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January 13, 2023

Via Electronic Submission (dualeligibles@cassidy.senate.gov)

The Honorable Bill Cassidy
United States Senator
United States Senate
520 Hart Senate Office Building
Washington, D.C. 20510

RE: Improving Care for Dually Eligible Enrollees

Dear Senator Cassidy:

The Senior Care Pharmacy Coalition (SCPC) appreciates the opportunity to respond to your November 22, 2022 letter seeking policy recommendations to improve care for enrollees dually eligible for the Medicare and Medicaid programs (the dual eligibles). We are grateful to you and your colleagues, Senators Carper, Cornyn, Menendez, Scott, and Warner, for your focus on this issue.

BACKGROUND AND ANALYTIC CONTEXT

As discussed in your letter, in 2019 the 12.2 million dual eligibles represented 19% of Medicare enrollees but accounted for 34% of program spending and represented 14% of Medicaid enrollees but constituted 30% of overall spending.[1] Combined Medicare and Medicaid spending for this group totaled $440.2 billion in 2019, $279.9 billion of which was Medicare spending (62% of the total) and $164.3 billion of which was Medicaid spending (38%).[2]

A significant percentage of dual eligibles need long-term services and supports (LTSS), including Medicare post-acute services. This subgroup disproportionately drives overall costs for dual eligibles, and accounts for a significant proportion of Medicare Part D spending because the subgroup is disproportionately reliant on prescription medications. Long-term care (LTC) pharmacies provide enhanced clinical and specialized services that improve care coordination, medication management, and outcomes for patients, while reducing or at least slowing growth in

[1] Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC), Data Book: Beneficiaries Dually Eligible for Medicaid and Medicaid (February 2022) at 27 (Exhibit 1) and 29 (Exhibit 3)(the MedPAC/MACPAC Data Book), available here.
[2] Id. at 18 (Table 7).

overall health care spending for this subgroup. Due to structural and policy design of both the Medicare and Medicaid programs, however, the majority of dual eligibles with LTSS needs do not have access to LTC pharmacy services, although most individuals who need LTSS reside in the community rather than LTC facilities – a setting in which both programs require that patients receive LTC pharmacy services. SCPC believes that affording all dual eligibles access to LTC pharmacy services regardless of the setting in which they live is essential to reducing Medicare and Medicaid expenditures for the entire group of dual eligibles and would substantially improve the quality of care for this population.

Before sharing our responses to the questions posed in your November 22 letter, we provide information concerning the scope of the dual-eligible population, their prescription drug utilization, and the services LTC pharmacies provide to meet these needs. It is important to understand the LTSS needs of dual eligibles, the characteristics of the LTSS population, the value LTC pharmacy provides to this population, and the existing disconnected statutory and regulatory landscape that fails to coordinate management of LTC needs between the Medicare and Medicaid programs.

Dual Eligibles and the Need for Long-Term Services and Supports. Dual eligibles who require LTSS account for a disproportionate share of the Medicare and Medicaid expenditures outlined above. For example, in 2019 there were roughly 6.7 million dual eligibles enrolled in Medicare fee-for-service (FFS).[3] Of this total, 2.6 million were full-benefit Medicaid beneficiaries.[4] Only 1.25 million of these dual eligibles required LTSS but accounted for $85.5 billion of combined Medicare and Medicaid spending ($32.6 billion in Medicare spending and $52.9 billion in Medicaid spending). Given that 12.2 million dual eligibles accounted for $440.2 billion in combined spending in 2019, roughly 10% of dual eligibles accounted for 19% of combined spending (12% of Medicare spending and 37% of Medicaid spending).[5] In addition, this group accounted for more than 5% of total Medicare and Medicaid spending in 2019.[6]

Dual eligibles who need LTSS drive a disproportionate and substantial portion of overall Medicare and Medicaid spending. In addition, dual eligibles also account for significant spending on prescription drugs. For example, in 2019, 94% of duals utilized Medicare Part D to pay for

