January 12, 2023

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

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

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

The Honorable Mark 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

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

Oak Street Health appreciates the opportunity to respond to your Request For Information (RFI) regarding care for Americans dually enrolled in both Medicare and Medicaid. This is a population for which Oak Street Health is uniquely qualified to offer our expertise - in 2021, on average, 42%[1] of our patients nationwide in the 21 states in which we operate were either partially or fully dually eligible. In fact, while we do not yet provide primary care in Delaware, New Jersey or Virginia, we do have thousands of patients in Louisiana, South Carolina and Texas. Among those states, 60% of our patients are dually eligible in Louisiana, 45% in South Carolina and 41% in Texas.

Over the past decade, there has been a lot of attention paid to how the healthcare system could be improved to better care for dually eligible beneficiaries. In many ways, the Oak Street Health primary care model, in its totality, is a structure uniquely built to care for the dually eligible population. However, a major impediment to our model working even better than it already does is the dysfunction in the way in which our nation cares for dually eligible individuals and the lack of integration between the various payment streams for this care. That is why we are thankful for this RFI and the attention you are paying to this critical area. We hope this is the first of many conversations on this subject that we have with you and your staffs.

Introduction

Oak Street Health is a national network of primary care centers for adults on Medicare. Founded in 2012, we currently provide care in 21 states to almost 210,000 Americans. Oak Street

[1] Patient Data as of 12/31/2021

Health's mission is to, "rebuild healthcare as it should be," by reducing costs, improving outcomes and providing high-quality care. We accomplish this by being personal, evidence-based, equitable and accountable. While we do provide top-rate primary care to seniors on traditional Medicare, our structure works best when we are reimbursed through a fully capitated value-based model, which allows us the flexibility to focus on those services that have the greatest impact on keeping people healthy. Our results versus Medicare benchmarks include a:

- ✓ 51% reduction in hospital admissions
- ✓ 42% reduction in 30-day readmission rates
- ✓ 51% reduction in emergency department visits

We invest substantially in support for behavioral health and food and housing needs and have intentionally rebuilt the entire primary care model. In fact, our financial model depends upon those under our care becoming and staying healthy, both physically and mentally. That is why we dedicate time daily for our providers to serve their patients who do not have a visit scheduled that day; **the difference in the Oak Street Health model is that rather than wait for a need to arise, our providers proactively reach out to their patients who may need support**. It is also why each of our facilities has an active community room with social and educational events for patients and the community.

Oak Street Health Response to Questions in the Request For Information

Question: 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?

Answer: Americans who are eligible for both Medicare and Medicaid face not only incredibly complex personal health situations but an equally complex and disjointed healthcare system. This dynamic plays out amongst those Americans arguably least able to navigate these two complexities and then the system asks them to do so in a fragmented and cumbersome environment in which federal and state governments rarely coordinate and, in the infrequent instances they do, do not do so in a streamlined and coherent manner. These forces are exacerbated when states shift as much of their Medicaid expenses as possible to the federal government, creating an even larger disincentive for collaboration. A basic yet relatable example of this systemic non-integration is that a dual eligible person oftentimes has multiple insurance cards including ones for Medicare, Medicaid and potentially Medicare Advantage. When Medicaid is overseen in a state by a managed care organization, a beneficiary may have a Medicaid card from one insurance company and a Medicare Advantage card from another. One can only imagine the confusion this causes for beneficiaries, their families and healthcare providers. At the most basic level, streamlining insurance carriers and cards would be a significant and welcome change for care coordination.

Defining Integrated Care

A more integrated, coordinated and aligned system requires increased collaboration between Medicare and Medicaid. From a financing perspective, this system would ideally include one payment stream across both programs, providing a single entity with a joint payment for covering all Medicare and Medicaid benefits. Any entity accepting accountability for this payment should be expected to facilitate care coordination led by a person or process that helps beneficiaries manage and engage with all Medicare and Medicaid benefits across programs.

In some specific areas, there are already definitions of integrated care for SAMHSA, but that language is limiting as it narrowly defines it as including only mental and physical health. There are also definitions of care coordination for Medicare Advantage but which still do not get at the totality of what is necessary; CMS also has a website about care coordination but those concepts are not in statute. There is also no statutory definition for aligned enrollment, although MACPAC does offer a definition within the confines of duals.

