. "Care coordination," "person-centered care," and "integrated care" have become common terms used in healthcare policy and yet a satisfactory definition and measurement of quality in each domain remains elusive. To gain trust and increase enrollment of persons with disabilities, we need clearer definitions of these terms. For example, what protection term place to protect consumers from conflict-of-interest care coordination? Is it allowable under CMS regulations for care planning and coordination to be conducted by the insurer side of the health plan rather than being conducted by providers and other members of an individual's care team who understand and will advocate for the needs of the consumers?

Network adequacy

DAAHR and other letters address the network adequacy concerns of the disability committee. However, the IC exec team believe it's important to note how critical **single case agreements** are to the sustainability of One Care. While we appreciate the administrative burden single case agreements can cause, we believe this burden is offset by the number of enrollees who, if not for single case agreements would not be enrolled in One Care. **Continuity of care** and access to specialized services is essential to persons with complex needs and chronic conditions such as individuals living with sickle cell anemia, and others dual eligibles with multiple morbidities that require the attention of multiple specialists and subspecialists, specialty hospitals and homebased care.

We urge CMS to strengthen individual access to single case agreements to reduce harm or potential harm and strengthen the D-SNP model.

Lower Beneficiary Cost-Sharing at The Pharmacy Counter

We applaud steps taken by CMS to reduce out-of-pocket expenses, but we do not believe the proposed change goes far enough. One Care has no out-of-pocket prescription or over-the counter medication costs for members. The Massachusetts Medicaid plan, MassHealth, pressed hard for this contract requirement input in large part to drive up enrollment of dually eligible individuals in One Care. In surveys of One Care enrollees, no out-of-pocket expenses is identified as one of the top three reasons why enrollees remain in One Care.

State Authority Over Enrollment

We believe that state Medicaid agencies should operationalize all enrollment functions. Having all enrollment functions performed by the state ensures increased seamless integration of contract requirements and smooth on-boarding of dually eligible individuals into One Care plans. Research conducted by the state and by disability advocates provide an evidence base that increased satisfaction is tied to member understanding of the One Care model and relationship with their care team.

However, **states should not be permitted to passively enroll dual eligibles into MMPs or DSNPs.** In addition to states not being permitted to passively enroll dual eligibles, dually eligible should of the right to disenroll or change plans on a monthly basis**. (See DAAHR section on enrollment)**

The IC has continued to oppose passive enrollment. We understand the importance of achieving scale to maintain sustainability. However, we believe MAs can achieve scale by providing quality products. **MA quality goals, not market share, should drive enrollment.** Increased scale has not correlated with improved service. The Council appreciates MassHealth's position and works constructively with the office on passive enrollment concerns but believe consumer choice and control should drive enrollment, not managed care growth targets.

We believe that churn will subside as members receive the levels of consistent services they require. When churn occurs due to dissatisfaction, we believe this level of activity is necessary to protect consumers from harm including against those with complex physical or mental health needs. We recognize that churn is a major challenge for plans and the state, and consequently work with the state to create strategies that will reduce the disenrollment/reenrollment cycle due to changes in income and other causes. The state has conducted research that shows a strong correlation between One Care enrollee understanding of the care model and satisfaction.

A Commitment to Evolve the FAI Beyond Today's Achievements

We believe that Massachusetts is on a journey to evolve the One Care model and to offer future innovations for CMS to consider and disseminate. This is a compelling journey for the IC on behalf of all persons with disabilities in Massachusetts. We must continue since we know that One Care is far from perfect, and we have a moral obligation to get this right. Moving away from the FAI will not help our cause.

We disagree with any messaging asserting that the D-SNP industry has matured to the point where there is no longer a need for demonstration projects. To the contrary, One Care is needed more than ever as a counterbalance to the enormous growth in the industry.

Our experience in Massachusetts makes it clear that One Care enrollees have not yet achieved the basic protections of consumer rights. We will continue to work with One Care plans to secure adequate and appropriate information, care planning, whole person-care coordination, appeals, and grievances procedures. We have also not yet realized the consistent collection of data and information on a regular basis to share in a transparent and public-facing way.

At multiple DAAHR virtual forms, One Care enrollees have increasingly shared stories and voiced concerns about non-existent care plans, the inability to identify or contact care team point persons, and decreased access to needed durable medical equipment and long-term services and supports (LTSS), including Personal Care Attendant (PCA) services.

In response to these complaints and trends in One Care plan practices identified by MassHealth and the One Care IC, MassHealth has convened a task force with the purpose of realigning One Care to its original whole, person-centered model committed to operationalizing independent living and recovery principles, and rebalancing priorities in spending to address upstream causes of preventable emergency department visits and hospitalizations.

MassHealth has contracted with Deloitte Innovation Solutions and re-engaged Robin Callahan, former Deputy Director of MassHealth and designer of the One Care program, to facilitate the task force. In addition to including representatives from MassHealth, the task force includes representatives from the three One Care plans, members of the One Care IC, DAAHR, and providers. We believe actions taken by MassHealth represent the strength of One Care as a demonstration and believe the loss of demonstration status would erode D-SNP plan commitment to change and take away resources needed by MassHealth to invest in the ongoing oversight and evolution of the One Care program.