[3] Of the 12.2 million duals enrolled in Medicare FFS in 2019, 55% (6.71 million) were enrolled in Medicare FFS. Id. at 43 (Exhibit 11).
[4] For an explanation of the distinctions between full dual eligibles and partial dual eligibles, see MedPAC/MACPAC Data Book at 4-5.
[5] These data either are taken directly from the MedPAC/MACPAC Data Book, particularly Exhibits 14, 15, 17, & 18, or are calculations based on data in these exhibits. SCPC will provide explanations of its calculations on request.
[6] Dual eligibles accounted for 30% of total Medicare and Medicaid expenditures, and FFS full dual eligibles accounted for 19% of spending for dual eligibles. Multiplying 30% of total expenditures by the 19% applicable to the identified subgroup, the result is that the subgroup – 1.25 million people – accounted for 5.7% of combined Medicare and Medicaid expenditures in 2019.

prescription drugs, accounting for $47 billion in Part D expenditures.[7] Remarkably, Medicare Part D expenditures for dual eligibles were more than Medicare FFS expenditures for inpatient hospital expenditures ($38.0 billion), skilled nursing facilities ($19.7 billion), home health ($4.3 billion) or other outpatient services ($46.4 billion).[8]

There is little doubt, therefore, that improving care and care coordination for dual eligibles in ways that reduce projected Medicare and Medicaid spending must focus on those dual eligibles who need LTSS. Better management of prescription drug utilization is essential to achieving these objectives. As the only Washington-based organization exclusively representing the public policy interests of LTC pharmacies, SCPC is well positioned to offer policy recommendations focused on the nexus between the health care, LTSS, and prescription drug needs of dual eligibles. SCPC's membership includes 75% of all independent LTC pharmacies. Our members own and operate 325 LTC pharmacies in every state across the country, serving more than one million patients every day, including residents living in skilled nursing facilities, nursing facilities, intermediate care facilities, assisted living facilities, other congregate care settings, and at home.[9]

The enhanced services LTC pharmacies provide drive better care coordination, improved patient outcomes, and lower overall health care costs. Unfortunately, disconnected policies both within and between the Medicare and Medicaid programs limits patient access to LTC pharmacy services primarily based on the setting in which the beneficiary resides rather than the LTSS needs of the beneficiary. SCPC believes that Medicare and Medicaid policies should be changed to provide access to LTC pharmacy services based on patient need, and that doing so would yield substantial benefits to dual eligibles and substantially reduce the amounts both programs otherwise would expect to spend over time.

The LTSS Population. Roughly four million Medicare beneficiaries need LTSS, three million of whom (75%) live at home and in the community and one million of whom (25%) live in LTC facilities.[10] Medicare beneficiaries who need LTSS are more likely to be dual eligibles than Medicare beneficiaries who do not. Sixty-eight percent of Medicare beneficiaries with LTSS needs living in LTC facilities are dual eligibles, and 42% of Medicare beneficiaries living in the

[7] MedPAC/MACPAC Data Book at 49 (Exhibit 14).
[8] Id. at 49 (Exhibit 14) and 50 (Exhibit 15) and internal calculations based on information from these Exhibits. explanation of calculations based on these Exhibits. While Medicaid also pays for prescription drugs for dual eligibles, Medicare Part D accounts for 99% of the prescription drug spending for the combined programs.
[9]This figure is based on pre-pandemic facility occupancy rates. Our members also serve an increasing number of individuals with LTSS needs, including dual eligibles, living in community settings and at home.
[10] ATI Advisory & SCPC, Understanding the Long-Term Care Needs of the Medicare Population and the Role of Long-Term Care Pharmacies in Addressing this Need 3 (July 2021). The data in this report is based on the 2018 Medicare Current Beneficiary Survey. This analysis uses impairments in two or more activities of daily living (ADLs) as a proxy for LTC or LTSS need. The Medicare data used in this analysis defines LTC facility to include both federally defined LTC facilities as described in note 16 below and assisted living facilities.

community are dual eligibles. Those needing LTSS are more likely to be over age 65 and, for those living in the community, are more likely to be under age 65 than Medicare beneficiaries who do not need LTSS.[11]

