Mathematica
Progress Together

Response to the Request for Information on

Integrated Care and Dually Eligible Individuals

January 13, 2023

Submitted to:		**Submitted by:**
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The Honorable Thomas R. Carper U.S. Senate 513 Hart Senate Office Building Washington, D.C. 20510	The Honorable John Cornyn U.S. Senate 517 Hart Senate Office Building Washington, D.C. 20510	
The Honorable Tim Scott U.S. Senate 104 Hart Senate Office Building Washington, D.C. 20510	The Honorable Robert Menendez U.S. Senate528 Hart Senate Office Building Washington, D.C. 20510	

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RE: Integrated Care and Dually Eligible Individuals

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

Thank you for engaging a wide stakeholder community in your efforts to improve coverage and care for those dually eligible for Medicare and Medicaid. Mathematica, as an organization committed to the production of research and evidence assessing programs supporting the public good, is highly invested in this population. We appreciate the opportunity to provide the attached response to your questions, as well as four additional suggestions regarding areas for further study that we hope will also be of interest to the Senate as it considers options for improving care for this important and diverse group of people.

Mathematica conducts a variety of research and technical assistance projects related to dually eligible individuals under contracts with the Centers for Medicare & Medicaid Services (CMS), the Medicaid and CHIP Payment and Access Commission (MACPAC), individual states, and foundations. This work includes two large ongoing projects for CMS' Medicare-Medicaid Coordination Office (MMCO): (1) the Integrated Care Resource Center (ICRC), which provides technical assistance to states on integrating care for dually eligible individuals; and (2) a set of studies examining dually eligible individuals' experiences in integrated care programs. We have also conducted several studies for MACPAC on the impact of various aspects of policies and programs for dually eligible populations, including factors influencing enrollment in Financial Alignment Initiative demonstrations and issues that influence states' decisions regarding implementing integrated care programs for dually eligible individuals. We also recently completed a study for Arnold Ventures on why dually eligible individuals stay in or leave certain types of integrated care plans. In addition, through our broader work with CMS and state Medicaid agencies, we have developed extensive knowledge of Medicaid and Medicare policies, programs, and related data sources, all of which are relevant to designing, implementing, and evaluating integrated care models for dually eligible individuals. We appreciate the opportunity to bring our expertise to bear in informing the Senate's work to address the important needs of the dually eligible population.

If you have follow-up questions or seek additional information or clarification related to our responses below, I am happy to connect you with two of our subject matter experts, Debra Lipson and Erin Weir Lakhmani, who contributed to our response, and who lead much of Mathematica's work in this area, including work cited in this letter. As an attachment to this letter, we have included brief biographies for Debra and Erin, as well as contact information, in case of any follow up questions or for additional information. For any questions about our response, please contact Mike Burns, Senior Director for Communications and Public Affairs, at MBurns@mathematica-mpr.com.

Sincerely,

Christopher Trenholm
Senior Vice President; General Manager, Health

Mathematica is pleased to respond to the Senate's request for information about care for dually eligible individuals dated November 22, 2022. In the section that follows, we respond to selected questions that are most relevant to our research and expertise, but we believe these responses will also inform broader areas of inquiry noted in the letter. In a subsequent section, we offer four suggestions regarding areas where further study might improve the federal government's understanding of and decision-making about policies and programs for dually eligible individuals.

Response to Request for Information

In the following subsections, we offer responses to Questions 1, 3, 4, 7, and 11 from the Senate's request for information.

Question 1 – How would you separately define integrated care, care coordination, and aligned enrollment in the context of care for dually eligible beneficiaries? How are these terms similar and how are they different?

Aligned enrollment is the simplest of these three terms to define: aligned enrollment simply means a dually eligible individual is enrolled in both a Medicare Advantage (MA) Dual Special Needs Plan (D-SNP) and a Medicaid managed care plan operated by the same parent company as the D-SNP.[i]

Definitions of ***care coordination*** vary, but most focus on helping beneficiaries identify and achieve specific health, mental health, and independent living goals, helping beneficiaries successfully navigate complex systems of care and supporting and streamlining communication and information sharing among all parties involved in an individual beneficiary's care.

Of these three, the term ***integrated care*** is perhaps the most ambiguous. In our work, Mathematica has found that successful integrated care programs for dually eligible individuals are characterized by all three of the following components.[ii] However, researchers and policymakers often use the terms *integration* and *integrated care* to refer to programs and systems that involve only one or two of these components.

- **Financial integration** is integration of Medicare and Medicaid payment methods and processes such that a single stream of payment flows from payer to plan and/or from plan to provider.
- **Administrative or operational integration**, which can include some or all of the following substrategies:
  - Integrated health plan enrollment processes
  - Development and delivery of integrated beneficiary materials (marketing materials for potential enrollees and enrollee materials, such as health plan ID cards and communications about plan benefits and enrollee rights for current plan members)
  - Integrated health plan operations, such as benefit determinations and unified Medicare and Medicaid appeal and grievance systems
  - Integrated Medicare and Medicaid *health plan* care coordination processes that assign a single care coordinator and care coordination team to identify, arrange for, and coordinate the services in the beneficiary's person-centered care plan
- **Clinical integration**, wherein all of a beneficiary's medical, long-term services and supports (LTSS) and social needs are clearly identified in the beneficiary's care plan; the interdisciplinary care team incorporates all key medical, LTSS, and social service providers; and all key providers

communicate with one another, with the beneficiary, and with the beneficiary's care coordinator seamlessly and effectively to promote holistic, person-centered treatment.