With this in mind, we come back to our original contention that an updated, modern federal legal definition of integrated care is necessary. Such a definition should take into consideration what we share here but also include supports outside of physicians and mental healthcare such as social and community health worker support, transportation and the panoply of services necessary to truly have integrated care in a modern, value-based manner streamlined by payer(s). This is an area in which Oak Street Health has expertise and would be ready to work with each of you to properly define.

Question: **In your view, which models have worked particularly well at integrating care for dual eligibles, whether on 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? (Examples of models include, but are not limited to: Fully Integrated Dual Eligible Special Needs Plans, Highly Integrated Dual Eligible Special Needs Plans, Financial Alignment Initiative demonstrations, or States that have taken steps to better align the Medicaid and Medicare programs).**

Answer: At Oak Street Health, we have a wide view into which models have worked well at integrating care for dually eligible beneficiaries. As an organization providing primary care in 21 states, mostly in underserved areas to a large percentage of dually eligible beneficiaries, our experience tells us that the CMS Financial Alignment Initiative, a demonstration program being tried in 10 states and in which Oak Street Health participates, is the model that works best for this population. This model allows for a three-way contract between CMS, a state and a managed care organization. The CMS Financial Alignment Initiative puts Medicare and Medicaid into a single payment stream - known as a Medicare-Medicaid Plan - and creates both fair reimbursement policies and streamlines care for beneficiaries. For providers, this initiative closely resembles Medicare Advantage and includes similar risk adjustment methodology making it familiar and easy to navigate. It is also a single program for all benefits in which the payer is responsible for all redetermination and eligibility dates in order to ensure there are no

lapses in coverage. In addition, it is our experience that Medicare Advantage payers are more comfortable with advanced primary care models and can quickly create access to value-based primary care, while Medicaid health plans have been slower to adopt value-based care structures due to the many differences among state Medicaid programs.

Question: 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 their needs?

Answer: Along the lines of our answer immediately above, we recommend building on and/or expanding upon the Financial Alignment Initiative. As stated in the June 2019 MedPAC Report, "Enrollment in the demonstration plans was stable, quality of care appeared to be improving, payment rates appeared adequate, plans had grown more confident about their ability to manage service use, and stakeholders remained supportive of the demonstration."

As CMS begins the process of transitioning the Financial Alignment Initiative and MMPs into the D-SNP program, we strongly encourage Congress and CMS to work with the states to preserve the integration features of the demonstration that helped create success in the dually eligible population.

We have been able to successfully demonstrate improved health outcomes for patients enrolled in the Financial Alignment Initiative. Within our Illinois dual population, those beneficiaries in the Financial Alignment Initiative were readmitted to the hospital 30 days after discharge at a 9% lower rate than those not in that program. In addition, this population saw a 12% reduction, compared to dually eligible beneficiaries not in the demonstration program, in initial hospital admissions from January 2021 through June 2022.

Question: If you believe a new unified system is necessary, what are the 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.

Answer: Prioritizing many of the components of the Financial Alignment Initiative, in our estimation, is the best improvement to prioritize in this area. Even in states where the Initiative has worked well, it has not grown due to health plans' lack of certainty in knowing if it will continue. The practical implications of this have been less infrastructure being built around the Initiative than would otherwise occur if it were a permanent, national program. A stable, congressionally supported commitment to much of the structure found in the Financial Alignment Initiative, even if moving many of those components into the D-SNP program, would be an important and necessary show of support by the federal government that has the additional bonus of continuity for the private sector to know this is a line of business they not

only want to be in, but that has the critical long term government support to encourage investment and spur its success.

Several areas of federal investment which would be helpful to the long term success of a nationally expanded integrated care initiative could include:

- Better data sharing for providers
    - It would be tremendously beneficial if value-based and at-risk providers were better able to access real-time data; when we take on the financial responsibility for Medicare beneficiaries, accurate data is essential. The two forms of data that would be most beneficial include historical claims data (which CMS has but which often is not shared with value-based providers via our Medicare Advantage partners) as well as timely information shared with us from hospitals if one of our patients has been admitted to a facility or visited an emergency room. Congress and/or CMS requiring Medicare Advantage health plans and hospitals to share this data with value-based providers, particularly in the dually eligible space but not solely isolated to it, would be significant.

- Increased flexibility for benefit design, in particular the ability to add services that more tightly integrate healthcare with nutrition, home based services, and other efforts aimed at helping patients work through the social determinants of health

- Strong incentives meant to spur value-based upside AND downside risk-taking by organizations and;

- Incentives to collect and screen for the social determinants of health and then link them to reimbursement.

