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EXAMINING MEDICARE AND MEDICAID COORDINATION FOR DUAL-ELIGIBLES

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BEFORE THE

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EXAMINING MEDICARE AND MEDICAID COORDINATION FOR DUAL-ELIGIBLES

WEDNESDAY, JULY 18, 2012

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:05 p.m. in Room SH–216, Hart Senate Office Building, Hon. Herb Kohl, chairman of the committee, presiding.

Present: Senators Kohl [presiding], Wyden, Whitehouse, Bennet, Blumenthal, Corker, and Johnson.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Good afternoon. We welcome our witnesses and all of you who are here today.

I commend Senator Corker for putting together and chairing this hearing on meeting the challenges of integrating care for beneficiaries who qualify for both Medicare and Medicaid. These so-called dual eligibles tend to have chronic conditions that must be carefully managed, such as diabetes and heart disease. They need high-quality, consistent Medicare services, and many depend on Medicaid for long-term services and supports.

Historically, the coordination of care for dual-eligible beneficiaries has been fragmented and resulted in higher costs and poorer health outcomes. This is not acceptable. Not only have these people earned benefits that should protect them when they need it, but the high cost is not sustainable in the current environment.

In our health care system today, dual eligibles are the most vulnerable of the vulnerable. The challenge for all of us is to figure out how to deliver care to them in a way that meets their needs but does not cost our health care system a fortune.

Today, at a cost of about $300 billion, these 9 million dual eligibles account for a disproportionate amount of spending. They represent 16 percent of Medicare beneficiaries but consume 27 percent of the program's spending. In the Medicaid program, dual eligibles make up 15 percent of beneficiaries but account for 39 percent of total costs.

Fortunately, efforts are now underway to try to eliminate costly duplication of services. The new Federal Coordinated Health Care Office, or the Duals Office, at the Centers for Medicare and Medicaid Services, is working with states to implement sound strategies for testing expanded models of coordinated care that we hope will lower costs.

While the national demonstration for dual eligibles is just beginning, we hope that this hearing will shed light on what gains we can expect to see as this national demonstration of unprecedented size and scope prepares to launch.

Some states, such as Arizona and New York, show great potential, and we look forward to hearing about the successes of those models. We'll also hear from Medicare-based plans, a national expert who understands the intricacies of the Medicare program, and also from the PACE program, which has a long history of participating in both Medicare and Medicaid.

As we go forward, it's important to consider whether there is sufficient oversight in place for the national duals demonstration which will include 26 states, including my own State of Wisconsin. Concerns have been raised as to whether beneficiaries will be able to choose the best form of care and how, if they wish to make a change, they can switch from one plan to another or return to traditional Medicare.

The issue of passive enrollment or enrolling Medicare beneficiaries in a program without their consent is a fundamental question of beneficiary choice which we cannot simply sweep under the rug.

There are also important questions about what kind of data we need and expect to see on an ongoing basis that will clearly show what quality of services are being delivered and the amount of actual cost savings that accrue from each and every participating provider and state.

We look forward to hearing from Ms. Bella and all of our witnesses.

I'd like to turn now to Senator Corker, who will chair this hearing.

Senator Corker.

STATEMENT OF SENATOR BOB CORKER

Senator CORKER [presiding]. Thank you, Mr. Chairman. I certainly appreciate all of the testaments. I thank you for allowing us to have this hearing, and I want to thank all who are participating in this hearing to get an update on care for seniors known as dual eligibles who receive both Medicare and Medicaid benefits.

Seniors in this vulnerable population usually suffer from poor health status and lack of financial resources to supplement their treatment. As a result, their care can be very complicated and costly, particularly because of Medicare and Medicaid's competing rules which create inefficiencies for the patients, providers, and payers.

There are about 9 million dual eligibles, and some recent estimates place their annual cost of care to be about $300 billion by Federal and state governments. According to the Centers for Medicare and Medicaid Services, dual eligibles represent 20 percent of Medicare enrollment but 32 percent of total Medicare spending. In Medicaid, they make up just 15 percent of enrollment but 35 percent of the program cost.

With the Medicare Trust Fund on track to be insolvent by 2024, and state and Federal budgets in dire financial predicaments, we must make sure that Medicare and Medicaid are working together to serve dual eligibles efficiently and cost effectively.

There have been some innovative solutions to fully integrate financial incentives and coordinate patient care. Existing models like Programs for All-Inclusive Care for the Elderly, known as PACE, and some Medicare Advantage special-needs plans are successfully navigating complicated rules to implement patient-centered care, but very few individuals are enrolled in these programs. There is much more that we can do so that dual eligibles get quality care at lower cost.

CMS is in the process of implementing state demonstration projects with the goal of achieving financial alignment between Medicare and Medicaid for the treatment of dual eligibles. Twenty-six states, including Tennessee, have applied under this demonstration program which allows states to have the flexibility to be laboratories of innovation and could expand integrated, coordinated care for dual eligibles from about 120,000 to as many as 3 million.

With any program of this size affecting the care of so many patients, there must be appropriate congressional oversight. Given a recent Congressional Budget Office report demonstrating how previous coordinated care demonstrations have not achieved sufficient savings, there is a lot riding on whether or not coordination and financial alignment can work to truly improve the quality and contain the cost of care for dual eligibles.

I look forward to hearing from our witnesses today on how we can currently serve dual eligibles and what more we can do. These issues are critical to protecting the retirement security of current and future seniors. And again, thank you for participating. Thank you for letting us have this hearing today.

We have two panels today. In the first of our panels, we look forward to hearing from Melanie Bella. Melanie is the Director of the Medicare-Medicaid Coordination Office at the Centers for MMS. According to CMS, Ms. Bella is the Senior Vice President for Policy and Operations at the Center for Health Care Strategies, focusing on integrating care for complex populations.

So, Ms. Bella, we thank you very much for being here and look forward to your testimony.

STATEMENT OF MELANIE BELLA, DIRECTOR, MEDICARE-MEDICAID COORDINATION OFFICE, CENTER FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, BALTIMORE, MD

Ms. BELLA. Good afternoon, Chairman Kohl, Senator Corker. Thank you for the opportunity to be here today. My name is Melanie Bella. I'm the Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare & Medicaid Services. We appreciate the opportunity to share our current efforts to provide high-quality, well-coordinated care for Medicare and Medicaid enrollees.

Today, there are over 9 million Medicare-Medicaid enrollees, and these low-income persons, seniors and persons with disabilities, receive care in a fragmented system that is neither easy to navigate nor designed to provide the best care possible.

For decades, there has been much discussion about providing better care to this population, and thankfully, through the Afford-

able Care Act, Congress has now given us tools to take action, and that's what we want to talk to you about today.

Simply put, the status quo is not working. Medicare and Medicaid enrollees are forced to navigate a myriad of rules and requirements and manage multiple identification cards, benefits and providers. These are real people stuck in broken systems.

Consider Jamie. Jamie is a 29-year-old with quadriplegia. He is a new Medicare and Medicaid enrollee. Among his many needs, he requires both a wheelchair and a shower chair. When Jamie became eligible for the second program, there was confusion about how to continue access to the medical benefits that he needed. As a result, Jamie did not get the services that he needed.

When things like this happen, and they happen every day, beneficiaries suffer, and we end up with institutional placements or admissions that could and should be prevented.

Now consider Ms. R. Ms. R. is an 80-year-old widow who lives with her daughter. Her daughter has recently taken a second job so that she can help provide care for her mother. Among her many health conditions, Ms. R. has heart failure, diabetes, dementia. She has advanced hip and knee osteoarthritis. She sees multiple specialists and rarely sees the same primary care provider twice. Her daughter, who is feeling overwhelmed, is considering nursing home placement.

Instead, the family was made aware of an integrated care program that was available for Ms. R. After six months in the program she has had no hospitalizations, her medication costs were cut in half, and she's had no ER visits. In addition, her daughter has had fewer work absences.

Care like Ms. R. receives should be the rule and not the exception. With that as our driving principle, the Medicare-Medicaid Coordination Office is focused on three areas. The first is program alignment, the second is data and analytics, and the third is models and demonstrations. Collectively, these areas form a platform for developing and advancing more integrated, person-centered systems of care for people like Jamie and the millions of beneficiaries across the country who are eligible for both Medicare and Medicaid but find themselves stuck in a broken system today.

Better coordination begins with program alignment. To address program barriers and inefficiencies, we launched what's called a program alignment initiative, which has served as our guide for streamlining Medicare and Medicaid rules, requirements and policies. The alignment initiative has provided an important forum for the public to comment on our work, and it's a guide to help us identify opportunities for program alignment that we can either address directly or we can address through current or future demonstrations.

Next is data. A critical aspect to everything we do is having a thorough and comprehensive understanding of this population. Last year, we initiated a new process to support States in their efforts to provide safer, better, and more cost-effective care through sharing data, Medicare Parts A, B and D data with States for care coordination.

Earlier this year, we released State-specific profiles that provide a snapshot of basic demographic information, utilization profiles,

cost patterns for the population that we're talking about, by State. We hope these tools will help serve ourselves and other policymakers better to address the needs of this population.

Complementing these efforts are models and demonstrations which further our work to better coordinate care. Through the financial alignment initiative, we have fostered a Federal and State partnership through demonstrations, one a managed fee-for-service model and one a capitated model, intended to test the alignment of service delivery and financing of the two programs. The demonstrations are designed to leverage the strengths of the State and Federal governments and to take the best aspects of both programs and put them forward in a way that meets the needs of beneficiaries, their caregivers and providers.

In addition to the financial alignment initiative, we are excited about a new initiative aimed at reducing avoidable hospitalizations among nursing facility residents. We are committed to openness and transparency and have made it an integral part of this process. We take public feedback very seriously and are continually working to address comments and recommendations.

This testimony reflects just some of the ways we are working to improve the overall beneficiary experience of care, strengthen the partnership between the States and the Federal Government, protect the integrity of the Medicare Trust Fund and taxpayer dollars, and promote more integrated and accountable systems of care.

While there may be differences in views on how we get there, there can be no question that we can provide better care for this population. Our job is not simply about numbers and charts and dollars and savings. It's about people, and we will continue to do our part and look forward to working with you and your support to do better for this population. Thank you very much.

Senator CORKER. Mr. Chairman, why don't you go first with questions?

The CHAIRMAN. Thank you. I will not be over long.

While state by state evaluations are required under the national demonstration, what kind of nationwide evaluation of the 26 states will CMS undertake? For example, have you identified ways to measure quality of care for dual eligibles that all states will be required to collect? And if so, will the results from each state be part of a national evaluation?

Ms. BELLA. I'm glad you asked that question. Evaluation is critical to these demonstrations. We brought an external evaluator, RTI, on board several months ago to begin working with us, knowing that we were going to want to have a very comprehensive evaluation. We will have, as you state, State-specific evaluation designs, and also a national evaluation. We will have core measures across all of the demonstrations, and then we will have variations within each demonstration to reflect, for example, the different models of care, the different target populations.

But the answer to your question, the answer to all your questions is yes. We will have a core set of measures, we will have State-specific designs, and we will have a national design that will look in aggregate across the demonstrations for both the managed fee-for-service and the capitated model.

The CHAIRMAN. Good. The Medicare Payment Advisory Commission, MedPAC, and others have expressed concerns that the demonstration is too expansive. At the same time, not all states are participating in a demonstration, and among the 26 that are, some are choosing to focus on a limited population. Still, it's clear that some states involved have an interest in quickly expanding their model.

What is CMS doing to balance the pressure to expand with the need to make sure the new models actually work? And how will the agency respond if some states do not do a good job and beneficiaries fail to get high-quality care?

Ms. BELLA. Well, a couple of points in response. The first is I think it's important to make sure that everyone realizes we have not approved any demonstrations yet, and we have not made any claims that we will approve demonstrations unless they meet the standards and conditions and the high bars that we've set for the demonstrations.

So there certainly is a lot of interest in the proposals that have all been publicly posted. The numbers are higher than we intend to approve through these demonstrations, and we have many checks and balances along the way where we can ensure that the beneficiary protections are in place, the financial safeguards are in place before we allow the demonstrations to unfold.

So, we have a group of States that's interested in implementing in 2013 and a group that's interested in 2014, and within each of those groups, they all want to phase differently. In order for us to continue with anything that we approve, again, we will have milestones to make sure those are met before we automatically allow enrollment of beneficiaries into these programs.

But, I think the first and foremost thing to emphasize is that nothing has been approved yet, and some things in State proposals—this will not shock anyone—are outside the boundaries of what CMS has indicated it would be willing to accept. So, there's going to be a lot of give and take between now and the time that we assess all the proposals.

The CHAIRMAN. Finally, the concept of passive enrollment for dually eligible beneficiaries is one that has not been tried in Medicare before, as you know. Is CMS concerned about setting a precedent that could be difficult to un-do?

Ms. BELLA. We look at these demonstrations as an opportunity to test new enrollment methodologies and to test new ways of communicating with beneficiaries to make sure they understand their choices and their options. So, we will be using enrollment brokers, choice counselors, leveraging ADRCs and SHPs out in the community, and that's something we haven't done in the past, quite honestly.

We had a limited run with passive enrollment when Part D started, and I think we've learned from that experience, and we're really trying to wrap around the beneficiary and make sure there is a strong network of information in accessible formats to help beneficiaries understand these choices, and we see that this demonstration is an excellent opportunity to test the passive enrollment model.

The CHAIRMAN. Thank you.

Senator Corker.

Senator CORKER. Thank you, Mr. Chairman.

As you can tell by the large number of people here, there's been a lot of input as it relates to this demonstration program, and I want to applaud you for trying to figure out a better way of dealing with dual eligibles, I really do. I know a lot of people here are interested in making sure that it works in an appropriate way.

There's been a lot of discussion about the size of this program. It's a pretty large demonstration program when you have potentially 9 million folks overall and 3 million have been projected to be a part of this program. I know that you may have a sense of what you think the real uptake is going to be in this program. I wonder if you might share with us how many people you think really will be a part of this demonstration project.

Ms. BELLA. Sure. Certainly, size has generated a lot of interest, as you know.

Senator CORKER. A lot of enrollees, a lot of dollars.

Ms. BELLA. We said last year when we announced the demonstrations that we had a target of up to 2 million beneficiaries. I think we feel that that is a reasonable target both to balance not putting too many people in, but also to allow us to test variation across the Nation in different delivery systems, different States, with different beneficiary populations.

So, we believe that is a size that's necessary for us to be able to provide information to Congress and others about how to better promote integrated care for these populations. We believe we're doing it with strong evaluation and oversight that will ensure that we're protecting the beneficiary interest because we have milestones along the way to do this, and again our target is 2 million. That doesn't mean that we will approve up to 2 million, but——

Senator CORKER. But your sense is there might be 2 million in participation.

Ms. BELLA. Certainly, there's been widespread interest from the States, and I would say we have had a small test of this in the past. We've seen other integrated programs, but they've been very small. So this is, in part, a way for us to test scale for a population that, I think in our view, is long overdue.

Senator CORKER. And how does the size of this compare to other demonstration programs that we might have carried out in Medicare in the past?

Ms. BELLA. Certainly by Medicare's definition, it's very large. But then there also have been, I think, observations about Medicare demonstrations in the past that they haven't been large enough for us to get an understanding of how we would scale those demonstrations and/or that they haven't moved quickly enough.

So again, we're trying to strike that balance. Certainly, when we test things in the Medicaid world, they're on a larger scale. So when we're trying to bring those two worlds together, we're trying to strike that balance, and we feel that up to 2 million is a reasonable balance.

Senator CORKER. So you think that's appropriate and feel comfortable with that? Again, I'm sure you're going to have a lot of input regarding that as it moves ahead.

I know that Senate Finance Republicans and MedPAC and others have been a little bit concerned about the effect that this is going to have on Medicare Part D and the competitive program that exists there, and I wonder if you might give any comments that you might have regarding keeping that competitive process in place and any negative impacts that you think this program could have on that.

Ms. BELLA. Well, as you can imagine, we worked closely with our Office of the Actuary as we structured this demonstration to ensure that we were putting the pieces together in a way that would not have a negative impact on Part D. We feel the way we've structured Part D as part of this demonstration will not have an impact on the Part D bids, and we will be closely monitoring and evaluating that over the course of the demonstration to ensure that, indeed, we're not having any unintended result.

Senator CORKER. And do you plan to allow states to substitute their Medicaid formulary for Part D?

Ms. BELLA. So we've been pretty strong in our policy that Part D stays intact. We're pleased with Part D. We believe that the beneficiary protections it affords and the protected classes are things that need to remain the same in the demonstration, and that's the policy that we've issued.

Senator CORKER. So based on that statement, do you think there will be much impact on the savings that we're seeing from Medicare Part D now?

Ms. BELLA. Again, based on our consultation with our Office of the Actuary, we don't believe that it's going to have any negative impact on the Part D program.

Senator CORKER. And as you can imagine, advocates, especially for people who have really complex situations, HIV, mental health, those kinds of things, are concerned, end-stage renal disease, all kinds of chronic issues. You feel certain that you're going to be able to put in place robust networks to care appropriately for individuals who have conditions like this?

Ms. BELLA. We certainly expect that the demonstration proposals that the States have put forward, and we approve are sensitive and reflective of the subpopulations through the requirements that they have on the health plans, for the care plans and the interdisciplinary teams and all of those things. Through our network adequacy and readiness reviews, that will be a strong component, we'll be looking to be sure that by subpopulation, the plan has an adequate network in place to provide care. We will be monitoring the care plans, the models of care, all of those things, not in a one-size-fits-all approach but sensitive to the different needs of the various subpopulations that you mentioned.

Senator CORKER. And you've talked a lot about the complexity, and you gave two great examples on the front end, and aligning incentives and all of that. You're projecting 26 states, I guess, participating in this. Tell me where you think the savings is actually going to come from and how will the savings be attributed between Medicaid and Medicare as you go forward.

Ms. BELLA. Sure.

Senator CORKER. And will that differ, by the way, per each state?

Ms. BELLA. So the first question is where do we think the savings will come from. Generally in three areas: one, improved coordination of care because we actually have now a coordinated system with an accountable entity. The second is reduction of duplicative or unnecessary care, which we know is happening today. And third is administrative efficiencies, by having entities that don't have to navigate both programs and do two sets of reporting requirements and two of everything essentially. So we believe that that will provide savings.

We anticipate that—we have not released a national savings target for the very reason that the savings opportunities will be different in each State. It will depend on what the intervention is, what the target population is, what the State's current mix of institutional and community-based placement is. All of those things, among others, will influence what the savings opportunity is in each State. So we do expect that it will vary, yes.

Senator CORKER. And how will you attribute those savings again? I'm not sure——

Ms. BELLA. Oh, I'm sorry, that was the third part of your question. The way this is designed, and it's designed to bring the two payers together in a way that aligns incentives, we would expect that the savings would be applied proportional to the contribution of each payer to the rate that gets paid for an individual. So Medicaid will not be grabbing all the Medicare money, and vice-versa. It will be a reflection of the way the payers contribute today to the care.

Senator CORKER. Some of the states have found some unmet needs for home and community-based services when they looked at newly enrolled beneficiaries. I'm just wondering how this is being factored into your projections.

Ms. BELLA. Particularly, it's something that we expect to see in some States, particularly those that are less rebalanced, if you will. The way the model is designed to work, and this is in the capitated model I assume we're talking about, we expect to see shorter-term savings in the Medicare arena, in the hospitalizations and readmissions and better pharmacy management. Those shorter-term savings can help offset some cost increases in the community-based services side.

When the shorter-term savings run out, that's when we expect to see some of the savings from Medicaid start to materialize. So the beauty of this model is when you put them together, one comes in sooner, the other comes in later, but by blending the two, they both share across the life of the demonstration. And so we believe some of the unmet need will be able to be funded through some of the opportunities that come through reduced hospitalizations and better pharmacy management.

Senator CORKER. I think, again, when you look at the interest that we've had in this hearing, the people that are here, you find this anytime there are changes in the Federal Government, people that have been serving a population in a certain way become concerned. So there have been a lot of process questions. Can you describe for the audience here today and those who care about this, obviously us here, what kind of process are you going to work through to refine these proposals with state governments, and

what kind of transparency and input are you going to be receiving all along the way?

Ms. BELLA. The transparency and stakeholder engagement has been a core part of this process from day one. All of the States in the development of their proposals, one of our major requirements was that they have a very robust and meaningful stakeholder engagement process all along the way while they were developing their proposal. Before they submitted their proposal to us, we required that they posted it publicly for comment for a 30-day period. Then we required that they incorporated those comments or that they showed us what they did and did not incorporate into their proposal.

Upon that part of the process, they were able to submit a proposal to CMS. We then posted that proposal for public comment for 30 days and gathered public comment directly to CMS. We are actively going through all of those comments. Some States have more than others, as you can imagine. But then that also guides our interaction with the States to go back and understand why they are or are not changing certain things that may have come in during the public comment period.

What that's all leading up to is the development of a memorandum of understanding. The memorandum of understanding is what memorializes the demonstration between CMS and a particular State. But there is no guarantee that the point of proposal will result in a memorandum of understanding because there's much that has to be worked out along the way.

CMS issued guidance in both January and March that laid out standards for these demonstrations, a heavier focus on the Medicare side, but clearly said these are the parameters and these are our standards for things like grievances and appeals and marketing and provider credentialing and licensure insolvency, all those types of things. So that's been out in the public domain. It's been very public.

In addition, I mentioned the memorandum of understanding. The template for the MOU was made public last year when we announced these demonstration opportunities, so we've tried to get information out in the public to make people aware of the types of things that would be part of these demonstrations. We've made a commitment that all those memoranda of understanding will be made public. So we really do want to encourage—not encourage, but live up to transparency along the way in the process. We meet with stakeholder groups frequently and oftentimes without the State, just upon request. So we are trying to make this, again, a very open process.

Senator CORKER. Thank you. I know we have two other senators that have just come in. I'll ask one more question, then have a few more for the record, if that's okay.

What do you see as a future of special needs plans, managed long-term care, PACE programs, outside of this demonstration? And are you thinking that there needs to be more than one model, if you will, as you go forward? I'm just wondering what you think the impact on these other programs will be as you move ahead.

Ms. BELLA. The ultimate goal for us is to have seamless coordinated systems of care for beneficiaries. So there is not a one-size-

fits-all approach. There's a very important place for the PACE program, and we are trying to work with our demonstration States to ensure that there continues to be a viable option for PACE. Special needs plans are important in that they focus on this population. We'd like to see those be more integrated.

But in answer to your question, there is not a one-size-fits-all approach, and we have variations of the two models that we have out there today, and we expect that we will learn from those things and we'll make adaptations. Again, the goal is not to have one prescribed model, but the goal is to have people in seamless, accountable systems of care.

Senator CORKER. Well, thank you very much. And with that——

The CHAIRMAN. I have one question.

Senator CORKER. Okay. Go ahead.

The CHAIRMAN. Ms. Bella, many of the state proposals for national demonstrations project that, over time, savings will come as a result of reduced hospitalization rates, emergency room visits, and long-stay nursing home admissions. From CMS' vantage point, what kinds of changes will be needed to produce significant savings in these areas, and realistically how quickly can they be realized?

Ms. BELLA. Well, unfortunately, there's no silver bullet, and nothing happens quickly. I mean, these things take time to show results. So I think we all have to have that expectation in mind.

Having said that; there are certainly opportunities in the areas that you mentioned. But one of the fundamental things that we have to overcome is this financial misalignment between the two programs, because right now the incentives are not aligned for many of the outcomes that you speak of. So part of what we're trying to do, where we have a lever at CMS is in these demonstrations and trying to change payment policy, and trying to change the benefit structure in a way to put accountability in the system that rewards improved quality and outcomes and aligns incentives to allow us to see the types of improved health outcomes that you speak of.

The CHAIRMAN. Thank you.

Senator CORKER. Thank you, Mr. Chairman.

Senator Johnson.

Senator JOHNSON. Thank you, Senator Corker. Sorry I was late. So if I ask some questions that have been covered, I apologize.

Just in reading the briefing materials here, one of the problems it seems like in the demonstration projects is states are moving way more individuals into these projects than was anticipated. Isn't there a relatively easy fix to that? Does that require some legislation, or am I overstating the problem?

Ms. BELLA. Certainly there's been a lot of attention on the numbers, and the numbers that are floating around in the public are higher. They're inflated based on what CMS intends to move forward with, and we believe that the number that we—we control whether we approve these or not. So I think you're right, it's not a complicated issue. There are differences in opinion on how large the size should be. We feel comfortable moving forward with the target that we set, and we do have mechanisms in place to ensure that we will only move forward with State proposals that are appropriate and have the necessary beneficiary protections.

Senator JOHNSON. In terms of trying to limit the increase in costs, and I think that's about all you can really do in health care, unfortunately. It's very difficult to actually reduce cost. But in terms of limiting the increase of cost, certainly from my standpoint, introducing free market principles into health care would be one of those things. Is there anything in this demonstration project that would start moving us in the direction of bringing some free market disciplines? In other words, putting patients more in charge of some of the payments?

Ms. BELLA. At this stage, we're not injecting any type of beneficiary payments for this population. We certainly are trying to encourage beneficiaries to be in more efficient systems of care, those that can give them additional benefits than they are receiving today in the sort of fragmented fee-for-service world. So I think that's the first step toward getting folks more engaged in their care.

Senator JOHNSON. So would you say the cost savings you expect really come more from that coordination of care versus just a capitated type of payment system? Is there any capitation involved in this at all?

Ms. BELLA. Yes. There are two demonstration models. One is a capitated model and one is a managed fee-for-service model, more like an accountable care organization model. But we think there are cost savings from improved care coordination, from reduction of duplicative and unnecessary spending, which happens quite a bit in this population, and from administrative efficiencies, by not having to deal with two sets of program rules and requirements that are completely different.

Senator JOHNSON. Are you running those two experiments side by side to determine which is best?

