June 30, 2023

The Honorable Bill Cassidy, M. D
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Thomas R. Carper
513 Hart Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
703 Hart Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington DC, 20510

The Honorable Robert Menendez
528 Hart Senate Office Building
Washington DC, 20510

Sent electronically to: dualeligibles@cassidy.senate.gov

Dear Sens. Cassidy, Carper, Scott, Warner, Cornyn, and Menendez:

To begin, we are very impressed with the work done to date to craft a new approach to ensuring dual eligibles are able to benefit from much-needed integrated care. It is no small task to create an entirely new title within the Social Security Act and by doing so it demonstrates the recognition that individuals who are dually eligible for both Medicare and Medicaid have very different needs, especially a need for an integrated approach to whole person care and services. We applaud this effort to deliver this integrated vision for these roughly 10 million dually eligible individuals.

The LeadingAge mission is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports (LTSS), and home and community-based services (HCBS). We also have providers who lead their own Medicare Advantage (MA) plans, Special Needs Plans (SNP), PACE programs, and other integrated models. Therefore, the focus of our remarks will be on the impacts of dually eligible older adults who our members serve in various residential and community-based settings.

Overall Thoughts and Missing Elements

While we applaud how far the initial draft legislation goes towards the vision of integration for dual eligibles, we've identified some important issues that are either unaddressed or key questions that must be answered to elevate the legislation to its full potential to deliver integration as envisioned.

The new Title XXII is entitled Integrated Care Programs (ICPs) for Dual Eligible individuals. LeadingAge strongly supports the establishment of a separate title focused exclusively on addressing the needs of those who are dually eligible and ensuring they have access to an integrated care model. Here a few overarching areas that we believe require some additional attention before introducing the legislation:

- **Add a preamble to Title XXII establishing intent and goals.** We think it would be helpful to include a preamble to the title explaining the senators' goals and/or guiding principles for dual eligibles. This can help in a couple of ways. It can help filter which provisions belong in the title and which are outside of the scope. It can also ensure that future revisions and additions to the title align with the original intent. Our reading of the draft legislation leads us to believe the intent is that duals should have access to an array of integrated care models and are best served when enrolled into such a model to ensure better care coordination, better resource utilization, and better outcomes for the individual. Integrated care must include person-centered care coordination, navigation and support; interdisciplinary care and support teams, and a single entity (either a provider organization or managed care organization) that is financially and clinically responsible for the defined services. Also, drafters should ask and answer the question, "Should duals only be permitted to enroll into an integrated care model?" Because of the unique complexities and challenges that dual eligibles encounter trying to navigate the differences between Medicare and Medicaid, we believe the answer is yes. No other population is faced with similar complexities.
- **Limit the new Title XXII to full-benefit duals initially, evaluate phasing in partial duals in the future.** While we support the effort to ensure integrated and coordinated care for more individuals, it is unclear where the benefits come for partial duals. They are not eligible for full Medicaid benefits but are merely assured that Medicaid will cover their Medicare premiums and other Medicare cost sharing. In this case, it is not clear what would be integrated for the individual nor how the benefits of participating in an ICP could help.

- **Streamline integrated models and choices by incorporating all current and future integration models under Title XXII.** Given Title XXII is specific to dual eligibles and integration, LeadingAge would recommend all integrated care models for duals be contained or incorporated by reference within this title. If all integrated care models – both current and future – are included within this title, then it creates a single door through which dual eligibles can select from a menu of integration choices. As written, Title XXII appears to create a new program of integrated care for duals, while leaving existing integrated care models as separate. Instead, we recommend that if this title is focused on integrating care for duals, then it should include all integrated care models. Therefore, we propose all existing integration models be incorporated by reference (preserving their current regulatory structure/authority and framework) into Title XXII. This approach could preserve existing and successful models such as PACE, D-SNPs, and some state-developed integrated approaches such as the OneCare Vermont, all-payer ACO model. Many of these existing models have proven successful at improving outcomes for dual eligibles while meeting or exceeding many of the same tenets identified in the new Title XXII ICPs, such as: person-centered care coordination, pooling payments, health risk assessments,

interdisciplinary care teams, etc. We should not throw out these proven integrated models nor reduce their viability by separating them from this new title. Instead, the committee is encouraged to acknowledge them within the new Title XXII as viable choices for dual eligible beneficiaries. With this in mind, we recommend that the legislation be amended to permit a dual eligible enrolled in one of these models to be determined to have enrolled into an integrated care plan and not be subject to passive enrollment. Title XXII should also include Medicare ACOs (Integrated-ACOs) and Institutional Special Needs Plans (DE-I-SNPs) that are required under the Secs. 302 and 210, respectively, to contract with their state Medicaid agency. ACOs and I-SNPs should be given an adequate transition window to become an I-ACOs and DE-I -SNPs to ensure appropriate infrastructure, training and staffing can be established to meet the integrated care requirements. Bringing all the integrated models into a single title (XXII) and construct allows us to compare them overtime, identify best practices and further innovate how integrated care is delivered.