Medicare beneficiaries with LTSS needs are clinically complex. Fifty-nine percent living in LTC facilities and 39% living in the community have four or more chronic conditions. Diabetes, heart conditions, lung conditions, depression, and other mental illnesses are among the more prevalent chronic conditions for this group. Cognitive impairment also is prevalent, with 75% of Medicare beneficiaries living in LTC facilities and 59% of Medicare beneficiaries who have LTSS needs also suffer from cognitive impairment. By contrast, only 16% of Medicare beneficiaries who do not need LTSS suffer from cognitive impairment.[12]

Not surprisingly, Medicare beneficiaries who need LTSS have high health care utilization rates. On an annual basis, 34% of this group living in LTC facilities and 33% living in the community have at least one hospital admission, compared to only 13% of Medicare beneficiaries without LTSS needs. Similarly, 35% of those living in facilities and 36% of those with LTSS needs living in the community who need LTSS have at least one emergency department visit a year, compared to only 20% for Medicare beneficiaries who do not need LTSS.[13]

Medicare beneficiaries who need LTSS also have disproportionately high drug utilization rates. Those living in facilities average twelve prescriptions per year and those in living in the community average thirteen prescriptions per year. This contrasts with only eight prescriptions per year for other Medicare beneficiaries.[14]

Medicare spending for beneficiaries with LTSS needs is two to three times higher than for those without LTSS needs ($27,317 per person per year for those with LTSS needs living in LTC facilities, $19,790 per person per year for those with LTSS needs living in the community, and $7,472 per person per year for those without LTSS needs). Medicare Part D drug spending is substantially greater for those with LTSS needs than those without such needs ($6,327 for those with LTSS needs living in facilities, $6,311 for those with LTSS needs living in the community, and $3,825 for those without LTSS needs).[15]

[11] Id.
[12] Id. at 4.
[13] Id. at 5.
[14] Id.
[15] Id.

The Value of LTC Pharmacy. LTC pharmacy clinical services provide significant value to Medicare and Medicaid beneficiaries, including:

- Direct and ongoing consultation with residents and their families.
- Participation in resident care management teams, including direct interactions with and recommendations to the facility medical director, nursing staff, and administration. This engagement requires familiarity with the resident's medical records and complete prescription drug profile.
- Drug utilization review to prevent over-or-under-utilization of prescription drugs and to improve outcomes and reduce costs when medically appropriate.
- Medication therapy management, including comprehensive medication reviews and targeted medication reviews for all LTC beneficiaries.
- Medication reconciliation, including at least daily reconciliation for opioids.
- Direct and ongoing training and contact with facility nursing staff.
- Pharmacist availability to provide medication and patient care services 24/7/365.
- Direct placement of peripherally inserted central catheters and insertion of Midline and PICC lines.
- Antibiotic stewardship and infection control.
- Specialized packaging to improve adherence and reduce medication errors.
- Access to prescription medications at all times pursuant to which patients must receive medications as soon as two hours after the pharmacy receives the prescription.

LTC pharmacies also provide specialized services including patient-specific unit-dose packaging, a systematic packaging system designed to reduce medication errors and increase patient adherence both in facilities and in community settings, and round-the-clock medication delivery. This combination of enhanced clinical and specialized services to increase improved care management, care coordination, and patient outcomes, secondarily reduces overall health care expenditures.

These services were designed to benefit individuals who require LTSS, a substantial percentage of whom are dual eligibles. Unfortunately, Medicare and Medicaid policies effectively limit beneficiary access to LTC pharmacy services based on the setting in which individuals who need LTSS reside. Federal Medicare and Medicaid statutes, regulations, and guidance require that

beneficiaries living in federally defined LTC facilities[16] – skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities (ICFs) – receive LTC pharmacy services and that payers recognize the additional costs associated with providing these services through higher LTC pharmacy dispensing fees.[17]

Federal Policies Regarding LTC Pharmacy. LTC pharmacy is not defined in federal statute. However, there are two elements in Medicare and Medicaid law, regulation, and guidance that effectively shape the clinical and specialized services LTC pharmacies provide.

First, the Medicare and Medicaid Requirements of Participation for LTC facilities include pharmacy services provisions with which facilities must comply. These pharmacy services requirements are identical for both programs, however the former pertain to skilled nursing facilities (SNFs) qualified to provide services pertaining to the Medicare skilled nursing benefit, while the latter pertain to nursing facilities (NFs) and intermediate care facilities (ICFs) qualified to provide services pertaining to the Medicaid LTC benefit. CMS has promulgated extensive regulations implementing these pharmacy services requirements,[18] and has provided detailed sub-regulatory guidance interpreting relevant statutory and regulatory provisions.[19] LTC facilities contract with LTC pharmacies to assure that relevant pharmacy services requirements are met.

