January 13, 2023

Senator Bill Cassidy, M.D.
Senator Thomas R. Carper
Senator Tim Scott
Senator Mark Warner
Senator John Cornyn
Senator Robert Menendez

RE: The Dual Eligible Population

Submitted electronically: dualeligibles@cassidy.senate.gov

Dear Senators,

Trinity Health appreciates the opportunity to respond to your request for ideas, data, and experience with the dual eligible population. Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, the second largest PACE program in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is $21.5 billion with $1.4 billion returned to its communities in the form of charity care and other community benefit programs.

Trinity Health has 17 Clinically Integrated Networks (CINs) that are accountable for approximately 2 million lives across the country through alternative payment models. Our health care system participates in 14 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes eleven markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the "enhanced track", which qualifies as an advanced alternative payment model (AAPM). Two of the 14 markets also participate in CPC+. In addition, we have 33 hospitals participating in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative, and three hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Trinity Health is a leading health system in value and our ACOs produce year-over-year improvements in clinical outcomes for Medicare beneficiaries across the country, many of whom are clinically and socially vulnerable. Together, our Medicare ACOs earned $43.7M in shared savings and achieved top decile quality for nearly 300,000 Medicare beneficiaries. In all of Trinity Health's ACOs, we care for 25,000 beneficiaries who are dually enrolled in Medicare and Medicaid. This population comprises 15% of our total ACO attributed lives nationally but is as high as 28% in one community.

As the largest not-for-profit provider of Programs of All-inclusive Care for the Elderly (PACE), our experience in caring for the Medicare/Medicaid, dually eligible population is considerable and positive – 94% of our PACE participants are dually enrolled. To qualify for PACE, a person must be age 55 or over, live in a PACE service area, and be certified by the state to need a nursing home level care.

The typical PACE participant is similar to the average nursing home resident. The typical participant is an 77-year-old woman with six medical conditions and limitations in multiple activities of daily living. Nearly half (46 percent) of PACE participants have been diagnosed with dementia. Despite a high level of care needs, more than 90 percent of PACE participants are able to continue to live in their community rather than a nursing facility.

PACE is a highly integrated system of care, both clinically and financially. It is:

- Community-based: Participants live at home in a geographic area served by PACE.

- Comprehensive: All services that help participants live independent are provided by the PACE program (medical, social, behavioral, including transportation, adult day services, etc.).
- Capitated: Paid for by both Medicare and Medicaid on a per member per month basis. Those funds are used to coordinate and integrate all needed care. The participant has no co-pays.
- Coordinated: All care is supervised by the Interdisciplinary Team (IDT).
- Integrated: Optimizes all Medicare and Medicaid benefits.

Trinity Health PACE currently has 13 programs and 19 centers (owned or managed) in 9 states with 3 more currently under development. Access and growth of PACE remains a high priority for Trinity Health.

Q & A:

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?
Integrated care is the ultimate goal for any health care model. True integration exists when the provider has accountability for the total cost of care and the outcomes for both Medicare and Medicaid funding, addressing the total needs of the patient, clinical, social, and behavioral, with a comprehensive plan of care. Integration includes the payor and provider, meaning communication flows, clinical accountability, and contracting is directly with the provider of care. PACE offers the best example of this method. PACE programs, through a 3-way agreement, contract with CMS (Medicare), the state (Medicaid) and the PACE program is the third piece (Provider). Under this arrangement, PACE not only coordinates all care needs and benefits under both Medicare and Medicaid, but it is also able to integrate financial, clinical, and social needs under the direction of an Interdisciplinary Team (IDT). PACE does this under a capitated, 100% full-risk method. PACE is truly the definition of Integrated care. Medicare and Medicaid, under traditional models, operate separately; different coverage and payment policies that lead to cost shifting, resulting in inappropriate utilization and poor outcomes. Working as one through an integrated network, those risks are mitigated if not eliminated. Care coordination is certainly important, but only one piece of integrated care. Coordination offers direction in the clinical space, while not necessarily optimizing benefits from different available payors. Integrated care also encompasses aligned enrollment. PACE programs for example assist the participant with the initial Medicaid application for enrollment, but also track eligibility through the redetermination process to maintain a smooth enrollment experience. If assistance is needed or questions answered, the PACE team steps the participant through what can be a very cumbersome and confusing process.