Thank you very much for the opportunity to respond to the RFI. Given the magnitude of change being proposed, we also ask for the opportunity to meet with members of CMS leadership to discuss the potential rule changes and their impact on the One Care program.

Sincerely,

Dennis Heaphy dheaphy@dpcma.org
Crystal Evans empowerenergy@icloud.com
Paul Styczko p.styczko@comcast.net
Jeff Keilson jkeilso@advocates.org

Disability Advocates Advancing our Healthcare Rights

March 7, 2022

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS–4192–P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via www.regulations.gov

Dear Sir/Madam,

Disability Advocates Advancing our Healthcare Rights (DAAHR) is writing to request CMS to permit Massachusetts and any other state implementing a Financial Alignment Initiative (FAI) the opportunity to continue to operate as a Medicare Medicaid Plan (MMP), either by maintaining their demonstration status or through the establishment of MMP status as a permanent higher tier of integration above the three types of Dual Eligible Special Needs Plans (D-SNP) in the proposed CMS rule. We believe that the Massachusetts/MassHealth One Care 2.0 proposal provides the best health care, integrated services, and immediate and long-range health outcomes for people with disabilities. CMS's efforts to raise the national standard of care for dually-eligible people with disabilities is commendable, but this should not be accomplished by lowering standards for those persons with disabilities in Massachusetts and other FAI states.

DAAHR is a statewide coalition of disability, healthcare, and legal services organizations formed in 2011 to proactively engage with MassHealth in shaping healthcare innovations made possible under the Affordable Care Act, including the FAI. We believe it is important to strengthen D-SNPs across the country and to set a high bar for D-SNP oversight and to support ongoing engagement by consumers in the development and implementation of integrated care plans. But we are deeply concerned that the CMS plan to do away with the FAI demonstrations will undo nine years of innovative work achieved through collaboration between disability and health care advocates, MassHealth, CMS and the health plans operating in One Care.

Dissolving the three-way contract will erode the foundation of One Care in Massachusetts for over 28,000 enrollees by destabilizing shared Medicare-Medicaid arrangements and the fully aligned financing that provides One Care plans with revenue. Under this arrangement, One Care enrollees have been able to access flexible services to support their ability to live healthier and more meaningful lives in the community. The proposed rule would default to a two-way contract arrangement, undermining the financial alignment achieved under the three-way contract and de-incentivize D-SNP plans from rebalancing spending priorities that have given emphasis to expanding home and community-based services and investment in upstream social services and supports. Long term services and supports are critical to thousands of low-income enrollees who often live in destabilized situations.

We wish to underscore that those served by One Care are typically highly medically-complex persons with significant disabilities, which may include, among many, people with I-DD, spinal cord injuries, ALS, ABI, SUD, a wide range of mental health conditions (PTSD, anxiety, schizophrenia, bipolar, etc.), MS, rare health conditions, and chronic health conditions including COPD, diabetes, and asthma. Many enrollees also present with multiple health needs. In addition, various social determinants of health—including unstable housing, racism, obesity, and food insecurity—challenge many enrollees. This fundamental setting is the one from which any changes to the program must be considered. Please consider the following enrollee profile as exemplar of what One Care supports.

A 38-year-old woman who developed a spinal cord injury from an infection, with the aid of an LTSS coordinator from an independent living center supported by a One Care plan, was assisted to find affordable and accessible housing. She enrolled in the PCA program, which gave her great independence, allowing her to flourish in the community as an advocate. She'd previously, in the fee-for-service model, only had limited, ineffective home health care. Her health was uncertain and interactions with health care systems frequent. She's also received ongoing support for trauma and mental health conditions from her health plan. She unabashedly ties her health, independence, and wellbeing to integrated care as delivered within One Care.

We believe the proposed CMS rule change puts the interest of the D-SNP industry ahead of dually-eligible individuals by undermining protections which advance health equity by infusing the consumer voice in all aspects of oversight, innovations, and partnerships. The proposed rule threatens the unique features of the One Care program including the consumer-led One Care Implementation Council (IC) and singular ombudsman services (MyOmbudsman) provided to One Care members by a disability organization contracted through MassHealth.

Destabilizing the current financial arrangement under the FAI will also lead to the loss of federal funding to support the federally-required State Health Insurance Assistance Program (SHIP), known in Massachusetts as Serving Health Insurance Needs of Everyone (SHINE). SHINE has assumed an increased level of responsibility under the FAI in response to the population's complex needs. SHINE has been an invaluable partner to disability advocates and dually-eligible individuals by providing people with access to an impartial source of information about their health plan options.

The recommended rule changes also do not include needed actions to increase trust among dual enrollees ages 21-64 in Medicare Advantage Plans. Terms such as care coordination, person-centered care, and integrated care have become common in healthcare policy and yet, because satisfactory definition and measurement of quality in each domain remains elusive, they sometimes seem as much aspirational as reality. To gain trust and increase enrollment of persons with disabilities, clearer definitions of these terms are needed. We are not certain any of these goals include measures to protect consumers from conflict-of-interest in care coordination. Care planning and coordination conducted by the insurer side of the health plan may be permitted under CMS rules, instead of care planning and coordination conducted exclusively by an enrollee and their care team, the people who understand and will advocate for the enrollee's needs. Members' trust in their plans and their actual health will hinge on these matters.