Ultimately, it would be best if integrated care models shared a common set of basic requirements such as the person-centered care coordination, interdisciplinary care team requirements, etc. as outlined in the Title XXII requirements. However, existing models should be able to prove that their current requirements meet or exceed these requirements and permitted a transition period if they do not.

Further, we recommend eliminating the D-SNP option in the traditional MA marketplace and transitioning them into Title XXII either by conversion to an ICP or by reference to their existing statutory and regulatory authority. Only dual eligibles are eligible to enroll in D-SNPs and therefore, they should be housed within Title XXII. Converting them to an ICP would eliminate the need for CMS to continue to develop regulations around Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) and Highly-Integrated Dual Eligible Special Needs Plans (HIDE) SNPs. Instead, FIDE and HIDE would be replaced with the new ICP and all other non-integrated D-SNPs should be discontinued. This would eliminate variations that are confusing to dual eligibles by streamlining them into one model called ICP. As part of this transition, the MMCO Director should examine current D-SNP requirements that would be important to incorporate into the new ICP structure and eliminate any potential redundancies between the two programs.

- **Balance simplification with beneficiary choice.** We should all have options for how we receive care and services regardless of whether we are dually eligible or not. However, abundant choice is not always beneficial and instead can be daunting when faced with too many options and a lack of tools to evaluate and compare them based upon criteria important to the potential enrollee. As noted above, we believe dual eligibles should have a choice of integrated care models including existing programs (e.g. PACE) and new models. Another aspect of choice is the ability to choose between provider led models and managed care organization (MCO) – led models, between national and local entities, and between those led by your doctor or those led by your residential care provider (e.g. nursing home). We are beginning to see consolidation within the MA market. Market dominance by a few entities creates fewer choices for beneficiaries, and squeezes out smaller integrated entities who lack the same resources but might be more responsive to geographic and cultural preferences and differences. It also is proving to create a financially tenuous situation for the providers who deliver the services under these models. Title XXII has the opportunity to deploy an array of integrated model choices targeted at dual eligible needs. We hope the committee will clarify its intent to not only permit

but to incentivize a diversity of integrated entities. One way to create a favorable environment for large and small, local and national entities would be through the RFP procurement process. For example, a state might award extra points to an applying entity that is located in the state/region to be served, and/or provider-led organizations to ensure diversity and limit market consolidation of just a few entities managing all care in a market. Also, we would hope that states would consider both statewide and regional ICPs to allow local provider organizations to serve their geography. Finally, to encourage a greater diversity of ICP applicants, states should be required to issue a separate procurement for dual ICPs from other Medicaid program procurements. In other words, some applicants may excel at serving dual eligible older adults but be less able to also serve a moms and kids program.

- **Adopt state flexibilities for integrated care plans and apply to both Medicare and Medicaid.** States have the flexibility within their Medicaid managed care programs to establish a variety of requirements of the plans or entities with which they contract that are not permitted currently within Medicare Advantage program. To ensure beneficiaries' access to services and the financial viability of providers, we strongly recommend that Title XXII clearly preserve states' ability to set provider rate floors for all services within ICPs and prohibit the application of the MA non-interference clause (section 1854(6)(B)(iii) of the Social Security Act) to ICPs. Ideally, we would ask the committee to consider eliminating the non-interference clause for MA, as well, to give CMS greater ability to ensure health care access through these programs by identifying provider rate adequacy. With MA enrollment reaching the 50% threshold nationwide, certain plans exert undue pressure over providers who can no longer refuse to contract if they wish to continue to provide services and yet, the rates offered are increasingly insufficient for aging service providers' viability. MA plans are paying Skilled Nursing Facilities (SNFs) and home health agencies 60-80% of Medicare FFS rates. At the same time, these MA plans are paid 20% more than what would be paid for the same enrollee under Medicare FFS, according to a University of Southern California Schaeffer Center study. Without action to curb these plan practices, ultimately, the health care system as a whole will pay the price of these continued inadequate payments, as providers close because they can no longer cover their costs or cease to participate in MA leaving individuals lingering in hospital beds. The non-interference clause may have been necessary at the MA (Medicare + Choice) programs' inception when the MCOs had little market share but this protection is no longer warranted and should not be extended to Title XXII nor retained within the MA law. Based upon these lessons in the MA program, we recommend the elimination of the non-interference clause as part of the conforming amendments section of this legislation.