Ms. BELLA. We're not—each State has indicated which model it's interested in testing. We have two States actually that are interested in testing both models, but they will be in different areas of the State. So we will have common measures across both models that will help inform the strengths, I guess, and the impact on quality of cost of one model over the other.

Senator JOHNSON. If you were to guess, which model do you think would be superior?

Ms. BELLA. We have more stability and predictability in the capitated model, and more accountability, because one entity is receiving both funding sources to arrange for the care. I think, though, that's a more tested model, and the managed fee-for-service model offers us a great opportunity to learn through aligning incentives in a different delivery system setup. So I think that both have tremendous promise, and honestly a lot of it just depends on the State and what the state's current delivery system environment is. So I think that they both hold great promise.

Senator JOHNSON. In an earlier response to a question, you were talking about the financial incentives just weren't aligned properly between the two systems. Can you just dwell on that a little bit more, try to get me to understand exactly what you're talking about there?

Ms. BELLA. Sure. A couple of examples: One is Medicaid programs typically have care management programs for high-risk,

high-cost folks, and those care management programs are intended to reduce hospitalizations or readmissions or improve medication management and those things.

For a dual eligible, if Medicaid pays a care management fee—say it's me, and they pay a care management fee for me but I'm a dual eligible, so if I have reduced hospitalizations or better drug costs, Medicare gets that money. So Medicaid doesn't want to make an investment if it has no ability to share in any returns on that investment. So that's one example.

Is that helpful? Today the Medicaid programs are excluding the dual eligibles for these programs, by and large, because of this financial disincentive. So neither program benefits, nor does the beneficiary.

Another example is between hospitals and nursing homes. So Medicare pays for hospitals, Medicaid pays for custodial nursing home stays. You see this incredible churn between the two payers largely driven by the misaligned financial incentives, and what happens is the beneficiary gets in the middle and we have all these unnecessary placements between the two settings, again in large part because each is paid for by a different payer.

Senator JOHNSON. How much does the different reimbursement rates enter into that equation in terms of misalignment of the financial incentives? I mean, are providers pushing more Medicare versus Medicaid because of reimbursement differentials?

Ms. BELLA. It happens for some services. Most of the services, it's pretty clear who is the primary payer, and so there's not as much of that. But certainly Medicare is a better payer than Medicaid, and particularly when it comes to skilled nursing care, nursing facility care. I think there is a greater interest in having Medicare be the payer than Medicaid in those settings.

Senator JOHNSON. Okay. Well, thank you. I'm out of time.

Senator CORKER. Senator Wyden.

Senator WYDEN. Thank you very much, Mr. Chairman. I want to commend you and Senator Kohl because I think this is an extremely important topic. I wish I had a nickel for every time I heard about how health care was going to be better coordinated, because I think we would all be in very solid financial shape if that was the case.

Ms. Bella, I want to touch on some of the issues that you and I have talked about in the past, and start with the proposition that coordination of dollars is not the same thing as coordination of care. My sense is that this room is probably filled today because most folks are interested in the former. They want to know where the dollars are going to go, and that's understandable, and I just want to make sure that the dollars actually go for the programs that do coordinated care for these very vulnerable people and deliver the highest possible quality.

Now, my view is—and we've talked about this in the past, and I'd just like to get this on the record—that the Independence at Home model is just about the best way to make sure that you coordinate care for these very vulnerable people. Would you largely share that view?

Ms. BELLA. I think Independence at Home is a great program for a segment of this population, yes.

Senator WYDEN. Well, I appreciate that because, as you know, I pushed very hard to get that into the Affordable Care Act. We were able to get that in. We've been able to make a modest start. We have this demonstration program underway. We saw in Portland that House Call Providers was chosen as one of the 16 groups to participate. I very much appreciate that. It's our desire to build on the extraordinary accomplishments of the VA program that has taken a population that's even sicker, with more of what you professionals would call co-morbidities, and produced astounding results. At the VA, the costs have been reduced by 24 percent, hospital days have been reduced by 62 percent, nursing home days by 88 percent. So the VA is coordinating care and saving money.

The question I had for you is we've been reviewing all the materials that you all have been getting out to the states, and you've told me again today that you think Independence at Home is a very good model. But as far as I can tell in terms of the information going out to the states, Independence at Home doesn't seem to get much attention at all, if any, as a delivery model for the states.

So can you tell me what is going on with respect to your efforts to make sure that states are aware of this? Perhaps we just haven't seen all the material that you all have sent out. But if you could tell me what the situation is in terms of your relationship with the states, that would be very helpful.

Ms. BELLA. Certainly, and the Independence at Home program, as you know, is led through our Center for Innovation. So I can go back and consult with our colleagues there to find out more about what outreach is going on to the States.

For our particular interaction with States on Independence at Home, we're particularly keying to States where there is an Independence at Home demonstration and who want to do one of our demonstrations to make sure that we are coordinating appropriately and make sure that there is the best situation for the beneficiaries. So most of our interaction around that program is specific to states where there might be potential overlap.

Senator WYDEN. Why don't you get back to me, if you would, on that point? Because I think it's been a concern in our office and among a number of the States. CMS has said that Independence at Home is a good model, it makes sense for the dual eligibles, but it has not gotten much mention, if any, in terms of what you all are doing to communicate with the States.

The second question touches on what's going on with the dual eligibles, but particularly in states like mine that have high Medicare Advantage penetration. As you know, Oregon has the highest percentage of seniors participating in Medicare Advantage in the country. It's about 42 percent. In fact, in the metropolitan Portland area, it's well over half of the seniors in Multnomah, Washington and Clackamas Counties are participating in Medicare Advantage programs. As you know, you see this all the way through the Pacific Northwest where Group Health is extraordinarily popular up in the Seattle area.

Now, Oregon would like to move forward with this kind of coordination for dual eligibles, but we're concerned about being disadvantaged because of how CMS proposes setting care reimbursement rates for this population. We're already getting hammered under

today's reimbursement rates. We're very appreciative of the work that you all have been doing with our governor's office, by the way, on this point. But it just seems to me that if we don't get this resolved, we could actually be moving backwards, particularly in states like mine that have high Medicare Advantage participation.

So on behalf of the governor and our state folks, we would like to have a commitment that you all will work to ensure that Medicare Advantage plans are not disadvantaged by integrating care for the dual eligibles. Is that something that you can offer up here today that I can take back to our State folks?

Ms. BELLA. We work very closely with your State folks and appreciate all of their dedication to this project. The goal of these demonstrations is not to hurt anyone. I think there is obviously a legitimate concern on the rate setting for States like Oregon, and other States as well, and our commitment is to work with the States to ensure that we can create a rate that is appropriate to allow plans to provide the services that beneficiaries need.

Senator WYDEN. Well, that's appreciated, and Oregonians do find ourselves working with you all a lot, and we appreciate that. We're trailblazers in many respects, and certainly on health care kinds of issues. As I've told you before, and I think Chairman Kohl and I have talked a little bit about this, I want to make sure that 10 years from now, 15 years from now, we have dramatically increased the number of folks, particularly the dual eligibles, that are treated at home.

Very often I come to hearings now on this committee and on the Finance Committee and I walk out saying the discussion isn't very different than the kind of discussion I participated in when I was co-director of the Oregon Gray Panthers years ago, and I point out to my staff I had a full head of hair and rugged good looks. We were talking then about demonstration projects, then, and here we are 30 years later still, day in and day out, seeing vulnerable seniors, dual eligibles, those who have chronic diseases, heart, stroke, cancer, diabetes, going off to hospital emergency rooms in the middle of the night, going to institutional services, when I know we can get more of those seniors care where they want to be, which is at home, at less cost to taxpayers.

We've talked about this before. I know this conversation will be continued. We appreciate what you're trying to do with Oregon, where we have the special concern because we're already discriminated against with respect to reimbursement rates, and then if you could follow up on the first point to make sure that the states fully understand the value of the Independence at Home model for treating dual eligibles, that would be most appreciated, and I look forward to talking to you in the future about these topics and working with you.

Chairman Corker, Chairman Kohl, thank you very much.

Senator CORKER. So, thank you very much. I want to say that I know a lot of folks are here and a lot of folks are interested for a lot of reasons, and certainly there's a lot of finance at stake with all of this. But I am very pleasantly surprised that the Administration is taking this on in the way that it is. You seem to be very knowledgeable and on top of this. I know you're going to be getting a lot of input from this panel coming after this, and I hope you will

at least understand when it's over what they have said and pay attention to that.

But I want to thank you for taking on a really tough issue that our country has been wrestling with for many, many years. I think with input from stakeholders who care deeply about the lives of these dual eligibles, and with oversight from Congress, I think we can have a very good outcome, and I thank you for taking those steps towards that end. So thank you for being here.

We'll have the next panel up, if that's okay.

So I'll go ahead and be introducing the panel as you're getting seated. Panel 2 consists of Jason Helgerson, Medicaid Director and Deputy Commissioner of the Office of Health Insurance Programs from New York State Department of Health in Albany; Dr. Bob Berenson, Institute Fellow, Urban Institute, Washington, DC; Shawn Morris, President of HealthSpring, a Nashville-based entity, Nashville, Tennessee, I might say; Tom Betlach, Director of the Arizona Health Care Cost Containment System, from Phoenix; and Dr. Dory Funk, Medical Director, Senior Community Care, Eckert, Colorado.

We thank all of you for being here and look forward to your input. I know there's a lot of interest in this, and we certainly, I know, will learn a lot from your testimony. If you can go ahead and give your opening comments in 5 minutes or so, we'd appreciate it, and we'll have some questions.

STATEMENT OF JASON HELGERSON, MEDICAID DIRECTOR AND DEPUTY COMMISSIONER, OFFICE OF HEALTH INSURANCE PROGRAMS, NEW YORK STATE DEPARTMENT OF HEALTH, ALBANY, NY

Mr. HELGERSON. Thank you, Senator, and thank you very much for the opportunity to be here today to testify before this committee on this very important topic. On behalf of Governor Andrew Cuomo, it's a tremendous honor to be here testifying and talking about New York's efforts to redesign its Medicaid program, and in particular the state's efforts to transform the health care delivery system for New Yorkers who are enrolled in both Medicaid and Medicare.

Currently, New York State spends more than twice the national average on Medicaid on a per capita basis, and yet at the same time New York ranks 31st in overall health system quality, and it ranks last for avoidable hospital utilization.

Upon taking office, Governor Cuomo issued an executive order which established the Medicaid Redesign Team. The MRT brought together stakeholders in a unique way from across the state to work together to reform the system, reduce costs and improve quality.

This team worked in two phases. The first phase was asked to identify $4 billion in immediate Medicaid savings. To do this, the MRT held hearings, established an interactive website, harnessed the social media, and collected feedback from citizens and stakeholders alike. In less than two months, these efforts generated over 4,000 ideas.

On February 24th, 2011, the MRT submitted its first report with 79 recommendations to the governor. This package achieved the

governor's Medicaid savings target, and subsequently the governor accepted those recommendations and forwarded them to the legislature. In somewhat unheard of standards in New York State government, the legislature actually adopted virtually all of these recommendations.

The MRT Phase 1 package introduced structural reforms that have significantly bent the Medicaid cost curve and improved outcomes for Medicaid members. Importantly, the savings were achieved without any cuts in eligibility, nor did the plan eliminate any optional benefits. New York State implemented all Phase 1 initiatives on time and within savings targets. These efforts generated not only substantial savings for New York taxpayers but for the Nation as a whole. Over the next five years, the MRT initiatives will reduce Federal Medicaid spending by $17.1 billion.

In Phase 2, the MRT broke up into 10 workgroups and focused on developing a multi-year action plan to really fundamentally reform the state's Medicaid program. The MRT completed its work earlier this year and the state now has a 5-year plan for transforming Medicaid. The major elements of that reform plan include the enactment of the first of its kind in the Nation Medicaid global spending cap that brings much needed fiscal discipline and transparency to the program. Also, care management for all, a proposal to over several years phase out the fee-for-service Medicaid program and replace it with a system of high-quality care management that rewards quality over volume.

1.8 million New Yorkers now have access to patient-centered medical homes that are nationally certified. And also, funding was provided to create Health Homes all across the state, an innovative new model which promises to provide high-quality care management and care coordination for Medicaid's highest needs patients.

And lastly, the plan included a major new partnership between the state and the Federal Government to integrate care between Medicare and Medicaid for the dually eligible individuals. New York is well positioned to partner with the Federal Government around duals integration. Duals are among the most fragile people living in New York, and the fact that Medicare and Medicaid have not worked together well has meant poor outcomes and high cost.

New York's approach to dual integration is multifaceted. First, the state will utilize Health Homes to provide care management for duals who do not require long-term care services. This initiative will be deployed in January of 2013 and will benefit 126,000 Medicaid members.

Next, the state will expand on its highly successful managed long-term care program, which manages the long-term care needs of roughly 50,000 duals today. This program, which has been around for over a decade, is now moving into mandatory status and will grow to more than 120,000 people by January of 2014. In that same year, the state will add Medicare services in coordination with the Federal Government to the existing plan benefit package so as to convert in place these duals into a fully integrated managed care product.

New York will also be working to expand its successful model to 10,000 duals with developmental disabilities.

Duals will have the option, of course, to opt out of Medicare managed care. However, we are confident that they will actually stay in the fully integrated option since they are already enrolled in and familiar with their plan. It's important to note that PACE will also be an option, and New York operates some of the largest PACE programs in the country.

Thanks to Governor Cuomo's leadership and the hard work of the MRT, New York is now in a position and is excited that we have a plan to fundamentally redesign the Medicaid program. Thanks to this effort and the efforts of our friends at the Duals Office, we now are on the path for a new partnership between the state and the Federal Government when it comes to integrating care for some of our most fragile New Yorkers.

Thank you very much for the opportunity to testify.

Senator CORKER. Thank you very much.

Dr. Berenson.

STATEMENT OF ROBERT BERENSON, MD, INSTITUTE FELLOW, URBAN INSTITUTE, WASHINGTON, DC

Dr. BERENSON. Thank you, Senator Corker, Senator Johnson. I appreciate the opportunity to testify on the CMS initiative for dual eligible beneficiaries. My orientation is to Medicare based on my experience as a practicing internist for 20 years, a senior official in the Clinton Administration responsible for Medicare payment policy and managed care contracting, and as vice chair of MedPAC until this past May. There is broad agreement on the need to do a better job on care for the duals. I long have supported a move from fee-for-service, which is proving increasingly dysfunctional, to capitation, so I endorse testing the general approach in the dominant integrated payment model in the CMS financial alignment initiative.

Because of the challenges of scaling and generalizing from impressive local initiatives, reports of successful Medicaid managed care programs and innovative Medicare Advantage special needs plans should lead to real demonstrations, accompanied by strong evaluations to produce the needed evidence on which to base policy. There are many examples of initiatives that proponents knew "worked" that proved not to work when scaled and subjected to evaluation.

CMS has indicated it wants to include 2 million or more in these state-initiated programs. Instead, my view is that CMS should scale down this demonstration to one that might involve as many as 500,000 dual eligibles in perhaps 8 to 10 states. Such a demonstration program would still constitute one of the largest demonstrations Medicare has ever mounted.

Reasons for this shift include, one, experience with mostly healthy adults and children does not qualify a managed care organization to serve duals who may have severe mental illness, developmental and other physical disabilities, HIV/AIDS, end-stage renal disease, dementia, multiple chronic conditions. Medicaid managed care plans currently serve only about 120,000 duals nationally.

SNPs do target duals care and serve about 10 times that many. Yet even with SNPs, there is little evidence that permits policy-

makers to presume, for example, that passive enrollment is in the beneficiary's best interest, a central premise in this initiative.

Two, Medicaid managed care plans lack capacity to accommodate the kinds of numbers that have been proposed by the states.

Three, the financial alignment initiative should require proof of concept before broad application. In fact, prior demonstrations and experience with SNPs do not demonstrate that these integrated programs actually produce savings. Further, a central purpose of demonstrations is to work out a myriad of operational issues before broad adoption.

Four, proper evaluation is essential to fulfilling the ACA requirement that the CMS chief actuary certify that a demonstration has reduced spending with no reduction in quality, improved quality with no greater spending, or both. The current size and scope of the demonstrations would make such evaluations problematic.

Most states have proposed including all duals or entire subpopulations in their programs. Given all the effort that would go into producing an acceptable program, it is unlikely that if the evaluation proved negative, a future CMS administrator would be able to tell a state to shut down the demo and return to the status quo ante. In the current parlance, they are too big to fail.

CMS has proposed a financing model that assumes up-front savings for Medicare, unlike the approach used in other important initiatives such as shared savings program for ACOs. The immediate response of financially pressured managed care plans could be to limit rather than expand long-term services and supports, and to cut provider payment levels from Medicare levels, threatening access to care. The initiative has been silent on the extent to which health plans can achieve savings through reduced payment rates to providers.

Of the $320 billion Medicare and Medicaid dollars estimated as spent on duals in 2011, 80 percent represent Federal dollars, more than two-thirds of which flowed through Medicare. Potential savings in this demonstration would come primarily from better management of Medicare-financed, acute care services. In recent years, there has been a marked ramp-up of Medicare programs and demonstrations for beneficiaries with serious, chronic health conditions, many of whom are duals. They include ACOs, the Independence at Home demonstration that Senator Wyden talked about, bundled payment, hospital readmission penalties, and increased Medicare Advantage enrollment.

As Senator Rockefeller suggested in his recent letter to the Secretary, instead of relying solely on a model that relies on multiple state efforts, CMS should also test models that bring care for duals under the Federal umbrella.

Thank you very much.

Senator CORKER. Thank you.

Mr. Morris, welcome.

STATEMENT OF SHAWN MORRIS, PRESIDENT, HEALTHSPRING, NASHVILLE, TN

Mr. MORRIS. Thank you. Senator Corker, I want to thank you and Chairman Kohl for the opportunity to appear today before the

U.S. Senate Special Committee on Aging to discuss improving care for dual eligibles.

My name is Shawn Morris, and I'm the President of Development and Innovation at HealthSpring, a Cigna Company. HealthSpring is one of the largest Medicare Advantage coordinated care plans in the United States, with over 400,000 Medicare Advantage and 1.2 million Prescription Drug Plan members. More than 122,000 of these Medicare Advantage members are dual-eligible beneficiaries.

Cigna and HealthSpring have been serving Medicare beneficiaries for 20 years, and our concentration on the big picture of improving beneficiaries' overall health and quality of life has allowed us to develop a unique approach to health care coverage. This approach is particularly beneficial to the vulnerable dual-eligible beneficiaries with complex health care needs.

At HealthSpring, we developed a partnership that provides what our members want, more access to higher quality preventive care, while giving physicians the tools and incentives they need to deliver that care. Specifically, HealthSpring develops: focused, data-driven networks; pays physicians for quality over quantity, and provides our physicians the resources they need so they can devote more time and attention to their patients. The result of this approach is engaged physicians and healthier members with lower medical costs. It's a common-sense model, but an uncommon practice.

Through long-term initiatives like our Living Well Health Centers and Partnership for Quality program, we are able to focus on our members' overall health by improving their experience of care and quality of life. HealthSpring's Living Well Health Centers provide an additional clinical support by adding health plan coordinators, nurse practitioners, pharmacists and behavioral health specialists at the point of care. This interdisciplinary care team increases patient satisfaction and improves adherence to evidence-based treatment plans.

Our Partnership for Quality program is also a clear win-win-win. Beneficiaries receive better care and stay healthier; empowered, engaged physicians earn more through quality bonuses; and HealthSpring spends less overall on delivering care. For example, members enrolled over a four-year period with Partnership for Quality physicians saw an 8 percent reduction in hospital admissions, and significant increases in preventive health services, such as a 73 percent increase in breast cancer screenings and 83 percent increase in colorectal screenings. Partnership for Quality turns the inefficient, volume-driven model of health care on its head, and everyone benefits.

The HealthSpring members that often benefit the most from our dedication to comprehensive care coordination and higher quality are our 122,000 dual-eligible members. That is why we strongly support CMS' recent efforts to improve care for this vulnerable population. The new Capitated Financial Alignment Model demonstration program offers a real opportunity to improve the quality of care for these long underserved beneficiaries and as a fortunate by-product, generates considerable budgetary savings.

We believe that in order for these demonstrations to succeed in identifying the best, long-term solutions for these patients, great care needs to be taken when selecting the participating plans. As MedPAC noted in its June 2012 report, "plan participation standards should be transparent and should at least consider quality rankings, provider network adequacy, plan capacity, and experience with Medicare and Medicaid services for dual-eligible enrollees."

We completely agree. We believe all plans that meet CMS designated quality and access standards, including Medicaid managed care plans as well as Medicare Advantage plans, ought to be eligible to participate in these demos. Frail, dual-eligible beneficiaries deserve nothing less.

That said, it's also important to recognize that when Congress created Medicare and Medicaid nearly a half-century ago, it established Medicare as the primary source of financing of medical care for seniors regardless of their eligibility for Medicaid. Indigent seniors should have the same Medicare coverage and the same broad access to physicians as more affluent ones.

In carrying out the Capitated Financial Alignment Model, we should not overturn this structure by preventing Medicare Advantage plans from participating or by requiring beneficiaries to relinquish the current coverage that they have actively chosen. Requiring dual eligibles to abandon their chosen plan and trusted physicians, that have experience in coordinating their care and forcing these beneficiaries into a plan with a less specialized care coordination model could undermine the intent of the demonstrations.

Lastly, by maintaining Medicare as the primary source of care for vulnerable dual eligibles, we'll ensure that they're able to benefit from the variety of new delivery system reforms that the dual-eligible population so desperately needs. Dual-eligible beneficiaries have the greatest need and the best opportunity for improving quality and lowering cost.

We strongly support these goals and look forward to working with this committee and other Federal policymakers to achieve these results. Thank you again for this opportunity to testify, and I welcome any questions you may have.

Senator CORKER. Thank you.

Mr. Betlach.

STATEMENT OF TOM BETLACH, DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, PHOENIX, AZ

Mr. BETLACH. Thank you for the invitation to discuss Arizona's use of managed care to improve the lives of individuals enrolled in both the Medicare and Medicaid programs. Arizona has maintained a system of managed care for its entire membership, including dual-eligible members, since the state joined Medicaid in 1982. Arizona built its Medicaid program on the principles of member protection, competition, choice, and accountability. Arizona also offers the unique perspective of a state that has one-third of our dual-eligible members in the same health plan for both Medicare and Medicaid.

The vision underlying Arizona's program is to place accountability for management, oversight, and care delivery with one enti-

ty, the health plan. Arizona's model works through private health plans that engage in a competitive bidding process and are financially at risk to coordinate care for their members. Members have their choice of health plan and doctor. Health plans establish their own provider networks, which we monitor to ensure access to care.

Thirty years of experience have shown it is precisely our frailest members who are most in need of the care coordination managed care offers. Recently we have seen a great deal of confusion and misinformation surrounding the use of Medicaid managed care for dual eligibles. My message to the committee today is simple: Medicaid managed care for dual-eligible members is not an experiment but instead, has proven to be a success in Arizona.

In Arizona, 82 percent of our elderly and physically disabled population that is at risk of institutionalization is dually eligible. The model of care for this population in many states is nursing home placement. Over the past decade AHCCS, through the work of our health plans has progressed from 40 percent of its elderly and physically disabled members in home and community to 72 percent, saving $300 million this past year. For members at risk of institutionalization with a developmental disability, 98 percent live at home or in the community, contributing to Arizona's number 1 ranking by United Cerebral Palsy.

More importantly, keeping people out of institutions increases member satisfaction and offers higher quality of life. Providing the right kinds of care coordination to keep people at home is a Medicaid skill set.

These care management successes also extend to prescription drugs. Arizona's drug costs for dual eligibles were $166 per member per month, compared to a national average of $266 when Part D was created. A study conducted by the Lewin Group showed AHCCCS health plans were not withholding care but rather effectively using generic and lower cost drugs. Without this effort, Arizona would have spent $90 million more per year on dual-eligible drug coverage.

Avalere Health recently completed an analysis of the health outcomes for dual-eligible members enrolled in Mercy Care Plan, an access contractor that is also a Medicare Advantage special needs plan, or D–SNP. Avalere compared 16,000 integrated dual members enrolled in Mercy Care Plan to national Medicare fee-for-service dual-eligible data. To ensure a fair comparison, Avalere created a risk-adjusted model. The results showed Mercy Care Plan performed considerably better than fee-for-service. Mercy Care Plan members exhibited a 31 percent lower rate of hospitalization, 43 percent lower rate of days spent in a hospital, nine percent lower emergency department use, and 21 percent lower readmission rates.

Arizona also has proven that passive enrollment works. When Medicare Part D was created, Arizona actively encouraged existing Medicaid plans to become D–SNPs. On January 1st, 2006, approximately 39,000 members were passively enrolled with their Medicaid plan for Medicare in order to provide better continuity of care for Part D implementation. Arizona's strong transition planning and protocols ensured member protections and minimal disruption during this enrollment process.

Overall, Arizona's Medicaid members are satisfied with their health plans. In fact, only three percent of more than 1.2 million total AHCCCS members change their health plan each year. I've been fortunate to be associated with the AHCCCS system for 20 years. For the past 10 years, I have served as the Deputy Director and now Director. Prior to that, I served in the governor's office for 10 years. I know the AHCCCS program is not an experiment. It is a proven model with documented success. So, for me, it is frustrating to hear others dismiss Medicaid managed care as an option for duals and suggest that states are either ill-intentioned or incapable of achieving success for this population.

This is not about achieving a budget target. States like Arizona want to move the system forward, improve care for our citizens, and be responsible with the taxpayers' dollars. To think, as I have seen some suggest, that Medicare can be the sole answer for dual members is simply wrong. Medicare has very limited knowledge and experience in home and community-based services, community supports, or behavioral health. States have managed these issues for duals, and it is the states that understand their local communities the best.

