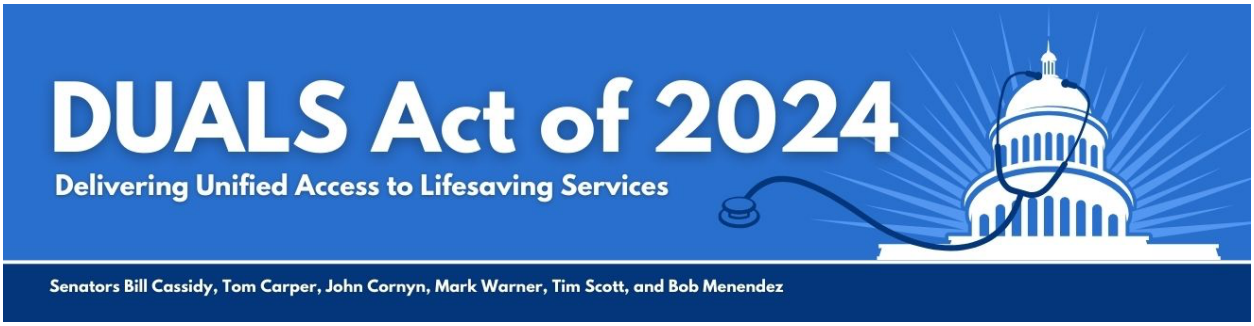


The Delivering Unified Access to Lifesaving Services Act of 2024

Senators Cassidy, Carper, Cornyn, Warner, Tim Scott, Menendez

WHO ARE DUAL ELIGIBLES

- Dually eligible beneficiaries are people enrolled in both Medicare and Medicaid who are eligible by virtue of their age or disability and low incomes.
- Approximately 12.2 million low-income or disabled people in the United States are jointly enrolled in Medicare and Medicaid.
- This is a diverse population that includes people with multiple chronic conditions, physical disabilities, mental illness, and cognitive impairments such as dementia and developmental disabilities. It also includes individuals who are relatively healthy.

WHAT ARE THE CHALLENGES

- Dually eligible beneficiaries account for a disproportionate share of spending. In Medicare, while only making up 19 percent of enrollment, they account for 34 percent of spending. In Medicaid, they account 30 percent of spending and 14 percent of enrollment.
- Most dual eligibles today are covered by two separate Medicare and Medicaid plans that do not coordinate care nor align enrollment. This discordance can lead to both poor outcomes for patients and inefficient spending for the health care system.

WHAT DOES THE LEGISLATION DO?

- Requires each state, with support from CMS, to select, develop and implement a comprehensive, integrated health plan for dual-eligible beneficiaries. States can create a new system or build off of existing coverage options.
- Improves beneficiary experience by requiring plans to develop and update care coordination plans, requiring the establishment of ombudsman offices, and establishing a care coordinator for each beneficiary.
- Reduces beneficiary confusion by reducing “look-alike” plans which target dual eligible beneficiaries for enrollment but don’t provide any coordination, creating a single appeals process instead of the current Medicare and Medicaid appeals process, and reducing third-party marketing organization incentives to target beneficiaries.
- Expands PACE coverage by requiring every state to allow PACE programs to be established, allowing enrollment at any time in the month, and expanding PACE coverage to individuals under the age of 55.

The DUALS Act of 2024 is endorsed by: Centerlight Health, Santa Clara Family Health Plan, Association for Community Affiliated Plans, PointClickCare, Welbe Health, American Kidney Fund, National Multiple Sclerosis Society, Alliance of Community Health Plans, LeadingAge, Bipartisan Policy Center, National Health Council, ChristianaCare, DaVita, and National Pace Association.