Second, key elements of the Medicare Part D program also shape LTC pharmacy services. The Part D regulations include a terse definition of LTC pharmacy that offers little guidance as to the

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[16] Long-term care (LTC) facilities participating in Medicare and Medicaid must provide pharmacy services to all facility residents. Medicare requires that skilled nursing facilities (SNFs), and Medicaid requires that nursing facilities (NFs) and intermediate care facilities (ICFs) provide "pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident." 42 U.S.C. § 1395i-3 (pertaining to SNFs participating in the Medicare program) and 42 U.S.C. § 1396r(b)(4)(a)(iii) (pertaining to NFs participating in the Medicaid program). For purposes of these comments and recommendations, the term "federally defined LTC facility" will include SNFs, NFs, and ICFs, and will be used to distinguish between residents of these facilities and community-dwelling individuals, including those residing in assisted living facilities, other congregate settings, or in private homes. CMS has promulgated extensive regulations implementing these pharmacy services requirement, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 208, 10-21-22). The Pharmacy Services provisions are delineated in § 483.45. In the State Operations Manual, CMS describes those services as essential to patient care.

[17] 42 C.F.R. § 483.45. Medicare Part D Plans recognize that pharmacies must provide more extensive LTC pharmacy services to residents of SNFs and NFs and pay a higher dispensing fee to cover the costs of those services. Such payment is recognized and approved by CMS. *See* Medicare Prescription Drug Manual, Chapter 5, Section 20.7, available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf; *see also* Larrick Memorandum to Part D Plans, December 15, 2021, available at https://ncpa.org/sites/default/files/2021-12/partddispfeeinstlevelcareneed.pdf (clarifying higher dispensing fees can be paid for prescription drugs dispensed to beneficiaries at home when such beneficiaries have an appropriate level of care need). These issues are explored in more detail below.

[18] 42 C.F.R. §§ 483.1-483.95.

[19] State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17).

services LTC pharmacies must provide.[20] Medicare Part D does require that Prescription Drug Plans demonstrate LTC pharmacy network adequacy, distinct from network adequacy in the community. The Medicare Part D Manual establishes ten performance and service criteria pharmacies must satisfy to be considered LTC pharmacies for purposes of LTC pharmacy network adequacy.[21]

LTC pharmacies receive reimbursement from Medicare Part D PDPs consistent with the general model for paying pharmacies, which includes two components. First, pharmacies receive payment for the costs associated with their acquisition of prescription drugs. Second, pharmacies receive a dispensing fee designed to compensate for costs associated with dispensing drugs. The combination of the additional services required of LTC pharmacies, and the costs associated with providing these services, has resulted in Part D Plans paying higher dispensing fees to LTC pharmacies for dispensing drugs and providing enhanced services to Part D beneficiaries residing in federally defined LTC facilities. These higher dispensing fees are designed to compensate for the additional costs inherent in providing LTC pharmacy clinical and specialized services, but do not include a separate component designed to compensate for these services.

Medicare Part D pays for the lion's share of prescriptions and related services LTC pharmacies provide to residents of LTC facilities. However, when LTC facility residents are on Medicare Part A or Medicare Part C post-acute care stays, the SNF pays LTC pharmacies for prescription drugs and related services because prescription drugs are included in the Medicare payments facilities receive. In many cases, in addition to payment for acquisition costs and dispensing fees, these contracts also provide separate payments for the enhanced clinical services that LTC pharmacies provide. It should be noted that a significant percentage of LTC facility residents on Medicare post-acute stays are dually eligible.[22]

Federal law essentially requires that Medicare and Medicaid beneficiaries living in federally defined LTC facilities – SNFs, NFs, and ICFs – receive enhanced clinical and specialized LTC pharmacy services and does so in a manner designed to assure that LTC pharmacies receive reasonable reimbursement for those services. Unfortunately, the same cannot be said for Medicare and Medicaid beneficiaries with LTSS needs living in the community, which represents a

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[20] "*Long-term care pharmacy* means a pharmacy owned by or under contract with a long-term care facility to provide prescription drugs to the facility's residents," 42 C.F.R. § 423.100.

