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## Introduction

Chairman Casey, Ranking Member Scott, and honorable members of the Special Committee on Aging, thank you for the opportunity to testify today.

My name is Jose Figueroa, and I am an Assistant Professor of Health Policy and Medicine at Harvard University. I am also a practicing physician in Hospital Medicine at the Brigham and Women's Hospital, where I take care of critically ill, hospitalized patients. For my research, I focus on how to improve the quality of care delivered to the sickest and most vulnerable patients in our country, including the dual-eligible population, which are people who qualify for both the Medicare and Medicaid program.

As a physician and researcher, I can attest to the fact that navigating our health care system is inherently complex for anyone. These challenges, however, are far more difficult for the 12.3 million dual-eligible patients living with disability, serious mental illness, frailty, multiple chronic conditions, and importantly, living in poverty.[1] Because of these vulnerabilities, dual-eligible patients are much more likely to require hospital care, nursing home care, long-term care, and home-based care, and are unfortunately at increased risk for experiencing poor health outcomes.[2,3]

One of the greatest failures of our healthcare system is that so much of dual-eligible patients' time is lost navigating the complex and confusing rules and regulations of the two programs, which they must do to ensure they get the care and services they need. This is valuable time that they would rather be spending at home, with their family and friends, and enjoying the things they love doing most.

As stewards of our health care system, we have an obligation to deliver better care to the dual-eligible population. With the remainder of my testimony, I hope to give you my perspective, as a front-line physician and health policy and services researcher, on the important needs of the dual-eligible populations, the complex challenges they currently face, and opportunities for promoting care models that offer true integration of care between the Medicare and Medicaid programs.

## Who Are Dual-Eligible Beneficiaries?

*Demographics, Health Status, and Social Determinants of Dual-Eligible Patients*

There is an estimated 12.3 million people who were dually eligible for Medicare and Medicaid in 2020, which account for an estimated 20% of Medicare beneficiaries and 15% of Medicaid beneficiaries.[1] People become dual-eligible because they share entitlement to both Medicaid and Medicare coverage, but the reasons for that entitlement varies across states. A major challenge in designing programs for dual-eligible patients is the fact they are quite diverse. Among the population, there are people with disabilities, complex multi-morbidities (like heart failure, end-stage renal disease, and diabetes), physical and cognitive impairments, behavioral health conditions, and serious mental illness, meaning their care needs are also diverse.[4] Because of this increased burden of disease and impairment, dual-eligible beneficiaries are more likely to self-report being of poor health and more likely to experience limitations on performing activities of

daily living compared to the Medicare-only population (with nearly 1 in 2 dual-eligible people reporting one or more ADL limitations).[4]

Of particular concern is the high prevalence of serious mental illness among dual-eligible beneficiaries, including schizophrenia/related psychotic disorders, bipolar disorder, and major depressive disorder.[5] Nearly 1 in 3 dual-eligible beneficiaries suffer from serious mental illness, which make it challenging for clinicians and other providers to manage both their physical and behavioral health needs.[6] Fragmented behavioral health services and physical health services delivered by different providers leads to barriers to access to care, and ultimately, leads to worse health outcomes.[7,8]

Dual-eligible patients are also disproportionately racial and ethnic minorities compared to the Medicare-only population (21% vs. 9%, respectively, are Black; 17% vs. 6%, respectively are Hispanic).[4] The presence of issues related to social determinants of health (e.g. financial insecurity, homelessness, food insecurity, low health literacy, and limited access to adequate transportation) are also much higher among dual-eligible patients, which places them at greater risk for experiencing poor quality of care, limited health care access, and ultimately, worse health outcomes.[9]