Equally disconcerting is this notion that states are moving too fast and the demonstrations are too big. We've had 45 years of fragmentation. We have decades of comparison data that show the shortcomings of the existing system. We don't need control groups in these dual demonstrations. We know what is not working for the people we serve and the taxpayers who are footing the bill. The current system is indefensible and unsustainable. We should not wait any longer to build upon a proven model.

We hope Arizona's example will dispel the myths around managed care and assuage the anxiety some feel about using this model for dual eligibles.

Thank you again for the opportunity to briefly share our experiences in Arizona with the committee.

Senator CORKER. Dr. Funk, your summary.

Senator Bennet has arrived.

Senator BENNET. I thank the Ranking Member for your leadership, and for you and the Chairman for holding this hearing, and I am looking forward to reading everybody's testimony. I apologize because I have another engagement, but I wanted to come and welcome Dr. Funk here.

Thank you very much for what you do in Colorado, and thanks for coming all this way to share your views.

In the end, we've got some hard decisions to make here, but I think if we approach this in the spirit of goodwill that Senator Corker, among others, have shown, we're going to be able to get this done with a view toward how it's actually going to affect the people that live in our states rather than the battle that's going on back here. So, thank you.

Senator CORKER. And thank you for your great service.

Senator BENNET. Thank you.

STATEMENT OF DORY FUNK, M.D., MEDICAL DIRECTOR, SENIOR COMMUNITY CARE, ECKERT, CO

Dr. FUNK. Thank you, Senators, for inviting me out for my first trip to Washington. My name is Dr. Dory Funk.

Senator CORKER. We have found that it has a negative effect on folks.

Dr. FUNK. Is that right?

[Laughter.]

Senator CORKER. I would not stay long.

[Laughter.]

Go ahead. Sorry to disconcert you.

Dr. FUNK. That's fine. I'm a medical director for a PACE program in rural Western Colorado run by Volunteers of America. It's a successful PACE program, and I'm here to tell you about three particular operational flexibilities that we've been granted by the State of Colorado by waiver that I think directly attributes to some of our success. The National PACE Association, or NPA, wants to see those applied more broadly to PACE organizations across the country.

PACE stands for Program for All-Inclusive Care of the Elderly. It's designed around an interdisciplinary team to meet the needs of frail, elderly, low-income people with chronic care and long-term needs in order to keep them in their homes and out of nursing homes. Participants in the PACE program must meet state-determined criteria for level of nursing home care. There are 86 programs in 29 states that currently cover 25,000 participants, 90 percent of which are dual-eligible Medicare and Medicaid beneficiaries.

Ours is a little bit different. In a traditional PACE program, one or two physicians are hired to care for all the participants. Therefore, upon enrollment, a participant has to leave their own physician, who they may have had for a decade or two. Under the traditional model, nurse practitioners have a role limited to acute care only, and the majority of the care provided to participants in the traditional model is delivered in a full-service PACE day center.

The contrasts in our program are as follows. At Senior Community we have a waiver to contract with community-based physicians so the participants get to keep their own physician. We then train the physician and incentivize him to provide care and medical practice within our PACE philosophies of care.

In Colorado, nurse practitioners have unrestricted license to provide primary care given the rural nature of our state. The waiver we obtained allows a broadening of the scope of care of our nurse practitioners. They can now provide basically attending care they do, require periodic assessments, participate more fully in care planning, and play a larger role in supporting the community physicians.

Finally, we also have a waiver to develop an alternative delivery site in a tiny community 30 miles from the nearest PACE delivery site where we have 25 participants. As you can imagine, if you're frail, elderly, multiple medical issues, 30 miles in a van can be a long ride, especially in the winter.

Owing in part to these operational flexibilities and the innovative leadership provided by Volunteers of America, we've achieved success in several quality measures.

First of all, we have a remarkable market penetration. Twenty-three percent of the PACE-eligible population in our area is enrolled in Senior CommUnity care. Typically, PACE programs achieve a market penetration of approximately 6 to 8 percent.

Secondly, our clinical costs are in line or meet NPA benchmarks. We spend $711 per member per month on doctors, lab tests, diagnostic studies and hospitals, while the NPA benchmark is $940 per member per month.

Thirdly, our total hospital days and our 30-day hospital readmission rates are outstanding. In fact, we have the lowest 30-day hospital readmission rate of all 86 PACE programs. It's 6.8 percent. Nationally, for the dual-eligible population, it's 21.7 percent. Our hospital days per 1,000 members is 2,900. For duals enrolled in nursing facilities, it's 5,000. For duals receiving home and community-based services in the community, it's 6,400 days per thousand.

So we also talked about in our hearing so far outlined incentives. As with any good idea where multiple parties are involved, our program has incentives aligned among community physicians, community hospitals, community ERs, and the PACE participant, all within a blended Medicare and Medicaid capitated payment system. Our physicians see their patients do well, they get to practice with guidelines of care that make clinical sense, and they get rewarded financially. Hospitals are seeing lower lengths of stays and lower readmission rates. Our emergency rooms get disposition help with our difficult patients that wind up in the ER. Finally, the patients get to stay in their homes, and the families get the support to do so.

PACE has been a proven leader in providing care to the particularly frail and elderly part of the dual-eligible population for 25 years. NPA would like to extend these operational flexibilities to other PACE programs across the country, as well as expanding PACE eligibility to include individuals under the age of 55 who meet their state's criteria for nursing home level of care, and to high-need, high-cost beneficiaries who may not yet meet nursing home criteria for care but currently are not well served.

NPA will be hoping for your support in their pursuit of legislative and regulatory solutions in order to achieve those goals.

Senator CORKER. Thank you for your pleasant testimony.

Just so no one is caught off guard, I'll call on Senator Johnson, and then Senator Blumenthal, and then Senator Whitehouse, and then I'll go last. I just want to make sure you all will be ready. I'll give you time to settle in here for just one moment. We welcome you.

Senator Johnson.

Senator JOHNSON. Thank you, Mr. Chairman.

Mr. Morris, can you just tell me, why did HealthSpring pursue this initiative, which I guess I would kind of consider is capitated coordinated care. Would that be an accurate description?

Mr. MORRIS. That would be correct. The initiative from the demonstration project? Just to clarify.

Yes. HealthSpring is a Medicare Advantage plan. We accept payments from Medicare A and B, and D. So we approach all of what we do in coordinating for any member, Medicare or dual eligible, in a capitated way.

So in that approach, the first thing we're going to do is align incentives for the providers downstream. We want to be innovative. We want to create programs such as the Partnership for Quality I spoke of in my testimony as well as the Living Well Health Centers, and so forth.

We are very interested in these demonstration projects, and we feel it aligns the incentives from a payer perspective, be that Medicare or Medicaid. But at the same time, we think that the people and the payers that can qualify, such as the different payers that have been represented here today, Medicaid, PACE and Medicare Advantage, not be, put at a non-competitive advantage to demonstrate what they can do in an innovative way.

Senator JOHNSON. This was something done on your own company's initiative, or is this something that was part of this particular government program?

Mr. MORRIS. This decision to participate in the demonstration project is on our own company's initiative.

Senator JOHNSON. Okay. The private sector did it. Okay.

Dr. Berenson, are you familiar with your Urban Institute study that compares the long-term contribution of retiring couples into Medicare versus what the expected benefit is? I don't want to be springing that on you if you're not familiar with it.

Dr. BERENSON. Well, that was done by a different branch. Gene Steuerle's work?

Senator JOHNSON. Right.

Dr. BERENSON. Yes, I'm aware of it. I don't know a lot of the details, but I am aware of it.

Senator JOHNSON. Roughly, I think he found, for a couple retiring today, basically a two average earner couple, that they would have paid in roughly about $116,000 into Medicare, with an expected benefit—and all these things are time-value-adjusted—of about $350,000, which kind of shows the mismatch of the funding mechanism.

The reason I raise that issue is when I take a look at the health care law, it was supposedly funded for 10 years by about half a trillion dollars in taxes, fees and penalties, and about a half a trillion dollars, $500 billion, in reductions to Medicare and Medicaid, Medicare Advantage. Is that roughly correct?

Dr. BERENSON. Medicare, Medicare Advantage, and provider payments, not Medicaid as far as I know. Largely Medicare cuts, yes.

Senator JOHNSON. To my knowledge, we really haven't even enacted the SGR doc fix, which is about $280 billion. I'm not quite sure. Are you aware that we're actually initiating those savings from Medicare over this 10-year period?

Dr. BERENSON. I believe the actuary has two estimates, one which is current law which assumes the SGR occurs, and then sort of a real-world picture in which it assumes that Congress does what it's done for the last 10 years and does not allow those cuts to go into place.

Senator JOHNSON. Here's my question and my concern. And again, I appreciate the fact that we're looking for efficiencies within the system, but I'm afraid the system is going to be horribly broken because if we roll the budgetary window forward to when the health care law actually gets fully kicked in, about 2016 with full

spending, the total cost of the health care law will be about $2.5 trillion over 10 years. The taxes, fees and penalties, currently about $500 billion, maybe those will grow, maybe they won't. That leaves about a $2 trillion deficit gap or money that's going to have to come from I guess Medicare or Medicaid, or something else.

Does that concern any of you in terms of what you're trying to do, working with either Medicare or Medicaid? And are you aware of that type of funding gap with the health care law?

I'll go to Dr. Berenson.

Dr. BERENSON. We could go in any number of directions on this. I also would, I guess, cite data that suggests that both CBO and the actuaries have projected that per-capita spending in Medicare for the next 10 years is projected to increase at about 1 percent above inflation or at about GDP. It's the best it's been since the founding of the program. Whether that's sustainable or not is up for debate. But it's clear that, at least in the 25-year projections, that the real pressure on Medicare funding, and it's significant, is from a near doubling of the beneficiary population who will be in Medicare. So we clearly have a serious problem. The question is whether per-capita spending reductions of the kind I think that these programs would lead to by itself can solve the problem.

Senator JOHNSON. So I guess my point being is we have a huge problem with Medicare. As it is, the health care law starting in 2016 adds about a $2 trillion problem to that figure.

So, thank you, Mr. Chairman.

Senator CORKER. Thank you.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you for holding this hearing on this critically important topic.

The additional costs to the Medicare program that you were describing result from the increase in the number of beneficiaries, does it not?

Dr. BERENSON. The data that I'm aware of suggest that about half of the increase over 25 years is from the increase in the population, and about half is from per-capita spending increases. But at this point in time, it's largely just inflation. It's the cost of doing business, plus a slight bit more.

Senator BLUMENTHAL. And let me ask you and Mr. Morris, if I may, because, Mr. Morris, you mentioned the preventive care element and the opportunities there for not only improving quality but reducing costs, and you say that Medicare should remain the primary source of care for the dual eligibles. What specific opportunities do you think there are in emphasizing preventive care for this population that will account for such a huge increase in costs?

Mr. MORRIS. We began the program I spoke of, Partnership for Quality, in 2006 with a local physician group in Gallatin, Tennessee; it was designed with the physicians. And at that time, when we looked at their adherence to the standards that that group came up with; along with us, and these are typical quality standards such as women over the age of 40 getting mammographies, and individuals over 50 years of age getting colonoscopies, just general things, their adherence to the agreed up quality standards was around 37, 38 percent.

Since then, that particular group today is up over 90 percent adherence to the standards. We have grown the Partnership for Quality program over a six-year period to include physicians that take care of 120,000 members or so, and the average of that is in the high 70s. This particular group, not being an outlier, is representative of what most physicians are when we audit adherence to those same standards.

I think the answer to your question "Can you do this", I think we can. I think you have to have consistent quality standards that you need to compare these demos to, I also think there needs to be benchmarks and there needs to be participation from the groups that you are going to be holding accountable; we've had a lot of success doing that.

Senator BLUMENTHAL. And I read about the Partnership for Patients program, and I've been very impressed by its potential and its accomplishments so far. But when you say in your testimony that physicians are empowered to devote themselves to their patients and our members receive better care and stay healthier, for the non-health care professional, what does that mean in practice?

Mr. MORRIS. In this program, I'll compare it to fee-for-service Medicare. For a physician in fee-for-service Medicare to invest the capital from a primary care physician's standpoint, to provide this level of service, they would not be reimbursed for such within the fee-for-service system. We all know the primary care physicians are busy. They're seeing 40 to 50 people a day, on average. So you can do that math. That's just a few minutes a day per patient.

To the average physician in the community, we embed in their practice an employee of HealthSpring, a clinical person to run a Web-based tool to extract data on their entire population of who are not meeting these established quality guidelines. It's not the people who come into the office where you see the majority of gaps. Most physicians do a pretty good job with these patients. It's the population of patients that do not come into the office and having processes in place to get those patients in, is where you can make more significant improvement.

Senator BLUMENTHAL. And I think that's a critical point. How do you get that population into the office, and how do you not just get them into the office physically but get them there a second and third time for the follow-up that's necessary to provide preventive care?

Mr. MORRIS. Well, by having a HealthSpring employee in that physician's or that group's office that is embedded there. So the patient feels that that employee is a part of that practice, and it's a different model than an insurance company calling from an insurance office to get that patient in. They react because they've met that employee, they've seen them at their doctor's office.

Is it easy? It's not easy. It takes a lot of work, especially in the population we're speaking to, in dual eligibles. These people tend to move around, they have multiple caregivers, and it takes creative, innovative processes of getting multiple cell phone numbers and multiple siblings' home numbers to reach them and get them in.

Senator BLUMENTHAL. Thank you.

Mr. Chairman, my time has expired. I want to thank you again, and I will be submitting for the record a statement, an opening statement, but I won't take the committee's time with it.

Senator CORKER. Well, thanks for being here. I will say, I've visited the operation that Mr. Morris has. It's phenomenal to see what happens there, and it really is a model of how health care can and should work in our country. So I do hope you'll spend a little more time with it because it's an incredible thing to witness and to see patients coming in, and to see the way they're treated, and to see the familiarity they have with the caregivers.

So thank you for your question.

Senator BLUMENTHAL. Thank you. I'd be interested in learning more about that.

Mr. MORRIS. Oh, we'd welcome any of you there. Love to have you.

Senator BLUMENTHAL. Thank you.

Senator CORKER. Thank you.

Senator.

Senator WHITEHOUSE. Thank you, Chairman.

I thank all the witnesses for being here.

I'd like to sort of give what appears to be a general perspective and see if you all agree with it, and then ask a very specific question.

The general perspective is that we have an enormously expensive health care system for the results that it produces. We burn 18 percent of our gross domestic product every year on health care, and I think the most inefficient other industrialized country in the world is at 12 percent. So we're 50 percent more inefficient than the least efficient of our industrialized competitors, which isn't a great place to be, and you can draw some conclusions about what savings are possible by simply becoming more efficient, by delivering health care better.

Some pretty responsible people have actually done that. The President's Council on Economic Advisors I think has pegged the number at about $700 billion every single year. The Health Care Institute I think puts it at about $850 billion every single year. The Institutes of Medicine just came out with a report that put it at $760 billion every single year. The Lewin Group and President Bush's Treasury Secretary O'Neill, who knows a lot about this from the Pittsburgh Regional Health Initiative, those two have pegged it at $1 trillion a year.

So I start from the proposition that there are enormous efficiency gains to be achieved in the health care system without compromising the quality of care, and that when you're in a discussion of let's leave the system in place and just cut people's benefits, you're in a horrible discussion and a wrong discussion. If you're in a "let's try to protect those benefits at all costs but let's see how we can deliver that benefit of health care more efficiently," you're in the right place.

I see a lot of heads nodding. So the second piece of that is that we're actually beginning to kind of sort out what the mechanism is for achieving that goal, and it's a combination of quality improvements so you don't have hospital-acquired infections and errors all over the place. It's payment reforms so that people are getting paid

to deliver better health care and better health outcomes rather than just more procedures. It's an emphasis on prevention and on primary care in places where those things can be demonstrated to actually save money by addressing problems early or preventing them in the first place.

The whole thing has to be supported by a health information infrastructure that is more robust and helpful, and we can do something about the kind of grotesque administrative costs that are associated with a lot of health care.

So I view this as a real time of opportunity, and from what I understand, I mean, there are folks like the Vanderbilt Medical Center in Tennessee just won an innovation grant. They're going down this path. Gundersen Lutheran, Senator Johnson, I've talked about before. They're one of the five or six real national leaders in improving this delivery.

Have I kind of correctly described the sweet spot that you all are aiming for with the Medicaid and Medicare delivery system reforms? I'll start with Mr. Helgerson, who is nodding most vigorously.

Mr. HELGERSON. Yes.

Senator WHITEHOUSE. He and Mr. Morris are tied for nodding among the five nodding heads.

Mr. HELGERSON. Yes, Senator, I agree 100 percent. I think it's a tremendous opportunity. In New York two years ago there was a study done by the Lewin Group that specifically looked at dual eligibles in New York State. There are 700,000 of those individuals, roughly about 48 percent of total Medicaid expenditures on that population, about 41 percent of total Medicare expenditures. They found in their analysis that if we moved to fully integrated managed care and that managed care was effective, as we would all hope, we could save up to $1 billion a year in Medicare and Medicaid savings. So there are absolutely substantial opportunities. There are a lot of inefficiencies in the system.

And in addition to that, I think also what we're excited about is that not only are there inefficiencies, but there are also just really poor patient outcomes, and the lack of the ability of the programs to work together and really have patient-centered care, as it's been described, that really leads to individuals who are clearly worse off.

We believe that one of the reasons why New York ranks 50th in the Nation in inappropriate hospitalizations is because for duals, the system has simply not worked, and these new duals initiatives really are an opportunity to get the system working for those individuals.

Senator WHITEHOUSE. How many of your duals tend to be in nursing homes?

Mr. HELGERSON. We have roughly—and it's an interesting comparison between Arizona and New York—roughly about 50 percent of our spent in long-term care is in nursing homes institutional level of care. Traditionally, that's been a spent that's been fee-for-service. It's now being moved into capitation. In Arizona, I think it's like 80/20, meaning roughly 80 percent is in the community. So I think that shows you, in a state that was entirely managed care from its beginning, that I think not only can it mean better outcomes, but I think we'll get closer to the Olmstead decision, which

is trying to keep people in the community as long as possible, and I think if we align the incentives more effectively, we can do that.

Senator WHITEHOUSE. Let me make one last point. I know my time has run out here. I'd love to work with any and all of you on trying to expand the definition of "meaningful use" for health information technology purposes, at least on a pilot basis to include nursing homes, at least for the dual-eligible population, because it really makes very little sense when you have patients who are cycling back and forth between a nursing home and a hospital very often, and creating an enormous amount of cost as they cycle, to have our system support the development of health information technology in the hospital but not in the nursing home. I think if you kicked it all the way open, it's too big of a bite and there's too much. But on a pilot basis, and particularly for these dual eligibles, we really ought to be able to try to find a way to push that aperture a little wider.

There's a similar problem with respect to behavioral health, somebody who has a behavioral health issue. Their behavioral health provider is likely to be their medical home because that's the one place where their doctor really understands not only their health problem but their limitations in grappling with the rest of the health care system, and yet we carve out behavioral health providers.

So if you're interested in that, hunt me down and come to my office, call my office. I think this is a simple correction that I hope the Administration could actually make on its own within the existing definitions of "meaningful use," and I'm putting pressure on them in every way I can to try to do that, again, at least on a pilot basis.

I'll close out. I was introduced by George Halvorson, who is the CEO of Kaiser Permanente. He's a pretty serious guy in health care in this country. In the course of introducing me he said, "There are people right now who want to cut benefits and ration care and have that be the avenue to cost reduction in this country, and that's wrong," he said. "It's so wrong, it's almost criminal," he said. "It's an inept way of thinking about health care."

So I applaud all of you for thinking in a non-inept way about health care and really trying to get after the improvements we can do in the delivery system. I know, Mr. Morris, you in particular have a great private-sector example. But in Arizona, New York and elsewhere, thank you very much for this. There's a road we must travel, and it's a road with immense rewards.

I thank the chairman for holding this hearing.

Senator CORKER. Thank you. Thanks for being here.

So, first of all, Dr. Berenson, when I said that being in Washington sometimes can have a negative effect, I wasn't referring to your testimony. I realize you're from Washington.

[Laughter.]

As I listened to sort of the summation of the first four witnesses' testimony, Mr. Helgerson, you all are in New York State, and you all are just robustly pursuing managed care, which is also sort of a pleasant surprise from that state, and it sounds like you're pretty robust, pretty excited about the changes that that will have for the people that you serve.

Dr. Berenson, if I summarize your testimony, it's that you think the demonstration project is too large and you worry about people being reimbursed at rates that are lower than Medicare. Those are two of the concerns that you seem to express most during your testimony.

Mr. Morris, it seemed to me your concern was that if people have the ability to be a part of the Medicare program now, you don't want to see that change so that they end up being administered through Medicaid.

Mr. Betlach, you have exactly the opposite view and think we ought to robustly pursue the states' ability through Medicaid to manage these dual eligibles.

But do you think there's any way, as we move ahead with this demonstration program, do you think there's a way to—especially, I guess, Dr. Berenson, Mr. Morris and Mr. Betlach—to reconcile the concerns that the three of you all have, which are very different in nature?

Mr. MORRIS. I think there should be flexibility. I think it goes back to consistency of the plan's ranking and which plans are going to participate in the demos, then making sure those health plans will engage quality standards and network adequate standards. We're a Medicare Advantage plan. We're used to working with Medicare, and we have years of experience in what an adequate network should be. They're stringent. There's give and take in what that looks like at the end of the day when you're expanding a network.

So Medicare Advantage is used to such a process. I don't know that it's a state versus Federal issue. It's really, for us, why would you preclude in a demonstration, innovative companies that have proven their ability to take care of dual eligibles for such a long period of time, and do that in a way that the beneficiaries have chosen you in an open market? So why would CMS and the State on the front end preclude innovative companies, no matter if they're Medicaid or Medicare? So have that open and allow plans that meet the standards over a three-year period. Make sure we have consistency in order to demonstrate that the demonstration projects are successful.

Senator CORKER. And at present, you think you will be precluded as it's taking off?

Mr. MORRIS. Some states have an open RFP process, and some states are moving members to Medicaid. There's a variety of things out there. As Ms. Bella said, they've made no decisions, but we think just in general, if it's a demonstration by nature, you want organizations that can qualify, be they for-profit, not-for-profit, whatever, in order to improve the ability for the demonstration at the end of the period to be successful.

Senator CORKER. Do you think your dialogue with CMS and others throughout the process will reconcile that in a way that will be acceptable based on things as they're moving ahead right now?

Mr. MORRIS. We are hopeful of that.

Senator CORKER. Okay, good.

Dr. Berenson.

Dr. BERENSON. Yes, I'd make a couple of comments, one on that point. One of my concerns is that, as I understand it, the sort of

priority for beneficiaries will be their passive enrollment into a managed care plan. There are some very important programs now that have started in Medicare. The most important in my view is accountable care organizations. CMS recently announced 2.4 million beneficiaries will be in the combination of the shared savings ACOs and the pioneer ACOs. And yet, as I understand it, people will be placed in a separate organization under the state proposal and then have to opt out.

I've talked to clinicians at Ann Arbor, at the University of Michigan, which has one of these that says, "yes, we're all worried about this because we're now going to have to work with all of our enrollees to get them to opt out." Well, in ACOs they are not enrollees. They're assigned. But actually, they are in a program which is dedicated to trying to improve efficiency in what hopefully will be a capitated way in the future. So I think the demo causes some dislocation there.

CMS is trying to work on a lack of overlap and duplication of demos. I think this is one area where they should do that.

I did want to make one or two comments about Mr. Betlach's presentation. I don't think Arizona is typical of many of the states. Really, they have a lot of experience in this area. Some of the other states don't, and the numbers that I've never seen contested is that nationally there are about 100,000 or slightly more dual beneficiaries who are in integrated managed care programs. So some of the other states are doing this sort of "on the come". Arizona has the experience. If we actually had an attitude that, "we're proving the concept—that this works", then I would assume CMS would select Arizona as one of the models that they would want to have in the program.

I would still have a problem with the idea that all of the duals or all of the disabled duals would be in it. I do think we want to have a control group, not a randomized group but a control group, and then prove the concept, not just to Avalere but to CMS' evaluators, and that establishes a much better basis for going forward.

Senator CORKER. And it sounds like the concern that you have fundamentally really probably won't get addressed. Is that correct? I mean the size of the program as announced is the size of the program, and so the concept you just put out there at the end is probably not going to happen.

Dr. BERENSON. Well, I guess. I don't know what CMS will do. My concern is less, frankly, with 2 million than it is with the idea that states would enroll all of their duals or all of their disabled under 65, as Massachusetts is proposing. That, in my view, means you can't go back. I mean, I don't think you enroll—in California we're talking about 800,000 to 1 million dual eligibles. That's in their proposal. I don't think, as I said, in three years the administrator calls the governor and says, "You failed, undo all of that." I think you want to be able to do a demonstration that is not a fait accompli, that you've basically done a Medicaid waiver. I think we want to keep these as demonstrations.

Senator CORKER. Thank you.

Mr. Betlach.

Mr. BETLACH. Thank you.

Senator CORKER. He's highly complimentary of you.

Mr. BETLACH. Thank you. In Arizona, we welcome all plans in terms of the competition. I mentioned that in terms of one of our principles. If a Medicare Advantage plan is interested in participating in the program, it can come and compete with other plans. That's been one of our guiding principles all along.

Arizona has had a lot of experience with this population, particularly since 2006, in terms of the passive enrollment that was done to support integration. We've shared a lot of our experiences with other states, with CMS, with others in terms of the type of oversight that we've done on plans, trying to build the strength within the entire system and not just relying on what Arizona has learned by going through this over a number of years.

Again, to summarize our testimony, it's simply to show the types of impact this integration can have and that the model can work. Therefore, we should be looking at moving that forward because we've had this fragmentation for so long, and we've talked a lot about the challenges and the outcomes. I think that when you look at the types of accomplishments we've been able to achieve, you will want to move forward in this endeavor.