In distinguishing these terms from one another, it is worth noting that, although care coordination and aligned enrollment are both necessary—and foundational—components of an integrated care program, **neither care coordination nor aligned enrollment alone is sufficient to achieve the full financial, operational, and clinical integration that would constitute our definition of true integrated care.** For example, care coordination might be important to overcoming fragmented Medicare and Medicaid systems of coverage for clinical services, long-term care, and social supports, but care coordination by itself does not address the need for financial or operational integration to simplify coverage of benefits, a beneficiary's understanding and navigation of those benefits, or provider payment. Similarly, aligned enrollment by itself does not achieve integrated care unless the aligned health plans take steps to ensure financial integration—for example, by allowing providers to submit bills to one plan rather than two. In addition, both CMS and state Medicaid agencies must take steps to require aligned plans to integrate administrative processes—for example, by allowing (and/or requiring) them to issue one health insurance card and use unified grievance and appeals systems. Many of the steps needed to achieve full financial, administrative, and clinical integration within aligned plans can be achieved through **exclusively aligned enrollment**, in which state contracts with D-SNPs limit enrollment to full-benefit dually eligible (FBDE) individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid Managed Care plan offered by the same parent company as the D-SNP.[iii]

Question 3 – In your view, which models have worked particularly well at integrating care for dually eligible individuals, whether on the state level, federal level or both?

The question of whether a particular integrated care model has worked well depends on the outcomes of most interest. The direction and strength of the evidence regarding different models' success varies by outcome.

To date, three main models of integrating care for dually eligible individuals have been rigorously investigated at local, state, and/or national levels: Programs of All-Inclusive Care for the Elderly (PACE), demonstrations under the Financial Alignment Initiative, and models using MA D-SNPs.[iv] Findings from these studies are mixed, with results that vary by the particular outcome(s) of interest. For example, although many studies have found enrollees in all three of these integrated care models have typically experienced reduced hospitalizations and readmissions (compared to dually eligible individuals who are not enrolled in the integrated care programs), findings regarding use of other services, such as emergency room services and LTSS, vary across different studies and programs, as have findings regarding mortality and Medicare and Medicaid spending.

To support the Senate's understanding of the current evidence base regarding the success of each of these models in addressing various outcomes of interest, we recommend the following two resources, which are objective and widely cited:

1. **MACPAC's Inventory of Evaluations of Integrated Care Programs for Dually Eligible Beneficiaries.** This inventory summarizes and links to numerous evaluations and research regarding integrated care programs, including federally funded evaluations of Financial Alignment Initiative demonstrations, D-SNP integrated care models, and PACE programs.

   a. Inventory (last updated in October 2022): https://www.macpac.gov/publication/inventory-of-evaluations-of-integrated-care-programs-for-dually-eligible-beneficiaries/
   b. August 2020 summary of findings across evaluations completed at that time: https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/

2. A 2021 study that RTI conducted for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), **Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care,** a rigorously designed study that compared several outcomes for dually eligible individuals enrolled in D-SNPs, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), or PACE to a matched group of individuals enrolled in regular, non-integrated MA plans. The final report from that study is available at https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles.

Mathematica also recently conducted several qualitative studies for CMS involving in-depth interviews with dually eligible individuals regarding their experiences with care coordination and unified grievance and appeals systems in Financial Alignment Initiative demonstrations. Issue briefs summarizing the results of the first two studies, conducted with dually eligible individuals in Rhode Island and Michigan, are now publicly available. As issue briefs summarizing the results of the other studies become publicly available, CMS will publish them within the state-specific pages of the Financial Alignment Initiative space on the CMS website.

Question 4 – After reviewing these models, would you recommend building upon current systems in place or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on their needs?

Our research and more than a decade of experience providing technical assistance to state Medicaid agencies has focused on understanding or improving current models. We provide Figures 1 and 2 primarily to show there has been a rapid increase in enrollment in D-SNPs - particularly integrated D-SNPs over the past four years. Given the amount of change that is currently in play, we believe there is potential for current integrated care models to be successful, even if that potential is not yet fully realized. We have not produced any evidence that would permit us to compare the potential in current systems to that of a new, unified system. Information we present here is pertinent if Congress should seek to build upon existing systems, particularly by using D-SNPs .[v]

Current models show enough promise to warrant further development and continued evaluation

As noted in our response to Question 3, evaluations of integrated care models have shown varying and mixed results for different outcomes. However, overall, we believe that existing integrated care models have shown enough promise to warrant ongoing evaluation and to potentially serve as foundations for ongoing development. For example, studies that have examined the impact of integrated care program enrollment on service use among dually eligible individuals enrolled in PACE programs and integrated D-SNPs have often found reductions in enrollees' hospitalization, emergency department (ED) use, institutionalization, and/or mortality rates.[vi,vii,viii,ix,x]

That said, certain aspects of these models require further examination and continued improvement. For example, only a few studies have carefully examined differences in enrollees' experiences across subgroups of dually eligible enrollees (for example, enrollees who are younger than 65 versus those