2.   What are the shortcomings of the current system of care for duals? What specific policy recommendations do you have to improve coordination and integration between Medicare and Medicaid programs?
Funding for care for the duals is a fundamental shortcoming. Reimbursement from Medicare and Medicaid has not kept up with the need or the expense to care for this population. For instance, many states have chosen not to offer PACE as an option because they question where the Medicaid funding will come from. States already fund nursing homes under Medicaid and without redirecting already existing money to PACE, they don't see a way to fund it. Rebalancing of the long-term care dollars in each state should include less for nursing homes and more for programs that keep people in their homes and community, a less expensive option, like PACE. In addition, care for the duals is often fragmented outside of PACE because of lack of integration of information and payors. Information is not carried over because providers are dealing with either Medicare or Medicaid, not typically both. In models such as the ACO, there is no financial or clinical integration. Data on cost of services provided via Medicaid is nonexistent. This provides for no opportunity or incentive to coordinate care. Therefore, public policy that fully integrates financial and clinical is the best practice in caring for the duals.

3.   In your view, which models have worked particularly well at integrating care for duals, whether at the state level, federal level, or both? Please provide data, such as comparative analyses, including details on outcome measures and control group definitions, to support your response.
The PACE model of care is by far the best way to care for the duals. The U.S. Department of Health and Human Services issued a final report in September of 2021 titled, Comparing Outcomes for Dual Eligible Beneficiaries in

Integrated Care. In this report, HHS determined that The PACE program, known for its focus on home and community-based service (HCBS) provision and full integration of a range of medical services and long-term services and supports (LTSS), stands out from the analysis as a consistently "high performer". They found that full-benefit dual eligible beneficiaries in PACE are significantly less likely to be hospitalized, to visit the emergency department, or be institutionalized, while their mortality risk is not significantly higher, compared to regular MA enrollees. PACE is designed to enroll people who have frailty levels qualifying for NF care, but who are treated at home as long as possible. This report clearly draws conclusions on the benefits of truly integrated care models, such as PACE. The data and outcome measures also support this claim.

Data from the National PACE Association:
- Lower Hospitalization Rate: A 24 percent lower hospitalization rate than dually eligible beneficiaries who receive Medicaid nursing home services.
- Decreased Rehospitalizations: 16 percent less than the national rehospitalization rate of 22.9 percent for dually eligible beneficiaries aged 65 and over.
- Reduced ER Visits: Less than one emergency room visit per member per year.
- Compared to data of FFS and ACO similar populations, PACE integrated model of care has the least number of hospitalizations and preventable hospitalizations.

	Hospitalizations	Preventable Hospitalizations
FFS*	962	250
ACO	899	132
PACE	547	100

*The studies highlighted use a PACE-eligible FFS population for comparison; for our ACO data we also used a PACE-eligible population, though not exactly the same.

4. *After reviewing these models, would you recommend building upon current systems in place (e.g., improving aligned enrollment and/or coordination of care between two separate Medicare and Medicaid plans) or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on need?*
Trinity Health recommends building on current systems in the following ways:
- Expand PACE to all states by making it a mandatory benefit under CMS.
- Pilot new models in PACE to care for new populations. The PACE Innovation Act of 2015 allows CMS to test new models, allowing for PACE to care for populations outside of the current eligibility requirements. Multiple conversations with CMMI and the National PACE Association (NPA) and Trinity Health, have encouraged the agency to move forward on pilots in PACE with new populations. There are currently no pilots being tested. This is an opportunity already allowed under current law.
- Apply the best features of PACE to other models. The best opportunity we see in traditional Medicare is full financial and clinical integration for patients attributed to ACOs who are also eligible for Medicaid. For those who have enrolled in Medicare Advantage, full financial integration of D-SNPs. Both would bring those models from care coordination to the higher standard of clinical and financial integration.