MMP compared to SCO in Massachusetts

As already indicated, we have numerous reasons for opposing downgrading One Care from an MMP model to a FIDE (fully integrated care for dual-eligibles) SNP. Concerns beyond those already mentioned are exhibited by a simple comparison between One Care and the Massachusetts FIDE-SNP Senior Care Options (SCO) plan. One Care was designed to support persons with disabilities to achieve independent living and recovery goals in the community by providing whole person-centered care to people ages 21-64 with complex care needs that often are high cost. SCO was designed to assist frail elders to remain safely in their homes. One Care provides transportation services that support independent living and recovery, SCO does not. One Care plans are required to provide flexible service opportunities to members. SCO does not. One Care also provides cuing and monitoring for PCA services and home modifications. And One Care has the LTSS coordinator, compared to the Geriatric Services Coordinator for SCO. Critically, the LTSS coordinators' work is rooted in independent living and recovery—this position must absolutely be sustained for One Care.

Further significant differences between the functionality of the two plans exist, and we have asked MassHealth to produce a document comparing the two plans side by side in order to highlight these structural differences.

Also, consumer voice, overall, is far more diminished in the SCO model compared to One Care. The SCO consumer advisory committee, while meeting the expectations of the proposed rule change for consumer engagement, is far less robust than the One Care Implementation Council (IC). The SCO committee agenda is created by MassHealth with minimal engagement or participation of SCO enrollees. In contrast, One Care enrollees/consumers drive the One Care IC agenda. The One Care IC is instrumental in advancing improved network adequacy requirements, readiness requirements, contract requirements, and accountability.

Without the three-way contract and aligned funding stream, MassHealth will not have the resources needed to support the One Care IC at current, robust levels and to evolve the care delivery system for dually eligible individuals to respond to their needs and advance their independent living and recovery goals.

Strengthening the MMP model

One Care is not perfect, but this does not mean the program needs to be wound down. It provides needed comprehensive care and services for people with disabilities that D-SNP plans would not provide, regardless of any claims to the contrary by the healthcare industry. Given the enormous growth in the D-SNP industry, with large national for-profit entities such as United Healthcare entering the Massachusetts marketplace, there is a greater need than ever for plans to have the kind of accountability, transparency, and performance improvement levers of MMP plans.

Over the last several years, we have seen a worrying tendency for One Care plans to drift away from the highly member-centric, independence-driven approach the demonstration began with towards a more standard health insurance model. It has become clear that significant advancements are still required in the areas of consumer rights, care planning, whole-person care coordination, appeals and grievances procedures, and the consistent collection and dissemination of data.

However, because of the conditions in the three-way contract, and the oversight mechanisms built into the program, we have had the means to pull the program back towards its intended focus. The Implementation Council has been able to hold plans accountable and continues to push for greater data collection. Significantly, the council also holds town halls where enrollees can share their concerns on the care and services they receive. When members began being regularly denied for services that used to be consistently covered, staff from the My Ombudsman program have been able to step in and negotiate with plans to get coverage restored.

Perhaps most importantly, the program was built from the start with an expectation that it would be highly member centric and transparent. This has led to a consumer base that regularly insists, with a loud, engaged voice, that they receive the care they were promised. At multiple DAAHR forums, One Care enrollees have shared stories and voiced concerns about nonexistent care plans, the inability to identify or contact care team point persons, decreased access to needed durable medical equipment and long-term services and supports (LTSS), including Personal Care Attendant (PCA) services. In response to these complaints and trends in One Care plan practices identified by MassHealth and the One Care IC, MassHealth has convened a task force with the purpose of realigning One Care to its original whole person-centered model committed to operationalizing independent living and recovery principles and rebalancing priorities in spending to address upstream causes of preventable emergency department visits and hospitalizations. It has contracted with Deloitte Innovation Solutions and re-engaged Robin Callahan, former Deputy Director of MassHealth and designer of the One Care program, to facilitate the task force. In addition to including representatives from MassHealth, the task force includes representatives from the three One Care plans, members of the One Care Implementation Council, DAAHR, and providers. This is a collaborative model embraced by all participants.

We believe these actions taken by MassHealth represent both the strength of One Care as a demonstration and the need for that status to continue. In the grand scheme of healthcare policy, the 8.5 years that One Care has been operational is a fairly brief time span. These demonstrations were launched in significant part to find out what it would take to actually provide people with disabilities the kind of healthcare that would enable them to live genuinely independent lives. Discovering the answer to that question will have massive implications for people with disabilities not just in Massachusetts but across the country. Cutting off demonstration status now would completely undermine that process. It would not only de-incentivize plans to engage with this process and commit to positive change, it would as well take away resources needed by MassHealth to invest in the future of One Care at the very moment they were needed most. This is a truly pivotal moment for people with disabilities!

Maintaining the MMP Option

We request that the proposed rule changes include more robust requirements of MMPs to strengthen their capacity to drive innovation and integrated care delivery and advance sustainability.