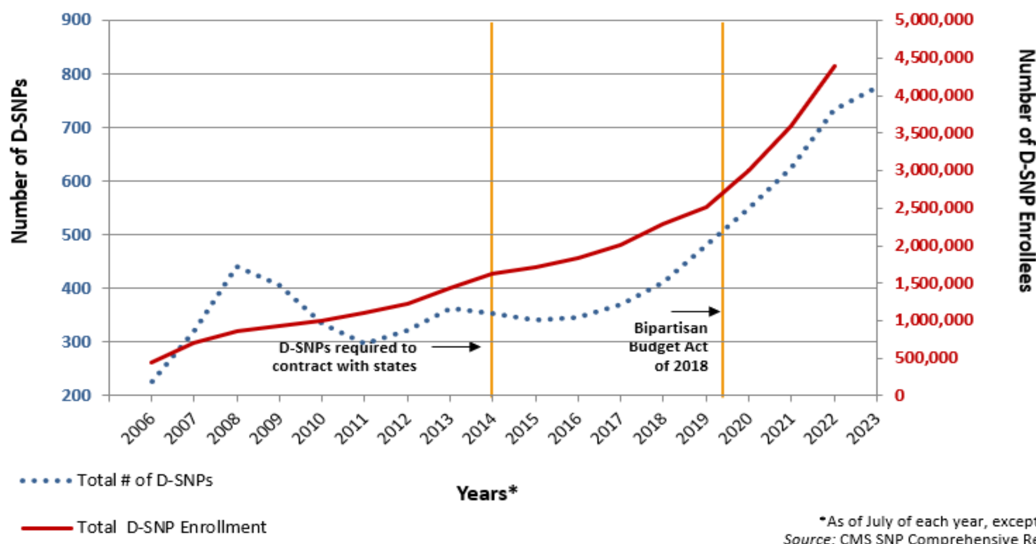
older than 65 and enrollees who are members of non-White racial or ethnic populations versus those who are White), and studies that have examined differences in subgroup experiences have found some important discrepancies.[xi,xii,xiii] To ensure that integrated care programs meet the needs of all dually eligible individuals, we need further research to identify and understand the diverse needs of dually eligible subpopulations and which policies or beneficiary protections are effective in meeting those needs and facilitating equitable access to the benefits that integrated care programs can provide.

In addition, because the extent of integration with Medicaid varies across D-SNP plans depending on state Medicaid requirements, research on beneficiaries' experiences, quality, and cost outcomes of D-SNPs must consider their level of integration. Additional research is needed to evaluate the effects of (1) new rules issued by CMS in 2019 and 2022, which require D-SNPs that meet only minimum federal requirements to increase coordination with state Medicaid programs and SNPs;[xiv,xv] and (2) changes in state contracts with D-SNPs that require them to expand the kind of financial, administrative, and/or clinical integration discussed in our response to Question 3.

Number and popularity of existing D-SNP models suggest further investment in these models

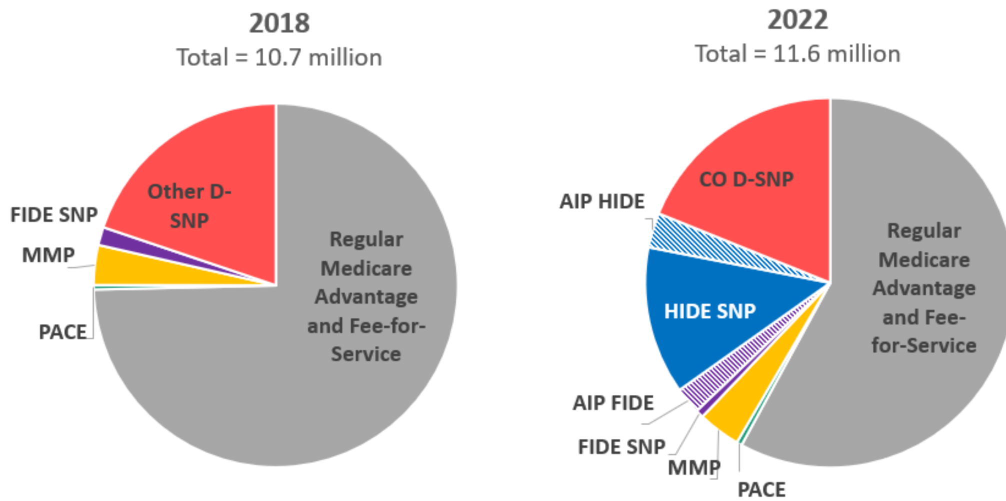
In contrast to the limited reach of PACE models and states' Financial Alignment Initiative demonstrations, D-SNP enrollment has grown steadily over the past several years (**Figure 1**). More than one-third of dually eligible individuals nationwide had enrolled in a D-SNP by December 2022, and D-SNPs are now available in all but five states.[xvi] In particular, enrollment in the most integrated types of D-SNPs (FIDE SNPs, highly integrated D-SNPs or HIDE SNPs, and applicable integrated plans, or AIPs[xvii]) has grown substantially in the past four years (**Figure 2**), as the new CMS rules issued in 2019 establishing HIDE SNPs and AIPs garnered fresh state attention for integrated D-SNP models.

Figure 1. Growth in D-SNP enrollment, 2006–2022



Sources: CMS SNP Comprehensive reports available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html. CMS. "SNP Landscape File." Available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn. 2023 Landscape data are not final.

Figure 2. Dually eligible individuals' enrollment in different types of Medicare plans, 2018 and 2022



Notes: **Data Sources:** CMS Monthly Enrollment by Contract, July 2018 and 2022: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract. CMS SNP Comprehensive Report, July 2018 and 2022: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data. CMS Quarterly Enrollment Updates, March 2018 and 2022: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

MMP = Financial Alignment Initiative Medicare-Medicaid Plan. CO D-SNP = Coordination Only D-SNP.

Several states have also spent significant time and resources building integrated care initiatives through D-SNP models, examples including Idaho, New Jersey, Oregon, Texas, and Washington.[xviii] In addition, the eight states that will continue to have capitated model Financial Alignment Initiative demonstrations in 2023 (Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas) are now investing resources to transition those demonstrations to D-SNP-based platforms by January 2026. Other states, such as Indiana and North Carolina, plan to use D-SNPs to develop integrated care programs in the coming years, as well.[xix] Given the resources these states have already invested (or will invest in the near future) in D-SNP-based models, it would be disruptive for the integrated D-SNP enrollees in those states to abandon D-SNP-based integrated care models in favor of a new, unified system of coverage.