Senator CORKER. Would everybody here, just on that note, would all the witnesses agree that we do, whether it's a 2 million or a 3 million person program or some other program, we do need to work towards alleviating the fragmentation that exists in dual eligibles? Is that a fair statement that everybody would agree with?

Mr. HELGERSON. Yes.

Dr. BERENSON. Yes.

Mr. MORRIS. Yes.

Mr. BETLACH. Yes.

Senator CORKER. And before we close out the hearing—and we thank you all for your testimony—are there any things you want to say in closing that might be, you think, a misimpression that might have been left here with any of the questions or something that one of the other witnesses might have said that you'd like to clarify?

[No response.]

Senator Johnson.

Senator JOHNSON. I'll just try to wrap up what I was trying to achieve with my questioning, first starting out with the question about the private sector, where you've actually come in the private sector and worked toward these solutions. This may be an unfortunate metaphor, but I think we're really whistling past the graveyard here, and that's the other point I was trying to make.

Again, I commend all of you in terms of your efforts in trying to, as Senator Whitehouse was talking about, trying to achieve those types of savings. But, Dr. Berenson, you alluded to this, under-reimbursing providers. My concern with what we've just passed here, what the Supreme Court just basically ratified, is we have a whole new entitlement now, and to encapsulate what it's going to do, it's going to increase the demand for health care while it decreases the supply, and it supposedly is going to be paid for by reductions in reimbursements to providers, reductions to programs that are also simply unsustainable.

I mean, this is great trying to figure out some way, shape or form through government to try to reform these programs, but I haven't

seen government do it. I think we need to look to the private sector, and we need to be very concerned about what's going to happen from the standpoint of debt, deficit, and those types of pressures on our medical system. I just don't think government is the solution to it. That was really what I was trying to get through with my questioning.

Senator CORKER. Thank you.

To each of you, I think we're at an interesting time, and Medicare reform is certainly—not necessarily the dual-eligible component but probably that, too—is going to be a topic that I think we may actually take up over the next six months to a year-and-a-half as part of fiscal reforms, and I think people like you that have had such a deep experience and broad experience in it, people like you are very helpful.

I will just tell you that I would welcome input in our office regarding this program as it develops and other concepts that you see that might improve the delivery of care there.

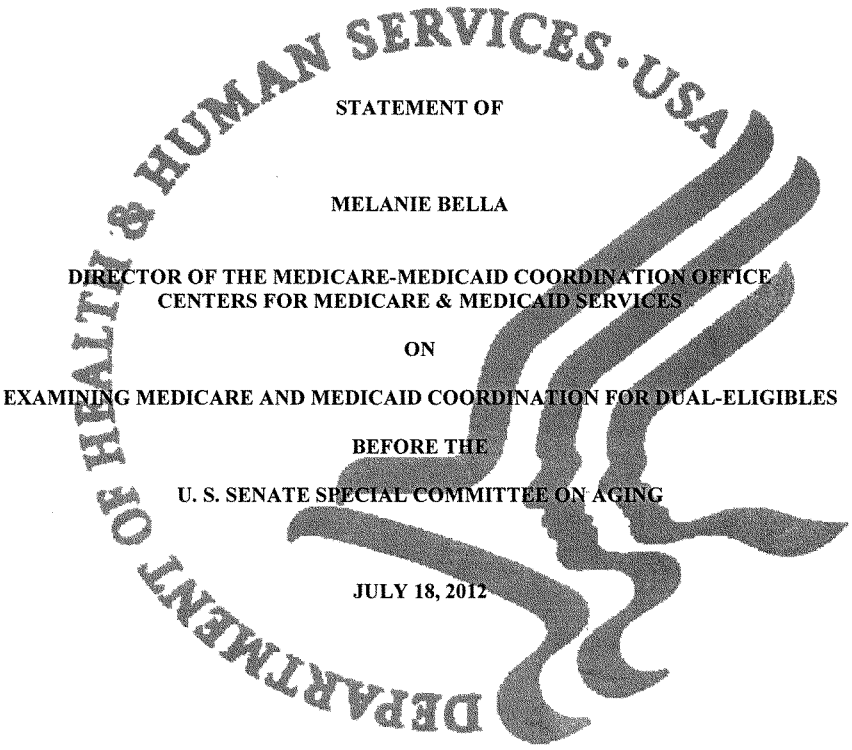
We thank you all for being here. We thank you for the roles you play in your respective states and here in Washington, and I hope if there's any additional input after this, you'll give it.

I do have a number of questions that I don't want to keep everybody here asking that we will ask in written form, if that's okay, and other members may have the same. If you could try to respond in the next week or so with those, I'd greatly appreciate it.

But thanks for your participation. Thank you.

[Whereupon, at 3:53 p.m., the hearing was adjourned.]

APPENDIX



STATEMENT OF

MELANIE BELLA

DIRECTOR OF THE MEDICARE-MEDICAID COORDINATION OFFICE
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

EXAMINING MEDICARE AND MEDICAID COORDINATION FOR DUAL-ELIGIBLES

BEFORE THE

U. S. SENATE SPECIAL COMMITTEE ON AGING

JULY 18, 2012

U.S. Senate Special Committee on Aging
Examining Medicare and Medicaid Coordination for Dual-Eligibles
July 18, 2012

Ranking Member Corker, Chairman Kohl, and Members of the Committee, thank you for the invitation to discuss the Center for Medicare & Medicaid Services' (CMS) efforts to improve and integrate care for individuals who are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). I appreciate the opportunity to be here today to update you on the many efforts underway at CMS to provide high quality, coordinated care for Medicare-Medicaid enrollees (commonly referred to as "dual eligibles").

Background

The Medicare and Medicaid programs were originally established in 1965 as distinct programs with different purposes. Medicare provides health insurance for individuals over the age 65 and individuals with disabilities, while Medicaid provides coverage for low-income families including children, pregnant women, parents, seniors and individuals with disabilities. Medicare and Medicaid are separate programs despite a growing number of people who depend on both programs for their care and the increasing need for the programs to work together to improve outcomes for these beneficiaries.

Medicare-Medicaid enrollees receive benefits and services from both programs: Medicare provides primary coverage for health care services and prescription drugs, and Medicaid covers additional benefits, such as long-term services and supports. Medicaid also provides help to pay Medicare premiums and cost sharing. Currently, the majority of Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (Original Medicare, a Medicare Prescription Drug Plan, and Medicaid) and manage multiple identification cards, benefits, and plans. As a result of this lack of coordination, care often is fragmented or episodic, resulting in poor health outcomes for a population with complex needs. It also leads to misaligned incentives for both payers and providers, resulting in cost-shifting, unnecessary spending and an inefficient system of care.

Today, more than 9 million Americans[1] are enrolled in both the Medicare and Medicaid programs; nearly two-thirds are low-income elderly and one-third are people who are under age 65 with disabilities.[2]

While pathways to becoming dually enrolled vary, Medicare-Medicaid enrollees either become eligible for Medicare first, e.g., when they turn 65 or qualify based on disability, and then later become eligible for Medicaid as a result of functional or financial decline; or become eligible for Medicaid initially, and then become eligible for Medicare based on age or disability. Medicare-Medicaid enrollees are among the most chronically ill and complex enrollees in both programs. Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees:

- Include higher proportions of women and minorities;[3]
- Are more likely to have low-incomes; and
- Are three times more likely to have a disability, and overall have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.[4]

As a result of the complexity of their health care needs, costs for individuals within this population are nearly five times greater than other individuals with Medicare.[5] Not surprisingly, Medicare-Medicaid enrollees are among the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care exceeds $300 billion across both programs.[6] In the Medicaid program, Medicare-Medicaid enrollees represent 15 percent of

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[1] Based on the Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.
[2] Kaiser Family Foundation, Medicaid's Role for Low-Income Medicare Beneficiaries, May 2011 Report *available at* http://www.kff.org/medicaid/upload/4091-08.pdf [hereinafter Kaiser, Medicaid's Role May 2011 Report]; Kaiser Family Foundation.
[3] Kaiser Family Foundation Program on Medicare Policy, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid 3, January 2011 *available at* http://www.kff.org/medicaid/upload/8081.pdf
[4] Kaiser Family Foundation, Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured 1, July 2010 http://www.kff.org/medicaid/upload/8081.pdf.
[5] Medicaid and Medicare Spending for Dual Eligible Beneficiaries 3, April 2009 *available at* http://www.kff.org/medicaid/7895.cfm; Kaiser Report, Chronic Disease and Co-Morbidity among Dual Eligibles, http://www.kff.org/medicaid/upload/8081.pdf..*supra* note 4 at 1.
[6] Based on the Centers for Medicare &Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010. This number reflects both full benefit and partial benefit Medicare-Medicaid enrollees.

enrollees but 39 percent of all Medicaid expenditures.[7] In Medicare, they represent 18 percent of enrollees and 31 percent of program expenditures.[8]

There are tremendous opportunities to strengthen the Medicare and Medicaid programs for Medicare-Medicaid enrollees by addressing inefficiencies and misaligned incentives. A fully integrated system of care that ensures all their needs - primary, acute, long-term care, behavioral and social- are met could better serve this population in a high quality, cost effective manner. This is consistent with the Medicare Payment Advisory Commission's (MedPAC) June 2010 Report to Congress which states, "Integrated care has the potential to offer enrollees enhanced, patient-centered, and coordinated services that target the unique needs of the dual eligible enrollees." There is also a growing awareness of the potential benefits that greater alignment across Medicare and Medicaid will provide not only to beneficiaries but also to providers, States, and the Federal Government in areas of improved quality of service, costs and program simplification.

Medicare-Medicaid Coordination Office

The Medicare-Medicaid Coordination Office was established by Congress through section 2602 of the Affordable Care Act to more effectively integrate the Medicare and Medicaid benefits and to improve the coordination between the Federal and State governments for individuals enrolled in both the Medicare and Medicaid programs.

Improving Care for Beneficiaries

The Medicare-Medicaid Coordination Office seeks to increase access to seamless, quality and person-centered care programs for Medicare-Medicaid enrollees. As part of this mission within CMS, the Medicare-Medicaid Coordination Office works closely with the Center for Medicare, the Center for Medicaid and Children's Health Insurance Program (CHIP) Services, and the Center for Medicare and Medicaid Innovation (Innovation Center) within CMS to foster significant reforms across the health care delivery system designed to improve the coordination

[7] Kaiser, Role of Medicare for People Dually Eligible, January 2011 Report, at 1.
[8] Medicare Payment Advisory Commission. A Data Book: Health Care Spending and the Medicare Program. June 2011.

of care for all patients, including low-income beneficiaries, many of whom are Medicare-Medicaid enrollees.

A major focus is working to improve the beneficiary's care experience with both the Medicare and Medicaid programs. As part of this, CMS continually engages with many national and local advocacy organizations to incorporate their input and the beneficiary perspective in its work. In addition to meeting on a regular basis with these advocacy organizations, CMS partnered in 2011 with the States of California, New Mexico, New York, Oregon, Pennsylvania, and Wisconsin to conduct beneficiary focus groups to asses and raise awareness of the beneficiary's care experience and needs in both the Medicare and Medicaid programs. As we work to better coordinate services, CMS will continue to work with advocacy organizations and other partners to ensure the beneficiary perspective is always a part of our work.

The Need for Coordinated Care

In 2008 Medicare-Medicaid enrollees accounted for approximately $128.7 billion[9] in combined Medicaid Federal and State spending– almost twice as much as Medicaid spent on all 29 million children it covered in that year.[10] While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 27 States.[11] These numbers demonstrate the critical need to build, sustain and strengthen Federal-State partnerships by better coordinating the benefits and services of the Medicare and Medicaid programs in a more efficient and cost-effective manner.

Medicaid is the major financing system for long-term services and supports (LTSS). In 2007, more than two-thirds (70 percent) of Medicaid expenditures for Medicare-Medicaid enrollees were for long-term services and supports (LTSS).[12] The average Medicaid spending per

[9] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries in 2012. http://www.kff.org/medicaid/upload/7846-03.pdf
[10] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm
[11] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries in 2012, at 11.
[12] Kaiser Family Foundation, Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011. http://www.kff.org/medicaid/upload/4091-08.pdf

Medicare-Medicaid enrollee was $16,087 in 2008,[13] more than seven times higher than the comparable cost of a non-disabled adult covered by Medicaid ($2,296) in 2009.[14] This spending mostly reflects the significant costs associated with a population that tends to have multiple chronic conditions, and, compared to other Medicare beneficiaries, is more likely to be hospitalized and in need of emergency room treatment and LTSS. However, there are opportunities for improved care coordination, simplification, and alignment of the Medicare and Medicaid programs to support and sustain a better health care delivery system.

The current system of financing care for Medicare-Medicaid enrollees often provides a financial incentive to push costs back and forth between the States and the Federal Government. For example, payment structures in Medicare and Medicaid may fail to adequately incentivize nursing facilities to intervene to reduce preventable hospital utilization. In particular, transferring Medicare-Medicaid enrollees receiving long-term care in nursing facilities to hospitals may be financially advantageous to facilities and States but raises Medicare spending. More information on this cost-shifting and CMS' work to address it can be found in the *Initiative to Avoid Hospitalizations among Nursing Facility Residents* section of this testimony. Partnerships to facilitate coordination of services between States and the Federal Government will work to eliminate these incentives and find real solutions that improve the experience and quality of care for beneficiaries while reducing costs.

As part of this ongoing partnership between the Federal Government and States, in July 2011, CMS established the Integrated Care Resource Center (ICRC). Through the ICRC, CMS is supporting States in developing integrated care programs and promoting best practices for serving Medicare-Medicaid enrollees and other beneficiaries with chronic conditions. This center provides technical assistance to all States, including those that are implementing or improving programs for Medicare-Medicaid enrollees using existing statutory vehicles in Medicaid and Medicare, as well as those planning new demonstration programs under new authority. States are able to contact the center with questions and support needs; the center then works with the States to answer questions, provides technical assistance, and works with CMS to

[13] Kaiser Family Foundation, Medicaid's Role for Dual Eligible Beneficiaries. April 2012. http://www.kff.org/medicaid/upload/7846-03.pdf

[14] Kaiser Family Foundation, State Health Facts. http://statehealthfacts.org/comparemaptable.jsp?ind=183&cat=4

meet the State's needs. To date, the ICRC has worked with nearly two-thirds of the States to implement best practices for Medicare-Medicaid enrollees, navigate use of new Medicare data, and support development of Medicaid health homes.[15]

Initiatives to Date

The Medicare-Medicaid Coordination Office has been working on a variety of initiatives to meet its Congressional charge and to further partner with States and other stakeholders to improve access, coordination, and cost of care for Medicare-Medicaid enrollees. Work falls into the following broad areas to support the overarching goals and mission of improving care, improving the health status of beneficiaries, and lowering costs:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

Program Alignment

Although established at the same time in 1965, the Medicare and Medicaid programs were designed with distinct purposes, which often create barriers for beneficiaries eligible for both programs to receive coordinated quality care and also complicates the administration of a more cost-efficient system.

An example of this fragmentation occurs with behavioral health services. Medicare covers reasonable and necessary "partial hospitalizations" and traditional outpatient and inpatient visits to behavioral professionals and providers, while Medicaid can cover a broader range of behavioral health services including supports and services to keep beneficiaries in the community. For individuals with severe and persistent mental illness, the fragmented care delivery system can lead to poor follow-up, especially for those individuals transitioning from inpatient care to a community setting. Lack of sufficient care coordination may increase the incidence of duplicative services, contraindicated therapies and drugs, inefficiencies in care, and

[15] CMS Integrate Care Resource Center: http://www.integratedcareresourcecenter.com/

cost-shifting.[16] To the extent current systems create waste, confusion or poor care, CMS' mission is to reduce or eliminate their underlying sources, creating a more streamlined system that delivers appropriate, quality, cost-effective care.[17]

To address such program inefficiencies, CMS launched the "Alignment Initiative" to facilitate development of a better, more cost-effective system of care that strengthens Medicare and Medicaid for beneficiaries, their caregivers, providers, States and the Federal Government.

As part of this effort, CMS compiled a wide-ranging list of opportunities for statutory, regulatory, and policy alignment and published it in the Federal Register to ensure public input in program development.[18] CMS received 108 public comments in response to the Federal Register posting. Feedback ranged from large-scale and broad reforms, to more issue-specific proposals, such as altered timeframes for appeals and an aligned Medicare and Medicaid mental health provider credentialing process. A common theme among comments was the basic need for increased communication and coordination between Medicaid and Medicare, as well as with States and Federal Government, to assure that beneficiaries have a seamless care experience across the two programs.

Since its development, the Alignment Initiative has served as CMS' guide for streamlining Medicare and Medicaid program rules, requirements, and policies. Department and agency-wide Medicare-Medicaid enrollee policy workgroups have been formed to continually engage, coordinate, and build upon opportunities for alignment. For example, an area identified in the Alignment Initiative was the practice of balance billing[19] Qualified Medicare Beneficiaries

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[16] MedPAC June 2010 Report. Coordinating the Care for Dual Eligibles, Chapter 5. http://www.medpac.gov/documents/jun10_entirereport.pdf; Kaiser Family Foundation, Health Reform Opportunities: Improving Policy for Dual Eligibles (August 2009). http://www.kff.org/medicaid/upload/7957.pdf

[17] Section 2602 (c)(1)-(8) of the Affordable Care Act specifically delineates the goals.

[18] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FederalRegisterNoticeforComment052011.pdf

[19] Balance billing refers to a practice where providers bill beneficiaries the unpaid co-pay or cost-share from services received. Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing.

(QMBs)[20], which is prohibited by law. Conversations within CMS and with external stakeholders such as beneficiary advocacy groups, providers, and others demonstrated a lack of awareness on this issue. In direct response, CMS issued both an Information Bulletin and Medicare Learning Network Article[21] to better inform partners and provide best practices to address. Other areas of the Alignment Initiative have also informed CMS work, including but not limited to, consideration of potential opportunities to improve the Program of the All-Inclusive Care for the Elderly (PACE) as well as for alignment in the appeals process, both of which were identified in our FY 2011 Report to Congress. The Alignment Initiative has also informed the development of Medicare and Medicaid program policy areas within our demonstrations, which are discussed in the Models and Demonstrations section of this testimony.

Improved coordination of the Medicare and Medicaid program rules, requirements and policies could help to create a more seamless, quality, and cost-effective system of care. The Alignment Initiative has provided CMS with important public input on this effort and will continue to act as our guide to strengthening the programs to better serve this population.

Data and Analytics

Medicare Data to States Initiative

Another opportunity to support care coordination occurs in improved access to Medicare data, which has been a long-standing barrier to States seeking to coordinate care for Medicare-Medicaid enrollees. Lack of Medicare data on hospital, physician, and prescription drug use has prevented States from having a complete picture of the care being provided to this population. For example, without access to service utilization data, a State cannot identify unnecessary duplicative services that could be harmful to the individual and costly to both Medicare and Medicaid. States have asked CMS to expand access to timely Medicare data to help them better analyze, understand, and coordinate a beneficiary's care.

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[20] QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

[21] CMS, MLN Matters, https://www.cms.gov/MLNMattersArticles/downloads/SE1128.pdf; CMS, Informational Bulletin, Center for Medicare & Medicaid Services, Informational Bulletin, http://www.cms.gov/medicare-medicaid-coordination/11_MedicareMedicaidGeneralInformation.asp#TopOfPage.

Through this initiative, CMS used existing regulatory and statutory authority to address these data challenges directly. Specifically, CMS established a new process for States[22] to access Medicare data to support care coordination, while also protecting beneficiary privacy and confidentiality by assuring compliance with the Privacy Act and Health Insurance Portability and Accountability Act (HIPAA). CMS works with States throughout the entire process of requesting and receiving the data. Currently, 25 States have already received or are in the process of actively seeking Medicare Parts A and B data and 20 States are in the same position regarding Medicare Part D data.[23] The process begins with a Data Use Agreement (DUA) that identifies and approves users to ensure data are used for care coordination purposes while requiring strict privacy and security safeguards. Medicare data will enable States to provide better, safer care based on the specific care needs of each Medicare-Medicaid enrollee.

State access to Medicare data for Medicare-Medicaid enrollees allows States to make more informed policy and program decisions. Nationally, States have varying levels of capacity to receive and analyze Medicare data but we are encouraged with the number of States that are working with CMS to actively seek Medicare data. We also plan to create opportunities for States to engage with and learn best practices from innovator States as they move forward on their respective data initiatives to improve coordination between Medicare and Medicaid. CMS will also continue to provide technical assistance to States seeking or newly using these data to coordinate care for Medicare-Medicaid enrollees. States' efforts in this area directly support CMS' goals to improve care and reduce costs – including Federal costs –for this population.

Medicare-Medicaid Enrollee State Profiles

As part of our efforts to better coordinate the Medicare and Medicaid programs, in June, 2012 CMS released Medicare-Medicaid Enrollee State Profiles[24] (State Profiles). CMS hopes these

[22] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/MedicareDataforStates.html

[23] Note: As of June 6, 2012, 20 States (Arkansas, California, Colorado, Connecticut, Iowa, Massachusetts, Michigan, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin) have been approved for Medicare A/B data. Twelve States (California, Connecticut, Massachusetts, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, Washington and Wisconsin) have been approved for Medicare Part D data. Other States continue to request access and are working with CMS to receive data use agreements.

[24] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

State Profiles will help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. The information released includes a national summary and overview of data methodology underlying the analysis, along with individual profiles for each of the 50 States and the District of Columbia. State-level profiles contain demographic characteristics, utilization and the spending patterns of the Medicare-Medicaid enrollees and the State Medicaid programs that serve them while the national summary provides a composite sketch of Medicare-Medicaid enrollees including demographics, selected chronic conditions, service utilizations, expenditures and availability of integrated delivery programs. CMS expects to update the State Profiles annually and continually engage with States and other key stakeholders to improve the data to better inform policy.

Demonstrations and Models

The Medicare-Medicaid Coordination Office, in coordination with CMS' program components, has created opportunities to develop, test, and rapidly deploy innovative and effective care models for Medicare-Medicaid enrollees. In 2011 CMS announced several new opportunities and resources: State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees, the Financial Alignment Initiative, and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. These initiatives are designed to improve the overall beneficiary care experience and coordination of services while addressing inefficiencies in care delivery that may result in health care savings.

State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees

As a first step to partnering with States to better integrate care, in April 2011 CMS awarded 15 States[25] up to $1 million each to design person-centered approaches to coordinate care across primary, acute, behavioral health, prescription drugs, and LTSS for Medicare-Medicaid enrollees.[26] These States were selected to develop new ways to meet the often complex and costly needs of Medicare-Medicaid enrollees. Early work with these States confirmed that a key component of a fully integrated system would be testing new payment and service delivery

[25] CMS awarded contracts to the following 15 States: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

[26] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html

models to promote better care and align the incentives for improving care with lowering costs for Medicare and Medicaid. Each of the 15 States has submitted a demonstration proposal to CMS, the majority of which are for one of the two models described in the Financial Alignment Initiative below.

Financial Alignment Initiatives

In July 2011, CMS announced the Financial Alignment Initiative, an opportunity for Medicare and Medicaid programs to test cost-effective integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees. The Initiative seeks to align the service delivery and financing of the programs to better align incentives for improving quality and costs between Medicare and Medicaid.

Medicare benefits focus primarily upon the acute medical care needs of beneficiaries, resulting in little incentives for State Medicaid programs to invest in care coordination for services for which Medicare is the primary payer. Financial savings gained through State-led care improvement efforts, resulting in decreases in hospitalization, emergency department uses, and skilled nursing care, are believed to primarily accrue to the Medicare program. This financial misalignment between the two programs has been a major barrier to better serving Medicare-Medicaid enrollees.

Through the Financial Alignment Initiative, CMS offered two models to test alignment of the payment and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees.[27] The first is a capitated model in which a State, CMS, and health plan or other qualified entity will enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. The second is a managed fee-for-service model (MFFS) under which a State and CMS will enter into an agreement by which the State would support care coordination networks in a fee-for-service context and would be eligible to benefit from savings resulting from MFFS initiatives that improve quality and reduce costs for both Medicare and Medicaid. Both models are designed to

[27] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

achieve State and Federal health care savings by improving health care delivery, encouraging high-quality, efficient care, and better streamlining services.

Twenty-six States,[28] after extensive consultation with and public comment from a range of stakeholders (including providers, beneficiaries, and their advocates), submitted Financial Alignment Demonstration (Demonstration) proposals to CMS. Of these States, eighteen are pursuing the capitated model, six the MFFS model, and two are pursuing both models. State approaches to financial alignment vary by scope, population, and model of care coordination, among other key factors. In some instances, States are building and leveraging existing programs and resources, such as Medicaid health homes,[29] to coordinate services for which Medicare is the primary payer (e.g., inpatient hospital stays and home health services). Other States are utilizing the demonstration to expand existing care management programs to serve Medicare-Medicaid enrollees. The Demonstrations recognize the diversity of different States in serving the Medicare-Medicaid enrollee population, and afford an opportunity to test better coordination of services in a multitude of settings.

As part of this effort, States in the Demonstrations must establish a fully integrated delivery system that provides more easily navigable and seamless path to care for beneficiaries. Every Demonstration approach must have strong beneficiary protections and safeguards. To that end, on both January 25, 2012[30] and March 25, 2012[31] CMS released Demonstration Guidance to establish baseline program requirements for States and entities participating under the capitated model.

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[28] These 26 States are: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Massachusetts, Michigan, Minnesota, Missouri, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin.

[29] Note: The Affordable Care Act created a Medicaid State Plan option for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. CMS expects States' health home providers to operate under a "whole-person" philosophy. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

[30] Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans. January 25, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf.

