MEDPAC Medicare Payment Advisory Commission

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July 11, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

RE: CMS demonstrations with states on integrated care programs for dual-eligible beneficiaries

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) respectfully submits the following comments on the Centers for Medicare & Medicaid Services' (CMS) demonstrations with states on integrated care programs for dual-eligible beneficiaries. MedPAC appreciates your staff's ongoing efforts to administer and improve the Medicare and Medicaid programs for dual-eligible beneficiaries, especially given the competing demands on the agency.

MedPAC would like to comment on the following five aspects of the demonstrations, which are the Commission's key areas of concern:

- scope of the demonstrations,
- passive enrollment,
- plan requirements,
- monitoring and evaluation, and
- program costs and savings.

The Commission has consulted with numerous stakeholder groups to understand their perspectives on the demonstrations. We have spoken with representatives from beneficiary advocacy groups, provider organizations, Medicare Advantage (MA) plans, Medicaid managed care plans, state Medicaid agencies, the Medicaid and CHIP Payment and Access Commission, and CMS. Our conversations with these stakeholders have informed the Commission's understanding of the potential impacts of the demonstrations.

Our comments apply to the financial alignment models and the state demonstrations to integrate care for dual-eligible individuals. Through the financial alignment models, CMS is collaborating with states to test two types of integrated care programs: a capitated model and a managed fee-for-service (FFS) model. These models are intended to align Medicare and Medicaid financing and coordinate care for dual-eligible beneficiaries. States can implement one or both models. Under the capitated model, CMS signs a three-way contract with a state and a health plan, and the health plan will receive a blended Medicare and Medicaid capitation rate. For the managed FFS model, states finance a care coordination program for dual-eligible beneficiaries. States can receive a retrospective performance payment if their managed FFS programs meet certain quality thresholds and if the programs result in Medicare savings net of the federal portion of any increased Medicaid costs. Under the state demonstrations to integrate care for dual-eligible individuals, CMS awarded 15 states contracts of up to $1 million each to design a program that covers primary, acute, long-term care, and behavioral health. The contracts were awarded before announcement of the financial alignment models. It is likely that many of the 15 states will propose the capitated model or the managed FFS model, but the 15 states have the discretion to propose other models. To date, 26 states have posted demonstration proposals for comment on their state website or on the CMS website.

The Commission has been researching ways to improve care coordination for dual-eligible beneficiaries. Our work is focused on how to change and improve care for dual-eligible beneficiaries through integrated Medicare and Medicaid programs. Many dual-eligible beneficiaries have high levels of need for medical, long-term care, behavioral health, and/or social services. Dual-eligible beneficiaries may have to navigate more than one delivery system for their care and their care can be uncoordinated. Moreover, many dually eligible beneficiaries are unable to establish regular sources of care.

Given these concerns, we should be clear that the Commission supports the goals of the demonstrations and believes they provide an opportunity to learn more about how to improve care management and quality of care for dual-eligible beneficiaries. The Commission understands that the current Medicare FFS system fails some dual-eligible beneficiaries who do not get the care they need or who experience poor quality of care. However, the Commission has identified concerns with the demonstrations. The Commission's comments on the demonstrations are motivated by the desire to protect dual-eligible beneficiaries – the comments are not an endorsement of the status quo.

The Commission's ability to comment in a constructive way is complicated by the process CMS is pursuing. CMS has released statements and guidance about the demonstrations (e.g., plan standards, defining and sharing savings). However, the ultimate structure of the demonstration in any state will be the product of a negotiation between the state, the plans, and CMS. Therefore, even with CMS's published guidance, we are unable to judge the outcome of the process in any state. Even if the Commission agrees with CMS's stated guidelines, there is no assurance that the final structure of a demonstration within any given state will be fully consistent with CMS's guidelines. In that vein, many of the following comments may be viewed as the Commission's advice to CMS regarding its negotiations with the states and plans.

Scope of the demonstrations

Most states have proposed to enroll all or the majority of their fully dual-eligible beneficiaries into the demonstrations. If all of these state proposals are approved, approximately 3 million dual-eligible beneficiaries will be enrolled into the capitated model or the managed FFS model. This would mean that approximately 40 percent of all full-benefit dual-eligible beneficiaries will be enrolled in the demonstrations.[a] The states' proposed enrollment of 3 million exceeds CMS's stated target enrollment of 1-2 million beneficiaries.[b] The final enrollment in the demonstrations will ultimately be decided by CMS' negotiations with states and the timing of the implementation of the demonstrations.