Avoid too many competing models

It might be possible to offer a new, unified model as an *additional* option, without supplanting existing D-SNP and PACE models. However, our previous research indicated having too many coverage options and competing models to choose from can be incredibly confusing for dually eligible individuals. In 2022, Medicare beneficiaries had an average of 38 Medicare Advantage plans to choose from: twice as many as in 2014.[xx] The availability of dozens of Medicare plans and coverage options can create unintended incentives for health plans and insurance agents to steer dually eligible individuals away from the most integrated coverage option.[xxi,xxii] Therefore, we do not recommend creating concurrent, competing integrated care programs in the same geographic region (with the exception of allowing PACE and D-SNP-based models to operate within the same geographic area, as PACE serves a specific subset of the broader dually eligible population [older individuals meeting nursing home level of care but residing in the community) and typically has a limited reach).

Question 7a – Should different coverage strategies be employed for "partial" vs. "full" benefit dually eligible individuals when it comes to improving outcomes?

The Medicare Payment Advisory Commission (MedPAC) and MACPAC, Congressional advisory bodies, recently discussed the advantages and disadvantages of limiting D-SNP enrollment to FBDE individuals.[xxiii] Their analyses have persuaded Mathematica that FBDE individuals likely stand to benefit more from D-SNP enrollment than partial-benefit dually eligible (PBDE) individuals; however, this is an area that needs further study. Because D-SNPs are designed to coordinate Medicare and Medicaid benefits, limiting D-SNP enrollment to FBDE individuals can help to streamline care coordination efforts and enrollee materials across the two programs. In contrast, because PBDE individuals do not receive Medicaid benefits beyond Medicare cost-sharing subsidies, PBDE individuals are more likely to benefit from enrollment in regular MA plans, which often offer supplemental benefits and cost-sharing reductions *not covered* by Medicaid.

Proponents of allowing PBDE individuals to enroll in D-SNPs contend that D-SNP enrollment can help to slow or prevent decline in health and function for PBDE individuals because D-SNPs can provide care coordination services not provided by other MA plans and D-SNPs can provide supplemental benefits not covered by Medicare or Medicaid.[xxiv] However, little to no evidence exists yet to support this assertion, so Mathematica proposed to conduct a study to fill this gap in evidence.

Supported by Arnold Ventures, Mathematica is currently assessing the potential value of D-SNP enrollment for PBDE individuals. In the first phase of the study, we examined how many PBDE individuals are enrolled in D-SNPs versus regular MA plans or traditional fee-for-service (FFS) Medicare (nationally and by state), as well as how many people enrolled in D-SNPs switch from partial- to full-benefit dual eligible status during the year. We found that in 2018–2019, about 87,000 PBDE individuals, one of every six PBDE individuals who were enrolled in a D-SNP, switched to full-benefit dual eligibility—enough to detect statistically significant differences in the outcomes to evaluate in the second phase of the study.

In the second phase, now underway, we will test the theory that prior enrollment in a D-SNP offers value to PBDE individuals by reducing their use of costly health and LTSS after they switch from partial-benefit to full-benefit dually eligible status, compared to PBDE individuals enrolled in regular MA plans or FFS Medicare. We will examine the following questions:

- What share of individuals who switch from PBDE to FBDE status began using Medicaid LTSS (home and community-based services [HCBS] or institutional care) immediately after becoming an FBDE individual? Among those who began using LTSS after the switch to FBDE status, did first use of HCBS or institutional care vary by coverage type before the switch (that is, were those enrolled in D-SNPs more likely to first use HCBS or institutional care than those in regular MA plans or traditional FFS Medicare)?
- What share of those who switch from PBDE to FBDE status had a Medicare skilled nursing facility (SNF) stay, hospital stay, or ED visit immediately preceding the switch to FBDE? Did SNF, hospital, or ED use patterns differ for PBDE individuals enrolled in traditional FFS Medicare, regular MA plans, and D-SNPs?

We expect to complete our analyses later in 2023.

Question 7b – What are the effects on cost, outcomes and beneficiary satisfaction of policy approaches designed to reduce frequent plan switching and improve retention in aligned Medicare and Medicaid products? Which of these approaches can be expanded to apply more widely across States?

Mathematica has conducted several studies on dually eligible individuals' disenrollment from and retention in integrated care plans. Our studies did not examine the effects of continuous enrollment in such plans on cost, outcomes, or satisfaction. Rather, we assumed the benefits of integrated care found in other studies, such as lower likelihood of hospitalization and long-term nursing home admission, and greater likelihood of using HCBS,[xxv] would be enhanced the longer dually eligible individuals remain enrolled in aligned Medicare and Medicaid plans.

In our work, Mathematica found several federal and state policies can help to increase retention in integrated plans and reduce unnecessary plan switching, explained in more detail below:

- Passive or default enrollment mechanisms, which serve to nudge dually eligible individuals toward integrated plans
- Policies that limit the types of MA plans available to dually eligible individuals to those that are more integrated with Medicaid, which reduces incentives for marketing agents and brokers to steer dually eligible individuals away from integrated plans
- Active outreach and education to dually eligible individuals by care coordinators about the benefits of integrated care
- State policies that allow dually eligible beneficiaries to be deemed eligible for Medicaid during temporary lapses in Medicaid coverage, which increases retention in integrated plans

Previous research found dually eligible individuals were more likely than those not dually eligible to disenroll from an MA plan.[xxvi] (*Note that rules in effect before 2019 influenced these findings, which allowed dually eligible individuals to change plans at any time during the year.*[xxvii] *We are unaware of more studies that have analyzed data since 2019.)*