MARCH 14, 2024

CASSIDY, CARPER, CORNYN, WARNER, SCOTT, MENENDEZ COMPREHENSIVE LEGISLATION IMPROVE CARE FOR PATIENTS JOINTLY ENROLLED IN MEDICARE AND MEDICAID

OVER THE LAST TWO YEARS, THE DUALS WORKING GROUP HAS GATHERED FEEDBACK FROM HEALTH CARE COMMUNITY

WASHINGTON – U.S. Senators Bill Cassidy, M.D. (R-LA), Tom Carper (D-DE), John Cornyn (R-TX), Mark Warner (D-VA), Tim Scott (R-SC), and Bob Menendez (D-NJ), members of the Senate Duals Working Group, introduced the Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024 to improve coverage for individuals jointly enrolled in Medicare and Medicaid, also known as dual eligibles.

"Patients dually eligible for Medicare and Medicaid have much worse outcomes than other groups even though there is a lot more money spent on their care," **said Dr. Cassidy.** "Making Medicare and Medicaid better work together makes patients healthier and saves money for taxpayers."

"Beneficiaries who are dually eligible for Medicare and Medicaid are often the sickest and most vulnerable patients in our country, and, particularly for these patients, we must reduce the unnecessarily complex nature of health care in America," **said Senator Carper.** "This bipartisan bill directly works to simplify complexities for the millions of dual eligible Americans in need, while simultaneously reducing bureaucratic headaches for the government,

health care providers, and patients alike. We've worked hard over the last three years to draft this legislation, and I'm proud to introduce the product of our years of work today."

"Medicare and Medicaid oftentimes don't coordinate care for individuals enrolled in both programs, which can lead to poor outcomes for patients and inefficient spending for our health care system," **said Senator Cornyn.** "By requiring states to develop an integrated health plan for these Americans, this legislation would help streamline the system, improve beneficiary experience, and ensure taxpayer dollars are spent responsibly."

"This bill is the result of a year of work and input from stakeholders across the country," **said Senator Warner.** "It responds directly to what we heard and what we've known for awhile, which is that the status quo isn't working. This bill will help make sure that duals have access to improved, integrated care, and that states receive additional resources so that they can more fully support this vulnerable population."

"Many states lack fully integrated care between Medicare and Medicaid, leaving dually eligible individuals with fragmented care and the headaches of confusing bureaucracy. We can, and must, do better for this vulnerable population," **said Senator Scott.** "Our bill will help ensure these programs work together so that patients across the nation can access the high quality care they deserve."

The DUALS Act of 2024:

- Requires each state, with support from the Centers for Medicare & Medicaid Services (CMS), to select, develop and implement a comprehensive, integrated health plan for dual-eligible beneficiaries. States can create a new system or build off of existing coverage options.

- Improves beneficiary experience by requiring plans to develop and update care coordination plans, requiring the establishment of ombudsman offices, and establishing a care coordinator for each beneficiary.
- Reduces beneficiary confusion by reducing "look-alike" plans which target dual eligible beneficiaries for enrollment but don't provide any coordination, creates a single appeals process instead of the current Medicare and Medicaid appeals process, and reduces third-party marketing organization incentives to target beneficiaries.
- Expands Program of All-Inclusive Care for the Elderly (PACE) coverage nationwide by requiring every state to allow PACE programs to be established, allows enrollment in a PACE program at any time in the month, and expands PACE coverage to individuals under the age of 55.

The DUALS Act of 2024 is supported by Centerlight Healthcare, Santa Clara Family Health Plan, Association for Community Affiliated Plans (ACAP), PointClickCare, Welbe Health, American Kidney Fund, National Multiple Sclerosis Society, Alliance of Community Health Plans, LeadingAge, Bipartisan Policy Center, National Health Council, ChristianaCare, DaVita, and National Pace Association.

Click **HERE** for the one-pager.

Click **HERE** for a section-by-section.

Background

The Duals Working Group convened in November 2022 as they sought feedback from the health care and patient communities to develop legislation that would improve coverage for dual eligibles. The working group requested specific information regarding shortfalls in the current

system of care for dual eligibles, how to improve patient health outcomes, and the role of federal or state governments in dual eligibles' care. In May 2023, the Working Group released discussion draft legislation for feedback.