Data Sharing

With respect to data - we encourage CMS to foster improved data sharing between Medicare, Medicaid and providers treating these beneficiaries. It should also include incentives to states to participate - and requirements for - improved data sharing. For instance, CMS could take the lead in developing a national data sharing platform specifically for dual eligibles and both provide incentives to, and also require, state Medicaid agencies to participate in the platform. This could be analogous to state Health Information Exchanges (HIEs) but on the national level and linked to Medicaid data on a state by state basis. Requirements for hospitals to provide real-time data to this platform when a dual eligible individual enters an emergency department or is admitted to a hospital would be particularly helpful to primary care providers such as Oak Street Health that take on the financial risk of their patients in a value-based manner.

Beneficiary Choice

At Oak Street Health, we urge Congress to develop a voluntary system aimed at enabling continuity of care and beneficiary choice. In Illinois, some dual eligibles have been randomly assigned into the state's Financial Alignment Initiative program, called the Medicare-Medicaid Alignment Initiative (MMAI), and it has led to disruption in the treating relationship. We caution Congress to avoid this via voluntary election into any program like this with a default to maintain their current provider wherever possible.

We also encourage CMS to ensure that enrollment rules provide dually eligible beneficiaries with ample opportunity and education to enroll in integrated products that best suit their needs. In general, we recommend enrollment follow the same incentive structure as MA, as this would ensure insurance agents do not put dual eligible beneficiaries in regular MA products lacking the additional support dual-designed products offer. It would also eliminate financial incentives for an agent to focus on higher income populations eligible for products that carry commissions.

An additional example of unnecessary disruption due to mandatory enrollment can be found in Ohio, where Oak Street Health operates 11 health centers and over 60% of our patients are dually eligible. In Ohio, a small set of payers have the Financial Alignment Initiative (called MYCARE) mandatory awards set by county. If the patient wants to leave an insurer but that insurer is not contracted - or will not contract with their provider - the dual eligible individual is forced into a disruptive situation. In this instance, they cannot receive care from their long-time provider and are forced to elect a D-SNP product that does not provide the same potential continuity for the beneficiary including the possibility of fewer benefits. In fact, the State of Ohio has recognized this potential for care disruption and urges dually eligible individuals to choose MYCARE for its ability to coordinate care (see these frequently asked questions, specifically number five).

Attribution in Value-Based Models

We see opportunity for improved care for beneficiaries in managed care arrangements, in which beneficiaries enroll in a single plan that coordinates Medicare and Medicaid benefits. However, we recognize that significant numbers of dually eligible beneficiaries are likely to remain in Medicare fee-for-service for the foreseeable future.

Within Medicare fee-for-service, federal policymakers have an opportunity to improve the experience of beneficiaries enrolled in both Medicare and Medicaid through value-based payment programs, in which provider payments are linked to performance on quality and outcomes. Oak Street Health participates in CMS' ACO Realizing Equity, Access, and Community Health (ACO REACH) model, in which we were the highest net-saver in the model's first year. In this model, we have cared for thousands of Medicare beneficiaries to achieve superior outcomes compared to standard fee-for-service.

In operationalizing ACO REACH and other value-based payment models, CMS annually establishes attribution rules that determine which beneficiaries a provider accepts accountability for. This attribution process impacts not only the providers, but also the beneficiaries, as different models provide different benefit flexibilities to attributed beneficiaries.

In establishing these attribution rules, Congress and/or CMS should develop processes that best honor the preferences of beneficiaries, and encourage beneficiaries to develop relationships with providers best suited to manage complex care situations. As noted earlier, Oak Street Health offers beneficiaries not just primary care access, but access to critically needed services, such as behavioral healthcare, social work and the expertise of community health workers as well as assistance navigating additional government programs.

However, beneficiary alignment has not kept pace with the modern structures of healthcare organizations and continues to link individual Medicare beneficiaries to individual healthcare providers even when providers work for larger organizations. In this spirit, we urge Congress and/or CMS to establish alignment processes that support beneficiary attribution through a Taxpayer Identification Number (TIN), rather than the individual provider. This change would bring attribution into the 21st century and ensure that when a healthcare provider retires, leaves or otherwise separates from a larger provider organization, that a beneficiary is not deemed to now be without a medical home, which often remains that larger organization even if the original provider is no longer in service there.

In sum, as Congress looks at reform for care of dual eligible individuals, Oak Street Health stands ready to work with you to incorporate the best lessons learned from the Financial Alignment Initiative, improve data sharing, ensure continuity of care and beneficiary choice and modernize beneficiary alignment.