[31] Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013. March 25, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MarchGuidanceDocumentforFinancialAlignmentDemo.pdf

Demonstration Guidance released in January focused on payment principles and standards in key programmatic areas, such as appeals, enrollment, network adequacy, and other key programmatic standards. Guidance also provided States and potential participating plans with further information about the Demonstration approval process and timeline. These requirements establish the operational framework to be utilized in key Demonstration areas. Any variation from these standards will have to be equally or more robust from a beneficiary perspective. One such area is network adequacy standards, where the Demonstration requires aligning Medicare and Medicaid network standards to provide beneficiaries with more comprehensive access to necessary services by incorporating the strongest protections and aspects from both programs. Generally, State Medicaid standards will be used for LTSS, while Medicare standards will be used for Medicare prescription drugs and other services for which Medicare is primary. Where either program requires a more rigorous network adequacy standard than would otherwise apply (including time, distance, and/or minimum number of providers or facilities), the more rigorous standard will be used. In addition, for the prescription drug benefit, as noted in the guidance,[32] States will be required to meet Medicare Part D requirements regarding beneficiary protections, protected classes, and network adequacy. No participating States will be permitted to alter standards in a manner that is less beneficiary-friendly or reduces access. In the March Guidance, CMS outlined the Medicare Plan Selection Requirements and other key Demonstration areas, such as Model of Care (MOC) requirements. As with the January Guidance, these standards guide the operations for indicated program areas under the Demonstration.

CMS is fully committed to an open and transparent process for the Financial Alignment Demonstrations. As a result, a robust public engagement process was required as part of the Demonstration proposal process. States held public forums, workgroups, focus groups, and other meetings to obtain public input on the development of their demonstration proposal. Each State was required to publicly post a draft demonstration proposal for a 30-day public comment period prior to submitting a proposal to CMS. After this 30-day period, States worked to address and incorporate public feedback in proposals before officially submitting their proposal to CMS. Once a State formally submitted its proposal to CMS, CMS then posted the proposal to the CMS

[32] January 25, 2012 Guidance, page 17.

website for a subsequent 30-day public comment period in order to solicit stakeholder feedback directly.

CMS will evaluate the care improvement resulting from these models, and implement rigorous Federal oversight and monitoring to assess the models' impact on beneficiary experience, quality and costs. CMS has contracted with an external independent evaluator to measure, monitor, and evaluate the overall impact of the Demonstrations including impacts on program expenditures and service utilization changes. The evaluator will design unique, State-specific evaluation plans for each individual State participating in the Demonstration, as well as an aggregate analysis that will look at the Demonstration overall including Demonstration interventions and impact on key subpopulations within each State. There will also be a CMS-State contract management team that will ensure access, quality, program integrity, and financial solvency under the capitated model, including reviewing and acting on data and reports, conducting studies, and taking quick corrective action when necessary. In addition, CMS will apply Part D requirements regarding oversight, monitoring, and program integrity to Demonstration plans in the same way they are currently applied for Part D for sponsors. CMS is working with individual States to develop a fully integrated oversight process, using the process currently employed in the Medicare Advantage and Part D programs as a starting point.

The overarching goal of the Demonstrations is to leverage the strengths of the Federal Government and States in a manner that incorporates the strongest aspects from each to best meet the needs of beneficiaries, their caregivers and providers.

Initiative to Reduce Preventable Hospitalization Among Nursing Facility Residents

Nursing facility residents are subject to frequent preventable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities.[33] Preventable hospitalizations among nursing facility residents stem from multiple system failures, including inadequate primary care, poor quality of care, poor

[33] Walsh, E., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J. (2010). *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community Based Services Waiver Programs.* Washington, DC: CMS.

communications, family preferences, lack of advance care planning, and other issues.[34] Compounding these problems, nursing homes have little incentive to reduce preventable hospital utilization, improve quality of care, and better coordinate transitions of care between hospitals, nursing facilities and in-home services.[35]

CMS research found that 27 percent of Medicare-Medicaid enrollees were hospitalized at least once during the year, totaling 2.7 million hospitalizations. More than a quarter of these hospital admissions could have been avoided, either because the condition itself could have been prevented (e.g., a urinary tract infection), or the condition could have been treated in a less costly and more appropriate setting (e.g., chronic obstructive pulmonary disease). The study also found that skilled nursing facilities were by far the most frequent setting from which preventable hospitalizations occur.[36] Furthermore, in 2011 alone, it was projected that the total costs for all potentially avoidable hospitalizations for Medicare-Medicaid enrollees were $7-8 billion, demonstrating opportunities for improvements in quality and costs.

To address these problems, CMS announced a new initiative to improve the quality of care for residents of nursing facilities by reducing preventable inpatient hospitalizations.[37] Through this initiative, CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 150 nursing facilities. Interventions will be targeted to nursing facilities with high hospitalization rates and a high concentration of residents who are Medicare-Medicaid enrollees. Applications for this demonstration were due June 14, 2012. CMS received applications from organizations in 29 States, including health plans, hospitals, Area Agencies on Aging, hospice groups, and other types of care management organizations. CMS is currently reviewing those applications and intends to start these demonstrations before the end of the year.

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[34] *See generally*, Grabowski, D., Stewart, K., Broderick, S., & Coots, L. (2008). Predictors of Nursing Home Hospitalization: A Review of the Literature. *Medical Care Research and Review, 65* (1), 3-39.
[35] Page 141 of June 2010 MedPAC Report; Intrator, O., Grabowski, D. C., Zinn, J., Schleintiz, M., Feng, Z., Miller, S., & Mor, V. (2007). Hospitalization of Nursing Home Residents: The Effects of States' Medicaid Payment and Bed-Hold Policies. *Health Services Research*, 42(4), 1651-71.
[36] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Insight-Briefs/downloads/pahinsightbrief.pdf
[37] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/ReducingPreventableHospitalizationsAmongNursingFacilityResidents.html

Conclusion

Congress has provided a unique opportunity for undertaking a number of initiatives to create a more seamless and efficient delivery system for Medicare-Medicaid enrollees. These initiatives are designed to enhance care coordination and person-centered care programs, focus on increased access to needed services, promote keeping individuals in the home and community, support a much needed focus on improving the quality of care received by beneficiaries, and achieve health care savings for both States and the Federal Government through better care management. While exploring new models through Demonstrations are a part of this effort, CMS is also working to improve and enhance existing programs that serve Medicare-Medicaid enrollees. In addition, we seek to better understand the population to provide Congress and other policy makers with robust data about the care experience, quality, and spending for this population.

We thank the Committee for its interest in improving care for Medicare-Medicaid enrollees. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

Testimony for Senate Aging Committee Hearing
July 18, 2012
Jason A. Helgerson
Medicaid Director, New York State Department of Health

Senator Kohl and Distinguished Members of the Committee,

On behalf of Governor Andrew Cuomo, thank you for the opportunity to testify today regarding New York's efforts to redesign its Medicaid program and, more specifically, the state's plan to transform health care delivery for New Yorkers who are enrolled in both Medicaid and Medicare.

Currently, New York State spends more than twice the national average on Medicaid on a per capita basis. And yet, New York ranks 31st in overall health system quality; and it ranks last for avoidable hospital use and costs.

Upon taking office, Governor Cuomo issued an Executive Order which established the Medicaid Redesign Team (MRT). The MRT brought together stakeholders from across the state to work to reform the system, reduce costs, and improve quality within Medicaid.

The Team worked in two phases. Phase One focused on identifying $4 billion in immediate Medicaid savings. To do this, the MRT held hearings, established an interactive website, and harnessed social media to collect feedback from citizens and stakeholders. In less than two months, these efforts generated more than 4,000 ideas.

On February 24, 2011, the MRT submitted its first report with 79 reform recommendations to the Governor. This package met the Governor's Medicaid budget target. Subsequently, the Governor accepted the MRT's recommendations and sent them to the Legislature. The Legislature later approved a budget that contained virtually all the recommendations.

The MRT Phase One package introduced structural reforms that significantly bent the Medicaid cost curve. Importantly, the savings were achieved without any cuts to eligibility, nor did the plan eliminate any "options benefits."

New York State implemented all Phase One initiatives on time and within savings targets. These efforts generated substantial savings not only for New York taxpayers but for the nation as a whole. Over the next five years the MRT initiatives will reduce federal Medicaid spending by $17.1 billion.

In Phase Two, the MRT continued its work and broke into 10 workgroups focused on developing a multi-year Medicaid reform action plan. The MRT completed this work earlier this year, and New York now has a five-year plan for transforming its Medicaid program.

The major reform elements of the MRT Action Plan include these items:

- *The enacting of the Medicaid Global Spending Cap that brings much needed fiscal discipline and transparency into program spending.*
- *Care Management for All, a plan to phase out costly and inefficient Fee for Service Medicaid and replace it with a system of high-quality care management that rewards quality over volume.*
- *1.8 million New Yorkers now have access to patient-centered medical homes (PCMHs).*
- *Funding to implement Health Homes across the state, an innovative model that promises to provide high-quality care management and care coordination for Medicaid's highest need patients.*
- *A new partnership with the federal government to integrate care between Medicare and Medicaid for dually-eligible members.*

New York is well positioned to partner with the federal government around duals integration. Duals are among the most fragile people living in New York, and the fact that Medicare and Medicaid have not worked well together has meant poor patient outcomes and high costs.

New York's approach to duals integration is multifaceted. First, the state will utilize Health Homes to provide care management for duals that don't require long term care services. This initiative will be deployed in January 2013 and will benefit 126,000 Medicaid members.

Next the state will expand on its highly successful Managed Long Term Care program, which currently manages the long term care needs of 50,000 duals. This program, now mandatory in the state, will grow to more than 120,000 by January 2014. In that same year, the state will add the Medicare services to the existing plan benefit package, so as to "convert in place" these duals into a fully integrated managed care product. New York will also be working to expand this successful model to 10,000 duals who are developmentally disabled.

Duals will have the option to "opt out" of Medicare managed care if they wish, but we're confident they'll stay with the fully integrated option since they're already enrolled in and familiar with their plan. It's important to note that PACE will also be an option.

Thanks to Governor Cuomo's leadership and to the hard work of the MRT, New York State is now redesigning its Medicaid program. A partnership with the federal government to better integrate care for duals is key to this reform strategy.

I thank you, Senator Kohl and Committee Members, for your time.

Testimony of Robert A. Berenson, M.D.

Institute Fellow, the Urban Institute

Before

The U.S. Special Committee on Aging Hearing

Examining Medicare and Medicaid Coordination for Dual-Eligibles

July 18, 2012

Senator Corker, Chairman Kohl, and members of the Committee:

I very much appreciate the opportunity to testify before the Aging Committee on the very important topic of the CMS initiative related to improved care for dual eligible beneficiaries. The hearing is very timely given the size, scope, and speed with which these programs are proceeding. It is especially timely to have an exchange of state and federal perspectives on these state-based demonstrations. I acknowledge up front that my orientation lies with the Medicare program, which I consider a highly successful, social insurance program. Frankly I don't understand the logic of having the states take the lead in care for dual-eligible Medicare and Medicaid beneficiaries, although I do appreciate the growing pressure on state budgets and states' desire for financial relief in their Medicaid spending. I also appreciate that some successes in state-based programs has provided impetus for this initiative. I hope to gain an improved understanding from my colleagues of the panel on what states bring to the shared desire to improve care for the duals.

I practiced general internal medicine for over twenty years, the last twelve in a small group practice a few blocks from here. For the last three years of the Clinton Administration I had operational responsibility for Medicare payment policy and contracting with what are now called Medicare Advantage plans. I recently completed a three year term as a Commissioner of the Medicare Payment Advisory Commission (MedPAC), the last two as Vice-Chair. I am an Institute Fellow at the Urban Institute, doing policy research and analysis primarily on delivery system change and Medicare policy.

There is broad agreement on the need to do a better job on care for the duals. I have long supported a decisive change in payment from fee-for-service, which is proving increasingly dysfunctional, to capitation -- to plans and providers – so endorse the general approach in the dominant integrated payment approach that twenty states have opted for under the CMS initiative. As I will detail later, in fact there are numerous initiatives in Medicare to test new payment and organization of care models, improvements that will directly affect the care for duals and offer promise of program savings.

It is also true that some of the problem lies with inconsistency of Medicaid and Medicare rules and incentives, particularly in the areas of beneficiary eligibility for skilled nursing care and home health services. As summarized by MedPAC in its June, 2010 report, "Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality." The Affordable Care Act (ACA) reasonably called for state-based integrated care programs, which are proceeding now as part of the Financial Alignment Initiative.

There have been some notable successes of state-supported programs for disabled and for duals that gives encouragement to proceed aggressively, just as there have been successes in primarily Medicare-supported programs for care for dual-eligible beneficiaries. However, as we have learned repeatedly in Medicare demonstrations the challenges of scaling and generalizing from successful local initiatives is daunting. Anecdotes of successful program initiatives, often resulting from unique leadership and culture, while pointing to a direction for additional progress, should be viewed skeptically, especially when marketers start promoting a "$300 billion dollar opportunity" for the managed care industry. Rather than assume success, as CMS guidance and many of the state proposals convey, we are still at the early stages of testing models of improved care for duals.

In short, the reports of successful state-based local programs and innovative Medicare Advantage -- Special Needs Plans (MA-SNPs) responsibly should lead to real demonstrations, accompanied by robust evaluations to produce the needed evidence on which to base policy. My primary concern is that CMS's Financial Alignment Initiative is proceeding not as a real demonstration but rather is implementing program modifications, regardless of studied performance, comparable to the practical effect of Section 1115 Medicaid waivers, which are supposed to be demonstrations but which are recognized by all stakeholders as permitting permanent program changes. Medicare demos don't work that way -- and should not -- especially for the care provided to the most vulnerable beneficiaries of both Medicaid and Medicare programs.

In recent weeks, a number of letters to HHS Secretary Sebelius and CMS Administrator Tavenner have raised important concerns about many aspects of how this initiative is proceeding. These include a July 11 letter from MedPAC, a July 10 letter from Senator Rockefeller, and a June 11 letter from seven Republican Senators on the Finance Committee, including ranking member Hatch. The titles of two recent Health Affairs articles by policy experts who have looked at the issues succinctly summarize what needs to be said about the CMS initiative. *There Is Little Experience And Limited Data to Support Policy Making On Integrated Care For Dual Eligibles*[1] and *Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans*[2]. These and other letters and commentaries have done a good job of explicating the many serious concerns about how the initiative is proceeding. I personally participated in MedPAC's deliberations that took place over many hours and can certify the non-partisan nature of the concerns. **Simply, while well-intentioned, the pace, size, and scope of the duals demo needs to be reviewed and substantially altered.**

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[1] Gold M., Jacobson GA, and Garfield RL. There is little experience and limited data to support policy making on integrated care for dual eligible. Health Affairs, June 2012, 31:1176.

[2] Neuman P, Lyons B, Rentas J and Rowland D. Dx for a careful approach to moving dual eligible beneficiaries into managed care plans. Health Affairs, June 2012, 31:1186.

Approval of current state applications for large capitation programs and smaller fee-for-service initiatives in 26 state demonstrations would involve three of the seven million dual-eligible beneficiaries fully eligible for Medicaid services. CMS itself has indicated it wants to include 2 million or more in these programs, which itself is far too ambitious. Instead, CMS should scale down this demonstration to one that might involve as many as 500,000 dual eligibles in perhaps 8-10 states. Indeed, such a demonstration program would still constitute one of the largest real demonstrations Medicare has mounted.

Arguments for this shift include:

1. Medicaid managed care plans' **lack of experience** in providing both Medicare and Medicaid services for dual-eligible populations. About half of the states are building their proposals on a Medicaid managed care platform; the others use MA-SNPs. Medicaid plans typically care for relatively healthy adults and children, not for beneficiaries with severe mental illness, such as schizophrenia; developmental disabilities; severe physical disabilities, such as quadriplegia; end-stage renal disease, HIV and AIDs, dementia, and multiple chronic conditions. Many reside in nursing homes or receive intensive home and community based services. While as dually eligible for Medicaid and Medicare, at a clinical level, these heterogeneous subpopulations require unique provider expertise and a kind of coordination that varies across the particular clinical conditions. Experience with moms and kids does not qualify a managed care organization to provide and manage a provider network for duals. Further, it will take time that is not built in to the demonstration time-line for health plans to develop the requisite provider networks capable of responding to the various medical, behavioral, and long-term care needs of the various patient subpopulations. That expertise and experience must be developed, and qualification to serve as plan of choice worthy of receiving passive enrollment of beneficiaries, as is being proposed as a core element of the initiative, must be thoroughly demonstrated, not assumed.

Today, it is generally accepted that Medicaid managed care plans serve only about 120,000 duals. That experience is insufficient to support wholesale passive enrollment of dual-eligible beneficiaries into these demonstrations. MA-SNPs currently care for 1.2 million dual eligible Medicare enrollees, so at least have experience caring for duals. Yet, even with the MA-SNPs that target dual-eligible beneficiaries, there is little evidence supporting a level of performance that permits policy makers to presume that passive enrollment is in the beneficiary's best interest.

2. Medicaid managed care plan **lack of capacity** to accommodate large numbers of dual eligibles. Although some states have managed care infrastructures with additional capacity, some of the proposals in the CMS initiative are overly ambitious and realistically cannot be met within the time frames proposed. They seem to be based on "rosy scenarios," such as the

broad availability and success of patient-centered medical homes, which represent a promising approach but one that remains mostly untested in caring for a regular patient population, much less a population with the diverse and complex clinical problems posed by many of the duals. California wants within 3 years to enroll all 1.1 million duals in the state into Medicaid managed care plans, with exemptions only for enrollees of Medicare Advantage plans. According to a recent Health Affairs issue brief, the two Los Angeles County managed care plans which currently serve 7500 duals under the state's proposal might have to serve up to 375,000.

3. **Uncertainty about what will work** in advance of actual experimentation and evaluation. As with ACOs, medical homes, and other major delivery initiatives, the Financial Alignment Initiative should require **proof of concept** before broad application. A real demonstration can provide that proof and can allow federal and state policymakers, and the managed care plans to work through a myriad of operational issues. For example, it may turn out that passive enrollment into definitively excellent managed care plans, with a well-functioning opt out provision, is a desirable approach to providing care for dual-eligible beneficiaries. However, working out exactly how to implement a real, workable opt out approach for beneficiaries with mental illness, developmental disabilities, and cognitive impairments, or for nursing home residents is likely to be very challenging and need revision as a demonstration proceeds. Similarly, currently there are no established quality measures to assess performance for some of the subgroups of duals, and as noted earlier, we have little information on which to base a conclusion that any particular manage care plan provides excellent care. A major demonstration would speed up development and implementation of serviceable quality metrics to permit elaboration of practical state-based programs to caring for duals.

4. **Effective evaluation as proof** is essential to fulfilling the ACA requirement that the CMA Chief Actuary certify that the demonstration has reduced spending with no diminution in quality, improved quality with no greater spending, or both. The current size and scope of the demos would not permit adequate evaluations. Yet, there would be political pressure to declare success regardless.

Although state-based policy makers express confidence that capitated managed care has to be better than uncoordinated fee-for-service, repeated experience with other "sure things" suggests caution. For example, for more than a decade health plan representatives touted the cost containing success of telephonic disease management administered by nurses in call centers, despite an absence of evidence from well done studies of positive effect. When finally subjected to a real test by CMS as the Medicare Health Support Program, albeit with demonstration design problems, it turned out that the approach did not actually reduce costs; many health plans have moved away from the call center approach to one of embedding nurses

in physician practices as a better strategy. What those with a stake in touting success knew to be the case proved to be wrong.

The ability of Medicaid managed care or MA-SNPs to do better than traditional Medicare on quality, access and costs remains a hypothesis in need of testing, not an assumption which, not incidentally, generates savings for state budgets. Although MA-SNPs have been in place since 2005, policy makers have little information on which to judge their performance. The available quality metrics are inadequate to assess relative quality of care; most are not relevant to the particular subpopulations of duals with very unique clinical circumstances. Further, on a national basis and in many of the states which have proposed interest in participating in the duals initiative, MA-SNPs actually spend more than traditional Medicare for providing Part A and B services. Although there may be some efficiency gained by aligning the Medicaid and Medicare funding through an integrated payment, there is no *a priori* basis for assuming that these programs will be more efficient than the current arrangements, even if on a theoretical basis capitation should provide a substantial advantage over fragmented fee-for-service in caring for patients with serious chronic conditions. A real demonstration with an adequate evaluation, rather than a waiver program, would help fill the current evidence gap.

5. **Too big to fail.** As noted earlier, under CMS's expressed strategy, about 30% of full dual-eligible beneficiaries would be asked to participate in these demonstrations; some would surely opt out. Some states propose that all of their duals or entire subpopulations of duals, e.g., all disabled dual beneficiaries, would be included in their state's demonstration. Setting these up would require prodigious effort on the part of participating managed care organizations -- to develop and contract with adequate provider networks, inform beneficiaries of being included and their rights to opt out, develop needed long-term services and supports, among other major obligations. The states and CMS would invest resources to develop and administer appropriate administrative oversight and monitoring procedures. Other parties that would have to spend substantial time and effort to support new activities include community support agencies, patient advocacy groups, and quality measure developers, among others.

Consider the following thought experiment. Assume that after 2 or 3 years, CMS's outside academic evaluators find quality or access problems in state programs, perhaps from inadequate provider networks. Based on this finding, according to the ACA, the CMS Chief Actuary next determines the demo as a whole has failed, despite some successes, and must be shut down. Would a future CMS Administrator actually then get on the phone to the involved Governors and tell them to shut down their programs and return to the *status quo ante*, once again dislocating beneficiaries, while disturbing state budgets. It won't happen, at least not in my thinking. In short, despite the lack of statutory authority, in effect, this demonstration

represents a permanent change to policy, as happens with Medicaid waivers. They will continue regardless of actual performance.

And, then, continuing with my thought experiment, once the political decision is made that the "demonstrations" will continue, there would be no credible basis for turning down any other state that wanted in using comparable approaches. **In short, the size and scope of the current CMS initiative is a glide path for placing most dual eligible Medicaid and Medicare beneficiaries into state-sponsored and/or supervised managed care plans, surely not a result intended by the ACA provision setting up CMS Innovation Center demonstrations.**

6. An assumption of **upfront programmatic savings.** CMS has proposed a financing model that assumes upfront savings for Medicare and the states, rather than testing whether savings are actually achieved, which is the right way to proceed with a demonstration and was the approach adopted by CMS in the Shared Savings Program for ACOs. The approach advanced in this initiative will lead states to reflect those assumed savings in payment rates to capitated managed care plans, which in turn will likely have to take immediate short cuts to achieve savings. Although the purpose of the demonstrations is to test approaches to improving care for duals, helped by reduced care barriers posed by different Medicaid and Medicare program rules, I am concerned that the immediate response of financially pressured managed care organizations will be to limit rather than expand needed benefits for long-term services and supports and cut provider payment levels from Medicare levels, further threatening access to care.

Medicaid managed care plans generally are able to shadow price Medicaid fee-for-service payment levels for providers, which in some states are well below Medicare levels. Using low payment rates, the demonstration then would not be a test of whether state-based plans can achieve savings from improved coordination and quality improvement, thereby enhancing dual eligible beneficiaries' well-being and quality of life in the process. Rather, it would implement what doesn't need testing at all – we know Medicaid managed care plans can pay providers below their costs. The initiative is silent on the extent to which health plans can achieve savings through reduced payment rates.

One of the central obligations Medicare assumes as the country's largest payer is to pay the average costs of a reasonably efficient provider. But health plans negotiate rates with providers – commercial plans pay much more on average than Medicare, while Medicaid plans pay less in many states. The Medicaid plans are under no obligation to pay average costs but rather can and do pay on the margin, in some cases even less than providers' marginal costs. Hospitals generally have to accept these rates and then may attempt to cost-shift the shortfall to commercial health plans and self-funded employers. Physicians often do not accept what they consider substandard rates and do not participate in Medicaid managed care plan

networks, thereby producing limited Medicaid provider networks. Again, a limited network might be acceptable for care for relatively healthy adults and children, but could lead to serious quality and access problems for duals with complex behavioral and physical problems requiring specialized clinical expertise. The financing model of taking savings off the top and permitting managed care plans to impose below-Medicare payment rates on providers could actually shift costs to Medicare as well as to commercial insurers and self-funded employers as providers try to recoup their shortfalls. A true test of integration through capitated payments to managed care plans would require that provider payment rates would be actuarially equivalent to Medicare rates.

7. **Evaluation challenges posed by risk selection.** Recent Urban Institute research has found that while many duals have very high spending, nearly 40 percent of dual eligibles had lower average per capita spending than non-dual eligible Medicare beneficiaries.[3] They are dual eligible based on being poor, not because of substantial chronic health problems. This finding confirms that the problem of risk selection, which is a central issue in all programs involving capitation, will be especially relevant in making accurate payments in these demonstrations. The need for accurate risk adjustment for health status is clear but will be a challenge, especially for some of the high cost subpopulations, such as the severely mentally ill. Current risk adjustment methods used in Medicare Advantage seems to under-estimate the costs associated with patients with serious chronic health problems. In addition, the reality of risk selection has implications for the size of the demonstrations and the nature of the evaluations that need to be performed. The commitment to passive enrollment with an opt out and lack of a lengthy lock-in period means that there will be systematic risk selection beyond the control of the plans taking place as beneficiaries exercise their right to not participate.

Further, as we have learned in Medicare Advantage, plans themselves can also encourage and discourage patient participation. And they can code diagnoses that are used for risk adjustment in ways to enhance payment. In this initiative, we want to try to avoid the phenomenon seen in the Physician Group Practice Demonstration of attributed savings being more apparent than real because of coding changes that make patients seem relatively sicker than they actually are or more precisely, sicker than in a control group for whom there not comparable incentives to code more aggressively. All of this suggests restraint in the size of the initiatives and a commitment to evaluation designs that rely on concurrent control groups from the same state. In Medicaid waiver programs there is an attempt to include all similarly situated patients across the entire state. In contrast, in Medicare demonstrations, such an approach is not desirable because it undermines the ability to conduct valid and useful demonstrations. The reality of the very heterogeneous, dual-eligible populations makes

[3] Coughlin, TA, Waidmann, TA, and Phadera L. Among dual eligible, identifying the highest-cost individuals could help in crafting more targeted and effective responses. Health Affairs. May 2012, 31:1083.

meaningful risk adjustment to accurately assess performance on spending is another reason to scale back this initiative to a manageable size.