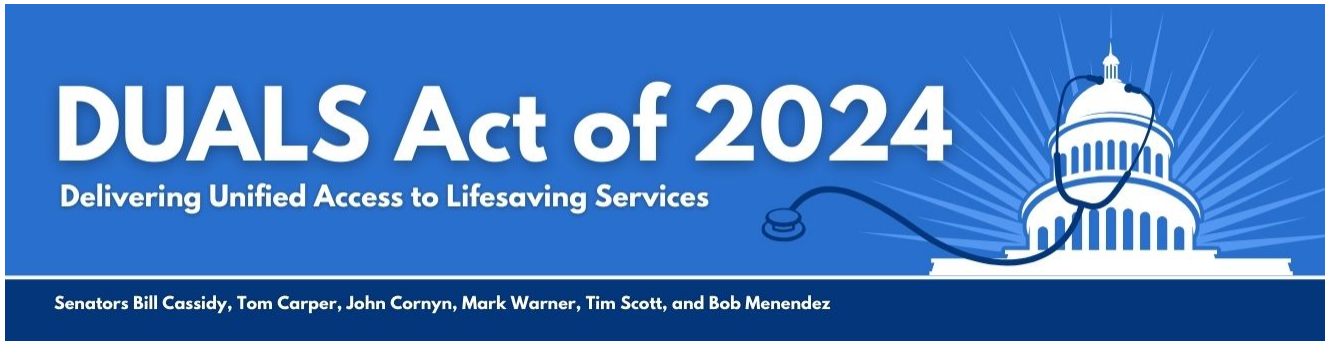
In May 2023, the Working Group released discussion draft legislation for feedback.

Cassidy also co-authored a Viewpoint in the Journal of the American Medical Association on patients jointly enrolled in Medicare and Medicaid. The Viewpoint asserts that poor payment coordination between Medicare and Medicaid drives uncoordinated care and worse outcomes for a majority of dual eligible patients.

Approximately 12.2 million low-income or disabled people in the United States are jointly enrolled in Medicare and Medicaid. Dual eligibles are a diverse group with a complex, unique set of needs. This population includes individuals with multiple chronic conditions, physical disabilities, mental illness, and cognitive impairments such as dementia and developmental disabilities, and others who are relatively healthy.

While representing a small proportion of Medicare and Medicaid beneficiaries, dual eligibles account for a disproportionate share of overall spending. In the Medicare program, 19% of enrollees are dually eligible but account for 34% of spending. Similarly, 14% of Medicaid enrollees are dually eligible but constitute 30% of overall spending. In 2019, combined Medicare and Medicaid spending on dual eligibles rose to a total of $440.2 billion.

The COVID-19 pandemic has further exposed the need for reforms to systems of care for dual eligibles. According to federal data, across every demographic group dual eligibles were more likely to contract COVID-19. More concerning, dual eligibles were more than three times as likely to be hospitalized from COVID-19 compared to Medicare only individuals.



The Delivering Unified Access to Lifesaving Services Act of 2024

TITLE I

Sec. 101. State Implementation.

Sec. 2201. Definitions.
This section includes definitions.

Sec. 2202. State Selection of Program Models, Development, and Implementation.
This section outlines how states must select and develop their state integration option. Within one year of the publication of program models by MMCO, the state shall select their model and begin working with the Director of the MMCO to begin standing up their program. States must have a program ready to enroll beneficiaries within 5 years after passage of this legislation. States may stand up their program and begin enrolling beneficiaries before the 5 year deadline if they choose. The Director also has discretion to extend the timing to a later date if necessary. The section also details development of implementation councils.

Sec. 2203. Enrollment in Integrated Care.
This section allows states to passively enroll eligible individuals into the newly created integrated model. States must notify individuals at least 90 days before they are enrolled initially, and 60 prior for any additional time. An individual may not be passively enrolled unless their primary care physician is in-network. States have the option to continuously enroll individuals. Beneficiaries may enroll in an integrated plan on a monthly basis, but may not disenroll into a non-integrated plan outside of the normal enrollment window.