Question: How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?

Answer: To minimize disruption, first and foremost, beneficiaries should continue to be able to choose their primary care physician. As noted earlier, policies that default beneficiaries into products at the cost of relationships with their established providers are tremendously disruptive. While we appreciate the value of beneficiaries being enrolled in products that better coordinate their benefits, that value can be offset by confusion relating to provider continuity.

Secondly, the more Congress and CMS can move towards value-based care payment structures, the better care will become and the smaller disruption will be. We encourage Congress and CMS to routinely engage with provider organizations that have an expertise in disproportionately caring for vulnerable and underserved beneficiaries, a large percentage of whom, as you know, are dually eligible individuals.

Question: In your analyses of data on dual eligibles, did you consider continuity of enrollment status or consistency of full and partial dual eligible status during a year?

Answer: In general, yes, we track this data closely. One of the well documented challenges when caring for dually eligible individuals is the churn associated with Medicaid enrollment, especially when someone is on the edge of eligibility. Though the data is imperfect, we looked at attrition with a national health plan for the first nine months of 2021. We found that dually eligible or lower income members churned at a higher rate than traditional HMO/PPO Medicare Advantage members. In our population, 30% of the overall member portfolio with that national health plan was on a SNP or Medicare-Medicaid Alignment Initiative (MMAI) product, and that group represented 37% of the attrition volume. 53% of the member portfolio with that health plan was eligible for the Part D Low-Income Subsidy and this combined group of both full and partial eligible beneficiaries accounted for 71% of the attrition volume, demonstrating that dual eligible and lower income beneficiaries have a higher rate of churn than the average Medicare Advantage beneficiary.

Due to the COVID-19 Public Health Emergency, there has not been Medicaid redeterminations in quite some time which will likely skew Medicaid enrollment data and may understate the churn among lower income members in the 2021 attrition analysis we cited above.

We encourage Congress to consider a program that will stay consistent for partial AND full duals and to recognize that payers and providers will need both a coordinated federal plan and lead time to ensure redeterminations after the public health emergency. Further, a duals integration strategy incorporating both partial and full duals while also limiting any potential incentives spurring frequent switching between products, would be ideal. Avoidable churn not only disrupts primary care provider visibility into the health of their patients, but also requires beneficiaries to be set up with a new set of ancillary benefits which takes considerable time and effort - especially given low levels of health literacy in these populations - and reduces the ability of dually eligible beneficiaries to capitalize on a consistent set of benefits supporting their overall health and wellbeing.

Two additional ideas which would greatly improve continuity for beneficiaries and providers include:

1. To reduce churn, dually eligible beneficiaries in a managed care plan who become ineligible for Medicaid could be defaulted into a Medicare Advantage plan - with necessary beneficiary protections - operated by the same carrier as their current managed care plan. Combining this concept with a 12-month continuous enrollment requirement supported by an enhanced Federal Medical Assistance Percentage (FMAP) would reduce churn even further and has been shown to increase continuity of care. Congress has recently passed such a policy for the Children's Health Insurance Program (CHIP) and expanding it to dually eligible beneficiaries would augment continuity.

2. Congress could mandate that dual eligible beneficiaries be enrolled in managed care, ideally value-based, on the Medicaid side so that when churn does occur, it is more likely that both a Medicare Advantage plan or a SNP is easily available and specific providers are in network, especially if the beneficiary remains with the same carrier. 41 states have some type of managed care in Medicaid, but codifying this at the federal level, at least for dually eligible individuals, would incentivize states and plans to increase coordination and integration.

Finally, due to our value-based model in which positive health outcomes rather than the number of services rendered are the focus, at Oak Street Health, we employ Patient Relations Managers (PRMs) at every center which also helps with continuity and health system navigation. The PRM is a patient service role blending aspects of social work, benefits navigation, and customer service. PRMs address a range of patient questions spanning from connecting a patient to financial support programs for heating bills, to understanding retirement benefit questions, to helping make sense of what supplemental benefits are available in the patient's MA plan. PRMs also assist with navigating integrated care products and ensuring services, payers and patients are all moving in the same direction, again, with just one goal in mind - keeping patients healthy. The more we expand value-based primary care, the more organizations will be incentivized to provide functions like PRMs.