Medicare's Role in Improving Care for Duals

Some of the rhetoric surrounding this important Initiative seems to assume that there has been a void of Medicare interest in improving care to the duals. In fact, in recent years, there has been a marked ramp up of Medicare programs for the duals. As noted earlier 1.2 million duals have affirmatively chosen to enroll in MA-SNPs. Almost twice as many have enrolled in regular MA plans. Testing accountable care organizations (ACOs), both in the Shared Savings Program and the Pioneer ACO program, is a major priority for CMS; Medicare beneficiaries with chronic health problems, including the duals, will be attributed to and cared for in ACOs. The Independence at Home Demonstration will test geriatric practice-based "house calls" for frail elderly who are often homebound – many are duals. Incentives on hospitals to reduce readmissions and bundled payment demonstrations are likely to spawn new approaches to care management for all Medicare beneficiaries, including duals.

As Senator Rockefeller suggested in his letter, instead of relying solely on a model that relies on multiple state efforts, CMS should also test models that bring care for dual eligible under the federal umbrella. Further, assignment to state-designated managed care organizations should not take precedence over these well-established Medicare programs and important demonstrations, essentially forcing beneficiaries to have to opt out of them in order to participate in Medicare-supported programs that they have affirmatively selected or, in the case of ACOs, been assigned to based on where they actually receive care.

Owing to the way services are covered in by Medicare and Medicaid, what makes dual eligibles high cost in one program does not necessarily make them high cost in the other. Urban Institute colleagues recently reported research finding a very small overlap in the highest spenders in the two programs.[4] Fewer than one percent of dual eligibles nationally were in the highest 10 percent of the spending distribution in both programs. Collectively high cost dual-eligible beneficiaries in both programs accounted for less than 5 percent of overall spending on duals in 2007. For top-spending Medicaid dual eligibles, the vast majority of their spending was for long-term care services, including the high costs of residence in nursing homes, most of which are paid by Medicaid. For top-spending Medicare dual eligibles, most spending was for acute care, often related to hospitalizations, which were overwhelmingly paid for by Medicare. The implication is that the financial pressure on Medicaid is related to financing long-term care, while for Medicare the pressure is related to potentially avoidable hospital and related

[4] Coughlin, TA, Waidmann, TA, and Phadera L. Among dual eligible, identifying the highest-cost individuals could help in crafting more targeted and effective responses. Health Affairs. May 2012, 31:1083.

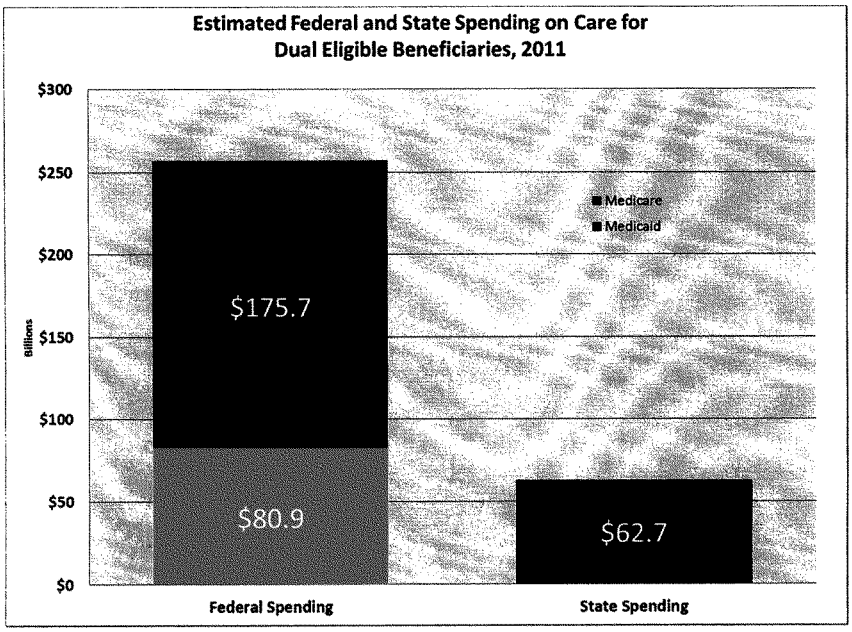
spending. As discussed above there are already extensive actions in place in Medicare to address avoidable acute care spending, some of which is by dual eligible beneficiaries.

Conclusion

Of the $320 billion Medicare and Medicaid dollars estimated as spent on duals in 2011, 80 percent represent federal dollars, more than two-thirds of which flowed through Medicare. (see attached table) Potential savings would come primarily from better management of Medicare-financed acute care services. As pointed out by Urban Institute colleagues, most of whom primarily study Medicaid, enhanced state, rather than federal, responsibility for overall spending increases the risk of cost-shifting to Medicare and undermining the quality of care for vulnerable beneficiaries.[5]

At the same time, while many dual eligibles do get their care from integrated Medicare Advantage plans and there are numerous Medicare initiatives, including ACOs, that will include duals, there has been little concerted effort on the Medicare side specifically to address the misalignment of financial interests between Medicare and Medicaid. That needs to change. In the meantime, it is reasonable to proceed with demonstrations of state-based initiatives given the great interest in the states and the extensive work that has already been extended in the Financial Alignment Initiative. However, the Initiative is far too large and needs to be substantially reduced with much more attention to the statutory requirement for high quality evaluations that permit a reasonably accurate assessment of the impact on spending and on quality of care for the affected beneficiaries.

[5] Feder J, Clemans-Cope L, Coughlin T, Holahan J, and Waidman T. Refocusing responsibility for dual eligible: why Medicare should take the lead. Urban Institute, October 2011.


Estimated Federal and State Spending on Care for Dual Eligible Beneficiaries, 2011
$300
$250
$200
$150
$100
$50
$0
Billions
$175.7
$80.9
$62.7
Medicare
Medicaid
Federal Spending
State Spending

U.S. Senate Special Committee on Aging
"Examining Medicare and Medicaid Coordination for Dual-Eligibles"
July 18, 2012

Testimony of Shawn Morris
President, HealthSpring

Chairman Kohl, Ranking Member Corker, thank you for the opportunity to appear today before the U.S. Senate Special Committee on Aging to discuss improving care for dual eligible beneficiaries. My name is Shawn Morris and I am President of Development and Innovation at HealthSpring, a Cigna company. HealthSpring is one of the largest Medicare Advantage (MA) coordinated care plans in the United States with more than 400,000 Medicare Advantage and 1.2 million Prescription Drug Plan (PDP) members. More than 122,000 of these HealthSpring members are dual eligible beneficiaries enrolled in one of our traditional MA plans or a HealthSpring Special Needs Plan (SNPs). Cigna and HealthSpring have been serving Medicare beneficiaries for 20 years, and our concentration on the big picture of improving beneficiaries' overall health and improving their quality of life has allowed us to develop a unique approach to health care coverage for our members. This approach is particularly beneficial to vulnerable dual eligible beneficiaries with complex health care needs.

At HealthSpring we develop a partnership that provides what our members want – more access to higher-quality preventive care – while giving physicians the tools and incentives they need to deliver that care. Specifically, HealthSpring develops focused, data-driven networks; pays physicians for quality over quantity of care; and provides our physicians the resources they need so they can devote more time and attention to their patients. The result of this approach is healthier members with lower medical costs. It is a common-sense model, but an uncommon practice.

Through long-term initiatives, like our *Living Well Health Centers* and *Partnership for Quality*, we are able to focus on our member's overall health and on improving their experience of care and quality of life.

HealthSpring's *Living Well Health Centers*, for example, provide additional clinical support, adding health plan care coordinators, nurse practitioners, pharmacists, and behavioral health specialists to the interdisciplinary care team. This integrated point-of-care approach increases patient satisfaction and improves adherence to evidence-based treatment plans.

Our *Partnership for Quality* program is also a clear win-win-win. Beneficiaries receive better care and stay healthier; participating physicians are paid more through quality bonuses; and HealthSpring spends less overall on delivering care. For example, members enrolled with *Partnership for Quality* physicians saw an 8% reduction in hospital admissions over a four-year period, and significant increases in preventive health services – such as a 73 percent increase in breast cancer screenings and an 83 percent increase in colorectal screenings. *Partnership for Quality* turns the inefficient, volume-driven model of healthcare on its head, and everyone benefits. Physicians are empowered to devote themselves to their patients and our members receive better care and stay healthier.

As I noted earlier, the HealthSpring members that often benefit the most from our dedication to comprehensive care-coordination and higher quality are our 122,000 dual eligible members. That is why we strongly support the Centers for Medicare and Medicaid Services' (CMS) recent efforts to improve care for this vulnerable population. The new *Capitated Financial Alignment Model* demonstration program, which allows states to integrate Medicare and Medicaid services and financing for dual eligible beneficiaries, offers a real opportunity to improve the quality of care these long-underserved beneficiaries receive and as a fortunate byproduct, generate considerable budgetary savings. HealthSpring is looking forward to the opportunity

to participate in this demonstration and is currently working with states and CMS to make sure the initiative is able to achieve its intended results.

We believe that in order for these demonstrations to succeed in identifying the best, long-term solutions for these patients, great care needs to be taken when selecting the participating plans. As MedPAC noted in its June 2012 report, "plan participation standards should be transparent and should at least consider quality ranking, provider networks, plan capacity, and experience with Medicaid and Medicare services for dual-eligible enrollees." We completely agree. We believe all plans that meet CMS-designated quality and access standards – including Medicaid managed care plans and Medicare Advantage plans – ought to be eligible to participate in the demos. Frail, dual eligible beneficiaries deserve nothing less.

That said, it is also important to recognize that when Congress created Medicare and Medicaid nearly a half century ago, it established Medicare as the primary source of financing of medical care for seniors, regardless of their eligibility for Medicaid.

Indigent seniors have the same Medicare coverage and the same broad access to physicians as more affluent ones, with Medicaid supplementing that coverage. In carrying out the *Capitated Financial Alignment Model*, we should not overturn this structure by preventing Medicare Advantage plans from participating or by requiring beneficiaries to relinquish the current coverage that they have actively chosen. Requiring dual eligibles to abandon trusted, high-quality plans with expertise in coordinating care for dual eligible beneficiaries and forcing them into a plan with a less specialized care coordination model and network of doctors and hospitals could end up undermining the intent of the demonstrations.

It is also important to note that Medicare plans already manage the bulk of services provided to the dual eligibles. Of the $319.5 billion estimated as being spent on duals in 2011, 80 percent are federal dollars, more than two-thirds of which flowed through Medicare. State expenditures on dual eligibles focus overwhelmingly on

long-term care, not medical or acute care where savings and quality improvement are most readily achievable.

Lastly, by maintaining Medicare as the primary source of care for vulnerable dual eligible beneficiaries, we will ensure that they are able to benefit from the variety of new delivery system reforms focused on the Medicare program that the dual eligible population so desperately needs.

Dual eligible beneficiaries represent the greatest need and best opportunity for improving quality and lowering costs. We strongly support these goals and look forward to working with this Committee and other federal policymakers to achieve these results.

Thank you again for the opportunity to testify today and I welcome any questions you may have.

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THOMAS J. BETLACH

DIRECTOR
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

BUILDING UPON THE SUCCESS OF MEDICAID MANAGED CARE FOR DUALLY-ELIGIBLE BENEFICIARIES

TESTIMONY BEFORE THE
U.S. SENATE SPECIAL COMMITTEE ON AGING

JULY 18, 2012

Chairman Kohl, Ranking Member Corker, and Members of the Special Committee, thank you for the invitation to discuss Arizona's use of managed care to improve the lives of individuals enrolled in both the Medicare and Medicaid programs.

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's single state Medicaid agency. AHCCCS is currently working with the Centers for Medicare and Medicaid Services (CMS) on the national effort to integrate care for individuals enrolled in both Medicare and Medicaid.[1] This is the first opportunity of its kind to address longstanding concerns regarding the coordination of care for the so called "dual eligible" population.

Who are the dual eligible members? In Arizona, duals represent:

- 9% of the State's Medicaid population.
- 82% of the State's elderly and physically disabled population that is at risk of institutionalization.
- Almost 50% of our members with serious mental illness.
- Over 5,000 members with a developmental disability.

Dual members are some of the most vulnerable members in our program and they heavily depend on critical Medicaid services, like long term care support services and behavioral health.

This opportunity is timely and exciting. For decades, we have asked the dual eligible population, among our nation's most frail citizens, to navigate three (sometimes more) complex, massive systems of care – Medicare, Part D and Medicaid. These systems are also operated as separate programs with no financial alignment, which means there is less incentive to coordinate care than in a model that holds one entity at risk financially. The result is exactly what one would expect – poorer health outcomes and higher costs. The status quo of poor health outcomes and system fragmentation is not only unacceptable, it is unsustainable.

Recently, we have seen a great deal of confusion and misinformation surrounding managed care and the role of Medicaid health plans in the provision of care to Medicaid and dual eligible beneficiaries. A great deal of this confusion is based on a lack of understanding of how managed care benefits dual eligibles. My message to the Committee today is that the managed care model being pursued by many states has proven to be a success in Arizona. Medicaid managed care is not an experiment. Arizona is a success story and a model of how managed care can work for everyone.

Arizona has maintained a system of managed care for its entire membership, including dual eligibles, since the State joined Medicaid in 1982. Arizona built its Medicaid program on the principles of member protection, competition, choice and accountability. The vision underlying Arizona's program is to place accountability for management, oversight and care delivery with one entity, the managed care health plan. Arizona's model works through private health plans that engage in a competitive bidding process and are financially at-risk to coordinate care for their members. It is a public/private partnership built on managed competition that leverages the private healthcare market to the greatest extent. Members have their choice of health plan and

[1] See the AHCCCS Duals Demonstration proposal at: http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx.

doctor. Health plans establish their own provider networks, which are monitored by the AHCCCS administration to ensure those networks are adequate to address member needs. This allows us to mainstream AHCCCS members into the broader healthcare system, avoiding reliance on Medicaid mills.

This partnership, however, requires proper oversight. AHCCCS staff oversees health plan performance and ensures the appropriate member protections and health plan accountabilities are in place. Arizona takes its role of member protection and fiduciary of public dollars very seriously. Accordingly, we have made the right investments in personnel, systems and data. AHCCCS has an entire division of 70 staff whose sole responsibility is oversight and monitoring of health plan performance. Staff is comprised of doctorate-level quality experts, actuaries, coders, clinicians, attorneys, bio-statisticians, data experts, economists, and people with health plan experience, among others. The State has also invested in systems that allow us to house claims and encounter data to monitor utilization, track trends and set rates.

This model has been a success for dual eligibles, as well as the broader Medicaid population. Holding one health plan responsible for the provision of all covered services to an individual member allows for a greater emphasis on prevention and early intervention, coordination of care, case management and disease management – all processes that are well integrated into the current AHCCCS model. AHCCCS health plans conduct health risk assessments and use predictive modeling to target appropriate interventions. AHCCCS health plans also incorporate evidenced-based guidelines, medical homes, health coaching and education and medical management into ongoing efforts aimed at managing chronic disease as well as maintaining good health. Through thirty years of experience with dual eligible managed-care enrollment, AHCCCS has confirmed that it is precisely these most frail individuals who require the care coordination and additional supports managed care offers.

Consider Arizona's elderly and physically disabled population that is at risk of institutionalization. Most of these members (82 percent) are dual eligibles. The model of care for this population in many states today is focused on nursing homes and institutional placement. However, our members wanted to receive their care at home or find alternatives that would allow them to stay in the community. Over the past decade, the AHCCCS program has progressed from 40 percent of its elderly and physically disabled members in the home or community to 72 percent, allowing Arizona to save $300 million this past year. In addition, 98 percent of AHCCCS members with developmental disabilities who are at risk of institutionalization live at home or in the community. The United Cerebral Palsy's 2012 report, *The Case for Inclusion*, ranked AHCCCS as the number one Medicaid program serving individuals with intellectual and developmental disabilities.

These percentages of Medicaid members living at home or in the community are among the highest in the country and they account for millions of dollars in annual savings. More importantly, these efforts increase member satisfaction and offer higher quality of life. Providing the right kinds of care management and care coordination to keep people at home is a uniquely Medicaid skill set, an area in which Medicare has no experience.

We also know that passive enrollment works. In Arizona, we have aggressively aligned the health plans of our dual eligible members. When Medicare Part D was created, Arizona actively encouraged existing Medicaid plans to become Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs). On January 1, 2006, approximately 39,000 members were passively enrolled with their Medicaid plan to provide better continuity of care for Part D implementation. Arizona has developed strong transition planning protocols, which ensured member protection and minimal disruption during this enrollment process.

The D-SNP option has allowed 40,000 of Arizona's 120,000 dual eligibles to choose their AHCCCS health plan for both their Medicare and Medicaid benefits. This alignment improves care coordination and lessens the burden that members and their families experience in navigating the system. Members are satisfied with their health plan and are obtaining quality care. In fact, only 3 percent of more than 1.2 million total AHCCCS members change their health plan each year. Furthermore, in January the plans that provide services to 25,000 long term care members (82 percent of which are duals) had a total of 10 members file a grievance; the month before that, 5 members filed a grievance.

The benefits of this alignment are clear. Nationally, dual eligibles are 15 percent of Medicaid's enrollment but represent 39 percent of the costs. Arizona's experience shows a different result; dual eligibles are 9 percent of the State's Medicaid enrollment and account for 18 percent of AHCCCS costs. Furthermore, according to Federal Funds Information for States (FFIS), when Part D was created, Arizona's drug costs for dual eligibles were $166 per member/per month (PMPM) compared to a national average of $266 PMPM. A study conducted by the Lewin Group showed that health plans were not withholding care but rather effectively using generic and lower cost drugs. Without this appropriate management of the drug benefit, Arizona would have spent $90 million more per year for dual eligible members (assuming the national spending average).

To look at the benefits of managed care even more closely, Avalere Health LLC recently completed an analysis of the model of care coordination on health outcomes for dual eligibles enrolled in Mercy Care Plan, one of the AHCCCS contracted health plans that is also a D-SNP.[2] Avalere compared 16,000 integrated dual members enrolled in Mercy Care Plan to the nationwide, Medicare fee-for-service (FFS) dual eligibles. To ensure a fair comparison between the populations, Avalere created a risk-adjusted model for the Mercy Care Plan population. The results showed that Mercy Care Plan performed better than FFS across all of Avalere's measures. Compared to the total national FFS dual eligibles and adjusted to match the risk of FFS duals, the study showed that Mercy Care Plan's members exhibited:

- 31% lower rate of hospitalization;
- 43% lower rate of days spent in a hospital;
- 19% lower average length of stay in a hospital;
- 9% lower ED use;
- 21% lower readmission rate; and
- 3% higher proportion of beneficiaries accessing preventive/ambulatory health services.

[2] Murugan, V., Drozd, E., Dietz, K. Analysis of Care Coordination Outcomes: A comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries. July 2012.

The Avalere analysis supports our own experience that the AHCCCS care coordination model provides quality, cost effective care.

Not only are costs contained by keeping people out of the hospital but, clearly, the quality of individuals' lives is improved if, with the support of a health plan, they are able to manage their own health. AHCCCS also separately monitors health plan performance related to the quality of care provided to AHCCCS members. Managed care health plans must maintain processes that effectively track and trend issues and result in investigation and resolution of quality of care concerns. For instance, AHCCCS monitors the long term care plans for gaps in attendant care services. Out of 1.9 million hours of attendant care authorized, there were only 836 hours where there was a gap in care. In addition, AHCCCS health plans overall measured above the national Medicaid HEDIS mean in 17 out of 25 performance measures.

AHCCCS health plans are also responsible for:

- Regular quality of care reviews and medical record reviews of primary care, high volume specialists and placement settings.
- Monitoring and improving access to evidenced-based care.
- Coordination with the state licensure agency regarding care concerns in facilities.
- Performance improvement projects utilizing data to identify focus areas.
- Reporting of any cases of abuse or neglect to ensure prompt action by the State.
- Discharge planning, coordination of care and monitoring to identify over- and under-utilization of services.

We have all heard the jargon around this issue, but what does managed care actually look like to the average member? To illustrate:

> John was recently deemed eligible for services through the Arizona Long Term Care System (ALTCS), which is AHCCCS' program for individuals who are at risk of institutionalization. John is quadriplegic and lives in his own home in the Phoenix metropolitan area. John has a choice of one of three ALTCS health plans available in his county. John has elected Plan A as his health plan because he is already enrolled with Plan A for his Medicare services. Plan A has been notified that John has enrolled with the health plan.
>
> Upon notification, Plan A contacts John to initiate the care coordination process (initial contact must occur within 7 days). At the point of initial contact, Plan A also determines whether John has immediate service needs and sets up the initial face-to-face visit, which must occur within 12 days of enrollment. The assigned case manager from Plan A meets with John and other parties chosen by John to participate in the assessment and service planning process. During the initial meeting, the case manager conducts an assessment of John's needs, discusses service and placement options, and develops his individualized service plan based on John's overall service needs as well as his preferences. Specifically, the Plan A case manager works with John and his team to address the provision of critical services, including attendant care, durable medical equipment and supplies, transportation, and behavioral health services. For any medical services, the case manager coordinates with the member's primary care physician to obtain the

appropriate medical order/prescription. For critical in-home care services, the case manager also works with John to develop a contingency/back-up plan, outlining who will provide care in the event that a provider does not show up as scheduled.

John's services are then initiated, as required, within a 30-day time frame. The case manager maintains ongoing contact with John to ensure that his service needs are being addressed and meets with John face-to-face at least every 90 days.

John's example shows the AHCCCS commitment to person-centered care. We also believe stakeholder engagement is critical, particularly as we embark on this journey to build upon the success of our model for dual eligibles. We remain committed to ongoing stakeholder involvement. Through an extensive stakeholder engagement effort, we heard one consistent message from dual eligibles and their families: the system is way too confusing. We agree. The current fragmented system means no one provider, health plan or system of care is seeing and serving the complete needs of the member. That means there is no single entity that is held accountable for their care.

We are firmly convinced that applying this proven and successful model of managed care to all 120,000 dual eligibles in Arizona through the duals Demonstration is the right thing to do for our members. Under the Demonstration, health plans will have the ability to assess the complete needs of and coordinate care for the whole person, not just the Medicaid half of the dual eligible. We also believe that the Medicaid health plans are best suited for the task of aligning care for dual eligibles. In addition to managing traditional "medical" services, these plans have the experience of providing home and community based services, behavioral health services and offering other needed supports that keep people at home and out of costly institutions for their care.

Based on our experience, we know that a single at-risk entity that is responsible for the full spectrum of care of dual eligibles will:

- Increase accountability;
- Build system efficiencies and minimize duplication;
- Improve care coordination;
- Reduce member confusion (one ID card, one place to call);
- Simplify the system for providers (one place to bill);
- Increase member satisfaction;
- Improve health outcomes by allowing health plans and providers to access all of the needed clinical information so they can work together to provide care to the whole person; and
- Bend the cost curve to create a more sustainable system.

I have been fortunate to be associated with the AHCCCS system for 20 years. For the past 10 years I served first as Deputy Director and now Director. Prior to that, I served in the Governor's Office for 10 years. I know the AHCCCS program is not an experiment. It is a proven model with documented success.

So for me, it is frustrating to hear others dismiss Medicaid managed care as an option for duals and suggest that states are either ill-intentioned or incapable of achieving success for this

population. This is not about achieving a budget target. States like Arizona want to move the system forward, improve care for our citizens and be responsible with the taxpayers' dollars.

To think, as I have seen some suggest, that Medicare can be the sole answer for dual members is simply wrong. Medicare has very limited knowledge and experience in home and community based services, community supports or behavioral health. States have managed these issues for duals and it is the states that understand their local communities best.

Equally disconcerting is this notion that states are moving too fast and the demonstrations are too big. We have had 45 years of fragmentation. Decades of comparison data show the shortcomings of the existing system. We do not need control groups in these duals demonstrations. We know the current system is not working for the people we serve or the taxpayers who are footing the bill. The current system is indefensible and unsustainable; we cannot wait to build upon a proven model.

We hope that Arizona's example will dispel the myths around Medicaid managed care and assuage the anxiety some may feel about using managed care to support care coordination for dual eligibles. Building upon a model with a proven track record of success makes sense and is the right step to address health care spending, improve our nation's system of care and do what is right for our most vulnerable citizens.

Volunteers of America®

PACE in Western Colorado

Effectively Serving Medicare/Medicaid Dual Eligible Patients in Rural America

Dory Funk, MD

7/18/2012

Testimony before the United States Senate Select Committee on Aging

Introduction

Chairman Kohl, Ranking Member Corker and members of the Committee, my name is Dr. Dory B. Funk and I am the medical director for Senior CommUnity Care, a Program of All-inclusive Care for the Elderly, or PACE program, operated in a rural area of western Colorado by Volunteers of America. PACE is a fully integrated interdisciplinary model for delivering comprehensive health care to frail older adults who meet the state's criteria for nursing home level of care. Our objective is to maximize our program participants' independence in the community and to delay or avoid entirely permanent nursing home placement. It is my honor to testify today on behalf of the 86 PACE programs in 29 states across the country, on ways to better integrate care for individuals with complex health and long term care needs – something that PACE programs have been doing for more than 25 years.

PACE History

PACE was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco, California. On Lok originated in response to the local Chinese-American community's desire to provide comprehensive medical care and social services for its elders without placing them in nursing homes.