5. *If you believe a new unified system is necessary, what are key improvements we should prioritize? What would such a system look like? Please provide details on financing, administration (e.g., federal government vs. state government), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.*
Although Trinity Health believes that building on the current system and the benefits of integration already seen in the PACE model would be best, changes are necessary to bring about positive outcomes. Currently our health care system for the dually enrolled is managed state-by-state. This system is not only cumbersome but lacks continuity

in almost every area. To truly make a change for the better in care for the duals, a national strategy is necessary. This would allow programs like PACE to become a national standard, not an optional choice of states. Any national strategy should include FMAP funding so that state Medicaid agencies can more easily transition to the national model and adequate Medicare reimbursement to encourage providers to participate in new and innovative models. In addition, an innovative ACO model of care for those with traditional Medicare, that fully integrates Medicaid payment, should be developed, and piloted by provider-led ACOs. Trinity Health would gladly work with policymakers to help design this model. We are recommending Congress hold hearings and allow providers with successful experience caring for the duals to demonstrate their effective models and show how a national strategy that encompasses a truly integrated ACO model and provider sponsored MA Plans that manage the care and the costs of the duals through a legislative pathway, is the means to a positive outcome for both patient and payor.

6.   *How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?*
A national system to determine or redetermine eligibility should be built in for greater continuity, ease of process, and fairness. We must also be cognizant of health literacy needs. Compared with people with disabilities who have only Medicaid coverage, dually eligible individuals are more likely to have three or more comorbid chronic conditions and to use long-term services and supports (LTSS). Losing Medicaid eligibility could mean losing critical services that help individuals live in the community and prevent them from entering institutions.

Second, dually eligible individuals are also more likely to have Alzheimer's disease or related dementia than people with only Medicaid. This means dually eligible populations might require more help navigating the process of renewing their Medicaid eligibility than other groups.

Therefore, Trinity Health believes it is essential that states provide plentiful, widely accessible, and robust assistance to Medicaid beneficiaries and their families as they explore the public and private programs available to them, navigate eligibility and enrollment requirements and weigh other factors that affect their ability to live independently. Options counseling in each state not only lacks continuity but also a full range of understanding of the available options. Dual eligible beneficiaries should have access to a strong Ombudsman service that provides options counseling in a timely and continuous manner so that critical information is available when decisions for enrollment need to be made. A comprehensive, competent, and conflict-free options counseling program would promote and protect the interests of consumers, caregivers, providers, policymakers, and taxpayers. Awareness, understanding and an ability to fully explain PACE and/or D-SNPs as an option is critical to the options counseling requirement.

In addition, changing or losing coverage can result in disruption of care by interrupting, delaying or even eliminating one's ability to see their chosen community physician. This has long been a concern when participants consider joining a PACE program. Participants must change doctors and start seeing the PACE physician. This deterrent to joining can be alleviated with a waiver to allow a community physician to continue to see the participant under certain rules. PACE ultimately manages and helps the participant navigate any changes in care or coverage in a way that supports their goals. This rarely happens in fee-for-service or even the ACOs or MA plans, where the need to help the duals navigate coverage can be great. As noted by Senator Cassidy in a recent Modern Healthcare opinion piece, "Navigating health insurance with one payer can already be difficult; two payers for health insurance is an unwanted challenge. Additionally, some studies indicate that patients are worse off with two uncoordinated payers. Strong consideration should be given to simplifying coverage, which could include unifying management of benefits under a primary payer. This would improve clinical outcomes and prevent unnecessary spending by clearly aligning financial incentives toward the best outcomes for patients."

