

United States Senate

WASHINGTON, DC 20510

November 22, 2022

To Whom It May Concern:

As Congress begins to look at ways to improve coverage for dually eligible enrollees, we seek more detailed information on existing data and improving beneficiary care. Approximately 12.2 million low-income or disabled people in the United States are jointly enrolled in Medicare and Medicaid. This population, known as “dual eligibles,” is a diverse group with a complex, unique set of needs. Dual eligibles include individuals with multiple chronic conditions, physical disabilities, mental illness, and cognitive impairments such as dementia and developmental disabilities, and others who are relatively healthy.

Dual eligibles, while representing a small proportion of Medicare and Medicaid beneficiaries, account for a disproportionate share of overall spending. For 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.¹ Combined Medicare and Medicaid spending on dual eligibles rose to a total of \$440.2 billion in 2019, with \$164.3 billion of it being Medicaid spending.¹

While the complex set of conditions represented by this population contributes to this high cost, the current fragmented and disjointed system of care for dual eligibles is also a driver of expenditure. Most dual eligibles today are covered by two separate Medicare and Medicaid plans that do not coordinate care nor align enrollment. This discordance can potentially lead to both poor outcomes for patients and inefficient spending for the health care system. For example, when a dual eligible is hospitalized, the patient’s Medicaid plan may have no knowledge of such an event unless the patient should need long term care or other Medicaid-covered services following an inpatient stay. Additionally, the Medicaid plan would have no incentive to prevent a patient’s hospitalization given that Medicare would be paying for the hospital stay. With no single payor responsible for all Medicare and Medicaid services, financial incentives exist for payors to shift costs to each other, a phenomenon that is well documented.²

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.³ It is time to reform care for dual eligibles now, before the next wave of COVID-19 or another pandemic leads to high morbidity & mortality for these vulnerable individuals. Through our research into

¹ Medicaid and CHIP Payment and Access Commission, & Medicare Payment Advisory Commission. (2022). *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. <https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf>

² Bubolz, T., Emerson, C., & Skinner, J. (2012). State spending on dual eligibles under age 65 shows variations, evidence of cost shifting from Medicaid to Medicare. *Health Affairs (Project Hope)*, 31(5), 939–947. <https://doi.org/10.1377/hlthaff.2011.0921>

³ *Exploring the impact of COVID-19 on dually eligible individuals*. (2020, November 2). Center for Health Care Strategies. <https://www.chcs.org/project/exploring-the-impact-of-covid-19-on-dually-eligible-individuals/>

outcomes for dual eligibles, we have come to understand that any such reform should be informed by these core principles:

- **Diversity of needs in the dual eligibles population:** Any solution(s) should take into account the heterogeneity of this population based on demographic characteristics such as age, race, gender, place of residence, severity and nature of chronic conditions, income and asset levels, access to community support, etc. This heterogeneity has a significant impact on the care needs, outcomes, spending, and patient experience for dually eligible beneficiaries. Some dual eligibles, such as those who reside in long-term care facilities from a young age, have the majority of their care covered by Medicaid, while others who live at home and may work part-time receive most health services under Medicare. This difference is particularly pronounced among the top 10% of dual Medicare spenders and top 10% of dual Medicaid spenders.⁴
- **Range of States' capabilities in supporting the care of duals:** States have varying levels of technical expertise and administrative capacity when it comes to managing Medicare benefits. Proposed reforms should be grounded in reasonable expectations for what states have the desire and capacity to do. States should have the resources to know which policy implementation pitfalls to avoid, so missteps from the past are not repeated.^{5,6} Additionally, each state has unique aspects of their dually eligible population that it may want to prioritize within any systemic reform.
- **Financial incentives drive health system behaviors on outcomes and efficiency:** New solutions should realign financial incentives to reduce inefficiency in care delivery and improve outcomes for patients. Some studies indicate that more coverage (i.e. having coverage through two payors) does not translate to higher quality care or better outcomes for patients. In fact, having dual coverage may be associated with negative outcomes when controlling for other factors.^{7,8,9,10} Coverage should therefore be aligned toward

⁴ Coughlin, T. A., Waidmann, T. A., & Phadera, L. (2012). Among dual eligibles, identifying the highest-cost individuals could help in crafting more targeted and effective responses. *Health Affairs (Project Hope)*, 31(5), 1083–1091. <https://doi.org/10.1377/hlthaff.2011.0729>

⁵ MedPAC. (2018). Report to the Congress: Medicare and the Health Care Delivery System (p. 273). <https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18-medpacreporttocongress-rev-nov2019-note-sec-pdf/>

⁶ Lipson, D., Lakhmani, E., Alena, T., & Cheminsky, D. (2018). *The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries* (pp. 20–30). <https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries>