Massachusetts is the only state in the country with a fully-aligned duals program specifically designed to address the uniquely complex needs of persons ages 21 to 64. As noted earlier, this is a population defined by a highly heterogeneous set of complex medical conditions (including mental health, intellectual and developmental disabilities, physical disabilities, brain injuries, rare health conditions, chronic health conditions). Broadly speaking, this is a significantly wider set of conditions than is typical among seniors, and consequently requires more benefits flexibility, deeper and broader provider networks, and robust ombudsman and appeal structures to ensure that each individual person is able to access the unique combination of HCBS, treatments, and durable medical equipment that will enable them to maximize their independence, health, and wellbeing. More than this, however, younger disabled people differ dramatically from seniors in their preferences and goals. The ability to travel, volunteer, socialize, pursue an education, and especially to work are tremendously valued by younger people with disabilities, and achievements of these ends are a metric of healthcare quality significantly relevant for this population. Younger people with disabilities also have very strong preferences for where they live— overwhelmingly they want to be not only in the community but among people of varied ages and disability statuses. A great success of One Care has been in helping address social determinants of health, prioritizing person-centered planning and independent living goals, and maximizing care flexibility.

The prioritization of persons with disabilities in One Care made possible new opportunities for envisioning how to achieve the triple aim of the Affordable Care Act of enhancing the experience of care for the person, improving the health of populations, and reducing the per capita cost of healthcare. People with disabilities and advocates, in listening sessions held by MassHealth and DAAHR, conveyed a high degree of distrust of the medical system because of systemic and individual bias, stigma, and discrimination experienced by persons with disabilities. There was strong demand for a shift from the toxic medical model to a whole person-centered care model—which MassHealth heard and responded to in its design of One Care, often working closely with advocates.

The most recent research and report by RTI on One Care identified neither losses nor Medicare savings over the first three years of the demonstration. The data from year three also suggested that plans are making progress to reduce hospitalizations and that over the course of all three years enrollees had a lower probability of long-term stays in a nursing facility. From the perspective of disability advocates, this reduction in long-term stays in nursing facilities is a significant success—the more so with the tragic backdrop of thousands of deaths from Covid in facilities in Massachusetts. It is not hyperbole to say that One Care saved the lives of a significant number of disabled people. This program deserves the chance to continue to innovate and build on these successes—people with disabilities must continue to have a growing and dynamic One Care program!

Enrollment

We believe firmly all enrollment functions should be operationalized through state Medicaid agencies. Having all enrollment functions done by the state will ensure increased seamless integration of contract requirements and dual beneficiary on boarding into plan. Research conducted by the state and by disability advocates show that member understanding of the one model and relationship with their care team leads to increased satisfaction and improved outcomes. Centralized enrollment facilitates active member engagement and ensure that accurate and comprehensive materials are distributed.

Advocates specifically support the requirement that states preserve the rights of dually eligible people to actively enroll in plans, whether they are MMPs or D-SNPs. Conversely, both DAAHR and the IC have specifically opposed passive enrollment from the start of One Care. We understand the importance of achieving scale to maintain sustainability. However, we believe MAs can achieve scale by providing quality products. **Quality, not market share goals** of MAs should drive enrollment, particularly since increased scale has not always correlated with improved service. While we believe that One Care generally provides very high-quality care, it is not the right choice for every dually eligible person, and being passively enrolled without their consent may expose members to disruptions in care when, for instance, critical providers now become out-of-network. DAAHR is increasingly working with MassHealth as they shape passive enrollment practice to ensure it can operate without harm to members, but more changes are needed before we would be willing to endorse the practice.

Finally, with regard to enrollment, we believe that and disenrollment should be permitted on a monthly basis. We recognize that churn is a major challenge for plans and the state, and are willing and able to work with the state and with plans to develop strategies to reduce it. However, churn has two significant causes, disenrollment and dissatisfaction, neither of which would be properly addressed by locking members into plans for extended periods Firstly, a significant part of churn is involuntary and due to disenrollment, as members eligibility fluctuates due to changes in income or other eligibility criteria. Here, we believe the solution is for plans to work with advocates to develop policies that will smooth members eligibility and allow them to remain in the plan during short-term income fluctuations, thus avoiding the disruption that cycles of losing and regaining coverage can cause to both members and plans. Meanwhile, where voluntary disenrollment occurs, we believe its primary cause is members' dissatisfaction with the care they receive. We believe this level of activity is necessary to protect against consumer harm, including against those with complex physical or mental health needs. If members are denied critical services, or feel they have been mistreated by plan personnel, they may need to switch to another plan or exit managed care altogether in order to access treatment that supports their well-being. While we are committed to working with MassHealth to find ways to minimize the impact of such churn, the fundamental solution to the problem, as with the question of active vs. passive enrollment, must be to raise the standard of care provided to members.

Medicaid managed care capitation rates

We believe that Medicaid managed care rates need to be actuarily sound, population appropriate, and include adjustments for social determinants of health such as housing and food insecurity, among others. We also believe it is critically important that oversight of managed care plan capitation rates be transparent, actuarily sound, and tracked over time to ensure that plan dollars are aligned with increased utilization of not only medical benefits, but HCBS, LTSS, and diversionary services.

The Necessity of Ombudsman Services and the Implementation Council

Arguably the single most important factor in the success of One Care is that it was not only initially built with significant input from the community it was designed to serve, it was designed with the intent that that input would continue. Two of the most critical aspects of that design were the One Care Implementation Council and what was originally the One Care Ombudsman office, which became My Ombudsman in 2018. These two entities have ensured not that One Care would always perfectly serve its members— such an outcome is likely impossible for any health plan, let alone one serving such a complex population— but that when One Care members encountered difficulty getting the care they need, they would have ready access to both a member-led forum where they could raise issues at a systemic level and to deeply culturally competent assistance that would work one-on-one with them and their plan to resolve their needs. Both entities rely on CMS funding for their existence, and we believe that both would be imperiled if the proposed CMS rule was adopted in its present form.