*Healthcare Utilization & Spending Among Dual-Eligible Beneficiaries*

Dual-eligible beneficiaries have higher rates of service utilization, including hospitalizations, emergency room visits, and community- and facility-based long-term care services, than Medicare- or Medicaid-only beneficiaries.[3] Likewise, they account for a disproportionate share of spending in both programs (34% of total spending in Medicare and 30% in Medicaid).[4] Of particular importance are the differences in the types of services dual-eligible patients need depending on their specific circumstances. For example, when we examined persistently high-cost dual-eligible patients (i.e. those in the top 10% of total spending across both Medicare and Medicaid over a 3-year period between 2010 to 2012), we found that young dual-eligible beneficiaries with disability spent over $160,000 per year; of which nearly 70% of costs were related to long-term care services, while very little was related to potentially avoidable hospitalizations (<1% of total spending).[10] Other work has identified that older dual-eligible beneficiaries require more intense use of nursing facilities and acute hospital care than younger dual-eligible patients.[11]

*Challenges Faced by Dual-Eligible Beneficiaries*

Medicare and Medicaid have a complicated division of coverage that makes navigating each program especially difficult for dual-eligible beneficiaries. Medicare provides coverage for primary care, preventive care, acute hospital, post-acute rehabilitative care, and prescription drugs for those with a Part D drug plan. Medicaid supplements this coverage by assisting with Medicare premiums and other cost-sharing.[12] In addition, Medicaid programs cover long-term services and supports and certain behavioral health services. However, the specific coverage rules vary not only state to state but also among private insurers. In some states, beneficiaries must enroll in multiple Medicaid plans to receive full coverage of health care services, further complicating their ability to seek care.[2]

These patchwork solutions exist largely because Medicare and Medicaid were not initially designed to work together for the benefit of dual-eligible patients. As a result, the lack of integration between the two programs leads to a disjointed and confusing experience for patients, their family members and caregivers, and clinicians and other health providers. In 2020, the Medicaid Payment and Access Commission (MACPAC) highlighted a series of important challenges.[3] They include misalignments between Medicare and Medicaid coverage rules, insufficient care coordination across the patient's care continuum, and maligned incentives that may lead to cost-shifting between programs.

As a physician, one of the most frustrating components of caring for dual-eligible patients is our inability to effectively help patients throughout this process given that we also lack full understanding of the rules and

regulations of their plans. Countless hours are spent by clinicians, care coordinators and social workers in our hospital trying to determine what the safest discharge plan should be for our patients. This can result in prolonged hospital stays and even deconditioning of our frail dual-eligible patients given limited capacity to perform necessary rehabilitative care in the hospital. The responsibility of coordinating care is thus often left to the patient themselves or their family members.

**Experiences with Current Integrated Care Models for Dual-Eligible Patients**

There is an urgent need for greater integration across the payment, delivery, and administration of health care services between the Medicare and Medicaid programs for dual-eligible patients. Better integration offers the opportunity to improve health outcomes and control rising healthcare costs through more efficient, affordable, and effective healthcare. However, to date, rollout for existing integrated care plans has been limited. Only an estimated 1 in 10 dual-eligible patients are enrolled in an integrated plan,[12] with 14 states and the District of Columbia lacking any integrated option.[13] Importantly, nearly 50% of dual-eligible beneficiaries do not even have access to an integrated model.

Given the complexity and heterogeneity of the dual-eligible patient population, it is unlikely that one care model will be effective across all patients living in our diverse country, especially since local healthcare capacity, community resources, and provider density vary significantly. For example, we should not expect that a program that is successful for urban adults with a physical disability will also be successful for older patients with cognitive impairment living in a rural area. Ultimately, dual-eligible beneficiaries will benefit from the expansion of different care models that can meet their local needs.

Integrated financing is important to ensure there are aligned financial incentives between Medicare and Medicaid. However, at its core, these models must revolve around a framework that is individualized and meets the local and diverse needs of patients. Today, there are three primary models that integrate Medicare and Medicaid services: The Program of All-Inclusive Care for the Elderly (PACE), the Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs), which can align with Medicaid managed long-term services and supports (MLTSS) programs, and the Financial Alignment Initiative (FAI) integrated care models. Below, I summarize some of the key findings about these models.

