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Written Testimony of Eunice Medina

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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.