The Implementation Council (IC) was developed through collaboration between the disability community and MassHealth leadership at the start of the MMP demonstration. It plays a key role in monitoring access to healthcare and compliance with the American with Disabilities Act, tracking quality of services, providing support and input to the Executive Office of Health and Human Services in Massachusetts, and promoting accountability and transparency. Unlike the Consumer Advisory Committees contemplated in the rule, which operate on a plan-by-plan basis with limited public access and primarily operating in an advisory context, the IC is a public body focused primarily on accountability, and one of the few places anywhere in the country where individuals with disabilities, state Medicaid officials, and plan representatives sit as equals as part of the same body. The IC has advised EOHHS on One Care, the Duals Demonstration 2.0, and related dual eligible matters, including actively soliciting input from stakeholders on those topics and giving members the ability to directly ask questions of key stakeholders. It directly reviews One Care plan quality, including by examining issues raised through the grievances and appeals process, receiving regular reports and data from MyOmbudsman, and examining access to services (medical, behavioral health, and long-term services and supports) in One Care. It has also participated in the development of public education and outreach campaigns related to One Care, the Duals Demonstration 2.0, and related dual eligible matters.

The IC Executive Team has been engaged with MassHealth in strengthening plan readiness requirements, tightening contract language, and providing input on selection of One Care plans. A majority of its members and executive team are mandated to be either MassHealth enrollees or family members of MassHealth enrollees, ensuring that its priorities are always driven by the enrollee community, but the fact that it also includes MassHealth and plan representatives means it is also a venue for substantive discussions about the direction and health of the program. The IC brings in external experts on topics including care planning and care coordination, quality measurement development, food-as-medicine, homelessness, and Substance Use Disorder, ensuring that those discussions are maximally informed. In short, unlike the member engagement committees across so many programs serving low-income or marginalized people that are often little more than box-checking exercises, the Implementation Council plays a meaningful role in the actual governance of the program. As a result, One Care itself operates far more like a partnership than a topdown government program, and members of the Massachusetts disability community are genuinely invested in One Care's success, as is proven every time hundreds of them turn out to our One Care public forums.

MyOmbudsman, meanwhile, has proven an absolutely vital lifeline for the One Care members who have the most acute needs. Currently seven states have operating ombudsman programs, assisting thousands of dually eligible people, the vast majority of whom are disabled or elderly. Demonstration enrollees, particularly those under 65, typically have highly complex medical conditions and require access to a wide variety of providers, equipment, and services in order to live healthy and independent lives. However, accessing these services requires understanding often obscure rules and policies, and navigating a tangled web of relationships between plans, providers, and state Medicaid agencies–often all while dealing with mental health diagnoses or cognitive disabilities, not speaking English fluently, or being on the wrong side of the digital divide. Ombudsman programs therefore provide a crucial helping hand to ensure that demonstration members can access in practice the benefits they are entitled to in theory. They decode arcane plan rules into plan language, negotiate with plan staff to find equitable solutions that work for everyone, and resolve emergency disruptions to care, averting potentially life-threatening consequences such as loss of access to oxygen services.

However, while several state ombudsman programs are run by nonprofits, MyOmbudsman is unique in being an Ombudsman program that is actually run by people with disabilities; the overseeing organization, Disability Policy Consortium (one of the members of DAAHR) is a disability rights organization with a 75% disabled workforce and entirely disabled leadership team. The program also trains all of its employees in disability history and culture, ensuring staff have a unique level of cultural competency on disability issues. As a result, ombudsman have the lived experience to understand what members are going through, to build the trust with members that is vital for dealing with issues that are frequently intimate and emotionally intense, and the knowledge of disability necessary to both make the often-Byzantine healthcare process accessible to members and to propose effective accommodations to meet members' needs.

Being situated in the disability community has also enabled My Ombudsman to innovate. It is the only health care ombudsman organization of any kind in the U.S. to have a Deaf ombudsman on staff. As a result, it has not only been able to offer native language services in ASL to a Deaf community that is often profoundly underserved by a healthcare system that communicates primarily in written and spoken English, but to conduct extensive outreach to the Massachusetts Deaf community about their healthcare rights and the services available through One Care, and even to advise partner organizations, MassHealth itself, and ombudsman programs in other states on how to better serve the Deaf community. Before the COVID-19 pandemic, MyOmbudsman staff were conducting regular in-person office hours at homeless shelters, immigrant services programs, and other organizations serving highly marginalized individuals, and these are slated to resume when it is safe to do so. The program has also now brought on a full-time data analyst in order to leverage the data the program generates to inform MassHealth, the demonstration plans, and the public at large about emerging issues of concern within the program. Meanwhile, member satisfaction surveys consistently show between 85 and 95 percent of those served by the program are satisfied by the service they receive from MyOmbudsman, with nearly 100% reporting feeling respected throughout the process and that plan staff were knowledgeable.