[21] Medicare Prescription Drug Manual, Chapter 5, § 50.5.2, available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidancedocuments/MemoPDBManualChapter5_09.30.11.pdf. In the 117th Congress, the Long-Term Care Pharmacy Definition Act of 2021 (S. 1574) would have codified these criteria into statute, thereby assuring application of the definition beyond the Part D program. Notably, the lead sponsors of that bill were Senators Tim Scott (R-SC) and Mark Warner (D-VA), and Senators Bill Cassidy (R-LA) and Tom Carper (D-DE) were among the twenty-two sponsors and co-sponsors of the bill. An identical companion bill was introduced in the House (H.R. 5632). We anticipate the legislation will be introduced again in the 118th Congress.

[22] MedPAC/MACPAC Data Book at 49 (Exhibit 14).

substantial portion of dual eligibles. For example, 37% of FFS dual-eligibles used institutional LTSS while 38% of FFS dual-eligibles used community based LTSS in 2019.[23] Since neither Medicare nor Medicaid requires LTC pharmacy services for community-dwelling dual eligibles who need LTSS, most do not receive LTC pharmacy services.[24] However, when such services are provided to community-dwelling patients – including dual eligibles – with LTSS needs, recent research demonstrates that overall health care spending declines despite enhanced payments for LTC pharmacy services.[25]

POLICY RECOMMENDATIONS

Our overarching policy recommendation is that LTC pharmacy clinical and specialized services be available to all dual eligibles who need LTSS regardless of where they live – federally defined LTC facility or community – and that the Medicare and Medicaid programs recognize the value of, and additional costs associated with those services through appropriate payment approaches. We believe that such a policy would result in dramatic improvements in care coordination and better clinical outcomes and quality of life for dual eligibles who need LTSS while also reducing or at least slowing growth in overall health care costs for this population.

We offer several general policy recommendations, followed by direct responses to four questions posed in your letter. Given our focus and expertise, it would not be valuable for us to provide responses to the remaining questions.

General Recommendations

RECOMMENDATION: Define LTC pharmacy in statute. It is important that LTC pharmacy be defined in statute as a predicate to support our remaining recommendations.

RECOMMENDATION: Amend the Medicare and Medicaid statutes, regulations, and guidance as needed to assure that dual eligibles who require LTSS are assured access to LTC pharmacy clinical and specialized services regardless of the setting in which they reside. Current research demonstrates the value of LTC pharmacy services in improving outcomes and reducing health care costs for Medicare beneficiaries who need LTSS, particularly those living in the community. A

[23] MedPAC/MACPAC Data Book at 50 (Table 14).
[24] For a more extensive discussion of the barriers community-dwelling beneficiaries face in accessing LTC pharmacy services, see ATI Advisory & SCPC, Expanding Long-Term Care Pharmacy in Home and Community-Based Settings: Understanding and Addressing the Barriers (November 2021).
[25] See, e.g., Shetty KD, Chen AY, Rose AJ, Liu HH. Effect of the ExactCare medication care management model on adherence, health care utilization, and costs. J Manag Care Spec Pharm. 2021 May;27(5):574-585 (Shetty, et al). This analysis concluded that LTC pharmacy services reduced per patient annual health care costs by roughly $2,000 at an annual cost of $240 per patient to compensate for LTC pharmacy services.

key driver of these results is effective medication management for a population heavily reliant on prescription drugs, which necessarily obligates the LTC pharmacy to coordinate among all prescribers for each patient, thereby both directly and indirectly driving better care coordination for each patient.

RECOMMENDATION: Assure that LTC pharmacies receive adequate reimbursement for the enhanced clinical and specialized services they provide to dual eligibles with LTSS needs, particularly those living in the community. While beyond the scope of this treatment, there are various regulatory and sub-regulatory provisions relevant to Medicare Part A, Medicare Part C, Medicare Part D, and Medicaid that should be modified to better align incentives within and across payment programs consistent with our other recommendations. We will provide a more detailed analysis of these provisions with more specific recommendations for legislative, regulatory, and guidance changes soon.