In 2020, Mathematica conducted a study to understand the reasons that explain variation in, and reasons for, dually eligible individuals' disenrollment rates from D-SNP-dominant MA plans.[xxviii] We examined the associations between voluntary disenrollment rates and (1) quality of care ratings; and (2) the D-SNPs' levels of integration with Medicaid, which varied from full coverage of Medicaid benefits and alignment with affiliated Medicaid managed care plans to no coverage of any Medicaid benefits at all (that is, D-SNPs with coordination-only contracts with state Medicaid agencies). Our study found that D-SNP disenrollment rates were associated with only three of nine quality and performance measures, leading us to conclude voluntary disenrollment rates were not a definitive measure of overall MA quality or performance. Nor did we find a statistically significant association between disenrollment rates and level of integration with Medicaid.[xxix]

Instead, through interviews with state Medicaid officials and senior health plan executives, we discovered several other reasons that explain differences in voluntary enrollment rates across D-SNP-dominant MA contracts.

- State Medicaid policies and programs related to coverage options for dually eligible beneficiaries play a particularly important role. State D-SNP and Medicaid contract requirements that

promote aligned D-SNP enrollment with Medicaid managed care plans increase the opportunity for Medicare-Medicaid care coordination, leading to higher rates of enrollee satisfaction among dually eligible individuals who need Medicaid-covered LTSS benefits. Clearly worded state Medicaid communications with beneficiaries about their coverage options also help them understand the benefits of integrated care and care coordination that are available in aligned D-SNPs and Medicaid managed care plans.

- Greater competition among MA plans in a state or region contributed to greater churn and higher rates of disenrollment from D-SNPs. For example, states with the highest mean disenrollment rates from D-SNPs included Florida (30.4 percent) and Texas (20.9 percent), and those states had more than five times as many MA plans as states with the lowest mean D-SNP disenrollment rates, such as Minnesota (2.3 percent) and Massachusetts (4.4 percent). In addition, marketing activities by D-SNP look-alike plans (regular MA plans that target marketing to dually eligible individuals) contributed to higher disenrollment rates in D-SNPs. [xxx] One state Medicaid official credited their agency's close monitoring of D-SNP look-alike activity and referrals to CMS for potential investigation as a factor in their state's lower rates of disenrollment from D-SNPs.
- Confusion among providers and beneficiaries about cost-sharing obligations for full-benefit and partial-benefit dually eligible individuals beneficiaries also contributes to D-SNP enrollees' decisions to disenroll or switch plans. For example, one health plan manager said that full-benefit dually eligible individuals disenrolled from the plan because providers improperly billed the members for the balance of charges not covered by Medicaid, despite federal prohibitions on balance billing for cost sharing that affect many of the plan's enrollees.

Based on the study findings, we identified several policy changes that could help to increase enrollment and retention of dually eligible individuals in the most integrated care plans. For example, CMS could award higher MA star ratings based on (1) plans' ability to retain members and (2) measures that directly reflect members' satisfaction (CMS will begin assigning greater weight to these measures in the quality ratings it will release in 2023). Federal and state officials could reduce the impact of beneficiary cost sharing on disenrollment among full-benefit dually eligible individuals through stronger enforcement of, and education about, the federal prohibition on balance billing of Qualified Medicare Beneficiaries (QMBs). States could also consider prohibiting regular MA plans from enrolling FBDE individuals in areas where they have a choice of D-SNPs and other types of integrated plans, along with traditional Medicare fee-for-service.[xxxi] This option has become more feasible now that 93 percent of Medicare beneficiaries have access to a D-SNP in 2022, compared to 77 percent of Medicare beneficiaries in 2012.[xxxii]

Mathematica also conducted a study for MACPAC in 2018 that examined factors affecting dually eligible individuals' enrollment and *retention* in Medicare-Medicaid plans (MMPs), the integrated care plans involved in capitated model Financial Alignment Initiative demonstrations.[xxxiii] For that study, we analyzed enrollment trends over time and interviewed officials from 10 demonstration states and senior executives from 15 MMPs with higher levels of enrollment and retention relative to other MMPs. The study found dually eligible individuals were more likely to enroll, and remain enrolled, in MMPs when the process of enrolling was easy, the benefits of doing so were tangibly and quickly demonstrated, and integrated care plans were cast as a preferred option over nonintegrated care arrangements. The study uncovered several significant findings, including:

- Passive enrollment into integrated care plans removed administrative barriers to enrolling and signaled to beneficiaries that such plans are preferred.
- Aligning key design features of state managed LTSS programs and demonstration MMPs, including the eligible populations, areas of operation, and participating plans, made it easier for the state, health plans, and community agencies to conduct targeted outreach about the benefits of choosing an MMP for coverage of Medicare and Medicaid benefits.
- Allowing MMP care coordinators to contact new enrollees before the effective date of passive enrollment and encouraging MMPs to conduct face-to-face visits with new enrollees as soon as possible helped to build trust and gave MMPs a chance to explain—and show—the benefits of care coordination.
- Eligibility deeming policies, which allow MMPs (and D-SNPs) to maintain coverage for dually eligible enrollees during temporary lapses in Medicaid coverage, also helped to increase retention.

Except for passive enrollment, which was allowed only in states with capitated model demonstrations under the Financial Alignment Initiative, any state that contracts with D-SNPs and aligned Medicaid managed care plans could readily adopt the three other policies listed above. Deeming policies can require some state coordination with D-SNPs, but states with such policies, such as Minnesota, New Jersey, Oregon, and Pennsylvania, show how to address these challenges.[xxxiv]

Question 11 - How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?