*The Program of All-Inclusive Care for the Elderly (PACE)*

The PACE program was first established in the 1970s and then permanently authorized by Congress in 1997. PACE is a highly integrated managed care program that provides comprehensive health care services to older adults who meet the criteria for a nursing home level of care though are able to live safely in the community with the appropriate support.[3] The PACE program provides all Medicare- and Medicaid-covered services, for which they receive capitated monthly payments from both programs. PACE is centered around adult day health centers, where participants travel to receive a range of integrated and coordinated services. The care team is composed of an interdisciplinary workforce, which includes physicians, nurses, physical and occupational therapists, a center manager, home care coordinator, dieticians, social workers, and others.[3]

Currently, there are 144 PACE programs operating 272 PACE centers across 30 states, serving about 55,000 beneficiaries,[14] 90% of whom are dual-eligible patients (accounting for <1% of all dual-eligible patients).[15] Evaluations of the PACE program have yielded mixed results, though it is important to recognize that there is substantial heterogeneity across different PACE sites. Prior work has found that PACE is associated with lower risk of hospitalization,[16-20] but findings on other outcomes (nursing home use,[16,19,21] spending,[21-23] mortality[21,24,25]) are mixed. One important aspect of the program is that patients can remain in the community as they age, arguably one of the strongest reasons why beneficiaries choose the PACE program. It also removes many complex insurance barriers that dual-eligible patients face, since it is one integrated program.

However, there are important limitations of the PACE program. First, eligibility criteria limit individuals who can potentially participate. For example, younger dual-eligible patients are not eligible (since age

criteria starts at the age of 55 years). Eligibility criteria for providers is also stringent given that they require nursing home level certification. As such, PACE programs are not available across all states, often due to lack of resources and support, state regulations, and other limitations.[26,27] Individuals who are currently eligible but not enrolled in PACE programs could benefit from PACE expansion.[27] In the past, the Medicare Payment Advisory Commission (MedPAC) has made several recommendations regarding the PACE program, which include broadening eligibility and developing a better quality framework for assessing the effectiveness of PACE.[28,29]

*Medicare Advantage (MA) Dual-Eligible Special Needs Plans*

MA Dual-Eligible Special Need Plans (D-SNPs) are private, managed care plans that receive monthly capitated payments to care for dual-eligible patients. D-SNPs were first introduced in 2003 under the Medicare Prescription Drug, Improvement and Modernization Act and later made permanent under the Bipartisan Budget Act of 2018.[3] As of February 2021, about 3 million dual-eligible beneficiaries were enrolled in D-SNPs across 43 states and the District of Columbia.[30] D-SNPs are required to contract with state Medicaid agencies. There are multiple types of D-SNPs, including fully integrated D-SNPs (FIDE-SNPs) and highly integrated D-SNPs. The FIDE-SNPs are intended to provide the greatest degree of integration with Medicaid.

There have been limited evaluations of D-SNPs that assess the value that these programs generate for dual-eligible patients. This is primarily because national data on plan performance is limited. The narrow evaluations that exist found evidence of decreased hospitalizations, readmissions, nursing facility admissions,[31-33] and per-person Medicare spending, with no effect on Medicaid per-person spending found.[34] Currently, MA Star Ratings, which rate plans on performance across various quality measures, are reported at the contract level across many plans and include non-dual patients, which make it impossible for dual-eligible beneficiaries to properly assess which plans are of higher quality in their local area. Recently, CMS proposed changes to make MA Star Ratings more specific to D-SNP performance.[35] This proposal offers an opportunity for transparency that may better drive quality improvement efforts for dual-eligible patients.

Of note, the number of dual-eligible beneficiaries enrolling in MA Plans is growing. One area of particular concern is D-SNP "look-alike" plans, which are MA plans that appear to aggressively enroll dual-eligible patients through their supplemental benefits and cost-sharing structure but are not actually integrated D-SNPs.[8] There are concerns that these plans may interfere with the goal of fully integrating care for dual-eligible patients, and CMS has considered action to limit the growth of these plans. Another concern is the increasing role of private equity in caring for dual-eligible patients.[36] It is absolutely essential that appropriate regulation and policies are in place to ensure that private-equity backed plans are meeting the needs of dual-eligible patients through better value of care and are not causing harm.