The Commission believes the scope of the demonstrations as proposed is too broad. Even CMS's target enrollment represents a program change in the delivery and financing of Medicare benefits for dual-eligible beneficiaries rather than a demonstration designed to test new models.

The Commission also has several other concerns with the scope of the demonstrations:

- The Commission and others have documented that only a limited number of health plans have experience managing the full range of benefits (i.e. acute, long-term care, behavioral health) in a capitated environment for these complex populations (cognitively impaired, frail, physically or developmentally disabled).

- Not all demonstration plans may have the capacity to serve large numbers of dual-eligible beneficiaries that will be newly enrolled into the plan en masse at the beginning of the demonstration.

- The large scope could complicate winding down or terminating the demonstrations if, for example, they are shown to reduce quality of care. If the demonstrations are statewide and enroll all or most dual-eligible beneficiaries in a state, it may be difficult to transition beneficiaries out of the demonstration plans and back into FFS or other Medicare plans. This will be particularly problematic if there have been market changes as a result of the demonstrations, such as a reduced availability of MA dual-eligible special needs plans (D-SNPs) in a state or fewer Part D plans operating within a region. In addition, it may be difficult for large numbers of beneficiaries to re-establish their provider networks in Medicare FFS if the demonstrations are ended (a difficulty that beneficiaries who opt out may also face).

- There may not be sufficient numbers of dual-eligible beneficiaries in each state to serve as a comparison group during the evaluation of the demonstrations if most or all beneficiaries in a state are enrolled.

- Finally, moving large numbers of beneficiaries into a new program creates a significant challenge if states are to fully monitor the program given the states' already limited resources.

We understand that one reason states are proposing to enroll most or all dual-eligible beneficiaries into the demonstrations is because these beneficiaries either currently are, or will be, mandatorily enrolled in Medicaid managed care plans for their Medicaid benefits. Nevertheless, these demonstrations would represent one of the largest single Medicare demonstrations, and the Commission believes that it is in the best interest of beneficiaries to test the demonstration models on a smaller scale within any given state.

In order to limit the scope, CMS should consider implementing demonstrations in only a few states. The criteria for choosing one state over another could involve the strength of a state's approach to beneficiary notification and opt out during passive enrollment; the level of state and health plan experience with dual-eligible populations, including providing the full range of care for these individuals; and the likelihood of credible savings to both Medicare and Medicaid.

By conducting the demonstrations in a limited number of states CMS could establish methodologically sound tests of key concepts without enrolling millions of beneficiaries. Perhaps one of the most important questions to be tested is whether private health plans will invest in the development of specialized delivery systems for patients with complex clinical and social needs if an appropriate payment method is offered. A sound test of the demonstration models requires a critical mass of potential enrollees in specified markets rather than much larger numbers of enrollees spread thinly over vast geographic areas. Therefore, within those states with approved demonstrations, enrollment could be concentrated in select markets. Within the participating markets, a large enough number of beneficiaries could be enrolled to test the critical concepts of the demonstration models. This approach to the scope would test the demonstration models while avoiding mass enrollment of dual-eligible beneficiaries into health plans with limited or no experience with this population, through passive enrollment methods that have not been widely tested for Medicare Part A and B benefits.

A second complementary strategy is to permit additional enrollment to occur if certain benchmarks are met. Benchmarks can include increased health plan experience and capacity, refinement of passive enrollment processes, high performance on monitoring and quality measures, and achievement of program savings.

Passive enrollment

CMS proposes to use passive enrollment with an opt-out provision for the capitated model demonstrations. Under this enrollment strategy, beneficiaries will be assigned to a health plan through intelligent assignment unless the beneficiaries opt out of the demonstrations or proactively select a health plan. Intelligent assignment refers to the process of matching a beneficiary to a health plan based on information about a beneficiary's care needs (such as which heath plan has most of the beneficiary's providers in-network) rather than through random assignment.