⁷ Lloren, A., Liu, S., Herrin, J., Lin, Z., Zhou, G., Wang, Y., Kuang, M., Zhou, S., Farietta, T., McCole, K., Charania, S., Dorsey Sheares, K., & Bernheim, S. (2019). Measuring hospital-specific disparities by dual eligibility and race to reduce health inequities. *Health Services Research*, 54 Suppl 1, 243–254. <https://doi.org/10.1111/1475-6773.13108>

⁸ Rahman, M., Tyler, D., Thomas, K. S., Grabowski, D. C., & Mor, V. (2015). Higher Medicare SNF care utilization by dual-eligible beneficiaries: Can Medicaid long-term care policies be the answer? *Health Services Research*, 50(1), 161–179. <https://doi.org/10.1111/1475-6773.12204>

⁹ Rahman, M., Gozalo, P., Tyler, D., Grabowski, D. C., Trivedi, A., & Mor, V. (2014). Dual eligibility, selection of skilled nursing facility, and length of Medicare paid postacute stay. *Medical Care Research and Review: MCRR*, 71(4), 384–401. <https://doi.org/10.1177/1077558714533824>

¹⁰ Pierre-Louis, Y. S., Perla, K. M. R., Perez, G. M., Jean-Charles, S., Tang, O., Nwaiwu, C. A., Weil, R., Shah, N. S., Heffernan, D. S., Moreira, C., & SURGE Lab Collaborators. (2022). The insurance coverage paradox - characterizing outcomes

achieving the best outcomes for patients, not the most revenue for the health system as a result of poor coordination of care and/or integration of benefits.

To build a lasting, effective legislative solution based on these principles, we need informative feedback and high-quality data from patients, providers, payors, and other stakeholders. We therefore invite your response to the following questions:

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?
2. What are the shortcomings of the current system of care for dual eligibles? What specific policy recommendations do you have to improve coordination and integration between the Medicare and Medicaid programs?
3. 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).⁴
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 their needs?
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.
6. How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?
7. 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?
 - a. Are there different coverage strategies that should be employed for “partial” dual eligibles vs. “full” dual eligibles when it comes to improving outcomes, such as

among dual-eligible hemorrhagic stroke patients. *Journal of Clinical Neuroscience: Official Journal of the Neurosurgical Society of Australasia*, 97, 99–105. <https://doi.org/10.1016/j.jocn.2021.12.023>

MedPAC's recommendation on limiting D-SNP enrollment to "full" dual eligibles only?^{11,12}

- b. Studies indicate that frequent plan switching can have a negative impact on beneficiary health outcomes, especially for dual eligibles who are enrolled in aligned managed Medicare and Medicaid products.¹³ CMS and States have taken different policy approaches to reduce excessive switching. Which of those policies have the best data on improving cost-effectiveness, clinical outcomes, and/or beneficiary satisfaction? Which of these approaches can be expanded to apply more widely across States?
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.
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?^{8,9,10,11}
10. There are individuals who can, or must, expend their assets on medical care until they financially qualify as dually eligible. Such spending can get these individuals access to long-term care under Medicaid, which Medicare would not cover. Another pathway to eligibility involves Medicaid beneficiaries who develop End-Stage Renal Disease (ESRD) and become Medicare eligible.¹⁴
 - a. Is there data that demonstrates the cost-effectiveness of providing select supplemental benefits to Medicare Advantage beneficiaries that may help them avoid becoming Medicaid eligible through high spending on medical care?
 - b. For Medicaid beneficiaries with risk factors for developing ESRD, such as chronic kidney disease, diabetes mellitus, hypertension, etc., which targeted care strategies have been proven to be effective at delaying development of ESRD and, in so doing, of Medicare eligibility until they turn 65 years old? Please share data on the costs vs. benefits of these interventions.

¹¹ MedPAC. (2018). Report to the Congress: Medicare and the Health Care Delivery System (p. 279).

<https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun18-medpacreporttocongress-rev-nov2019-note-sec-pdf/>

¹² *Glossary of terms related to dual-eligible beneficiaries of Medicare and Medicaid*. (n.d.). Cbo.gov. Retrieved July 11, 2022, from <https://www.cbo.gov/publication/44309>

¹³ Riley, G. F. (2012). Impact of continued biased disenrollment from the Medicare Advantage Program to fee-for-service. *Medicare & Medicaid Research Review*, 2(4), E1–E17. <https://doi.org/10.5600/mmr.002.04.a08>

¹⁴ Medicaid and CHIP Payment and Access Commission, & Medicare Payment Advisory Commission. (2022). *Data book: Beneficiaries dually eligible for Medicare and Medicaid*. <https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf>

11. 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?

By providing comprehensive answers to these questions, you will inform our work on transforming the quality of care for this vulnerable population. Please send responses to dualeligibles@cassidy.senate.gov by January 13, 2023. Responses will be treated as confidential and not released publicly without your approval. We look forward to reviewing your submissions.

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Tom Carper

Thomas R. Carper
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Tim Scott

Tim Scott
United States Senator

Mark R Warner

Mark R. Warner
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John Cornyn

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