- **MMCO Director Must Seek Stakeholder Input into Assigned Tasks.** The draft legislation requires states to obtain stakeholder input but does not have the same requirement for the MMCO Director. The director is given an extensive list of responsibilities to define benefits, identify integrated care models, develop unified appeals and other administrative processes for the new program. We recommend that the legislation also include a requirement that the MMCO director seek stakeholder input either through establishing an advisory council, a technical expert panel and/or through rulemaking processes. We believe that by engaging stakeholders early in the development of key aspects of Title XXII that we will avoid many unintended consequences and achieve a more optimal program. Also, we encourage the committee and its staff to consult the current MMCO director to determine if the proposed implementation timelines are appropriate for the individual tasks and the quantity of responsibilities being added to the director's purview.

- **Ensure adequate compliance and oversight functions in new program.** We have observed as the MA program has grown that the current oversight and compliance infrastructure is inadequate in identifying and addressing compliance issues. By way of example, the April Office of Inspector General report found some MA plans were inappropriately denying or delaying beneficiary access to care. The existing audit process was not adequately catching these issues. As we embark on a new program for dual eligibles, we encourage the committee to ensure the legislation includes a robust oversight and compliance function for these new plans.

Additional Detailed Recommendations

While the above reflect some overarching themes we believe are important to address, below we provide some specific recommendations to particular sections of the draft legislation to clarify sections or address issues that may not have been considered in the initial drafting, or may require further consideration.

- **Prohibit MA Look Alike Plans:** We support efforts to eliminate D-SNP "look alike" plans. MA "look alike" plans do not serve duals well and as such, this should not be a choice for duals. Sec. 207 of the draft legislation proposes to reduce the threshold for look-alike D-SNP plans under MA. We support this language. However, to best serve dual eligibles, our preferred approach would be that the legislation prohibit MA plans from enrolling full-benefit dual eligibles into their products. If the intent of the new Title XXII is to ensure dual eligibles receive integrated care, then traditional MA plans should not be an option as they do not offer an integrated care model, including having no or a limited care coordination function, no alignment with state Medicaid programs, and no interdisciplinary model. By prohibiting MA plans from enrolling dual eligibles, it eliminates the need for CMS to track and police how many duals are in a MA plan to ensure it is below any established threshold. This legislation presents an opportunity to correct this bad practice altogether.

- **Clarify How Eligibility for Services will work.** Medicaid eligibility can be based upon income and clinical eligibility. For example, sometimes an older adult is determined to be at a nursing home level of care and as such eligible for Medicaid Long Term Services and Supports either in a nursing home or under a Medicaid waiver. What is not clear in the draft legislation is whether, once an individual is determined dually eligible, if they are eligible for all Medicaid state plan and/or Medicaid Home and Community Based (HCBS) waiver services including nursing home care and community LTSS services under Title XXII, or just those services through which they have obtained initial eligibility.

- **Supplemental Benefits:** We appreciate this legislation permits ICPs to offer "customized, supplemental benefits" to its enrollees without the current SSBCI limits. This provides parity with other MA/SNP plans that may be available in a given market. However, this section needs further clarification about what is meant in this section, "…as long as the plans demonstrates to the Director and the State that the offering of such benefits has a positive impact on patient health."
    - How can this be demonstrated? What kind of evidence would need to be provided? Would the evidence be on the individual level or aggregate (e.g., all diabetics benefit from X service)?
    - In addition, what qualifies as a "positive effect"? While a warm weather vacation in the winter would have a positive effect on one's mental health, the legislative intent is

unlikely supportive of funds being spent on a dual eligible taking a trip to Mexico to soak up some sun.
    - For the purposes of this section, does “health” refer to physical health, mental health, etc? We would support all aspects of health being addressed including the benefit offering even addressing social risk factors (e.g. affordable housing, transportation and nutrition)

- **Implementation Council –** Requires each state to establish an implementation council that includes “a wide range of stakeholders.” This council is to provide advice and counsel to the state related to implementing its selected ICP models. LeadingAge supports this provision but would encourage the committee to be more specific about the categories of stakeholders to be included. We would recommend not only including acute care, primary care and physician specialists but also those providers that assist individuals with activities of daily living such as nursing homes, assisted living facilities; and those that coordinate and deliver services for low-income seniors in affordable housing. LeadingAge also recommends that states utilize the implementation council after implementation to help evolve models and address issues/unintended consequences.