Because of its successes serving One Care enrollees, the program has actually expanded twice, first in 2018 to serve members of Masshealth's ACOs and MCOs, and in January of this year to cover all MassHealth members regardless of plan. However, it would be a serious mistake to imagine that the program could simply keep going without federal support; funding specifically from CMS accounts for over a third of the program's budget, and this actually represents an undercount of the extent to which the program is serving demonstration members; as of 2021 a majority of MyOmbudsman's cases were working with One Care's members, meaning that MassHealth is arguably already cross-subsidizing the program's ability to serve the demonstration program. The loss of federal funding would seriously imperil the continued existence of the program. Moreover, the success of the program has been built in significant part on the fact that the three-way contract requires plans to cooperate with MyOmbudsman. From the proposed rule, it is not obvious that this relationship would continue under a D-SNP structure, which could substantially undermine the program's ability to be effective.

In short, both the Implementation Council and MyOmbudsman as programs have been highly effective at giving members a sense of ownership over the program, a public forum to engage with MassHealth stakeholders, the benefits of clear oversight on their quality of care, and a free, culturally competent source of assistance in accessing the benefits that they need to live healthy and independent lives. Both programs combined consume a very small quantity of federal funds but would be significantly harmed if not outright discontinued by the discontinuation of those funds, let alone the withdrawal of their respective statuses under the three-way contract. Rather than potentially eliminating these programs by doing away with the demonstration, we would instead urge CMS to consider using them as a template for genuinely member-driven Implementation Councils and Ombudsman Programs in other states, whether as part of a MMP or D-SNP structure.

Consumer appeals

The proposed regulations do not go far enough in providing for integrated benefits and an integrated appeal system. 42 CFR 422.634 continues to look at services as Medicare services or Medicaid services with separate standards of review and separate appeal paths. 42 CFR 422.634 should be amended to more fully integrate the appeals process. The current three-way contract with the Massachusetts One Care plans is illustrative of a more integrated appeals process. This contract provides that after the initial internal appeal, traditional Medicare A & B services are automatically sent to the IRE while MassHealth only services (such as PCA, dental) may be appealed to the MassHealth Board of Hearings. (2.12.1.2.4.) 42 CFR 422.634 is consistent with this. But the three-way contract also recognizes that some services are covered by both programs. It provides that:

2.12.1.2.4.4. Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the Contractor, and an Enrollee may also file a request for a hearing with the Board of Hearings. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of theEnrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

The three-way contract also integrated the criteria to review medical necessity, something that the D-SNP regulations do not do. It provides: "2.12.3.1.3 The CMS IRE must apply both the Medicare and MassHealth (which shall be considered supplemental services) definition for Medically Necessary Services when adjudicating the Enrollee's Appeal for Medicare and supplemental services, and **must decide based on whichever definition, or combination of definitions, provides a more favorable decision for the Enrollee**."

Also, the proposed regulations do not adequately set out what should be included in an integrated organization determination notice. 42 CFR 422.631 should be amended to require notices to also include citations to the regulations supporting the decision; the right to be provided upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the decision, and how to request that information; the right to submit new evidence in support of the appeal; what coverages will be considered by the IRE and what will be considered by the Medicaid Board of Hearings; make it clear that both the IRE and BOH appeal paths are available to the enrollee, when, and how to access them; that the enrollee is entitled to implementation of the most favorable decision from the IRE or the BOH; when benefits continued during the appeal will be collected from the member; the right to language access, including ASL, in the appeal process; and the right to receive the notice in the alternative format that meets the enrollee's needs, and how to access alternative formats.

In addition, 42 CFR 422.629 or 422.630 or both should be amended to require D-SNPs to have specific publicly published procedures for making reasonable accommodation requests under the Americans with Disabilities Act (ADA), for D-SNP plan consideration of such requests, and procedures for disputing denials of reasonable accommodation requests. Plan enrollees need to know that they have a right to make a reasonable accommodation request, how and where to make the request, what they need to submit for the request, and the process that will be followed for plan consideration of the request.

Provider Directories, Network Adequacy, and Quality Standards

Provider directories should be updated at least monthly and be available in multiple formats and languages, including American Sign Language. Consumers should be able to access provider directories without submitting an account or policy number and distinguish between providers who are in network accepting new patients and providers who are not accepting new patients. Consumers should be able to easily search provider directories by tier, product, languages spoken by provider in addition to languages available by interpreter, disability accessibility (accessible examination equipment, dressing room, parking etc.) and information about specialty and subspecialty providers.

For persons with complex care needs, mental health diagnoses or other needs, the care coordinator or other member of the person's care team should be responsible for assisting the individual locate the appropriate provider that will need their needs and request. The baseline requirements for both Medicaid and Medicare do not meet the needs of the most vulnerable populations enrolled in D-SNPs. This is why the increased flexibility and use of rebalanced funds to cover expanded services are a critical part of successful demonstration programs. Continuing One Care, which allows for single case agreements to ensure access to provider networks with expertise needed to meet their unique care needs is vital. Robust single case agreement policies enable members to see out-of-network providers, or receive medically necessary services that are not typically covered, with minimal friction. Single case agreements have proved absolutely vital in enabling highly medically complex individuals to even enroll in the MMP demonstrations without fear of losing access to their key specialists. This is particularly vital for individuals with rare diseases, who may have very limited choice of providers with expertise in their condition or even have to cross state lines to receive adequate services.