Sec. 2204. Plan Requirements and Payments.
This section outlines the requirements that states and plans must meet. It requires plans to give beneficiaries a 30 day period to continue coverage if they change plans, as well as a 90 day minimum for active treatments. It requires plans to assign a care coordinator and administer a health risk assessment, and establish supplementary benefits for the beneficiary. It outlines the specifics of the HRA as well as the supplementary benefits.

The section also requires plans to cover all services that a beneficiary may need, although states have flexibility in how those benefits are received. Finally, it details the requirements of the care coordinator.

Sec. 2205. Data Collection and Reporting.
This section requires annual collection of data on beneficiaries by plans and states. It also allows states to require plans to collect additional data.

Sec. 2206. State Ombudsman.
This section requires states to establish an ombudsman office to assist dual eligibles and their caregivers. It sets a minimum staffing level for the office, and provides funding from the federal government for the first two years, then moves to Medicaid matching for each subsequent year.

Sec. 2207. Funding.
This section provides the federal match funding for the integrated plan, as well as additional funding for general administrative expenses and data collection efforts. It also requires shared savings between states and the federal government.

Sec. 2208. Federal Administration Through the FCHCO.
This section establishes the FCHCO as the primary authority for implementing the integrated care model and outlines their responsibilities to implement sections of this legislation. It also gives them direct hire authority to ensure they have the staff they need to carry out their responsibilities.

Sec. 102. Providing Federal Coordinated Health Care Office Authority over Dual SNPs
This section provides authority to the FCHCO over Dual SNPs.

Sec. 103. Additional Conforming Amendments.
This section modifies current Medicare and Medicaid statute regarding enrollment and payments.

TITLE II

Sec. 201. Identifying Opportunities for State Coordination with Respect to Eligibility Determinations.
This section requires the Secretary, in consultation with states, to determine if there are opportunities to align eligibility for state and federal health programs with respect to dual eligibles.

Sec. 202. Alignment of Bidding, Reporting, and Other Dates and Deadlines for Integrated Care Plans.
This section requires the Director, within 180 days, to review bidding, reporting, and other dates and deadlines within the Medicare, Medicaid, and integrated programs, and gives them the authority to align those dates and deadlines.

Sec. 203. Grants to States and Local Community Organizations for Outreach and Enrollment.
This section appropriates an unspecified amount of money for the Secretary to award grants to state and local community organizations to conduct outreach and enroll beneficiaries in the integrated care models. It also requires the Secretary to create model standards for the outreach, such as easy to read materials and materials available online and easy to access for people with disabilities.

Sec. 204. Application of Model Standards to Information Requirements for Integrated Care Plans.

This section requires the Director and CMS Administrator to issue regulations on how information is distributed to beneficiaries.

Sec. 205. Enrollment Through Independent Brokers.

This section requires the Director and CMS Administrator to issue guidance that only independent brokers may enroll beneficiaries into integrated care plans, that the broker will only receive a commission on the initial enrollment each year, and that if a broker disenrolls a beneficiary from an integrated care plan to a non-integrate plan, they must inform the beneficiary of the health benefits they are being disenrolled from, and that the individual is being enrolled in a plan that may provide partial or no integrated care.

Sec. 206. Reducing Threshold for Look-Alike D-SNP Plans Under Medicare Advantage.

This section requires the Secretary to implement regulations reducing the number of duals allowed in a non-integrated plan to 50 percent. It only counts full-benefit dual eligibles in that number.

Sec. 207. Requiring Regular Update of Provider Directories.

This section requires the Director to issue regulations requiring integrated care plans to regularly update their provider directories, and include this as a measure in the star rating system.

Sec. 208. Review of Hospital Quality Star Rating System.