- **Continuity of Care:** On page 11, item (2)(A) of the draft legislation, it proposes to require an ICP, to cover out-of-network primary care services for 30 days following a plan change to another ICP or disenrollment from the ICP with no new ICP selection. It is not clear which entity would be required to cover those costs for the 30-day timeframe. We have the following questions: Would it be the individual’s original ICP, or the new ICP or Medicare/Medicaid FFS that would be required to pay for the services? Or is this provision trying to indicate, that the individual’s new plan would be required to treat the out-of-network physician as in-network during the 30-day grace period? We would also suggest that the committee align this provision with the CY2024 Medicare Advantage, Part D and PACE Policy and Technical rule finalized in April 2023 calls for “active course of treatment” to be covered for the lesser of 90 days or the duration of the treatment. Under the rule, the receiving plan/payer must cover the services.

- **Application of Frailty Factor:** At present, this is permissive language versus requiring states to apply a frailty factor. If ICPs are exclusive to duals, is it better to say that ICP payments must be based upon the higher cost and frailty profile of dual eligibles in comparison to the general non-dual population. Without further detail on the payment model, it is difficult to understand where this provision fits in. Therefore, we would suggest that this topic be included in the section on how payments would be developed.

Sec. 2203: Enrollment into Integrated Care Plans.

- **Passive Enrollment with Opt Out**: In general, we are supportive of this idea but do not believe this passive enrollment or requirement to enroll in an integrated product should be limited to just the ICPs but also include other integrated care models such as integrated ACOs(I-ACO) and PACE programs. We would recommend amending the passive enrollment language to clarify that a dual eligible who is already enrolled in an integrated care model such as PACE or an I-ACO, etc. meets the requirements of being enrolled in an integrated care model and therefore, not be passively enrolled into another ICP. In addition, for those who are passively enrolled, the passive enrollment algorithm should only enroll an individual into a ICP that includes the dual eligibles primary source of care (e.g. 50% or more

of care received – nursing home, primary care, specialty care or HCBS). To achieve this, we recommend on page 8, amend item (3)(B) by inserting after "physician", "and, if applicable, their current nursing home or HCBS provider." Continuity of care is critical. Individuals who already reside in a nursing home should not be required to move from their "home" and acquaint themselves with new caregivers. It takes time to find a trusted caregiver especially for intimate care and services. For this reason, if a person has an established relationship with an HCBS provider, they should be able to retain that provider by only being passively enrolled in plans that include their current caregivers. Individuals passively enrolled should be enrolled in an ICP whose provider network includes their current caregivers from which they receive frequent care. The state should be able to match individuals using Medicaid claims data. In addition, if a dual eligible is only eligible for a subset of Medicaid services (i.e. HCBS waiver services) and not the full array of services, they should be assigned only to an ICP or other integrated model that includes those services. In addition, SHIPs and any other approved enrollment entities should suggest options that consider the best interests of the individual. For example: PACE programs are very adept at caring for and coordinating services for individuals with dementia; therefore, the benefits to the participant of enrolling in a PACE Program could outweigh the continuity benefits of ensuring they retain access to their existing primary care physician.

- **Change of Enrollment**: Continuity of care and care coordination are critical for dual eligibles. For this reason, we have concerns about permitting duals to change plans on a monthly basis, which would undermine the goals of integrated care. We would suggest instead that individuals be permitted to change ICPs one time per year beyond the annual enrollment period unless they meet certain special exceptions that would warrant a change, such as: the ICP making a material provider network change during the plan year; an individual moves to a new geography not covered by their current plan and/or the individual opts to move into a long-stay nursing home. In these situations, the individual may seek a plan that offers different supplemental benefits, or covers their new residence. We propose adding the following on p. 10 after (b)(1)(B): "(C) when the individual's ICP makes a material change to the plan provider network (e.g., primary care provider or nursing home is dropped); (D) when the individual moves to a geographic area not covered by their current ICP; (E) the individual moves into a long-stay nursing home."