We also know that additional counseling - be it from the federal government, a state government, or a contracted navigator such as the Senior Health Insurance Assistance Programs (SHIPs) - can provide beneficiaries with critical advice related to the pros and cons of switching plans. For example, several states coordinate with SHIPs to contact D-SNP enrollees who have signaled an intention to leave an integrated product in favor of a non-integrated product. These conversations can provide beneficiaries with an opportunity to understand the potential benefits of remaining in a product that facilitates all Medicare and Medicaid benefits. Even with this in mind, Oak Street Health's PRM function is a single, trusted point of contact located in a patient's doctor's office which helps guard against the need for additional appointments, phone calls and potential beneficiary confusion or disruption.

Question: 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?

Answer: We applaud the authors of this RFI for exploring ways to look at the dually-eligible beneficiary population not as a single monolith, but as a collection of smaller sub-groups. To that end, an augmented set of reporting requirements looking at all program performance measures through the lens of race/ethnicity, gender, income status, disability and sexual orientation, among others is a critical place to start in order to take into account the diversity of the dually eligible population.

We view wider adoption of value-based care models as the most effective way to achieve improved care access and quality, while taking into account the diversity of the dual-eligible population. To support adoption of value-based care, the quality program (i.e. MA STARS) and risk adjustment must be aligned to this goal, and additional incentives for providers to take on downside risk may also be needed. Our specific suggestions include:

- ✓ **Accounting for Social Determinants of Health in Quality Measurement:**
  - The MA STARS rating system is an important way CMS creates incentives for plans and providers to focus on quality of care. The structure of the current system, however, creates disincentives to provide care to underserved populations. The current MA STARS rating system is structured to reward communities - typically more affluent ones - having higher levels of health literacy, broadband access, medical and social services, and financial resources. These communities often have a higher base starting point on many of the MA STARS rating measures. For a health plan, a high MA STARS rating can often be more easily reached by disproportionately offering coverage - or directing MA sales efforts - toward affluent communities versus the more challenging, but important work, of investing in care and social services in underserved communities.
  - To encourage care investment and innovation in all communities, we recommend adjusting MA STARS ratings to account for social risk factors. Possibilities for CMS to consider include:
    - Urging CMS to codify their December 27, 2022 proposed rule to create a Health Equity Index in the MA STARS structure
    - Developing a quality score based on an improvement above a starting baseline for a local geographic area, for instance by census tract or zip code
    - Developing different cut points for MA STARS measures based on dual-eligible patient mix in a given population
    - Introducing outcomes measures, such as hospitalization avoidance and emergency room visit reductions, versus a baseline.

- ✓ **Accounting for Social Determinants of Health and Social Complexity in Risk Adjustment:** We believe risk adjustment methodology can be improved to more fully include social complexity and the social determinants of health, which are correlated with increased total healthcare costs, and which require providers to make investments in social services to holistically address patient needs.
  - There are a number of already widely available indices we suggest adding to the risk adjustment model. In addition, **we recommend risk adjustment not only capture demographic factors, Medicaid status and chronic condition burden, but also the social complexity of a given population, which is correlated with increased total cost of care.** We see this as a necessary component to addressing the historic inequities which continue to impact our healthcare delivery system. **We also believe this can be done in a cost-neutral**

way if, at the same time, changes are made to limit or eliminate risk adjustment from one-off in-home health risk assessments.

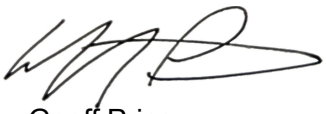
Question: How does geography play a role in dual coverage? Are there certain coverage and care management strategies that are more effective in urban areas as compared to rural areas?

Answer: In general, geography has a large impact on duals coverage because the depth of a state's Medicaid program plays the most determinative role in the type of care a dually eligible individual receives. For instance, Illinois has among the highest enrollments in its version of the Financial Alignment Initiative. In this situation, we see better coordination and better outcomes versus states that are not participating. In fact, when Illinois transitions away from this demonstration project by the end of 2025, the state estimates it will incur $30 million to $55 million in additional costs. This strikes us as unnecessary when a proven solution is at hand and one which Congress and/or CMS could certainly ameliorate by permanently expanding the best parts of the Initiative on a national basis.

Conclusion

Thank you for the opportunity to respond and, hopefully, engage with each of you on this important subject going forward. If you have further questions or would like to speak in greater detail about our response, please contact our Vice President and Head of Government Affairs, Andrew Schwab at andrew.schwab@oakstreethealth.com.

Sincerely,



Geoff Price
Oak Street Health Co-Founder & Chief Innovation Officer