We conducted a study for MACPAC in 2020 and 2021 about the factors, including geography, that facilitate or hinder state contracting with D-SNPs, and the policies and strategies that can help to address the challenges of operating D-SNPs in rural areas. [xxxv] Through in-depth interviews with 42 individuals from state Medicaid agencies, health plans, consumer advocacy groups, and other key stakeholders, we found states face several challenges to contracting with D-SNPs in rural or frontier areas. In particular, (1) the numbers of dually eligible individuals in rural states tend to not be large enough to make it financially viable or attractive to operate a D-SNP in those states, (2) relatively low MA payments to plans can limit D-SNP interest in serving rural areas, and (3) D-SNPs often find it difficult to meet CMS network adequacy requirements in rural areas because of insufficient numbers and types of providers.[xxxvi]

Based on these findings, we identified several strategies and policies that could help address the challenges of D-SNP contracting in states with large rural areas:

1. States could launch Medicaid managed care programs to help health plans develop provider networks and a membership base in rural areas.
2. CMS could develop a Medicare waiver authority for D-SNPs that cannot meet its network adequacy requirements in certain areas but must operate statewide to meet states' selective contracting requirements.
3. States could use their D-SNP contracting authority to contract exclusively with county-owned health plans in rural counties (in states with such plans).

4. States could work with plans to increase the use of telehealth in rural areas.
5. States and CMS could use network adequacy requirements developed for Financial Alignment Initiative demonstrations with D-SNPs.

As more states seek to implement integrated care plans for dually eligible individuals, it will become more important to help states and D-SNPs overcome the challenges of operating in rural areas to ensure rural dually eligible individuals are not left behind.

Additional Suggestions Regarding Areas for Further Study

In addition to sharing our findings and perspectives related to the questions highlighted in the previous section, we also wish to offer four additional suggestions regarding areas where further study might improve the federal government's understanding of and decision-making about policies and programs for dually eligible individuals. Specifically, we suggest that further research is needed to examine: (1) the ways in which Medicare and Medicaid benefit eligibility churn may impact or interact with efforts to integrate Medicare and Medicaid benefits for dually eligible populations, (2) the impact of Financial Alignment Initiative demonstration close-out and transition processes for dually eligible enrollees, (3) the extent to which transitions from partial-benefit to full-benefit dual eligibility status affects patterns of health care utilization and whether integrated care plans may offer any benefit during those transitions, and (4) options for improving the collection and quality of the Medicaid administrative data needed to perform these kinds of analyses.

First, benefit eligibility churn is a well-documented and major issue that could significantly affect any attempt at reforming the way that Medicare and Medicaid benefits are delivered for dually eligible individuals. Because dually eligible individuals may be more likely than other Medicaid populations to lose eligibility due to challenges navigating eligibility redetermination processes, as opposed to real changes in their income or disability status,[xxxvii] they may be especially likely to benefit from continuous eligibility policies. This topic is timely in light of CMS' and states' effort to unwind temporary Medicaid eligibility policies at the close of the COVID-19 Public Health Emergency (PHE). An examination of dually eligible individuals' rates of Medicaid eligibility churn within and across states as redeterminations occur, would be helpful to understanding the extent to which continuous eligibility policies may improve continuity of care for this population – an important precursor to the development of a new, unified integrated care program if such a program is to be developed.

Second, we also recommend following the transition of beneficiaries from the Financial Alignment Initiative demonstrations to D-SNPs carefully by either commissioning a study or collecting state findings to develop an evidence basis to assess the impact – and any potential disruption – of these transitions for the demonstrations' dually eligible enrollees. Understanding the full impact of these changes in coverage for this population would contribute significantly to planning a new, unified integrated care program or continuing to develop new requirements for D-SNPs.

Third, while it is premature to predict any outcomes from this study yet, we assume that there may be value in using additional, future research to build upon the study that we reference in our response to question 7a – a study supported by Arnold Ventures on patterns of care among partial-benefit dually eligible individuals who transition to full-benefit dual eligibility status. For example, the Senate might want to examine potential differences among those who transitioned from partial-benefit to full-benefit dual eligibility status during the PHE versus those who did not. There is very little evidence in this area yet to underpin reform, so we expect that additional research will likely be

needed to better understand whether integrated care programs can offer any benefit to partial-benefit dually eligible individuals at all, and if so, what those benefits may be.

Finally, drawing on our considerable expertise with Medicaid data, we think it is important to note that the indicators in the T-MSIS Analytic Files (TAF) enrollment records that are used to indicate who is dually eligible appear to be of reasonable quality and usable in the vast majority of states. However, there is less certainty about the quality of the data indicating which category of dual eligibility a person falls into, particularly with regard to the categories of partial-benefit dually eligible individuals. Further research is needed to examine ways to improve state reporting of these dual eligibility categories to make sure T-MSIS/TAF data can be used effectively to study the experiences of different types of dually eligible individuals, including the extent to which integrated care programs are (or are not) benefitting partial-benefit dually eligible populations. As an extension of this work, CMS could also complete quality assessments regarding the completeness of cost-sharing information in T-MSIS/TAF to ascertain whether states are submitting all appropriate crossover claims for dually eligible individuals receiving services that are covered by both Medicare and Medicaid, in order to make sure that Medicaid payment data for dually eligible populations is as complete and accurate as possible, as well.

Biographies for subject matter experts and contact information

Debra Lipson, senior fellow. Ms. Lipson is a nationally recognized expert in Medicaid managed care, LTSS for older adults and people with disabilities, integrated care for Medicare-Medicaid dually eligible individuals, and HCBS quality measurements. She has more than 35 years of experience in qualitative research methods and comparative health policy analysis. She holds a master's in health services administration, with a concentration in health policy and planning, from the University of Michigan and has written numerous reports and briefs for federal and state policymakers and is widely published in peer-reviewed journals.