Sec. 2205 Data Collection and reporting: We would propose that a cognition assessment be part of the annual health risk assessment (HRA) and that score also be reported. This would show progression of disease and could be compared to associated costs. For some duals, it could establish an early cognition baseline to determine if/when a person develops dementia. Those who have multiple chronic conditions and cognition deficits are more costly to care for. This information could help both the ICPs, CMS, planners, and researchers in better policy and planning models for the future. We also think minimum loss ratio data should be reported to ensure adequate funds are being used for enrollees' care needs. Finally, CMS may want to consider collecting shadow claims data from the ICPs to help with future rate setting as more individuals shift to ICPs and other integrated care models where CMS does not pay claims. Finally, we would ask that these data collection initiatives balance the benefit of collecting the information against the administrative burden of collecting the information. Ideally, we would recommend the demographic data be collected in the health risk assessment so it is standardized, and at least, updated annually by the ICP.

Sec. 2206 State Ombudsman for ICP for DE individuals: This Office is established to "provide support and feedback for dual eligible individuals enrolled in ICPs." This sounds like the role SHIPs provide relating to Medicare counseling and assistance about beneficiaries' Medicare choices. Traditionally, ombudsperson offices, like the Ombudsperson for LTC program, are designed to help "resolve problems related to the health, safety, welfare, and rights of individuals who live in LTC facilities, such as nursing homes, board and care and assisted living facilities, and other residential care communities. Ombudsman programs promote policies and consumer protections to improve long-term services and supports at the facility, local, state, and national levels." Every state is required to have an Ombudsperson under the Older Americans Act. Perhaps this program should be revised to assist all older adults who receive both residential-based care, HCBS and care delivered through integrated care plans.

Recommendation: Instead of establishing a new entity, we would suggest the role of SHIPs be expanded, along with corresponding funding to support providing information, and enrollment support for dual eligibles on available integrated care models in their marketplace, including ICPs, PACE and integrated ACOs. This assists in creating a single point of entry and both Medicare and Dual Eligible related questions and counsel. The more than 10 million duals already have access to SHIP services so this proposal would merely expand the required knowledge and available products with which SHIP staff need to be familiar. This approach will also expedite the implementation of these services because it does not require establishing a new office but instead just hiring additional staff to support the required services and relevant training. We support ensuring that these functions are adequately staffed but thing the staffing ratios may require further thought and better placed as a task for the MMCO director. If the intent of the provision is to also set up an individual complaint resolution function to ensure duals are fairly treated once enrolled in ICPs, we would suggest creating a one-stop to provide these functions instead adding these functions to an existing entity such as the Area Agency on Aging or an existing and relevant ombudsperson program.

Sec. 2207 Funding. In general, there is much we need to understand in order to adequately provide feedback on this section. Based upon the available language, we would recommend payments to the states related to the ICP retain the same federal matching level as under Medicaid, while still being eligible for the additional shared savings payment. In other integrated models, Medicaid expenditures rise when efforts are made to reduce unnecessary hospitalizations and care (Medicare expenditures). For this reason, we would argue that the Medicaid base rate should be the same and the shared savings will help fund those additional Medicaid expenditures. **Correction**: We noticed what we think is a drafting error. It appears on page 20, line 6 the section reference is wrong. It should be "section 2602(d)(18)" not (16).

Sec. 102 on p. 22 starting at line 7- Conforming Amendments: This section adds new responsibilities to the MMCO related to implementation of Title XXII.

- **Unified Appeals process**: At present within MA/SNPs, several layers of appeals go through the internal plan process first, often with little change or additional input. This slows the process to a timely resolution and access to care. We recommend amending the draft legislation to direct the MMCO Director to develop a conflict-free unified appeals process that allows for beneficiaries to designate someone to appeal on their behalf, allows for evidentiary support from their caregivers,

etc. and is streamlined to ensure more real-time access to medically necessary care. As the April Office of Inspector General report noted, MA plans are making errors in their coverage determinations and claims processing. The lesson here is an independent review of these determinations earlier in the process would ensure equitable access to care for these individuals. We would like to see the ICP unified appeals process to develop such an approach for duals and potentially consider expanding it to MA enrollees too.