7.   N/A

8.   *What is the best way to ensure that this system takes- into-account the diversity of the dually eligible population and is sufficiently targeted to ensure improved outcomes across each sub-group of beneficiaries? How should these sub-groups be defined and how should the data be disaggregated?*

Please provide examples of methodology and the evidence-based rationale for each example?
Current risk-stratification and identification methods are mostly clinical, without the socioeconomic factors which strongly impact the lives of the duals. The CDC/ATSDR Social Vulnerability Index (SVI) tracks 16 social factors and groups them into four related themes including socioeconomic status, household characteristics, racial and ethnic minority status along with housing type and transportation. These databases identify and map communities that will most likely need support, especially before, during, and after hazardous events. This information provides valuable information to health care providers in identifying vulnerable populations to prioritize outreach and support in the communities served.[1]

The Frailty Index further defines populations that are 55 years and older and have a presence of at least two conditions of twelve specific frailty indicators including abnormality of gait, protein-calorie malnutrition, adult failure to thrive, cachexia, debility, difficulty in walking, history of falls, muscular wasting, and disuse atrophy, muscle weakness, decubitus ulcer of the skin, senility without mention of psychosis, and/or durable medical equipment. Based on this peer-reviewed patient segmentation methodology, it identified the "frail elderly" as the largest proportion of high-cost patients. Health systems, hospitals, and clinicians looking to reduce costs and improve outcomes may benefit from using this patient segmentation methodology.[2]

The Trinity Health Mission and Core Values compel us to advocate for change to the systemic policies that limit and shape opportunities for minority and underserved populations. We have undertaken systemwide efforts led by our senior leadership to examine our role as a health system in advancing equity in every community we serve. As part of this effort, we have developed a set of principles to guide our journey to health equity, which can be found here. The Core Values of reverence, commitment to those who are poor, safety, justice, stewardship, and integrity guide this work to improve the health of all communities and dismantle barriers to inequities in health care. Our comments are aligned with and in support of these principles and goals. Below, we offer comments in support of these shared goals on 1) stratifying quality measures by race and ethnicity and 2) improving demographic data collection.

<u>Stratification of Quality Measures by Race and Ethnicity</u>
Trinity Health supports efforts to expand stratification of quality measures beyond dual eligible status to race/ethnicity and to include those social factors that impact beneficiary health outcomes, such as housing. We believe it is critical to have accurate and complete information on race/ethnicity, and eventually other social factors that contribute to health, to identify areas where interventions are needed to reduce health disparities and close the health equity gap. However, interventions that are designed using incomplete or inaccurate data will not achieve our shared goals to advance health equity.

Previously, CMS sought feedback on the benefits and challenges of using indirect estimation for race/ethnicity data. We understand CMS thought of using this method to improve missing race/ethnicity data for reporting purposes and we fully support CMS' focus on minimizing provider burden. However, indirect estimation may not yield accurate data on race/ethnicity, which would seriously limit its utility and could inadvertently lead to the creation of interventions or efforts that do not achieve the intended goals of identifying where disparities exist and advancing equity in the longer term. For instance, race/ethnicity information provided through Medicare claims data are often inaccurate. Trinity Health recommends Congress request that CMS focus on developing a plan with providers and other stakeholders to collect race/ethnicity data in a centralized and standardized manner and would discourage using indirectly estimated data for any reporting or payment purposes in the meantime.

CMS also previously requested stakeholder feedback on ways to address challenges in defining and collecting demographic information. Again, we believe collecting standardized and accurate information on identified

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[1] https://www.atsdr.cdc.org/placeandhealth/svi/fact_sheet/fact_sheet.html

[2] K. E. Johnt, J. F. Figueroa, N. Beaulieu, R. C. Wild, E. J. Orav & A. K. Jha (2017). Segmenting high-cost Medicare patients into potentially actionable cohorts. *Healthcare (5*), 1-2, 62-67. Retrieved from: doi.org/10.1016/j.hjdsi.2016.11.002

demographic variables, including race/ethnicity, disability, language preference, and housing status, among other variables is foundational to advancing health equity. However, collecting these data at point of admission will require significant training of staff to ensure standardization and accuracy. Our ministry in New York is participating in a CMS pilot, which includes screening for social determinants of health (SDoH). They have used and integrated an abbreviated 8-question tool but have found that it has been difficult to integrate even a short questionnaire into staff workflow at point of care. From our experience, we have found there is a hesitancy among the workforce to ask about these social and demographic aspects of public health data.

