



TO: Senators Bill Cassidy, Thomas Carper, Tim Scott, Mark Warner, John Cornyn, and Robert Menendez

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DATE: June 29, 2023

SUBJECT: Comments on Dual Eligible Beneficiaries Discussion Draft

Thank you for the opportunity to provide feedback on your discussion draft sent on May 18, 2023 that seeks to promote better health care and outcomes for dual eligible beneficiaries. Please find our comments below on select sections of the draft.¹

State Ombudsman Programs

Proposed Sec. 2206(a) under Sec. 101 directs each state to establish an Office of the Ombudsman for Integrated Care Programs for Dual Eligible Individuals (referred to as the “Office”), which may operate independent of, or in connection with, the state agency responsible for administering the Medicaid program.

Establishing and sustainably funding dedicated state ombudsman Offices is an important part of supporting the needs of dually eligible beneficiaries and their caregivers. As we noted in our RFI response, the Commonwealth Fund Task Force on Payment and Delivery System Reform recommended that the Centers for Medicare and Medicaid Services (CMS) require and fund all state Medicaid programs to enhance their capacity to improve care integration with the Medicare program, including by having dedicated ombudsperson programs for dually eligible beneficiaries.²

We recommend that policymakers ensure or incentivize that these Offices closely coordinate with existing Medicaid or Long-Term Care ombudsman programs and with the State Health Insurance Assistance Program in their states to ensure alignment with existing Medicare and Medicaid assistance programs. We also believe it is reasonable to allow for state autonomy in determining where the Offices should be housed, whether that’s within an existing state agency or an external nonprofit organization. The Integrated Care Resource Center published a technical assistance brief that explored varying

¹ The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

² Commonwealth Fund Task Force on Payment and Delivery System Reform, *Six Policy Imperatives to Improve Quality, Advance Equity, and Increase Affordability* (Commonwealth Fund, Nov. 2020).

https://www.commonwealthfund.org/sites/default/files/2021-01/CMWF_DSR_TaskForce_Six_Policy_Imperatives_report_v3.pdf#page=14

approaches that states took in structuring their ombudsman programs under the Financial Alignment Initiative demonstrations.³ Based on their interviews with state Medicaid agency and ombudsman program staff, the researchers found that the decision on where to house an ombudsman program depended on a range of state-specific circumstances (e.g., experience with implementing managed care programs, the involvement of beneficiary advocates, budgetary considerations, existing knowledge and resources). For instance, building ombudsman programs within existing state systems can enable staff to leverage institutional knowledge, build on existing relationships, and minimize start-up costs. On the other hand, programs housed within non-profits may be perceived by stakeholders as more neutral third parties and may be more reflective of the communities they serve. Ultimately, we believe ensuring that ombudsman programs reinforce rather than duplicate each other is more important than where the new Office is housed.

New Star Rating System for Integrated Care Plans

Sec. 102(f) directs the Federal Coordinated Health Care Office “to develop a new star rating system for integrated care plans for dual eligible individuals under title XXII that rates the performance of each plan type separately, with State-specific measures and tied to single contracts, instead of the collective performance of all of the offeror’s plans under contract with the State under that title, that include measures which directly reflect enrollee satisfaction, and that awards higher star ratings to plans based on their ability to retain enrollees.”

Recent Fund research surveyed experts in Medicare Advantage who recommended separate performance ratings for SNPs vs. non-SNPs to establish star ratings.⁴ Rating the performance of each plan type separately would improve the utility of the ratings for beneficiaries who are plan shopping, as well as for regulators who are overseeing plan performance over time. Moreover, fine-tuning the quality measures to better detect differences in treatment and outcomes among different types of beneficiaries would strengthen their utility. To better monitor and address disparities in health care use and outcomes across populations, policymakers should also ensure the collection of standardized, comprehensive data by race and ethnicity across datasets that include dual eligible beneficiaries—and across federal government agencies writ large, where appropriate.⁵ As it stands, these data are highly variable within sources like the Transformed Medicaid Statistical Information System Analytic Files (TAF),

³ Nancy Archibald and Danielle Perra (Center for Health Care Strategies) and Alena Tourtellotte and Kenneth Lim (Mathematica), “State Approaches to Developing and Operating Ombudsman Programs for Demonstrations under the Financial Alignment Initiative,” Integrated Care Resource Center, March 2021.

<https://www.integratedcareresourcecenter.com/sites/default/files/Ombudsman%20Programs%20brief.pdf>

⁴ Martha Hostetter and Sarah Klein, “Taking Stock of Medicare Advantage: Special Needs Plans,” To the Point (blog), Commonwealth Fund, Mar. 31, 2022. <https://doi.org/10.26099/z020-me79>

⁵ Grantmakers in Health (GIH) and National Committee for Quality Assurance (NCQA), “Federal Action Is Needed to Improve Race and Ethnicity Data in Health Programs,” October 2021. <https://www.gih.org/wp-content/uploads/2021/10/GIH-Commonwealth-Fund-federal-data-report-part-1.pdf>

given the differences in how states collect and report.⁶ CMS can play a role in developing best practices for self-reported race and ethnicity data at the point of enrollment and supporting states.⁷

PACE

Title IV expands the Program of All-Inclusive Care for the Elderly (PACE) program in several ways, including by requiring states to offer PACE program services to eligible individuals (Sec. 401) and extending eligibility to Medicare-eligible individuals under 55 (Sec. 403).

PACE is one of the most successful models for integrating care for high-need people requiring acute and long-term services and supports. Studies and evaluations of PACE have shown positive outcomes for patients, including reductions in hospitalization, rehospitalization, and emergency department use; reductions in long-term nursing facility placements; reductions in mortality; lower rates of functional decline; and better reported health status and quality of life.⁸

A 2020 Fund-supported study found that the greatest opportunity for PACE growth is to increase enrollment among those who are already eligible.⁹ Researchers estimated that while over 53,000 people are currently enrolled in PACE, nearly 9.8 million people across all states are currently eligible, according to Medicaid claims data. Given that some states limit the number of PACE organizations that can be established, ensuring sufficient supply to meet predicted demand for services would require changes to (or preemption of) state policy.¹⁰

Medicare-eligible individuals under 55—i.e., those who are eligible due to a disability, amyotrophic lateral sclerosis, or end-stage renal disease—also stand to significantly benefit from access to integrated care via PACE. While about 13 percent of current PACE beneficiaries have high needs and high costs, nearly 40 percent of younger adults (ages 21-54) with developmental disabilities and almost 70 percent of those with ESRD had high costs as well as high needs.¹¹ In addition to these cost considerations, PACE programs may need to evolve to ensure they offer the right blend of services to meet the needs of a younger population (e.g., educational and employment supports as opposed to the current adult day center-based model of support).¹²

⁶ Grantmakers in Health (GIH) and National Committee for Quality Assurance (NCQA), “Improving Data on Race and Ethnicity: A Roadmap to Measure and Advance Health Equity,” December 2021. <https://www.ncqa.org/wp-content/uploads/2022/01/GIH-Commonwealth-Fund-federal-data-report-part-2-1.pdf>

⁷ Sarah H. Gordon, K. John McConnell, and William L. Schpero, “Informing Medicaid Policy Through Better, More Usable Claims Data,” To the Point (blog), Commonwealth Fund, June 21, 2023. <https://doi.org/10.26099/xgj2-km09>

⁸ Sara Karon et al., Expanding the PACE Model of Care to High-Need, High-Cost Populations (Commonwealth Fund, Oct. 2020). <https://doi.org/10.26099/4454-z770>

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.