The Commission supports the use of passive enrollment with opt-out under certain circumstances. This enrollment strategy is already used for the low income subsidy (LIS) population under the Part D drug benefit. Passive enrollment under Part D is not fully comparable because Part D covers only the drug benefit, and the demonstrations would cover the full range of Medicare and Medicaid benefits. That said, passive enrollment is one way to increase enrollment into integrated care programs, thereby encouraging investment in the necessary clinical infrastructure to care for complex, and vulnerable, patients. It can also create enough enrollment to conduct an evaluation and to achieve the critical mass for plans to assume full financial risk for all Medicare and Medicaid services. Additionally, the demonstrations can test the effectiveness of passive enrollment, particularly the challenges in informing complex subgroups of dual-eligible beneficiaries, such as individuals that are frail or cognitively impaired, about the demonstrations and their choices.

However, all beneficiaries should be notified and given the opportunity to opt out at multiple points in the process. Beneficiaries should first be notified and given the opportunity to opt out of the demonstrations before they are passively enrolled. Some dual-eligible beneficiaries and their caregivers are actively engaged in managing their care. These beneficiaries may have already established their "network" of providers within FFS and may choose to opt out of the demonstrations. Other beneficiaries may not have regular access to care in FFS. These individuals should be made aware of their choices, and that passive enrollment into a health plan which increases access to care and coordinates care would be to their benefit.

Moreover, CMS and the states should be cognizant of overlap between these demonstrations and other integrated care programs, as well as other CMS demonstrations. CMS and the states should also consider providing dual-eligible beneficiaries' with access to more than one program that could improve their quality of care. Beneficiaries who are already enrolled in integrated care programs, such as the Program of All-Inclusive Care for the Elderly (PACE), or other CMS demonstrations, such as the Accountable Care Organization demonstration, should not be disenrolled from the programs in order to be enrolled in one of the new demonstrations without a clear understanding of their choices. In addition, in each year of the demonstrations, beneficiaries should be notified and given the choice to enroll in PACE, another CMS demonstration, or any other options.

The Commission has identified strategies and beneficiary protections that could help CMS successfully implement passive enrollment with opt-out. We encourage CMS to incorporate the following strategies and beneficiary protections into the passive enrollment policy for every state demonstration:

- *Employ a multi-channel beneficiary education strategy*. CMS and the states should utilize an aggressive and multi-channel beneficiary education strategy. Prior to passive enrollment, beneficiaries should be notified through multiple ways and media about the demonstrations and how they can opt out or select an alternative health plan. Ways to

notify beneficiaries include letters, phone calls, notices in community publications, and outreach through community-based organizations. CMS and the states should be cognizant that some beneficiaries may be difficult to reach or may require more intensive outreach or in-person education.

- *Partner with independent third-party entities*. CMS and the states should also partner with independent third party entities to help beneficiaries make a decision and to facilitate passive enrollment. Community-based organizations, such as Area Agencies on Aging, could have face-to-face conversations with interested beneficiaries and their family members about their choices. CMS and the states could also contract with an independent third-party broker to facilitate enrollment. The brokers could be required to refer beneficiaries to community-based organizations for advice about their choices.

- *Conduct outreach to beneficiaries' current providers*. CMS and the states should educate beneficiaries' existing providers about the demonstrations before their patients are enrolled. It will be important for providers to be aware of the upcoming change to their patients' Medicare and Medicaid services. Outreach to providers before their patients are enrolled could also secure provider buy-in to the demonstrations and to any new care management arrangements that will affect them during the demonstrations. This outreach could also be used to help plans identify key providers for the dual-eligible beneficiaries.

- *Require plans to contact and assess beneficiaries shortly after enrollment*. CMS and the states should require the demonstration plans to contact beneficiaries and conduct a comprehensive assessment of their care needs shortly after enrollment. This is necessary for the plans to develop and implement a care plan for each enrollee. Before a beneficiary's new care plan is implemented, the beneficiary should still have access to his or her former providers, care plans, and prescription drugs.

- *Require plans to arrange care with beneficiaries' existing providers during a transition period*. In order to maintain beneficiaries' continuity of care, CMS should require that the demonstration plans permit beneficiaries' to receive care from their existing providers if those providers are not in the plan's network. Plans should make every effort to include such providers in their network. If the providers are unwilling to contract with a plan, CMS and the states will need to establish payment guidelines to ensure that plans and providers are treated fairly during the transition period, with beneficiaries having continued access to these providers.