Equally important to the appeals process is the communication to the beneficiary about a coverage or payment denial. The specific reason should be given to the individual so they can adequately appeal. (e.g., patient diagnosis not provided and therefore could not confirm appropriateness of proposed care; or documentation needed to support medical necessity – assessment needed.)

- **Oversight (p.26, starting at line 10):** The legislation notes that MMCO will administer and provide oversight of integrated care plans for duals. This includes: establishment of a medical loss ratio, and network adequacy standards. We would suggest that a provision be added that establishes oversight of other ICP compliance functions, including a mechanism for beneficiaries, caregivers, and providers to submit complaints or instances of ICP non-compliance issues. We've learned in the MA/SNP program that this level of input is lacking and therefore, CMS is not fully aware of the depth and breadth of non-compliance issues making enforcement delayed and inadequate. Plans can act with impunity at present. The April 2022 OIG report on MA plans' erroneous denials of care and payment is a good example that CMS did not realize this was happening consistently until identified by OIG. We recommend that an online and call-in complaint line be established for reporting ICP non-compliance issues and that it permits not only dual eligibles but also their providers and caregivers to report into the system to ensure they are receiving the care envisioned by the legislation and they are not being taken advantage of. Such a system enhances current audit processes to identify compliance issues and initiate corrections more quickly.

- **Star Rating System:** We support the establishment of a separate star rating system for ICPs. However, we would encourage the committee to go further and have a single system for all integrated care models – ICPs, I-ACOs, PACE, etc. This would allow CMS and dual eligibles to compare across integrated models giving CMS insight into which model(s) perform best and providing beneficiaries actionable information when evaluating and selecting in integrated care model. We also encourage the new star rating system to be applied at the plan-level not at the entity level. Outcomes may vary by plan within a single organization and amalgamating their results dilutes the usefulness of the data. The proposal that an ICP would be awarded a higher star rating based on their ability to retain enrollees is an interesting one. If MA plans are any indication, beneficiaries don't often disenroll. Plans have extrapolated that to mean satisfaction when in fact, it may be a matter of inertia and a lack of desire to have to repeatedly make plan selections. Alternatively, if a plan reports high disenrollment, then given this inertia, one may be able to conclude serious issues. The question is how much variation will we see across plans on disenrollment? If little, then this is not a valid measure.

- **Quality Measures:** We agree that a single set of quality measures should be developed and aligned across all integrated care models including those that aren't ICPs but reflect existing models. By applying the same standards, it would be easier to determine which model is most successful in delivering integrated care and achieving better outcomes for the dual eligibles. Quality measures should look at whether a person's goals, as defined in their care plan, are being achieved under the

model. Models should also be judged for timely access to care and monitored for inappropriate care denials or access to care issues.

Additional conforming changes to Titles XVIII and XIX may be necessary to align with new Title XXII to ensure an equitable playing field among offerings and those who deliver integrated care. For example, Medicare Advantage regulations should remove the D-SNP option from the MA regulations moving into Title XXII and prohibit MA plans from enrolling duals into their products. Alternatively, we suggest further amending Sec. 210 of the draft legislation on p. 43, line 7 after "INSTITUTIONAL" insert "AND CHRONIC CONDITION" . Also, on p.43, lines 13 & 24, after "Institutional" add "Chronic Condition". Chronic Condition SNPs (C-SNP) also serve dual eligibles and could also be well positioned to deliver an integrated model. However, we think the drafters should also consider not requiring, existing ACOs, I-SNPs and C-SNPs to contract with state Medicaid agencies. These existing care models also serve non-duals and should be permitted to continue to target a non-dual population. If the committee agrees that existing models should continue to serve non-duals, it could instruct the MMCO director to evaluate how to align all SNP models and PACE within the ICP program. For example, perhaps the integrated care models the director identifies for states to choose from might include: a residential-based ICP – could be targeted at nursing home level of care individuals residing in a nursing home or assisted living; a community-based ICP; and a targeted chronic care ICP. By creating new nomenclature it could assist in providing a clearer distinction between those models that serve duals and those that do not.

We hope the information and suggestions we've shared provide helpful insight as you further enhance the draft legislation. We offer our support to these efforts and would be happy to discuss any or all of our recommendations with staff and/or the committee members.

Sincerely,

Nicole O. Fallon
Vice President of Integrated Services & Managed Care
LeadingAge
202-508-9435
nfallon@leadingage.org