RECOMMENDATION: When considering the costs associated with dual eligibles, particularly but not exclusively those with LTSS needs, consider the importance of prescription drug utilization and Part D costs as well. In 2019, Part D paid for prescription drugs for 94% of the 6.71 million Medicare FFS dual eligibles at a cost of $47.1 billion. By contrast, for the same population, 94% of this group used Part B services at a cost of $46.4 billion for Part B coverage, 24% used inpatient hospital services at a cost of $38.1 billion, 12% used home health services at a cost of $4.3 billion, and 12% used SNF services at a cost of $11.9 billion. In other words, Medicare paid more for prescription drugs for this group than it did for FFS hospital, skilled nursing, home health, or physician services, and Part D spending represented 32% of total Medicare expenditures for this group. Of the combined Medicare and Medicaid spending on prescription drugs for full benefit dual eligibles who also received Medicare FFS benefits, Part D covered 99% of combined drug costs while Medicaid covered only 1% of these costs.

Recommendations in Response to Selected Questions

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?

   Response: See our analysis and general recommendations pertaining to dual eligibles who require LTSS.

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).

Response: There are three existing models that could form the basis for a coordinated delivery system for dual eligibles that integrates health care, LTSS, and enhanced LTC pharmacy clinical and specialized services, better coordinates and manages care, and effectively manages medications. These models include two government programs: Medicare Special Needs Plans (SNPs), particularly for dual eligibles (D-SNP) and for beneficiaries who require institutional care, and the Program for All-Inclusive Care of the Elderly (PACE). There are also are various market-based arrangements between LTC pharmacies and Medicare and Medicaid managed care plans pursuant to which LTC pharmacies receive Part D reimbursement from PDPs for acquisition costs and dispensing fees and also receive payments for enhanced clinical and specialized services for beneficiaries who need LTSS and live in the community. LTC pharmacies generally receive capitated payments from the managed care payers with which they contract, and in some cases assume risk for all or a portion of payments from the managed care payers. In risk-bearing models, LTC pharmacies must demonstrate reductions in overall health care expenditures for the management care plans to receive payment. [26]

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

   Response: The above proposal should result in no disruption in current beneficiary care. Instead, the proposal will reduce overall spending, improve the consumer experience, and provide for more efficient care.

8. What is the best way to ensure that the 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.

   Response: As discussed above, Medicare beneficiaries who need LTSS and who live in the community are more likely to be Black or Hispanic, are more likely to be women, and are more likely to be under age 65. Due to the legal requirements and regulatory

[26] See Shetty, et al, which describes one such model and documents the cost savings generated by providing LTC pharmacy services to beneficiaries living in the community who need LTSS. SCPC has retained ATI Advisory to prepare a case study analysis of several SCPC member LTC pharmacies that have negotiated such arrangements, the results of which are expected to be available in Q2 2023. SCPC will provide this report upon completion.

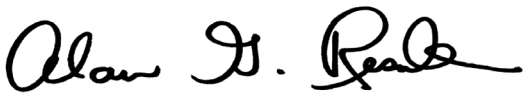
parameters of the Medicare and Medicaid program, dual eligibles who need LTSS and who live in the community are far less likely to have access to LTC pharmacy services, which demonstrably improve their outcomes while reducing their overall health care costs. For dual eligibles with LTSS needs, the most significant policy change to address diversity within this population would be to assure equal access to LTC pharmacy services regardless of where the individual lives – in a federally defined LTC facility or in the community.

CONCLUSION

Thank you for your consideration of these comments. We believe your efforts offer a significant opportunity to improve the care dual eligibles receive while reducing the amount Medicare and Medicaid otherwise would spend on this care. We also believe that equal access to LTC pharmacy services is a crucial linchpin to achieving this goal for the most expensive cohort among dual eligibles – those who need LTSS.

We look forward to a continuing dialogue as you develop specific policy proposals designed to achieve this goal and welcome any questions you may have or additional information you may require. Please feel free to contact me at arosenbloom@seniorcarepharmacies.org or (717) 503-0516 if we can provide any additional information.

Respectfully submitted,



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