- *Passively enroll beneficiaries only into high-quality plans*. Even if all precautions and measures are taken, there will still be some beneficiaries that are uninformed or unaware of their choices and will be passively enrolled into a demonstration plan. These individuals may not understand that the change in their care is occurring, or its impact on their access to care. It is therefore important that beneficiaries be passively enrolled into high-quality plans. Doing so also gives the demonstration plans a better chance of improving care for the dual-eligible beneficiaries relative to FFS.

Ideally, the Medicare program would have robust quality measures for dual-eligible beneficiaries. Quality measurement for dual-eligible beneficiaries is an area that is still under development. There is a lack of robust quality measures for dual-eligible beneficiaries, particularly for subgroups of dual-eligible beneficiaries, such as the severally mentally ill and the developmentally disabled. Therefore CMS will have to use existing Medicare and Medicaid quality measures to identify high quality plans. For example, we agree with CMS's position that organizations that are currently under a Medicare enrollment and/or marketing sanction will not be eligible to participate in the demonstrations (and therefore will not be eligible for passive enrollment). CMS should not passively enroll beneficiaries into plans with low quality indicators.

Plan requirements

The Commission has identified two issues of concern related to the plan requirements during the demonstrations. The first is whether demonstration plans will be held to Medicare requirements for MA plans. The second is how Part D will function under the demonstrations.

MA standards should represent a minimum standard

For the capitated model, CMS has indicated that it intends for the Medicare requirements for demonstration plans' benefit package, network adequacy, drug benefit, and administrative processes to represent a minimum standard. CMS will then negotiate with states to develop the final requirements for areas where Medicare and Medicaid requirements overlap or conflict. The Commission believes that the requirements for MA plans should represent the minimum standard in every demonstration. This would provide a baseline standard of requirements and also would enable CMS to negotiate with the states to enrich some processes beyond the MA standard. Our consultation with states suggests that they expect the demonstration plans to adhere to the MA standards.

Part D

The Commission also wishes to draw CMS's attention to the potential consequences of the treatment of Part D under the demonstrations. The first issue is that CMS will not require the demonstration plans to submit Part D bids. We are concerned that this policy could de-stabilize the Part D prescription drug plan (PDP) market for LIS beneficiaries by affecting the available number of benchmark plans and the amount of the premium subsidy. Dual-eligible beneficiaries are a large portion of the LIS population, and because the proposed scope of the demonstrations is so large, bids would be missing from the LIS benchmark calculation for most or all dual-eligible beneficiaries within a state.

It is difficult to predict what effect removing large numbers of dual-eligible beneficiaries from the LIS benchmark calculation will have on plan availability or premium subsidy amounts in a given year. If PDP enrollment for the remaining LIS population is concentrated in a few plans, the LIS

benchmark will be based on bids from a small number of plans. This could lead to large swings in the benchmark amount which could cause year to year changes in the plans that qualify as premium-free for LIS enrollees. This instability could lead to an increase in plan turnover which would result in more LIS beneficiaries having to be reassigned more frequently. At a minimum, CMS should monitor the impact of the demonstrations on the PDP market. If the market begins to destabilize, CMS should consider requiring the demonstration plans to submit bids on the dual-eligible enrollees.

The second issue is whether the drug benefit remains under Part D or reverts to a Medicaid benefit, as one state currently proposes to do. Competition among private plans in the Part D program has resulted in greater use of generic drugs. Additionally, beneficiaries have high degrees of satisfaction with the benefit. The Commission is concerned that a widespread movement of the drug benefit back to the states will result in an uneven benefit across the country for the LIS population and will lessen or undo the competitiveness in the current drug benefit.

Monitoring and evaluation

CMS has stated that every demonstration program will be evaluated on the program's ability to improve quality and reduce costs. The Commission agrees with CMS and suggests that CMS collect a core set of measures from every demonstration to monitor access to care and quality during the demonstrations. CMS should also collect a core set of outcome measures that can be used to evaluate the effectiveness of the demonstrations.