Erin Weir Lakhmani, senior researcher. Ms. Weir Lakhmani serves as the project director for Mathematica's Integrated Care Resource Center project under a contract with CMS, which provides technical assistance to states on developing integrated care initiatives for dually eligible individuals. She also serves as a Medicare, Medicaid, and dual eligibility policy expert and advisor on several other projects, including Mathematica's qualitative studies with dually eligible individuals about their experiences in integrated care programs. She has presented in several national forums on topics related to integrating care for dually eligible individuals and she has authored several technical assistance tools, research publications, and blog posts related to dual eligibility, integrated care, health policy, and health equity. She holds a master's in social work from the University of Michigan and is a licensed social worker in Illinois.

For follow up questions or additional information, please contact Mike Burns, Senior Director for Communications and Public Affairs, at MBurns@mathematica-mpr.com.

Endnotes

[i] For detailed information about aligned enrollment and policy steps states can take to promote aligned enrollment in D-SNPs and affiliated Medicaid managed care plans, see the ICRC's tip sheet on promoting aligned enrollment at https://integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf, as well as its recent webinar on state contracting with D-SNPs at https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-using-d-snps-integrate-care-dually.

[ii] We define success in an integrated care program as improvement in both beneficiaries' experiences of care and health outcomes.

[iii] For information about exclusively aligned enrollment, see the ICRC webinar on exclusively aligned enrollment available at https://integratedcareresourcecenter.com/webinar/exclusively-aligned-enrollment-101-considerations-states-interested-leveraging-d-snps. In 2022, CMS developed a new term, Applicable Integrated Plans (AIPs), for fully or highly integrated D-SNPs that operate with exclusively aligned enrollment. CMS requires AIPs to have integrated plan-level appeals and grievance processes. As of 2025, CMS will require all FIDE SNPs to have exclusively aligned enrollment starting in 2025, which means all FIDE SNPs will be AIPs.

[iv] We do not include here Medicare or Medicaid accountable care organizations (ACOs), as ACOs have not been designed specifically with the intention of integrating Medicare and Medicaid benefits for dually eligible beneficiaries.

[v] Because PACE is a small program with limited reach, we have focused our comments here solely on the value of using D-SNP-based models. However, it is worth noting that PACE has demonstrated positive outcomes for the specific subgroup of dually eligible individuals the PACE model seeks to serve, making it worthwhile to continue to identify ways to expand that model, as well. (See MACPAC's inventory of integrated care evaluations for several evaluations of PACE programs: https://www.macpac.gov/publication/inventory-of-evaluations-of-integrated-care-programs-for-dually-eligible-beneficiaries/.)

[vi] Anderson, W.L., and Z. Feng. "Minnesota Managed Care Longitudinal Analysis." RTI International Report for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE), March 2016. https://aspe.hhs.gov/reports/minnesota-managed-care-longitudinal-data-analysis-0.

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[viii] MACPAC. "Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps." Issue Brief, August 2020. https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/.

[ix] Feng, Z., et al. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report." RTI International Report for ASPE, September 2021. https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles.

[x] Keohane, L.M., Z. Zhou, and D.G. Stevenson. "Aligning Medicaid and Medicare Advantage Managed Care Plans for Dual-Eligible Beneficiaries." *Medical Care Research and Review*, vol. 79, no. 2, 2022, pp. 207–217. https://pubmed.ncbi.nlm.nih.gov/34075825/.

[xi] Keohane, L.M., Z. Zhou, and D.G. Stevenson. "Aligning Medicaid and Medicare Advantage Managed Care Plans for Dual-Eligible Beneficiaries." *Medical Care Research and Review*, vol. 79, no. 2, 2022, pp. 207–217. https://pubmed.ncbi.nlm.nih.gov/34075825/.

[xii] Roberts, E.T., and J.M. Mellor. "Differences in Care Between Special Needs Plans and Other Medicare Coverage for Dual Eligibles." *Health Affairs*, vol. 41, no. 9, September 2022, pp. 1238–1247.

[xiii] Haviland, A.M., et al. "Do Dual Eligible Beneficiaries Experience Better Health Care in Special Needs Plans?" *Health Services Research,* vol. 56, no. 3, June 2021, pp. 517–527. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8143688/.

[xiv] Centers for Medicare & Medicaid Services. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register,* April 16, 2019. https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

[xv] Centers for Medicare & Medicaid Services. "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." *Federal Register*, May 9, 2022. https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[xvi] D-SNP enrollment data and information on states with D-SNPs in 2022 are from the December 2022 CMS Special Needs Plan Comprehensive Report, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data. Total number of dually eligible

beneficiaries from CMS Ever-Enrolled Trends Report, 2019 data, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

[xvii] Applicable Integrated Plans are D-SNPs that cover at least certain Medicaid benefits and operate with exclusively aligned enrollment. For more information, see the ICRC's tip sheet on D-SNP definitions at https://www.integratedcareresourcecenter.com/resource/definitions-different-medicare-advantage-dual-eligible-special-needs-plan-d-snp-types-2023.

[xviii] Twenty states, the District of Columbia, and Puerto Rico have Highly or Fully Integrated D-SNPs in 2022 (CMS Special Needs Plan Comprehensive Reports, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data).

[xix] Indiana and North Carolina have both received financial support from Arnold Ventures via the foundation's Advancing Medicare & Medicaid Integration Initiative. A brief summary of Indiana's plans is available here: https://www.arnoldventures.org/stories/investing-in-integration-indianas-long-term-care-system-redesign-focuses-on-dual-eligible-populations, and a brief summary of North Carolina's efforts is available here: https://www.arnoldventures.org/stories/building-state-specific-recommendations-to-support-integrated-care-for-dual-eligible-individuals.