This section requires the Administrator to review the hospital quality star rating system and identify any administrative or legislative fixes to ensure adequate information is collected.

Sec. 209. Requirement for FCHCO and State Medicaid Agencies to Develop Maximum Staffing Ratios for Care Coordinators.

This section requires the Director, in consultation with State Medicaid agencies, to develop model legislation that sets staffing ratios for care coordinators. They must submit this legislation to Congress within 180 days of enactment.

Sec. 210. CMMI Testing of Coverage of Partial Benefit Dual Eligible Individuals Through State Integrated Care Program.

This section requires CMMI to develop a demonstration program allowing states to cover partial-benefit duals under the integrated care plans developed by states.

TITLE III

Sec. 301. Alignment of Billing Codes Under Titles XVIII, XIX, and XXII.

This section requires the Director to review billing codes under Medicare, Medicaid, and the newly integrated model program, and make adjustments so that codes are uniform in each program, where possible.

TITLE IV

Sec. 401. Requiring States to Offer PACE Program Services to Eligible Individuals.

This section establishes, within 180 days of enactment, PACE providers may operate in any state.

Sec. 402. Enrollment of PACE Beneficiaries at any Time.

This section allows PACE to enroll beneficiaries at any time during the month, instead of on the first of the month.

Sec. 403. Extending Eligibility for PACE to Medicare-Eligible Individuals Under the Age of 55.

This section allows PACE to enroll beneficiaries under the age of 55 if they are Medicare eligible.

Sec. 404. Removal of Quarterly Restrictions for Submission of a New PACE Organization Applications, and Removal Quarterly Restrictions for Applications in New Service Areas.

This section allows PACE organizations to submit multiple applications within the same quarter and in the same service area.

Sec. 405. Ensuring Medicare-Only PACE Program Enrollees Have a Choice of Prescription Drug Plans Under Medicare Part D.

This section allows Medicare-only PACE beneficiaries to purchase prescription drug plans through a separate Part D plan as opposed to a PACE formulary.

From: clarkeross10@comcast.net <clarkeross10@comcast.net>
Sent: Monday, January 22, 2024 5:32 PM
To: 'Reynolds, Parker (Cassidy)' <Parker_Reynolds@cassidy.senate.gov>
Cc: 'Chavez-Fernandez, Artin (Menendez)' <Artin_Chavez-Fernandez@menendez.senate.gov>; 'Nguyen, Colleen (Warner)' <Colleen_Nguyen@warner.senate.gov>; 'Carle, Victoria (Carper)' <Victoria_Carle@carper.senate.gov>; 'McCully, Meghan (Scott)' <Meghan_McCully@scott.senate.gov>; 'Walsh, Lilly (Cornyn)' <Lilly_Walsh@cornyn.senate.gov>; clarkeross10@comcast.net
Subject: RE: Seeking endorsement of dual eligible legislation

Dear Parker:

Please express our sincere appreciation to Senator Cassidy and colleagues for the initiative and serious thinking about greatly enhancing integrated services and supports for persons dually eligible for Medicare and Medicaid. Thank you.

We are not prepared at this time to endorse the legislation, but appreciate the Senator's efforts. **Maybe the greatest unanswered question that we have is the impact and unintended possible disruption of services and supports currently assisting the daily lives of the millions of persons dually eligible for Medicare and Medicaid who are served through Medicaid HCBS (home-and-community-based services) programs.**

In 2019, 7.8 million persons received Medicaid Home-and-Community-Based Services. [Mathematica for CMS. "Medicaid Beneficiaries Who Use Long-Term Services and Supports, 2019." July 22, 2023]. Of these persons, 1.9 million were served through the Section 1915 © program. [CMS. "Medicaid Section 1915 © Waiver Programs Annual Expenditures and Beneficiaries Report," June 9, 2023.] Nationally, 3 million people received HCBS services through Medicaid waiver programs. [Kaiser Family Foundation, "Medicaid Home-and-Community-Based Services: People Served and Spending During COVID-19, May 4, 2022.] [The variety of Medicaid HCBS state plan benefits and waiver options offered by states is documented in MACPAC. "Access To Home-and-Community-Based Services," chapter 4, MACPAC June 2023 meeting book.] Many of these persons are dually eligible for Medicare and Medicaid.