Quality measurement is imperfect and work on identifying the best measures of quality of care for dual-eligible beneficiaries is still underway. CMS will have to utilize measures that are currently available. To the extent possible, the core set of monitoring measures should be collected on a real-time basis. This will help CMS and the states identify problems with quality or access to care and intervene during the demonstrations. Measures that can be used for monitoring include plan disenrollment rates, whether ordered services were given, rates of how quickly assessments were done after enrollment, and the number and nature of appeals and grievances. Outcome measures can also be used for monitoring and they can be used during the evaluation of the demonstrations. An additional option is for CMS and the states to develop a list of utilization measures. Examples of these measures include the number of primary care visits, emergency department visits, hospitalization, nursing home admissions, and hospital readmissions.

Every demonstration should be evaluated on measures of quality of care and cost. Ideally, the evaluation methodology would be structured to assess how the demonstration plans affect quality and cost relative to FFS or to the programs that dual-eligible beneficiaries were enrolled in before the demonstrations. CMS should endeavor to evaluate the demonstrations while they are ongoing and have the final evaluation completed as quickly as possible following the third year of the demonstrations. The evaluation should measure Medicare and Medicaid costs and estimate the financial impact on both programs separately so that policymakers can learn where savings were achieved for both programs (e.g. avoided hospitalizations for Medicare and avoided nursing home stays for Medicaid).

Program costs and ensuring savings

One of CMS's and the states' goals for the demonstrations is to reduce Medicare and Medicaid expenditures. In general, reductions in Medicare costs come from reductions in acute care use, such as emergency room use and hospitalizations. Reductions in Medicaid expenditures generally come from avoided nursing home placements. Under the managed FFS model, states will finance care coordination activities and will be able to share in any Medicare savings achieved.

As we understand it, under the capitated model demonstrations, CMS and the states will develop a combined Medicare and Medicaid spending baseline that is the estimate of how much each program would have spent on dual-eligible beneficiaries absent the demonstrations. CMS and the states will then model the amount of Medicare and/or Medicaid services that they expect the demonstrations to reduce. The expected reductions in services will be converted into an aggregate (i.e. combined Medicare and Medicaid) savings estimate. CMS and the states will then reduce the Medicare and Medicaid capitation rates to the plans by the aggregate savings estimate, resulting in total Medicare and Medicaid spending that is below the spending that would have occurred absent the demonstration.

The objectives of the demonstrations should be to first improve quality and care coordination for dual-eligible beneficiaries and then ideally reduce Medicare and Medicaid expenditures. The Commission has great concerns regarding the financing of these demonstrations and the approach to achieving savings. First, savings will be allocated between the Federal government and states based on the respective Medicare and Medicaid shares of total spending even though savings are more likely to come from one program or the other depending on the circumstances of the individual patient. Data recently published indicates that dual-eligible beneficiaries tend to be high cost to either Medicare or Medicaid, but are not often high cost to both programs simultaneously.[c] Thus, CMS has proposed a method for allocating savings without providing evidence that sharing based on the proportion of Medicare and Medicaid spending will be equitable. It would be better if CMS were to estimate savings separately for Medicare and Medicaid and then adjust each program's capitation rates based on these estimates. An alternative methodology for setting the capitation rates is discussed below.

Second, some states and plans view the demonstration as a method of using Medicare funds to supplement Medicaid funds. Some plans and states have indicated that they expect Medicaid costs to increase in the short run (from greater home and community-based care and higher state administrative oversight costs). Those plans and states expect to use their portion of up-front Medicare savings to finance these costs. The question is whether these immediate cost increases are ultimately offset by avoidance of nursing home stays in the long run. This is a good question to test through the demonstrations. However, if the assumption that there will be savings in the long run is incorrect, and large scale enrollment in these plans makes it difficult to reverse the demonstrations, Medicare trust fund dollars would be subsidizing Medicaid expenditures. It is also theoretically possible that Medicaid could end up subsidizing Medicare if Medicaid savings appeared in the short-run and Medicare savings failed to materialize. This is another reason to test

the demonstrations on a smaller scale, and CMS should only select demonstration plans that show a credible pathway to both Medicare and Medicaid savings.