[xx] The Commonwealth Fund. "Medicare Data Hub." https://www.commonwealthfund.org/medicare-data-hub/medicare-advantage#plan-avail.

[xxi] Lipson, D., E. Weir Lakhmani, A. Tourtellotte, and D. Chelminsky. "The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries." Mathematica report for MACPAC, December 2018. Available at https://www.mathematica.org/publications/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations.

[xxii] Lipson, D., L. Kimmey, D. Chelminsky, et al. "Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans." Mathematica report for Arnold Ventures, January 15, 2021. Available at https://mathematica.org/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans.

[xxiii] Medicaid and CHIP Payment and Access Commission. "Report to Congress on Medicaid and CHIP." June 2020. Chapter 2, "Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options," https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf and Medicare Payment Advisory Commission (MedPAC). "Report to the Congress: Medicare and the Health Care Delivery System." June 2019. Chapter 12: "Promoting Integration in Dual-Eligible Special Needs Plans." https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf.

[xxiv] Medicare Advantage D-SNPs are required to develop models of care and provide care coordination that are not provided by regular (non-D-SNP) MA plans or through traditional FFS Medicare. Although regular MA plans may also cover supplemental benefits, D-SNPs can offer supplemental benefits that specifically cater to the needs of dually eligible populations.

[xxv] Feng, Z., et al. "Comparing Outcomes for Dual Eligible Beneficiaries in Integrated Care: Final Report." RTI International Report for ASPE, September 2021. https://aspe.hhs.gov/reports/comparing-outcomes-dual-eligibles.

[xxvi] For example, nearly 15 percent of high-need dually eligible beneficiaries enrolled in an MA plan switched to traditional Medicare in 2014 or 2015, nearly three times as many (4.6 percent) as high-need *non-dually eligible* Medicare beneficiaries. Meyers, D.J., E. Belanger, N. Joyce, J. McHugh, M. Rahman, and V. Mor. "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries." *JAMA Internal Medicine*, vol. 179, no. 4, 2019, pp. 524–532. https://pubmed.ncbi.nlm.nih.gov/30801625/.

[xxvii] As of 2019, dually eligible beneficiaries can change plans only once per quarter except in the last quarter of the year (42 CFR §423.38(c)(4)(i)). In contrast, Medicare-only beneficiaries are locked in to MA plans for the entire year when they make a plan selection (with some exceptions).

[xxviii] Because CMS reports disenrollment rates at the MA *contract* level, and a given MA contract can include multiple MA plan types (D-SNPs as well as regular, non-SNP MA plans), we restricted our study sample to MA contracts that enrolled all or mostly (more than 70 percent) dually eligible individuals, which we called D-SNP-dominant MA plans.

[xxix] Lipson, D., L. Kimmey, D. Chelminsky, et al. "Why Dually Eligible Beneficiaries Stay or Leave Integrated Care Plans." Issue brief, Mathematica, January 2021. https://www.mathematica.org/publications/why-dually-eligible-beneficiaries-stay-or-leave-integrated-care-plans.

[xxx] The use of deceptive or misleading marketing practices was also described in a recent report by the U.S. Senate Finance Committee: "Deceptive Marketing Practices Flourish in Medicare Advantage." 2022. https://www.finance.senate.gov/imo/media/doc/Deceptive%20Marketing%20Practices%20Flourish%20in%20Medicare%20Advantage.pdf.

[xxxi] Lipson, D. "Should I Stay or Should I Go? Why Dually Eligible Beneficiaries Stay or Leave Integrated Health Care Plans." Mathematica blog, February 10, 2021. https://www.mathematica.org/blogs/should-i-stay-or-should-i-go-why-dually-eligible-beneficiaries-stay-or-leave-integrated-health-care.

[xxxii] The Commonwealth Fund. "Medicare Data Hub." https://www.commonwealthfund.org/medicare-data-hub/medicare-advantage#plan-avail.

[xxxiii] Lipson, D., E. Weir Lakhmani, T. Alena, and D. Chelminsky. "The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries." Report for MACPAC, December 2018. https://www.macpac.gov/wp-content/uploads/2019/01/Enrollment-in-Integrated-Care-Demonstrations-for-Dually-Eligible-Beneficiaries.pdf.

[xxxiv] Weir Lakhmani, E., A. Lomas, and E. Wood. "Preventing and Addressing Unnecessary Medicaid Eligibility Churn Among Dually Eligible Individuals: Opportunities for States." Integrated Care Resource Center Technical Assistance Brief, March 2022. https://integratedcareresourcecenter.com/resource/preventing-and-addressing-unnecessary-medicaid-eligibility-churn-among-dually-eligible.

[xxxv] Although many D-SNPs operate in rural areas, four of the five the states without any D-SNPs in 2022 are largely rural (Alaska, New Hampshire, North Dakota, and Vermont). The fifth state, Illinois, chose not to contract with D-SNPs as it offers a statewide Financial Alignment Initiative demonstration for dually eligible beneficiaries. Illinois will transition its current demonstration to a D-SNP model in 2026.

[xxxvi] Weir Lakhmani, E., D. Chelminsky, A. Tourtellotte, A. Bosold, D. Lipson, and J. Verdier. "Advancing Integrated Care for Dually Eligible Individuals: Factors Influencing State D-SNP Contracting Decisions." Mathematica issue brief, July 2021. https://www.mathematica.org/publications/advancing-integrated-care-for-dually-eligible-individuals-factors-influencing-state-d-snp.

[xxxvii] Weir Lakhmani, E. "When the Public Health Emergency Ends: What Will it Mean for Dually Eligible Individuals?" *Health Affairs Forefront*, April 8, 2022. https://www.healthaffairs.org/content/forefront/public-health-emergency-ends-mean-dually-eligible-individuals.