Trinity Health recommends Congress direct CMS to explore ways to collect certain demographic variables at point of enrollment in Medicare that would be shared with providers (e.g., race/ethnicity, language preference) so that they are actionable. We also urge CMS to work towards collecting key demographic data using interoperable health information exchange at point of care to ensure communication of both fixed and changing demographic and social factors to providers. In addition, specific training and educational supports are necessary to support staff in addressing the social aspects of how these questions are asked and incorporated into different workflows – and at multiple points in the health care continuum.

Demographic Data Collection to Synthesize Results Across Social Risk Factors
Trinity Health supports efforts to expand and standardize collection of demographic factors such as disability and language preference. In our Advocacy with CMS, we asked the agency to consider adding housing status, written, and spoken primary language, and veteran status as additional factors to be included as part of a minimum set of demographic data elements. Our system is working with Epic and other health system partners to standardize collection of housing status, among other variables, given the well-documented relationship between housing and health outcomes. Trinity Health would welcome the opportunity to share additional information on these efforts. In addition, we recommended that CMS examine how Medicaid managed care organizations (MCOs) collect demographic data through comprehensive assessments and the applicability of or lessons learned from this approach that could be applied to the Medicare program.

We believe that standardized, accurate and robust data collection should include race/ethnicity, gender identity and sexual orientation, and that these data should be reported and shared between health systems, other clinical providers, public health departments and government for disease prevention, detection, and mitigation. Further, health care and public health professionals should use a mandated standardized data set that includes data elements such as race/ethnicity, gender identity, and sexual orientation.

Demographic data collection efforts should be based on standardized electronic data definitions and should be available to providers via interoperable health information exchange. As the federal government develops potential approaches for collecting demographic data at point of admission, CMS should consider challenges unique to sub-populations of beneficiaries. For instance, we have found it is very challenging to collect demographic information for homeless patients – and that successful collection requires one-on-one discussion, which is time and resource intensive. We also recommended that all demographic information be self-reported to ensure accuracy and to eliminate the potential for any bias on the part of those collecting data.

9.   Does your data identify subgroups of individuals for whom having coverage from two payors is inefficient or is associated with worse clinical outcomes, as seen in academic literature?
As stated above, plans like PACE that are truly an integrated financial and clinical model, have the best outcomes for the duals. Whereas, other plans that provide care coordination, without the consideration of multiple payors and benefits, have less-desirable outcomes. Clearly an all-inclusive, capitated, full-risk, integrated model, is the exception to the rule, but should be viewed as best practice and imitated across models. Please see the data above in response to question 3 that indicates differences in outcomes for Medicare beneficiaries in non-coordinated FFS, coordinated but not integrated ACO, and fully coordinated and integrated PACE models.
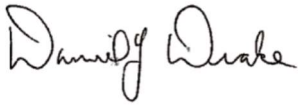
10. N/A

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

Geography plays a crucial role in how the duals receive care. A lack of providers in rural areas has the biggest negative impact. That, with a lack of transportation or just the sheer distance to a provider, also negatively impact access to care. PACE programs are most often located in high-density urban areas, central to many duals. But because PACE must limit the amount of time a participant spends on the bus in transport to the Center by regulation, many rural areas are simply not accessible. Two ways to deal with the lack of providers and the distance is a continuation for patients to have access to care through telehealth and for providers, like Home Health, to be reimbursed for Remote Patient Monitoring (RPM) to have real-time reports on high-risk patients. Telehealth and RPM became widely used during the pandemic and have proven that for many, it is the best way to keep them safely in their homes and community.

Trinity Health appreciates the opportunity to provide input and we are happy to answer any questions or provide information and expertise should you need that going forward. Please contact Donna Wilhelm, Vice President of Advocacy and Government Relations for Trinity Health Continuing Care at donnaw@trinity-health.org or 251-504-7353 for more information.

Sincerely,

Dan Drake
President and CEO, Trinity Health PACE