It is a general Commission principle to consider the impact of policies on the Medicare trust funds and the long-run sustainability of the Medicare program. We highlight the following considerations for CMS to adhere to during negotiations with states and the demonstration plans:

- *Accurately estimating the Medicare and Medicaid spending baseline*. It is critical that CMS and the states accurately estimate what Medicare and Medicaid would have spent on the dual-eligible beneficiaries' that are likely to enroll in the demonstrations, absent the demonstrations. If the baseline spending is not accurately estimated, then the capitation rates to the demonstration plans may not produce savings to each program or may over-estimate savings. There are many complications with developing the baseline, including trying to predict which dual-eligible beneficiaries will enroll in the demonstrations and whether those individuals would have been in FFS or enrolled in an MA plan absent the demonstrations. CMS should be transparent about the assumptions made in the development of the Medicare and Medicaid spending baseline in each state, and information about the methodology should be publicly available. For example, it is our understanding that CMS plans to build into its Medicare baseline the recent quality payments for MA plans that CMS added to plan payments using its demonstration authority. The Commission has strongly objected to CMS's use of its demonstration authority to make unilateral changes in payment rates. Including these payments in the demonstration baseline institutionalizes these payments to the plans and, all things being equal, is an additional subsidy for Medicaid services.

- *Developing realistic savings estimates to develop capitation rates*. It is important that CMS and the states determine realistic and appropriate estimates of savings from the demonstrations. CMS should ensure that the portion of state savings attributable to federal matching contributions to the states is returned to the federal treasury. If the savings estimates are set too low, the capitation rates will exceed the cost of care, and the health plans will benefit. On the other hand, if the savings estimates are set too high, the capitation rates will be set lower than the cost of care, and the health plans may struggle to provide services to enrollees. CMS should be transparent about the savings assumptions in each state, including which types of services are expected to decline, as well as the amount of savings attributed to different categories of services.

- *OACT certification of the baseline and the capitation rates*. Because a crucial element for the success of the demonstration is the ability to accurately set the baseline, estimate the savings, and develop the capitation rates, it is important that the CMS Office of the Actuary (OACT) certify the accuracy of the baseline and the savings estimates.

- *Setting reasonable capitation rates*. Baseline spending will be an estimate of how much Medicare and Medicaid would have spent on the beneficiaries enrolled in the demonstrations absent the demonstrations. Taking into account the costs of administering the demonstrations and possible additional costs of providing Medicare and Medicaid services (reflecting unmet needs or the initial provision of additional services); it is likely

that the costs of the demonstrations will exceed baseline spending, at least during the first year of the demonstrations. Our site visits to states that have implemented integrated Medicare and Medicaid programs for dual-eligible beneficiaries indicate that Medicaid costs can increase as health plans provide more personal care and other home-and-community based services to potentially avoid nursing home stays, and as the states increase their monitoring and oversight activities.

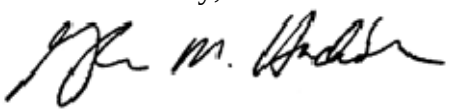
An alternative methodology to the one CMS is currently pursuing for capitated plans is for CMS to not reduce the capitation rates in the first year of the demonstrations. This could be a more prudent approach given that it is unknown how much costs will be under the demonstrations and whether the health plans will be able to provide services to the beneficiaries under the reduced capitation rates. The capitated model demonstrations would then monitor whether costs decline over time and whether the capitation rates could be re-set in years two and three of the demonstrations to reflect those lower costs. Under this option, savings to states and the federal government are not guaranteed in the first year of the demonstrations because any savings accrue to the plans. If this method is used, the health plans would have to report cost and utilization data at a level of detail so that CMS and the states could monitor the plans' costs and savings.

Conclusion

MedPAC appreciates your consideration of these policy issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on dual-eligible beneficiaries, and we look forward to continuing this relationship.

If you have any questions on our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman

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[a] We estimate from the 2010 CMS denominator file that there were approximately 7.4 million full benefit dual-eligible beneficiaries in 2010. Beneficiaries were defined as full benefit dually eligible if they had full benefit dual-eligible status for at least one month when they were eligible.

[b] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2011. Letter to State Medicaid Directors regarding financial models to support state efforts to integrate care for Medicare-Medicaid enrollees. Baltimore, MD: CMS. July 8.

[c] Coughlin, T.A., T. Waidmann, and L. Phadera. 2012. Among dual eligibles, identifying the highest-cost individuals could help in crafting more targeted and effective responses. *Health Affairs* 31, No. 5.