DAAHR is particularly concerned that, as currently constituted, the proposal would seem to rely on standard Medicare quality metrics (along with associated practices such as giving plans star ratings) rather than adopting as a best practice the use of more specialized quality metrics that are appropriate to the specific needs of people with complex disabilities, as has been the case in demonstration programs. Standard quality metrics fail to reflect the particular needs of individuals with complex disabilities, who in many cases will not recover from their conditions in a traditional medical sense, but who experience widely varying quality of life depending on the extent to which their case actually supports their independence and functionality. Most important quality measures should promote meaningful outcomes that matter to enrollees.

We are concerned that in the absence of disability-specific metrics, MA's will lose significant leverage to ensure plans are actually adequately serving their members, and financial incentives for plans to adhere to independence-focused models will be weakened. Moreover, some common quality metrics that this proposal could push plans towards using might actually generate perverse incentives that could harm people with disabilities; for instance, if plans are judged on the degree to which they reduce hospitalizations, they would be incentivized to achieve this metric by getting their most unwell members off of the p plan. We therefore urge CMS to require all states to adopt standardized, disability-informed quality measurement tools. Because the complex needs a population served by DSNP, states should be required to adopt both the National Core Indicators-Aging and Disabilities, and Consumer Assessment of Healthcare Providers and Community Based Services surveys.

At minimum, health plans should adopt standardized quality metrics as one of the key criteria to select providers to be included in the plan networks. These quality metrics include: (1) the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, HEDIS CAHPS survey, and Core 24 and any new measures developed via the Pediatric Quality Measures Program (PQMP). In addition, QIS should include common collection and reporting standards that can be easily understood and compared as a mechanism to foster accountability. Public reporting should factor in the multiple end-users who will be engaged in evaluating QIS activities: state oversight and marketplaces, health plans, consumers, employers, providers and provider organizations. It is important to use consumer tested language to ensure measures are collected and reported in a uniform format that are publicly displayed.

The National Picture

Many of the comments above and the concerns to which they speak can be applied to programs for people with disabilities in other states. We also believe that many of the recommendations set out in the proposed rule changes are important first steps in addressing the misalignment of resources, regulations, policies and practices leaving dually eligible beneficiaries trapped between a fractured fee-for-service system and Medicare Advantage plans rife with fraud and look alike plans.
We rally with our brothers and sisters with dually eligible status in other states to endorse CMS efforts to increase the quality of care they receive and improve integration of HCBS, LTSS behavioral health services that can lead to increased opportunity to live meaningful lives in the community.

One critical aspect of what we have learned in Massachusetts is that even the highest level of SNP integration (as exists in SCO) is not always sufficient to meet the needs of disabled members, let alone less integrated tiers. The rule change should therefore provide a glide path that would require and support state transition of HIDE-SNPs to FIDE-SNPs by 2026. Moreover, failure to require all D-SNPs to integrate behavioral health services into D-SNP requirements will perpetuate the ongoing misalignment of services experienced by dual-eligibles living with mental health diagnoses or addiction, and further perpetuate the national double standard wherein services for mental health conditions are less available and less valued than those for physical health conditions.

Impact of Proposed Rule Change on Other States

The rule changes proposed by CMS do not address the main factors that determine dually eligible long-term engagement in a FAI or D-SNP. These factors are identified in a recent report released by Community Catalyst in partnership with Arnold Ventures and The Scan Foundation. Factors include: access to providers needed to maintain their health; the ability to make an informed decision after reviewing materials meeting their needs; direct access to persons knowledgeable about the FAI and; the opportunity to access additional or supplemental benefits. Also, notably absent and lacking from their proposed rule changes are the impact of limited networks and provider access on dually eligible decisions to participate in a D-SNP and, the negative impact of the passive enrollment process by limiting the ability of dual-eligibles to review accessible materials, speak with a knowledgeable person and learn about the benefits offered by MMPs, and the need for alignment of grievance procedures to make life easier for members, plans, and the state.

The rule changes are set out our fragmented and do not provide a clear picture of how states are to achieve fully integrated care models. It fails to take into consideration the variations in state capacity or competency or variations in their resources. We are very concerned that plans will not be required to re-invest monies back into improving or increasing services, and rebalancing spending and LTSS, which is not required under the DSNP model. The funds that are not reinvested will instead serve as profits.

Based on our experience with MMPs and D-SNPs, disability advocates believe the rule change should:

- Provide opportunity for enhancement of existing MMPs to support ongoing innovation.
- Increase alignment between Medicare and Medicaid streams, one of the primary barriers to integrated care, as opposed to turning the clock backwards for MMPs.
- Provide a satisfactory definition of care integration or at least a definition that can be measured for quality in a way that is meaningful to beneficiaries and their families.
- Require integration of HCBS, LTSS, and negative determinants of health.
- Provide a satisfactory definition of care planning and care coordination.
- Provide a clear goal to be achieved by integrating care for dually eligible individuals.
- Strengthen oversight requirements of MA plans.