*Medicare-Medicaid Financial Alignment Initiative (FAI) Models*

The Financial Alignment Initiative (FAI) was launched by the CMS Medicare-Medicaid Coordination Office (MMCO) in 2011. This demonstration project allowed for states to financially align Medicare and Medicaid programs through three models: 1) a capitated model that establishes Medicare-Medicaid Plans (MMPs), 2) a managed-fee-for-service (MFFS) model (implemented in Washington and Colorado), or 3) an alternative model developed by the state and approved by CMS (implemented in Minnesota). The first demonstrations began in 2013, and in total, 13 states originally participated, though only 11 states continue with their programs today (Virginia and Colorado's demonstrations have ended).

Most states have chosen to participate in the capitated MMP model, which offers the highest level of integration in comparison to other integrated care models. Under this model, CMS, the state government, and participating health plans agree on a blended capitated monthly rate for all Medicare and Medicaid benefits for dual-eligible beneficiaries. However, there is limited market penetration in MMPs, as only an estimated 29% of eligible beneficiaries enrolled in qualified plans across 9 states in 2017.[37]

There have been preliminary evaluations of state FAI models that have yielded mix results.[37] In some states, MMP enrollment was associated with reduced hospitalizations, nursing home admissions, and lower emergency department use.[38] Most evaluations have only focused on Medicare utilization and spending, omitting an analysis on Medicaid outcomes due to issues in data availability. However, long-term data on its effectiveness and final evaluations are still pending.

**Strategies for Improving Dual-Eligible Integrated Care Models**

Truly integrated and coordinated programs have the potential to transform care for dual-eligible beneficiaries for the better, including better quality of care, better patient experience, and potentially lower costs. While much of the evidence to date is mixed, it is important to note that the data reveals many positive signals that show the promise of integrated care programs. In addition, there are ample opportunities to continue improving existing integrated models, which can be supported by better data availability on performance and understanding important tradeoffs of existing programs.

Below, I summarize recommendations of how we may improve integrated care models for dual-eligible beneficiaries, which are supported by several reports and evaluations.[13,39-43] They include the following:

1. Every dual-eligible individual should have access to an integrated care model. Congress can consider options to help states progress towards adoption or expansion of integrated models. In some states, clear guidance, technical assistance, and financial support may be necessary.
2. Integrated care models for duals must provide better value for patients than alternative, default models in their local area. They should also meaningfully feel like one program that covers services across the entire patient care continuum (from primary care and specialty care to long-term care and behavioral health services). If not, integrated care plans will continue to struggle with enrollment.
3. The enrollment process into care models must be easy, with readily accessible information that patients need to help make informed decisions about what type of model is best for themselves.
4. Beneficiaries must receive adequate support to help understand the tradeoffs of their coverage options that is free from biased marketing agents and brokers who may have financial incentives to enroll patients into particular plans. Clinicians, case managers, and social workers caring for duals will also benefit from this support.
5. Better and timelier data is necessary to help us understand how well integrated care models are performing relative to other alternatives. Additionally, there is significant heterogeneity even among specific integrated models (i.e., across D-SNPs, across state MMPs, and across PACE programs). It is challenging for policymakers, clinicians, patients and their families to make decisions about which programs are best to meet their needs without this information. Congress has an opportunity to help ensure that reliable and relevant data is made available in a timely manner for all to benefit.
6. Given heterogeneity of the dual-eligible population, integrated care models must be flexible and take advantage of 21st century technology, including virtual health, for patients who prefer being taking care of at home. However, issues of proficiency with technology, broadband accessibility, disabilities, and cognitive impairment that limit participation must be addressed.
7. Better patient-specific quality metrics that capture quality of life, patient-reported outcomes, and patient satisfaction with their integrated care plans should be developed and adopted. The use of claims-based measures of utilization (e.g. hospitalizations, ED visits, home care visits) as quality measures are limited because they sometimes signal appropriate patient care and not necessarily reflect poor quality of care.

In summary, it is important for Congress to continue promoting policies that make integrated care models for dual-eligible beneficiaries more widely available and structure incentives that promote even greater integration among existing models. In doing so, we can ensure high quality and affordable care for the millions of people who are dually enrolled in the Medicare and Medicaid programs.

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