The PACE community-centered approach pioneered by On Lok proved so successful in enabling older adults to remain in their homes that the federal government extended the program to additional sites across the country through a demonstration program beginning in 1986. Based on the demonstration's success, in the Balanced Budget Act of 1997, Congress authorized PACE as a permanent Medicare provider and Medicaid state option.

Today, eighty-six PACE providers serve approximately 25,000 enrollees in 29 states. Ninety percent of our participants are dually eligible for both Medicare and Medicaid. On any given day, PACE enables over 90 percent of its participants to remain living in their homes, rather than residing permanently in nursing homes.

In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country. Thanks to this law, 13 rural PACE programs – including Senior CommUnity Care -- have been developed. States' interest in PACE is growing, driven in large part by policymakers' desire to find better solutions to address dual-eligible beneficiaries' health care needs and, at the same time, to provide more predictability and control of their Medicaid payments.

Key Features of the PACE Program

PACE organizations have three fundamental characteristics: (1) they are community-based care providers, not health plans; (2) they provide comprehensive, fully-integrated care; and (3) they are fully-accountable and responsible to their enrollees, their families and federal and state governments for the quality and cost of care provided.

PACE is a community-based provider of care. Since its beginning as a demonstration program more than 25 years ago, PACE has provided innovative person-centered care for frail older adults that allows them to stay in their homes and in their community, an option many families do not think is even possible. Without PACE, many of these frail adults would be in nursing homes. PACE is the recognized gold standard for older adult care and a model for how others looking to improve the system could succeed.

PACE provides comprehensive and fully integrated care. The PACE financing model bundles fixed payments from Medicare and Medicaid or private sources into one flat-rate payment to provide the entire range of health care services a person needs – including paying for hospital and nursing home care, when necessary. While a number of ideas are circulating about possible ways to coordinate care, PACE is a "real" program that has a long history of combining care into one seamless delivery package. Our programs are not large insurers primarily involved in approving and paying medical claims. Rather, they are the primary caregivers for the beneficiaries they serve.

At the heart of the PACE delivery model is an interdisciplinary team (IDT) comprised of doctors, nurses, therapists, social workers, dieticians, personal care aides, transportation drivers, and others who meet daily to discuss the needs of PACE participants. Through PACE's unified financing system, older adults receive individualized care that revolves around their unique needs and at a fixed payment amount. Services are typically provided at a PACE Center – a full-service delivery site where participants can receive a broad range of services including primary care; nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work, personal care, and transportation.

PACE is accountable to its enrollees, their families and government, accepting full responsibility for the cost AND quality of care it provides. The result is better health outcomes, controlled costs and better value. PACE participants utilize, on average, about three days of hospital care annually. A 2009 interim report to Congress from the Department of Health and Human Services (DHHS) examined the quality and cost of providing PACE program services and found that PACE generates higher quality of care and better outcomes among PACE enrollees than the comparison group. PACE enrollees reported better health status, better preventive care, fewer unmet needs, less pain, less likelihood of depression and better management of health care. PACE participants also reported high satisfaction with their quality of life and the quality of care they received.

The bottom line is that PACE providers accept 100 percent responsibility for the cost and quality of care they deliver. The focus on prevention and wellness means avoiding unnecessary care and the escalating costs that go along with it. Through PACE's integration of all services, not just financing, costs are controlled and health care outcomes are high.

History of Senior CommUnity Care

Volunteers of America applied for and received a federal grant in 2006 to develop a rural PACE program in Delta and Montrose Counties of western Colorado. Our service area is home to approximately 77,000 people living across 3,383 square miles, or just under 23 people per square mile. Sixteen percent of the population

is eligible for Medicare. There is a 49 bed hospital in Delta County and a 75 bed hospital in Montrose County, each with fulltime emergency rooms, radiology services, and surgical services. In addition to a broad cadre of specialists, there are 44 primary care physicians and nurse practitioners practicing in the region.

Senior CommUnity Care opened in August 2008. Volunteers of America sought to adapt the traditional PACE model to the rural nature of our area in ways to better fit the community at the origination of our program. By utilizing some operational flexibility within the PACE model as granted by waivers from our state and the Centers for Medicare and Medicaid Services (CMS), SCC became the fastest growing PACE organization in the nation. Growth has slowed but remains robust. We currently have 225 participants, 95% of whom are dual eligibles. SCC is the largest of any rural PACE organization in the nation, serving more than 23% of the PACE eligible population in our service area. Nationally, PACE organizations generally see market penetration from 6 to 8 %. Furthermore, our quality measures consistently are equivalent to or better than National PACE Association benchmarks.

Applying Operational Flexibilities in PACE

Senior CommUnity Care growth can be attributed, in part, to three waivers that gave us some flexibility in providing PACE services to our rural population. First is our ability to contract with community based primary care physicians, allowing them to remain their patient's doctor when they join PACE. Typically, PACE organizations hire staff physicians to provide primary care in our centers. At Senior CommUnity Care, however, we also utilize community based primary care physicians to be primary care providers for a number of our PACE participants. The physician-patient relationship is very durable, perhaps more so in rural America. By allowing patients to maintain long-standing relationships with their primary care physicians, we were able to remove a significant barrier to enrollment in the program, i.e. their reluctance to leave a usually trusting relationship with a long-term care provider. Contracting with community-based physicians also has helped us serve a geographically remote region, building our capacity to reach individuals in several small communities and unincorporated areas.

The community based physicians actively participate on Senior CommUnity Care's interdisciplinary teams (IDTs) via monthly conference calls involving the entire IDT. Each of their patients is fully reviewed and care plan issues are discussed during these calls. They also participate in an ad hoc fashion when acute medical issues arise. The community based physicians are educated about PACE philosophies of care including notions like 'the dignity of risk' and focus on elder independence.

We use the NPA Model Practices to orient the doctors to providing evidence based medical care for our geriatric population. The NPA Model Practices were developed by the NPA Primary Care Committee to provide guidelines for preventative care and specific common medical conditions (diabetes, chronic lung disease, congestive heart failure, and chronic kidney disease) based on participants chosen pathways of care or advanced directives.

We reimburse our contracted physicians with a monthly stipend per participant, and office visits are reimbursed are rates matching the highest paying local private insurance (currently 148% of Medicare allowable). Probably the most important "buy in" factor for our local doctors is that they see their patients do well. We typically enroll their sickest and neediest patients who often are the greatest users of their services as well as the local emergency rooms and hospitals. The usual pattern is for these patients to dramatically reduce their use of the primary care physician's office as well as the ER once they have a comprehensive care plan in place.

I would like to share an example of how care is provided by our PACE organization. David is an elderly gentleman with severe Chronic Obstructive Pulmonary Disorder who was notorious for not taking his medications as instructed. He lives in a senior subsidized housing unit about two blocks from Delta County Memorial Hospital. David was infamous in both of our community hospitals for walking in with his bags packed for a hospital stay. He was known on a first-name basis by radiology techs, nurses, administrative staff, you name it. He even went so far as to leave a sign on the door to his apartment during his sojourns

that said "Gone to the ER." Since his enrollment in Senior CommUnity Care in December 2010, David has had only one unanticipated ER visit and hospitalization.

The second operational flexibility we enjoy is a waiver that allows an expanded role for nurse practitioners. Our nurse practitioners are able to perform the functions traditionally reserved for primary care physicians on the PACE interdisciplinary team. This includes performing periodic assessments and taking a bigger role in care plan development. In Colorado, nurse practitioners have unrestricted license to practice as primary care providers given the fact that much of the population lives in rural areas where access to primary care services are limited. Inasmuch, some of our participants have nurse practitioners as their attending care providers even before they enroll in PACE. Having this waiver allows us better support the role of the community based primary care physician in the PACE model and breaks down another barrier to providing needed medical care to people in need.

Considering our geography, the third operational flexibility is critical for the delivery of needed care. In addition to two full-service PACE centers in the towns of Montrose and Eckert, we obtained a waiver that allows us to maintain an alternate service delivery site in a senior center in the small town of Paonia (population 1639). . The site is open two days each week and provides meals, showers, and nursing services. A primary care physician is on site to see patients a half-day each week. Each of our sites is approximately 30 miles from the next closest one. Without the alternative delivery site, participants in that portion of our service area would have to endure up to an hour of one way van travel to the nearest center, sometimes longer during the winter months.

We have several success stories concerning the Paonia site. Sandra is an 81 year-old lady who joined our program in July 2011 after a prolonged hospitalization for new onset polymyalgia rheumatica (a severe, very painful inflammatory condition requiring treatment with steroids), new onset diabetes and out of control hypertension. She lives in Paonia with her disabled daughter. As you can imagine, she was discharged with a complicated medical regimen of pills, insulin shots, and blood sugar monitoring and wound up in a nursing

home with her disabled daughter left to fend for herself. It turns out that our Paonia site is less than two blocks from her home. She was discharged from the nursing home to SCC. Given our proximity to her home, we were able to see her two times a week until her conditions stabilized. She has not returned to the hospital or emergency room for her conditions since her enrollment and now her daughter is a member of our program as well.

Health Outcomes for the Participants

The aforementioned waivers have allowed SCC to integrate PACE services and philosophy of geriatric care into our community, resulting in better health outcomes for our dual eligible population. We "push the model into the community" through close involvement with community physicians, local hospitals, emergency rooms, skilled nursing facilities, assisted living facilities, personal care agencies, senior organizations, ambulance services, dialysis centers, and others. The hospitals, nursing homes, and physician offices all have access to pertinent electronic medical records, including a real-time medication list and basic demographic information. This effort has led to very low hospital readmission rates and low overall hospital days. The all-cause 30 day hospital readmission rate for Senior CommUnity Care is **6.8 %** for the last fiscal year. Nationally, the 30 day hospital readmission rate for the dual eligible population is **21.7 %.** For PACE overall the dual readmission rate is **19.3%.** Hospital days per thousand member months per year for SCC the last fiscal year is 2982. For PACE nationally the number is 3440. The national number for nursing home placed duals it is 5247 and for duals receiving home and community based services it is 6447.

Aligned Incentives under Medicare/Medicaid Capitation

PACE programs accept 100% responsibility for the cost and quality of care they deliver. By law, Medicaid pays PACE an amount equal to or less than what it would have otherwise spend on beneficiaries needing nursing home level of care. Because of the capitated payment to PACE organizations, financial incentives align with participants' wishes and needs. By emphasizing prevention and primary care, PACE programs help participants avoid unnecessary (and costly) nursing home and hospital stays.

These incentives resonate with our community based physicians as well. When the community docs "get it", they practice with PACE philosophies in mind.

Moreover, we find that the adaptations we have made to the PACE model have had no impact on cost or quality. Clinical costs such as labs, diagnostics, community based primary care, specialists and hospital costs are $711 for Senior CommUnity Care, compared to $920 for the traditional model. The take home point is that appropriately oriented community physicians can be trusted to practice within PACE guidelines.

State Dual Integration Demonstrations

Colorado is a progressive state in the realm of health care delivery and is concerned with providing appropriate care for the dual eligible population. In the State of Colorado's dual eligible coordination demonstration, there existed a lock-in period that would restrict those dually eligible who met the care and age criteria for PACE to be unable to enroll. We were able to work in a variety of forums to highlight the concerns and limitations this lock-in would place on these complex and high-need individuals. Additionally, we participated in multiple stakeholder meetings with the state and, earlier this year, Pam Cook, the executive director of Senior CommUnity Care and representatives from InnovAge, a well-established and successful PACE organization in Denver, gave testimony at the Colorado State legislature. We have been fortunate in that leadership in both the state government and state legislature recognized the necessity of PACE and through enabling legislation has made it so that qualified potential enrollees are both educated about the option to choose PACE for their care, and that duals who are eligible for PACE are never locked out of enrolling in PACE. The bill modified Colorado Revised Statute §25.5-5-412, -which is the state level PACE enabling statute. We are confident that SCC will remain a viable and attractive option for regional care organizations as they develop in western Colorado. That said, many of my fellow PACE organizations face a more uncertain environment. Several states have proposed lock-ins and auto-enrollment provisions that could potentially limit dual eligibles' access to PACE services. NPA has commented at the state and federal level on these proposals, and I know they continue to work with CMS to ensure that PACE remains a viable

option alongside these demos. As supporters of the PACE program, I hope that you will use your position on this committee and as our elected leaders to ensure that our health and long term care delivery system maintains a robust role for the PACE program.

Moving Forward

Utilizing operational flexibilities within the PACE model, Volunteers of America has built a very effective PACE organization in rural western Colorado. Senior CommUnity Care's operational differences within the PACE model has accomplished the following:

1) Quality and cost effective care to the dual population as demonstrated by low hospital days and readmission rates
2) A greater distribution of needed services to the frail elderly dual population in our rural area as demonstrated by an extraordinary market penetration percentage
3) Aligned incentives with this Medicare/Medicaid capitation system as demonstrated by low clinical costs while utilizing independent community based physicians

PACE programs are effective at serving the dual eligible population and their number is growing. For example, Volunteers of America is currently developing PACE organizations in multiple states subsequent to their success at Senior CommUnity Care. However, the population of duals served by PACE could grow even faster if the operational flexibilities described in this testimony were encouraged and applied to a broader range of PACE organizations To achieve this objective, the National PACE Association is pursing legislative or regulatory solutions that would:

1) Expand PACE eligibility to include individuals under the age of 55 who meet their states' eligibility criteria for nursing home level of care, individuals with physical, intellectual and developmental disabilities, and high-need, high-cost beneficiaries who may not yet meet their eligibility criteria for nursing home level of care and currently are not well-served.

2) Reduce PACE organizations' reliance on the PACE Center as the primary location for the delivery of service and expanding PACE organizations' use of alternative care settings and contracted community-based providers.
3) Offer greater flexibility around the composition of the interdisciplinary team.
4) Allow PACE organizations to contract with community based physicians.
5) Provide other flexibilities that would allow PACE organizations to serve more high-risk, high-need individuals.

Given the experience of Senior CommUnity Care and other PACE organizations who have experimented with these flexibilities, we believe that PACE programs would be able to adopt these changes while still providing high-quality, cost-effective care to some of our nation's most vulnerable citizens.

CONCLUSION

Thank you, again, for allowing me the privilege of visiting our nation's Capital and the honor of reporting on our successes in western Colorado. Before becoming a PACE medical director, I practiced full spectrum family medicine in two of the smaller towns in Delta County for many years. When Volunteers of America approached me about being the medical director for this "experimental program," I was thoroughly skeptical about its potential benefits or viability. The great changes in SCC's participants' lives, as well as an uplifting of general geriatric medical care and social awareness in our communities has made me a true believer in the PACE model of care. I look forward to its continued recognition as a leader in providing care to the dual eligible population and whole heartedly encourage any actions the committee may take in supporting its growth.

Melanie Bella's
Additional Written Questions for the Record
On
"Medicare-Medicaid Eligible Beneficiaries"
From
The Senate Special Committee on Aging

July 18, 2012

Senator Gillibrand (D-NY)

1. **Is it true that some states are limiting plan participation to Medicaid managed care plans? In my view, any plan that can meet quality and network adequacy standards – including Medicaid managed care plans and Medicare Advantage plans – should be eligible to compete to participate. Why would we exclude certain care models? Isn't the goal to maximize innovation and identify best practices?**

Answer: You are correct that innovation and identifying best practices are important goals in the Demonstration. In addition, the Demonstrations are intended to leverage the Medicare and Medicaid programs in a manner that incorporates the strongest aspects from the federal and state governments to best meet the needs of beneficiaries, their caregivers and providers. To participate in the Demonstration, plans must meet certain Medicare and Medicaid requirements. Any plan that can meet the Medicare requirements and State-specified Medicaid requirements is eligible to participate. While States may utilize differing mechanisms to select eligible plans, no care models have been explicitly excluded from the Demonstration.

2. **As you know, when Congress created Medicare and Medicaid nearly a half century ago, it established Medicare as the primary source of financing. What steps are you taking to ensure that Medicare remains primary as the demo goes forward? Are you going to hold all participating plans to the Medicare network adequacy standard?**

Answer: Yes, all participating Demonstration plans are required to meet Medicare network adequacy standards for services for which Medicare is primary payer. State Medicaid network standards will be used for long-term services and supports, and benefits for which Medicaid is primary payer. In addition, plans participating in the Demonstration are required to meet critical Medicare Part D standards (e.g., beneficiary protections, protected classes and network adequacy). All proposed Demonstrations must have strong beneficiary protections and will be subject to Federal oversight and monitoring.

3. **How does CMS plan to evaluate whether the demos are successful?**

Answer: There will be a rigorous independent evaluation of the Demonstrations. CMS has contracted with an independent evaluator, RTI to measure, monitor, and evaluate the impact of the Demonstrations on cost, quality, utilization, and beneficiary access to and experience of care. CMS also plans to conduct individual state-specific evaluations, as well as a meta-analysis that will look at the Demonstration overall. All demonstrations will be subject to comprehensive and

rigorous independent evaluations, which will closely inform any decisions about future expansion. Once the models have been in the testing phase long enough to generate sufficient data, the CMS Office of the Actuary will review the data as part of the determination of whether a modification, termination, or expansion of the model is warranted.

QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR GILLBRAND (D-NY)

For Shawn Morris, President, HealthSpring:

1. Some policy experts have noted that the best way to actually achieve savings for dual eligible members is to have strong community and home based care programs that ultimately keep people out of institutionalized nursing home care. This not only lowers costs, but is also what most patients want. Does HealthSpring have much experience with home and community based care and do you see this as playing a role in improving care for dual eligibles?

Role for Home and Community Based Services

HealthSpring believes that home and community based services (HCBS) play an important role in improving care for dual-eligibles. Keeping beneficiaries out of institutions through well-managed HCBS not only influences and improves quality of life but it facilitates health maintenance while reducing costs.

HealthSpring's Experience

We think that it is important for plans that participate in the Financial Alignment Demonstrations to meet not only a minimum quality standard but also to have experience with the dual eligible population as well as a demonstrated commitment to innovation. Through the Texas STAR+PLUS program, Healthspring covers Medicaid services, including home and community based services, that were traditionally covered by the state and has contracted with 2,236 providers for Medicaid Services within our coverage areas.

Furthermore, HealthSpring has several programs in place to help Medicare Advantage plan members maintain their health and quality of life while living at home. Most notably, the "HealthSpring at Home" program assists beneficiaries to do just that.

The Program is centered around a HealthSpring Care Coordinator, who completes relevant assessments, performs medication reconciliation if needed, and works with the individual and the interdisciplinary care team to develop the care plan. A Personal Health Record is provided, as are any written materials for disease process education or self-management skills. The Care Coordinator assists in the coordination of medical services and benefits as well as the assessment and utilization of community resources. The Care Coordinator contacts the beneficiary at least once monthly working towards attaining the individual's goals. The care plan is updated according to the risk level of the beneficiary or when there is a status change or goals are met.

2. In your testimony, you described the HealthSpring model and some of the quality improvements that you have achieved. As you know, one of the goals of the demo is to cut costs, in addition to improving quality. While I believe that the primary goal should be improving health care quality, I am interested in hearing more about your model and whether you believe it is realistic to achieve cost savings through integrating Medicare and Medicaid benefits for the dual eligibles.

HealthSpring's extensive experience with vulnerable Medicare and dual-eligible beneficiaries has shown that improved quality of care can result in medical cost savings as a fortunate byproduct.

The current system of financing care for Medicare-Medicaid enrollees often provides a financial incentive to shift costs between the States and the Federal Government, resulting, we believe, in both an avoidable escalation of costs and most importantly, a potential reduction in the quality of care that dually eligible individuals receive. If implemented appropriately, we believe the demonstration program has the potential to demonstrate improvements in all of the above through the alignment of incentives; integration of benefits; and improved coordination of care.

HealthSpring's model is rooted in our physician engagement model that establishes the primary care physician (PCP) as the Provider that is responsible for the coordination of care with an emphasis on preventive care. This model is enhanced by our Partnership for Quality (P4Q) program, case management/care coordination programs, interdisciplinary care teams, risk assessment and stratification, and LivingWell Health Center.

Our data indicates that while typically our Dual-eligible Special Needs Plan (D-SNP) members have higher risk scores and more co-morbidities than traditional, fee-for-service dual-eligible beneficiaries, our experience shows lower inpatient admission days and lower emergency room utilization.

Several components of the Capitated Financial Alignment Demonstration clinical model have the potential to promote cost savings:

- ***Home and Community Based vs. Institutional Long-term Care*:** One of the goals of the Capitated Financial Alignment Demonstrations is to improve access to and utilization of community based services. Studies have suggested that States that have well-developed HCBS care programs tend to have a lower rate of Medicaid spending growth in the long-run. Furthermore, a 2006 study from the Journal of Health and Social Policy found that in 2002, HCBS waivers for older people and adults with disabilities saved $15,210 in public spending per enrollee when compared with nursing facility care. [1]

- ***Integration of Benefits:*** Medicaid and Medicare benefits often conflict, resulting in unnecessary costs. One example of this conflict concerns the difference in Medicaid nursing facility reimbursement rates and Medicare reimbursement rates. Nursing facilities are incentivized to send dual-eligible beneficiaries for whom institutional long-term care is covered by Medicaid to the hospital for a three-day inpatient stay so that upon discharge, the nursing home can receive an increase in payments via a Medicare-covered nursing facility stay for up to 100 days. Misaligned incentives like this that actually encourage higher Medicare spending could end up increasing costs for dual-eligibles. This is just one more reason why Medicare should continue be the primary source of coverage for these vulnerable beneficiaries.

- ***Improved Care Coordination:*** A unified delivery system for Medicaid and Medicare benefits improves care coordination. It facilitates communication among stakeholders as well as proactive interventions and follow-up to avoid unnecessary hospitalizations and readmissions - and the costs associated with them. There are several key components of the Financial Alignment Demonstrations that have the potential to promote improved care coordination:

    - Regular risk assessment, enrollee stratification and monitoring

[1] M. Kitchner, T. Ng, N.Miller and C. Harrington, "Institutional and Community Based Long-Term Care: A Comparative Estimate of Public Costs." Journal of Health and Social Policy 22, no. 2 (2006).

- Medical Home model
- Provider network familiar with Medicare and Medicaid benefits and services
- Care Transitions program to prevent avoidable hospital readmissions within 30 days

HealthSpring's Partnership for Quality (P4Q) program has shown measurable quality improvements that can help achieve lower costs. Some specific examples over a 4-year period include:

- Hospital admissions decreased by 8%
- Mammograms increased 73%
- Diabetic eye exams increased 109%
- Flu vaccines increased 86%
- Colorectal Cancer screenings increased 83%
- Pneumonia vaccines increased by 60%
- HbA1c screening increased by 58%
- Diabetes Cholesterol testing increased by 21%
- Coronary Heart Disease Cholesterol testing increased by 25%

Medicare plans currently manage the bulk of services provided to dual-eligibles and we strongly believe that long-term solutions for the dual eligibles should build upon the best of what is already working for these individuals. Therefore Medicare should continue to be the primary source of coverage for these individuals. In fact, of the $319.5 billion estimated as being spent on duals in 2011, 80 percent ($256.6 billion) are federal dollars. Moreover, many of the new delivery reforms, such as penalizing providers for preventable readmissions, are focused solely on the Medicare program. Medicare plans are uniquely positioned to not only improve overall care, but also achieve cost savings, which is why we strongly support making sure Medicare plans are included in the dual-eligible demonstration programs. We believe that it is important for plans that participate in the Financial Alignment Demonstrations to meet a minimum quality standard, to have experience with the dual eligible population, and to have demonstrated a commitment to innovation.

Statement for the Record

Hearing on Examining Medicare and Medicaid Coordination for Dual Eligibles

Senate Special Committee on Aging

July 18, 2012

2:00 pm

Steven B. Kelmar
Senior Vice President
Government Affairs & Public Policy
Aetna

151 Farmington Ave.

Hartford, CT 06156

Chairman Kohl, Ranking Member Corker, and other members of the Senate Special Committee on Aging, I would like to share Aetna's experience in coordinating care for individuals who are eligible for both Medicare and Medicaid (commonly referred to as "dual eligibles"). As you know, compared to other Medicare beneficiaries, dual eligibles have more medical needs. Fifty-five percent have three or more chronic conditions compared to 44 percent of other Medicare beneficiaries. Half are in fair or poor health, compared to 22 percent of other Medicare beneficiaries.[i] The administration of care for dual eligibles is fragmented and complex, leading to quality of care issues and costly and inefficient patient care.

A recent analysis demonstrates that Arizona's Mercy Care Plan, managed by Aetna, performs better than Medicare fee-for-service (FFS) in providing care to dual eligibles in four measures: (1) access to preventive/ambulatory service; (2) inpatient utilization; (3) emergency department utilization; and (4) all-cause readmissions.[ii] The study showed that Mercy Care dual eligible members exhibited:

- 43 percent fewer days spent in the hospital (per 1,000 months of beneficiary enrollment);
- 31 percent fewer in-patient discharges (per 1,000 months of beneficiary enrollment);
- 19 percent lower average length of stay;
- 21 percent lower readmission rate;
- 9 percent fewer Emergency Department visits (per 1,000 months of beneficiary enrollment); and
- 3 percent higher proportion of members accessing preventive/ambulatory health services.

The study reveals that a state-based, integrated approach to care for dual eligibles can result in a simplified health care experience for beneficiaries. Rather than navigating two programs, dual eligibles enrolled in a coordinated managed care program benefit from a network of providers who can meet their complex needs.

In addition, a decreased rate of Emergency Department use and readmissions among Mercy Care dual eligibles translates to cost savings. Finally, the success of the Mercy Care Plan is evidenced by improved health outcomes for dual eligibles. Coordinated care through the plan has resulted in high scores on quality metrics such as appropriate diabetes care (85 percent), provision of annual flu shots (93 percent), and compliance with persistent medications (93 percent).[iii]

Less than 100,000 of the country's 9.9 million dual eligibles are enrolled in a fully integrated managed care plan, which indicates a significant opportunity for increased coordination.[iv] Aetna looks forward to leading additional efforts to improve health outcomes and coordination of care for dual eligibles, while simultaneously achieving savings for states and the federal government during this time of budget constraints.