- Build in incentives to rebalance priorities and spending.
- Increase protections of appeals and grievance rights for dually eligible individuals.
- Increase transparency of MA plan utilization management processes and expenditures.
- Address potential flaws in current MLR that facilitate plans mislabeling administrative costs as medical expenses.
- Eliminate carve outs of benefits in FIDE-SNPs and HIDE-SNPs to support total integration of LTSS, HCBS, behavioral health, and SDOH services.
- Require all D-SNPs with capitated contracts to cover this entire state to provide and guarantee continuity of care to dually eligible individuals.
- Rather than go into each of these issues in detail, we would like to wholeheartedly endorse the comment submitted by [DREDF, Justice in Aging, etc.] which delves more significantly into significant best practices which are critical to incorporate into a national D-SNP model.

In closing, we wish to restate our desire that the Massachusetts One Care Program, in its 2.0 iteration, be allowed to continue as a MMP demonstration. This is fundamental to persons with disabilities in the state who have come to depend on the program for essential integrated care and services.

Sincerely,

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Angelina Ramirez, Stavros Center for Independent Living
Cathy Costanzo, Center for Public Representation
Danna Mauch, Massachusetts Association of Mental Health

U.S. Senate Special Committee on Aging
"Improving Care Experiences for People with both Medicare and Medicaid"
February 10, 2022

Questions for the Record
Ms. Jane Doyle

Senator Mark Kelly

A proposed rule that CMS released in January would make a fair amount of changes to make Dual Eligible Special Needs Plans more integrated and streamlined for the consumer. This includes changes like limiting plan offerings within a contract so people better understand the quality of what they're enrolling in, and integrated materials for the beneficiary to make notifications less confusing. It also proposes requiring each plan to have an advisory committee of beneficiaries in each state, and for each Special Needs Plan to assess physical, psychosocial, and functional needs.

Question:

Could you speak to the way having a more streamlined process would be helpful as a beneficiary? You mentioned outreach to legal services nonprofits and the Medicare Rights Center—it should not be so hard to have accessible health care. What changes would be most beneficial to you to make your life easier?

Response:

Dear Senator Kelly,

Thank you so much for your interest in this very important but difficult subject. It is my pleasure to provide you with my thoughts and experiences that may help you with future legislation.

Personally, while eligible I have never sought a "Special Needs Plan." To my knowledge, they are similar to Medicare Advantage Plans under a Managed Care Model with integrated service packages. Having been employed in local public service government for nearly 14 years and having had to access public benefits, I have a unique understanding of public benefits from both sides of the fence. From my experiences, benefits are often not well understood by the very people who are responsible for assessment and delivery. Most certainly, more training is needed in that area. Often there are breaks in the chain of information and some of the most vulnerable fall through the cracks. One such problem I experienced was the issue of my mother being possibly eligible for additional benefits such as Veterans Benefits and Employer Based Retirement Benefits. One benefit can limit or even cancel another out. Most community services do not know the rules of overlapping benefits leaving vulnerable individuals in potentially devastating life-long situations from merely a wrong choice. Perhaps more specialized personnel specific to Special Need Programs may be beneficial.

The simple answer to your question is ideally, a simplified integrated plan for the most financially and medically vulnerable would indeed be beneficial. However, from my experience in Pennsylvania, I have seen many short falls in the main Medicaid Managed Care Model. I have concerns that we have to first address the problems at the base plans before integrating subsets of more specialized plans

From my experience with Pennsylvania's basic Medicaid Managed Care Model, and from my experience of overseeing my mother's Employer Based Medicare Advantage Plan combined with Medicaid Dual Eligibility, I have seen the following problems:

1. When Pennsylvania went to a mandatory Medicaid Managed Care Model, doctors were even harder to access. Private physicians have steered clear of these plans due to lower reimbursement rates, high administrative demands and a learning curve. Doctors who are employed by hospital networks accept Medicaid only because they are receiving additional Federal and State funding. Large patient loads add to additional access problems leaving patients to rely on Urgent Care Centers and Emergency Rooms for acute problems. Subsequently, this likely leads to higher healthcare costs and reduced quality of care.

2. It's been my experience that government regulated Medicare Advantage Plans promise benefits beyond what are truly delivered and can be very misleading. For example, my mother who requires 24/7 care was offered 2.5 hours of care per week under her Medicare Advantage Personal Care Benefit. Additionally, only one home healthcare agency participated in her plan. Transportation to her medical appointments was offered through Medicaid's Public Transportation Contract, not a service contracted by her insurance. Several hours to and from appointments, often late to appointments, is not suitable for frail and severely ill individuals.

I would advocate for plans that service the very ill, severely disabled and financially vulnerable be better evaluated to ensure access to already established providers and ensure delivery of "promised" services needed to meet the individual's needs. Additionally, I am very happy to hear you intend to impose an advisory committee of beneficiaries in all states. I think there is no better source for analyzing the system than those who have to navigate it. These are complex programs operating under a complex system serving people with unique needs. It is inevitable that unforeseen problems are going to arise.

One last thought worth mentioning, I have had traditional fee for service "Medicare" for 24 years from having Multiple Sclerosis. I have never come across a doctor who didn't accept it. Perhaps we have tried to integrate services into one model beyond our ability to manage and operate without the expertise.

I hope I have addressed your question and have provided some insight that may help you in developing future legislation for "Dual Eligible Special Needs Programs." Thank you for your time and attention to this important matter. The most vulnerable depend on it. If you have any further questions, I would be happy to answer them.

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