JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 1, 2020

Katherine Hayes
Director of Health Policy
Bipartisan Policy Center

By email: khayes@bipartisanpolicy.org

Dear Ms. Hayes:

Re: White Paper: Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid

Thank you for the opportunity to comment on the white paper, "Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid." We appreciate the thoughtful and detailed contributions of the white paper.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging has been engaged in the Financial Alignment Initiative (FAI) since its inception, working closely with advocates in the affected states and participating in policy analysis and development. Our comments are grounded primarily in that experience.

COVID-19 implications

The impact of the COVID-19 pandemic on state Medicaid program budgets is yet to be fully assessed but will certainly be substantial. As important is the impact on the financial viability and the operational aspects of the many programs serving dual eligibles. The future of many long-term services and supports is particularly concerning. In California, for example, the recent proposed state budget would totally eliminate two programs that play a major role in allowing dual eligibles to remain safely in the community and avoid institutional placement. Health services as well, such as community clinics and hospitals, also are being seriously impacted. Integration and coordination of services is of little value if the underlying services being coordinated are shuttered or decimated. There also will be a need to look at lessons learned from the COVID-19 emergency on efficient and safe delivery of home and community based services.

We expect that in the short and medium-term, stabilizing long-term services and supports for dual eligible beneficiaries and ensuring their effective operation in a post-COVID environment will – and should—take precedence over major changes in the superstructure of delivery systems for dual eligibles.

Policy Options and Rationale

We appreciate the proposals to address regulatory barriers to alignment, provide incentives and assistance to states and improve the beneficiary experience. Although there is much detailed work to be done in all areas, expanding access to and improving the quality of home and community based services must be a primary goal of delivery system reform for dual eligibles. We therefore urge prioritizing alignment, incentives and standards that move that goal forward. Much can be learned from the experiences of the FAI in this area.

Stakeholder involvement in the development of new policies, measures and standards must be meaningful and sustained. Transparency both in the development and execution of measures and standards is essential so that all stakeholders, including beneficiaries, can judge the effectiveness of a program is in delivering needed services and improving care.

The proposal to allow states to implement 12 months of continuous Medicaid eligibility for dual eligibles is one where legislative action is needed and would be particularly welcome. Increased funding for SHIPs and ACL to assist dual eligibles also is critical for the success of any transition and the education of beneficiaries. One important learning from the FAI that was not highlighted in the white paper was the value of a program-specific ombudsman program. As was demonstrated in the FAI, the ombudsman programs were particularly important in identifying systemic issues so that both plans and states could address them at early stages. Beneficiaries, plans and the states benefitted from the ability of the ombudsman to elevate concerns at an early stage. In many cases, appeals could be avoided, leading to quicker resolution of problems and strengthening of beneficiary protections.

The rest of our comments focus on the last set of recommendations under the heading "Require full integration of Medicare and Medicaid."

Required integration: We have concerns about "requiring" integration if that means requiring dual eligible beneficiaries to enroll in integrated products. We believe it is important for every dual eligible to have an integrated option available. Enrollment into an integrated model should, however, be optional. As Part 1 of the white paper shows so well, dual eligible beneficiaries are a diverse population with many different levels and types of needs. Dual eligibles, like all Medicare beneficiaries, should be able to choose whether original Medicare or an integrated product better serves their particular needs. The fact that dual eligible beneficiaries require assistance from their state Medicaid program does not and should not take away that autonomy.

Timeframe: As noted above, the COVID-19 pandemic has set back the timetable for much of what has been in the planning stage for both Medicare and Medicaid. More generally, we have concerns about setting a national timetable for full integration, even if further out. Currently, the experience of the states with integrated options varies greatly. Even those states that have developed highly integrated options often have only rolled them out in certain portions of the state or with specific sub-populations of dual eligibles. State experience has shown that integration efforts require a great deal of preparation, and input and buy-in from consumers, providers and many other stakeholders. Experience, including experience with the FAI, has also shown that beneficiary access to care can easily be affected if any components in a new system are not working well.

We would urge an approach in which CMS works with states individually on programs and timelines that work for those states. Setting milestones can be valuable but care must be taken to ensure that deadlines do not lead to launch of programs before they can be fully developed.

FIDE-SNPs: We appreciate that the paper recognizes that the FAI, managed fee-for-service, PACE and other models offer alternative approaches that states could choose to integrate care. We note, however, that much of the discussion within the paper focuses on FIDE-SNPs (as does much discussion in the policy world more generally). We hope that as states and CMS consider ways to better integrate care for dual eligibles, they do not narrow their focus to D-SNPs or FIDE-SNPs. Although we recognize the attraction of having one uniform national model, we think it is premature to determine that D-SNPs should be the only or dominant choice.

D-SNPs have been around for many years and, to date, experience with them has been very mixed. Though some D-SNPs in some states have moved benefit integration forward, there are far too many instances where D-SNPs have done little to distinguish themselves from ordinary Medicare Advantage products. In light of this unexceptional record, we think it is far too early to settle on D-SNPs as the preferred vehicle for integrating care for duals. Experience with FIDE-SNPs has been even more limited.

We also are concerned that abandoning the concept of full financial and operational integration tested in the FAI in favor of falling back into a less integrated D-SNP model would be a lost opportunity. Further the managed fee-for-service model piloted in Washington state appears to have offered an improved experience and financial savings in a model that is significantly less complex than FIDE-SNPs. More experience with these models, rigorously tested and compared with FIDE-SNP models, should inform any decision, and particularly any legislation, that would lock in a preference for FIDE-SNPs.

We also would not support requiring that Medicare Advantage plan sponsors must offer a FIDE-SNP in every market where they operate. Many states with Medicaid managed care have chosen to contract with a limited number of plans. The proposed requirement would put pressure on states to contract with more plans than are actually qualified or that the state has capacity to oversee and regulate. Further, we see little value for beneficiaries and potentially a lot of confusion if, for example, ten or more FIDE-SNPs were offered in the same market.

Federal option: We do not have a position on a federal option for states that wish to cede integrated care responsibilities for their dual eligible beneficiaries. We do note that the requirements to ramp up federal expertise and oversight with respect to long-term services and supports would be significant.

Thank you for the opportunity to share our thoughts. We are very appreciative of the contributions of the Bipartisan Policy Center to policy development in this critical area for beneficiaries.

If any questions arise concerning this submission, please contact Georgia Burke, Directing Attorney, at achrist@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director