Much of the aging and disability movement supports proposed legislation to make Medicaid HCBS either a Medicaid state plan option or a mandatory Medicaid state plan benefit. This complicates the needed expansion and reforms Senator Cassidy has proposed.

Our preferred policy approach is to be as consistent as possible with colleague national organizations in the Consortium for Constituents with Disabilities (CCD) and Disability and Aging Collaborative (DAC), in coordination with home-and-community-based services advocates in the Mental Health Liaison Group (MHLG). We look forward to discussing the Senator Cassidy dual eligible individual proposals with our colleagues.

The Senator's legislation addresses many topics of great AAHD and Lakeshore Foundation interest: e.g., meaningful involvement of the individual's primary care physician to focus on whole-person health; connecting and coordinating multiple types of services and supports; provider network availability; assistance of a care coordinator; a comprehensive whole-person plan; individual and when appropriate family involvement in the plan's development and implementation; required behavioral health and long-term services and supports (LTSS); demographic data collection and reporting; state ombudsman programs; state advisory councils; best practices and training – just to name a few topics, But, given the evolution of disability self-determination, personal choice, and person-centeredness, the larger community will likely have different ideas on the definition, application, and implementation of these topics.

The Senator's legislation contains important items that may use disability unfriendly and or too medically-oriented terminology and practices, such as health "risk" assessments and "care" coordinators. Proposed enrollment requirements and provisions will likely be a concern to many. The legislation's quality measurement provisions are substantially behind recent CMS initiatives.

We are delighted with the Senator's ideas for meaningful and significant PACE expansions and we look forward to learning the ideas of the National PACE Association. Thank you for these initiatives.

Thank you again for your leadership, outreach, and raising these issues. The effort is great, and appreciated. We are not prepared at this time to endorse the legislation, but look forward to the discussions and considerations of members of Congress, the Administration, and the disability and aging community. Thank you for your understanding, communication, and sharing.

Sincere regards, Clarke

American Association on Health and Disability
And
Lakeshore Foundation

E. Clarke Ross, D.P.A.
AAHD Public Policy Director
Lakeshore Fd Washington Representative

From: Reynolds, Parker (Cassidy) <Parker_Reynolds@cassidy.senate.gov>
Sent: Monday, January 22, 2024 10:23 AM
To: clarkeross10@comcast.net
Cc: Chavez-Fernandez, Artin (Menendez) <Artin_Chavez-Fernandez@menendez.senate.gov>; Nguyen, Colleen (Warner) <Colleen_Nguyen@warner.senate.gov>; Carle, Victoria (Carper) <Victoria_Carle@carper.senate.gov>; McCully, Meghan (Scott) <Meghan_McCully@scott.senate.gov>; Walsh, Lilly (Cornyn) <Lilly_Walsh@cornyn.senate.gov>
Subject: Seeking endorsement of dual eligible legislation

Hi Clarke, thank you very much for your submission to our RFI asking how to improve care for dual eligibles. We really appreciated your thoughts and proposals, and our final text includes provisions that address some of them.

We require states to develop and implement an integrated care plan with one benefit package, fully-aligned benefits, and a streamlined set of measures. We improve data collection, including disability status, and collect it for all duals. We also take steps to limit broker involvement and limit look-alike D-SNP plans.

We plan on introducing our legislation on February 27th. We would love to have the support of the American Association on Health & Disability. I have attached a copy of the bill text for y'all to review. If you would like to endorse the bill, let us know by February 20th. Thanks again for your interest in our work to improve care for dual eligibles, and we look forward to hearing from you.

Parker Reynolds
Health Policy Advisor
Senator Bill Cassidy