A state-based program with flexibility and incentives is one option to assure dual eligibles receive integrated managed care that:

1) *Recognizes the unique needs of dual eligibles:* Mercy Care offers a Medicaid managed care plan and a Medicare Advantage Special Needs Plan to serve dual eligibles. Approximately 23 percent of the Mercy Care dual eligible population receives long-term care and five percent are developmentally disabled. Mercy Care's patient-centered approach has led to successful collaboration with interdisciplinary teams to meet members' health care needs. Since its inception in 1982, Arizona's Medicaid program has required all participants to enroll in a managed care plan.

2) *Builds simplicity into navigating the health care system:* Dual eligibles, in the absence of a combined program, must find different networks of Medicare and Medicaid providers and understand which program provides primary coverage. The provider networks can differ significantly, with many providers not accepting Medicaid patients. One study showed that 28 percent of all doctors and 40 percent of internists do not accept Medicaid patients.[v] A Kaiser study of physician willingness to accept Medicaid patients under health care reform revealed concerns about paperwork hassles and finding specialists to treat beneficiaries.[vi]

   Enrollment in a coordinated managed care program will assure that there is a network of providers and case managers available to see patients in a timely manner, in addition to improved program administration. Participants in the Mercy Care study showed a three percent increase in access to preventive/ambulatory health services compared to FFS dual eligibles.

3) *Provides financial savings for the government and taxpayers:* The current FFS payment model rewards providers based on volume of services rather than quality of care or health outcomes. This financial incentive leads to an increase in utilization and costs for payers and consumers, with no connection to quality.

   An integrated program can lead to substantial savings across the dual eligible population. In the past decade, Arizona's state Medicaid agency has progressed from 40 percent of its elderly and disabled members in the home or community to 72 percent, saving Arizona $300 million in the past year. Most of these members are dual eligibles.[vii]

We encourage Congress to learn from the successful Financial Alignment Demonstrations and consider legislative options to make it easier for states to adopt integrated care models that result in positive outcomes such as those achieved by the Mercy Care plan.

Aetna is one of the nation's leading diversified health care benefits companies, serving approximately 36.1 million people with information and resources to help them make better informed decisions about their health care. Aetna serves over 1.2 million Medicaid members in 10 states.

[i] Kaiser Family Foundation Program and Medicare Policy, "Medicare's Role for Dual Eligible Beneficiaries," April 2012.

[ii] Avalere, "Analysis of Care Coordination Outcomes: A Comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries," July 2012.

[iii] 2010 HEDIS data and 2011 CMS Part C Star Ratings Report Card (CAHPS member survey).

[iv] Kaiser Family Foundation Program and Medicare Policy, "Medicare's Role for Dual Eligible Beneficiaries," April 2012.

[v] Center for Studying Health System Change, "A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey," September 2009.

[vi] Kaiser Commission on Medicaid and the Uninsured, "Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians," April 2011.

[vii] Thomas Betlach Testimony Before the United States Senate Special Committee on Aging, July 18, 2012.

Federation of American Hospitals
Statement for the Record

U.S. Senate
Special Committee on Aging

Medicare and Medicaid Coordination for Dual-Eligibles

Wednesday, July 18th, 2012

216 Hart Building

Federation of American Hospitals
Statement for the Record
Medicare and Medicaid Coordination for Dual-Eligibles
U.S. Senate Special Committee on Aging
Wednesday, July 18, 2012

The Federation of American Hospitals (FAH) is pleased to submit the following statement for the record as the Senate Special Committee on Aging considers care coordination for individuals dually eligible for Medicare and Medicaid.

The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals. Our hospitals have long been a critical part of the health care safety net serving dual eligible individuals in urban and rural communities, and the FAH is fully committed to working with Congress, the Centers for Medicare & Medicaid Services (CMS), the states, beneficiary organizations and other stakeholders to improve the care delivery system for these vulnerable individuals.

Congress established the Federal Coordinated Health Care Office as part of the Affordable Care Act in recognition of the need to address barriers to delivering comprehensive, integrated, care to dual-eligible beneficiaries. Dual-eligible individuals frequently suffer from multiple complex, chronic illnesses that are costly to treat. According to a recent analysis conducted by the Kaiser Family Foundation, 35 percent of dual-eligible individuals have four or more chronic conditions, and 49 percent of the population has a mental impairment.[1] Dual-eligible individuals also have fewer financial resources than the general population, with more than 86 percent of dual-eligible individuals having incomes below 150 percent of the Federal Poverty Line.[2] It is widely believed that there are many opportunities to improve the quality of care that dual-eligible individuals receive, and that there is the possibility of achieving savings by improving care delivery while simultaneously removing administrative barriers to care integration.

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[1] Patricia Neuman et al., "Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans," Health Affairs, 31, no.6 (2012):1189.
[2] Gretchen Jacobson et al., "Medicare's Role for Dual eligible beneficiaries," [internet] Washington DC, Kaiser Family Foundation; April 2012 (Issue Brief No. 8138-02)

The Federal Coordinated Health Care Office has developed a number of initiatives aimed at integrating care for dual eligible-individuals, and the FAH commends the dedicated staff for their clear commitment and efforts to improve care for these vulnerable individuals. The program alignment initiative to identify conflicting requirements between Medicare and Medicaid, and the data and analytics efforts to develop reliable, integrated information on dual-eligible individuals are important steps to improving care coordination for this population. Director Melanie Bella has been tireless in reaching out to beneficiaries, provider groups, and other key stakeholders to understand the opportunities, as well as the concerns, associated both with these initiatives and the Financial Alignment Demonstrations, which are the focus of the remainder of the FAH's comments.

As we have previously communicated to CMS, and would like to stress to the Committee, the FAH has strong concerns that the Financial Alignment Demonstrations are moving too quickly and are too broad in size and scope. Twenty-six states have submitted proposals to participate in either the capitated, managed care model or the managed fee-for-service model under this initiative, and CMS indicates that up to two million duals may be enrolled nationwide. Many of the states propose enrolling 60 percent, 80 percent or even 100 percent of their duals populations statewide into managed care plans that have not yet demonstrated the capability or capacity to meet the diverse needs of the populations they are intended to serve. Proposals of such size and scope risk restricting beneficiary access to care and could result in the dismantling of the current care delivery infrastructure that must remain as a fail-safe for enrollees whose health needs are not being met by demonstration models. Changes of this magnitude, in reality, are program changes that prioritize bringing models to scale before testing and evaluating them to determine which models truly represent improvements in the delivery of care to dual-eligible individuals.

The FAH is furthered troubled that many states propose using a passive enrollment approach with an "opt-out," rather than ensuring that enrollees make a positive selection to opt-in to a plan. Passive enrollment denies Medicare beneficiaries their fundamental enrollment rights and risks disrupting their provider relationships by shifting them into plans they themselves have not selected. In addition, certain state proposals envision using a "lock-in," which would prevent beneficiaries from dis-enrolling from a health plan, at least for part of the year.

Both passive enrollment and "lock-in" enrollment policies result in diminished enrollment rights for dual-eligible beneficiaries when compared to their current enrollment rights and when compared to middle and upper income beneficiaries. Beneficiary enrollment rights must remain paramount, particularly given that the proposed models are demonstrations and thus have not yet proven that they improve care coordination, quality, and cost saving, separately or concurrently. Therefore, the FAH strongly urges the elimination of the option for states to passively enroll dual-eligible beneficiaries into participating health plans and opposes any proposal to "lock-in" beneficiaries after enrollment.

The FAH urges prioritizing care coordination and enhanced quality over savings, and further stresses that any achievable savings should come from improvements in health outcomes and quality, not restrictions in benefits or reductions in provider payments. This is of particular concern given the CMS stipulation that "[the plan capitation] rate will provide upfront savings to

both CMS and the State. Absent savings for both payers, the demonstration will not go forward."[3]

Demonstration plans will be serving new, complex populations, providing new services, making new investments in technology and implementing untested approaches with the hope of improving care coordination and quality and thereby reducing costs. However, the requirement for immediate savings will put pressure on plans with capitation rates that already are set below current Medicare and Medicaid spending to achieve savings through short cuts such as provider rate cuts. Adequate provider payment rates are essential to building and maintaining coordinated networks that ensure beneficiary access to high-quality care – access which is threatened through arbitrary cuts to already low Medicare and Medicaid rates.

FAH Principles

There clearly is an opportunity to improve care coordination and quality for dual-eligible enrollees, and the FAH and our member hospitals stand ready to partner with policymakers to develop demonstration models to integrate care for this vulnerable population. As outlined below, the FAH has developed a set of guiding principles that we believe are critical to the success of the demonstration and to further safeguard beneficiaries' access to quality care, freedom of choice and scope of services.

- The primary goal of the demonstrations should be to enhance quality and care coordination for dual-eligible individuals. Savings should be subsidiary to these aims and should not be taken up-front.

- Savings should come from care coordination and quality improvements, not reductions to provider payment rates, which already fall well below the cost of care.

- Demonstration plans, at a minimum, must retain all current Medicare fee-for-service benefits and services.

- Enrollment for dual-eligible demonstrations should be on a voluntary (opt-in) basis which preserves the Medicare enrollment rights of dual-eligible beneficiaries. Passive enrollment and excessive or otherwise unreasonable lock-in provisions should be prohibited.

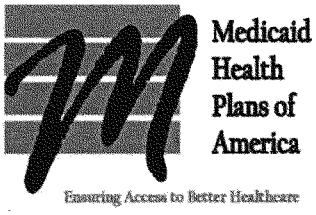
- Network adequacy requirements must ensure that demonstration programs do not disrupt existing relationships between beneficiaries and their providers. Medicare Advantage network adequacy requirements are a minimum and should not be waived.

- Demonstration programs should not be statewide. Instead, they should be limited in size to reflect the experimental nature of this program until demonstration models are evaluated independently and shown to improve care coordination and quality.

[3] CMS guidance on Capitated Financial Alignment Demonstration Plans, January 25, 2012.

- CMS and state administration of demonstrations should reduce administrative barriers to caring for enrollees and administrative burdens on providers

Improving the alignment of the Medicare and Medicaid programs to better serve dual-eligible enrollees is an important policy priority, and I thank the Committee for holding this hearing to examine the initiatives underway and to further discuss opportunities to improve care for this vulnerable population. The FAH and its member hospitals stand ready to work with federal and state policymakers, other providers, and the dual-eligible beneficiaries that our hospitals care for every day.



Statement for the Record

Hearing on "Examining Medicare and Medicaid Coordination for Dual-Eligibles"

July 18, 2012

U.S. Senate Special Committee on Aging

Thomas L. Johnson

President & CEO

Medicaid Health Plans of America

Introductory Remarks

Chairman Kohl, Ranking Member Corker, and other distinguished members of the U.S. Senate Special Committee on Aging, I am pleased to submit this Statement for the Record on behalf of Medicaid Health Plans of America (MHPA) for the hearing, "Examining Medicare and Medicaid Coordination for Dual-Eligibles," conducted on July 18, 2012. My comments address the pressing need for more care coordination for the dual-eligible population, the scope of the Capitated Financial Alignment Demonstrations (CFADs) being implemented as partnerships between the Center for Medicare and Medicaid Services (CMS) and states, the importance of passive enrollment, Medicaid managed care organizations' experience serving elderly and disabled populations, and the plan selection process for the capitated demonstrations.

MHPA is the leading association solely focused on representing the common interests of Medicaid health plans. Our 113 member plans serve more than 14 million beneficiaries in 34 states and the District of Columbia. MHPA represents both non-profit and for-profit plans, ranging from large multi-state insurance corporations to small community-based plans. We believe that Medicaid managed care has proven to be a highly successful model for coordinating care for low-income and culturally diverse populations and our plans are eager to expand this model to include dual eligible beneficiaries, whom CMS now refers to as "Medicare-Medicaid enrollees."

Need for Care Coordination for Medicare-Medicaid Enrollees

MHPA believes the existing payment silos and fragmented FFS delivery systems are failing Medicare-Medicaid enrollees and are fiscally unsustainable for both the federal and state governments. We also believe that conflicting payment incentives in the two programs discourage care coordination and lead to poor outcomes and higher spending. According to an analysis by the Urban Institute, the combined cost of Medicare and Medicaid care for this population in 2007 exceeded total Medicare expenditures for all other Medicare beneficiaries, a group four times as large.

Today, less than 10% of Medicare-Medicaid enrollees receive Medicaid coverage through Medicaid managed care plans, while only about 120,000 are in programs that fully integrate Medicare and Medicaid services. The vast majority are left to navigate two separate health systems and obtain other social supports with little or no care coordination. Most of their health care and related services – primary, acute, prescription drugs, long-term care, behavioral health, and social supports – are delivered separately. Few, if any, of their providers have access to claims data or complete health records. According to a recent CMS study, over a quarter of hospital admissions for Medicare-Medicaid enrollees could have been avoided either by prevention of the condition causing hospitalization or treatment in a less costly or more appropriate setting.

Medicare-Medicaid enrollees are sicker and poorer than the general Medicare or Medicaid populations. According to reports done by the Kaiser Commission on Medicaid during the last several years, 86% of Medicare-Medicaid enrollees in 2008 had

annual incomes below 150% of the federal poverty level, compared to 22% of non-dual Medicare beneficiaries. Almost half have difficulty with at least one instrumental activity of daily living (ADL), such as dressing or bathing. They are three times more likely to have a disability and have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness. The population served by Medicare and Medicaid most in need of care coordination currently has the least access.

As noted in the Medicare Payment Advisory Commission's (MedPAC) June 2012 Report to Congress, as of 2011, Medicaid-Medicare enrollees represented just 15% of the Medicaid population but accounted for 40% of total Medicaid spending. In Medicare, they represented only 18% of Medicare FFS enrollment, but about 27% of total FFS spending. Total federal and state spending on this population now exceeds $300 billion. Almost two-thirds of Medicaid spending for this population is for long-term care. While nursing home care is a Medicaid entitlement benefit for individuals meeting state income eligibility criteria, in most states access to home and community-based services, which is an optional service, is generally more restricted. An Urban Institute analysis of 2007 data also showed that total per capita Medicare and Medicaid spending on Medicare-Medicaid enrollees averaged $29,868, more than four times per capita spending on other Medicare beneficiaries. As a society, we can and must do a better job of providing elderly and disabled Medicare-Medicaid enrollees higher quality and more cost-effective health care.

Scope of Capitated Demonstrations

MHPA strongly supports the unprecedented efforts of the U.S. Department of Health and Human Services (HHS) to strengthen health care services and to improve the quality of life for close to 10 million Americans dually eligible for both Medicaid and Medicare. Through the Medicare-Medicaid Coordination Office (MMCO), and in partnership with the Center for Medicare and Medicaid Innovation (CMMI), HHS is seeking to better integrate Medicare and Medicaid services, to align administrative requirements, quality measures and consumer protections, and to improve health outcomes for Medicare-Medicaid enrollees.

The capitated demonstrations represent one of two models MMCO is testing—three-way contracts between CMS, states and health plans—which will provide a single, blended capitation payment to fully cover all Medicare and Medicaid services, including prescription drugs and long-term care services and supports. We believe the CFAD initiative is an integral part of the overall strategy HHS is pursuing to better integrate care and improve health outcomes for Medicare-Medicaid enrollees.

Under this model, person-centered plans and interdisciplinary teams of providers will be used to provide the most appropriate set of services in the most appropriate settings, allowing more Medicare-Medicaid enrollees to receive care in their homes and communities. Health plans will also be expected to coordinate non-medical supports offered through separate programs and providers. Payment incentives will be shifted away from volume of services to quality of care as outcome measurements are put in place to assess performance, including new measures for evaluating the quality of long-

term care. In addition, incentives for payers and providers to cost-shift between the two programs will be eliminated by making a single entity accountable for costs across all services.

MHPA believes that the demonstrations should include as many Medicare-Medicaid enrollees as possible and supports the enrollment numbers proposed by states in their proposals submitted to MMCO. Participation will allow each beneficiary to receive a baseline health risk assessment and further risk appraisals, a person-centered care plan, and coordinated Medicare and Medicaid services, as well as other non-medical supports. We feel strongly that as many Medicare-Medicaid enrollees as possible should have the opportunity to receive care coordination and reject the notion that the status quo is adequately meeting the health care needs of this population.

We note that previous Medicare demonstrations that were intended to improve care coordination have shown inconclusive results due to limits on enrollment. Also, without sufficient volume, it will be more difficult for health plans participating in the demonstrations to build the necessary capacity to treat the wide range of chronic conditions of Medicare-Medicaid enrollees. We also note that the 20 states proposing capitated demonstrations have about 4.1 million full benefit dual-eligible beneficiaries, but have targeted slightly more than half this number for participation in their capitated programs, at least immediately. In addition, each participant will have the opportunity to "opt out" of a demonstration, so every state will continue to maintain a FFS population, which can serve as a control group for comparison of outcomes measures and cost-effectiveness.

Pharmacy benefits are a critical aspect of care management and we believe they must be included in the integrated demonstration plans, as they currently are, in order for them to work. MMCO has been careful to ensure Part D protections apply to pharmacy benefits within the demonstration, and that savings attributable to Part D are retained in the Part D benefit and not the demonstration. Part D-covered pharmaceuticals provided within the demonstrations will not be subject to Medicaid formularies or the Medicaid Drug Rebate Program.

Passive Enrollment

Under the capitated financial alignment model, CMS is allowing states to use passive enrollment, but is also requiring them to allow individuals to opt out of the integrated program either prior to enrollment or anytime afterward. MHPA supports this approach and recognizes that many Medicare-Medicaid enrollees have complex medical and behavioral conditions. MHPA agrees that states should be careful to ensure that participating health plans have sufficient capacity to meet the particular needs of every included subgroup, and that rates paid to plans are sufficient to cover the cost of all necessary services.

Passive enrollment of Medicare-Medicaid enrollees is not untested. As part of the initial enrollment process for the Part D prescription drug program in 2006, Medicaid plans in

13 states were allowed to passively enroll members of affiliated Dual-Eligible Special Needs Plan (D-SNPs). This process successfully enabled tens of thousands of Medicare-Medicaid enrollees to receive a more integrated set of benefits.

Data sharing agreements being put in place between CMS and states should ensure that Medicare-Medicaid enrollees are assigned to health plans that are best able to meet their needs. However, we also think it essential that all of the same data be shared with participating health plans in advance of the start date of the demonstrations. Health plans can then use this information to provide participants immediate access to necessary health care services and non-medical supports. MHPA also strongly believes that extensive outreach and education will be required to ensure that Medicare-Medicaid enrollees are fully aware of their options and rights.

In addition, states and plans should be able to provide additional supports and services beyond those already available through Medicare and Medicaid as incentives for participation, as well as non-nominal incentives such as coupons for over-the-counter drugs to encourage enrollees' participation in care management activities or to reward desired behaviors (e.g., getting screening tests).

Plan Experience

MHPA believes that Medicaid managed care plans have sufficient experience working with different subgroups of Medicare-Medicaid enrollees and sufficient capacity to deliver a full range of Medicare and Medicaid services. Medicaid health plans have developed an infrastructure for care coordination, access and quality improvement that results in improved outcomes for beneficiaries. This includes information systems capable of integrating large volumes of information used to identify members in need; programs such as utilization management, disease management and health risk appraisals; and care management personnel dedicated to coordinating health and other services for members.

Medicaid managed care health plans are accredited by The National Committee for Quality Assurance (NCQA) and URAC, which evaluate them on rigorous standards relating to network management, access, quality and beneficiary rights. Medicaid health plans report on care quality using standard Healthcare Effectiveness Data and Information Set (HEDIS) metrics that enable states to evaluate quality improvement over time. For example, in 2011, Colorado health plans improved in 17 of 24 performance measures required by the state, addressing topics ranging from chronic disease medication monitoring to increasing use of prenatal care monitoring.

Some states also use Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate health plan performance and beneficiaries' satisfaction. In its June 2011 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that data from the 2010 CAHPS survey showed that Medicaid enrollees gave their plans higher marks than patients in privately insured or

Medicare plans. No such comprehensive quality measures or surveys exist in FFS Medicaid.

Health plans serving the Medicaid population already serve large numbers of elderly and disabled persons. MHPA member companies operate Medicare Advantage plans serving close to 4.7 million Medicare recipients. Another 567,000 Medicare beneficiaries are enrolled in their Medicare Special Needs Plans, with three-quarters participating in D-SNPs. MACPAC's March 2012 report to Congress also included an analysis of Medicaid Statistical Information System (MSIS) data that showed that approximately 2.6 million disabled persons were already enrolled in comprehensive, risk-based Medicaid managed care plans as of 2008.

Our plans understand that under the capitated demonstration program they will be held to high performance standards. They expect no less, but welcome the challenge of applying their experience acquired by serving low-income, culturally diverse populations in Medicaid to improve the quality of care for Medicare-Medicaid enrollees. In some states, we've already seen promising results. For example, a third of Arizona's 120,000 Medicare-Medicaid enrollees already receive both Medicaid and Medicare benefits through health plans that also operate D-SNPs and are under contract with the Arizona Health Care Cost Containment System (AHCCCS). A recent analysis by Avalere Health LLC of 16,000 dual-eligibles served by one of these plans, Mercy Care Plan, used a risk-adjusted model to compare outcomes for this group to the nationwide Medicare fee-for-service (FFS) dual-eligible population. Among other findings, risk-adjusted Mercy Care Plan members had a 31% lower hospitalization rate and 21% fewer readmissions.

Plan Selection Process

MMCO has given states the flexibility to contract with plans they believe are best able to meet the health care needs of Medicare-Medicaid enrollees given their experience with the aged, blind, and disabled (ABD) population and their local insurance markets. Whether or not a state chooses to use plans already serving their Medicaid population or decides to use an open bid process, MHPA believes that this flexibility is an important aspect of the CFAD initiative.

Conclusion

In closing, we believe that the integrated care demonstrations will greatly improve outcomes for Medicare-Medicaid enrollees. We know that this population is more likely to be institutionalized and is subject to higher rates of hospitalization and re-admissions, as well as emergency room visits. Many lack family support to help them navigate between programs and providers. Without a major change in policy, this population will continue to get sicker and will continue to drive a disproportionately high share of Medicaid and Medicare spending.

Thank you for the opportunity to submit this Statement for the Record on behalf of MHPA.

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MEDICARE RIGHTS CENTER TESTIMONY

ON Examining Medicare and Medicaid Coordination for Dual Eligibles

to the
United States Senate
Senate Special Committee on Aging
Wednesday, July 18, 2012
Submitted Wednesday, August 1, 2012

SUBMITTED BY:

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AND

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Introduction

The Medicare Rights Center is a national, nonprofit beneficiary service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. Through our direct work with Medicare beneficiaries, their caregivers, providers and families we have specific insights into implications of changes to the Medicare program, and the potential such policies have to affect those with Medicare. In this testimony, we will address our concerns regarding state demonstration proposals for beneficiaries dually eligible for Medicare and Medicaid. Additionally, we will highlight three promising practices from the New York proposal that we believe all demonstrations should utilize.

Each year through our consumer helpline we speak with nearly 15,000 people with Medicare as they navigate their health insurance, appeal coverage denials and try to determine which coverage best suits their health needs. We are also an appointed consumer group member of the National Association of Insurance Commissioner's (NAIC) Senior Issues Task Force statutory Patient Protection and Aforrdable Care Act (ACA) Subgroup. In New York, Medicare Rights is part of a statewide coalition and steering committee comprised of organizations that serve disabled and older consumers, including {LIST} on the implementation of New York's Fully Integrated Duals Advantage (FIDA) demonstration proposal. .

Efforts to coordinate care for beneficiaries who are eligible for Medicare and Medicaid

Dually eligible beneficiaries are among the most vulnerable people served by the Medicare and Medicaid programs. These individuals are more likely to fall below the federal poverty level and are more likely to be in ill health than beneficiaries enrolled into only Medicare or only Medicaid. We believe that the state-based demonstration projects envisioned through the ACA offer a unique opportunity to address the numerous and complex health problems faced by dually eligible Americans; however, we are concerned there are critical issues that must be addressed before many of these projects move forward. More specifically, we are concerned that:

- Demonstrations may save the states and the Federal government money; however, the demonstration savings targets must be transparent and realistic. And most importantly access to services and quality of care cannot be compromised in the name of saving money.

- Inadequate provider buy-in may result in poor quality of care and limited access.

- The move from fee-for-service to insurance-based managed care may compromise care by disrupting provider relationships, destabilizing the current safety net and creating a care system based on networks rather than patient need.

- New regulations governing demonstration plans may undermine, ignore, or circumvent important beneficiary rights and protections grounded in the Medicare and Medicaid laws and in State and Federal Constitutions.

- There are Inadequate requirements to ensure health plan compliance with the Americans with Disabilities Act (ADA) and inadequate penalties for health plans that fail to comply with the law.

- Demonstration plans may not meet the unique needs of subpopulations being served by programs tailored to those needs that currently exist in the Medicaid program.

- Demonstration programs may have the unintended consequence of incentivizing institutionalization, in contradiction to the implementation of the Supreme Court's decision in *Olmstead v L.C.*, 527 U.S. 581 (1999).

These concerns and others are more fully explained in a letter submitted by 33 beneficiary advocacy organizations representing older adults and persons with disabilities, including Medicare Rights Center, to the Medicare and Medicaid Coordination Office (MMCO) on July 18, 2012. We refer the Committee to this letter for a more nuanced articulation of our concerns and recommendations. The letter and supporting documents can be accessed on the Medicare Rights Center website.

Although these concerns require serious attention, so too do the promising practices developed through the state demonstrations. Medicare Rights Center and our partners are leading consumer voices in New York's ongoing dialogue to transition dually eligible beneficiaries to better integrated care. Given this, we wish to highlight three aspects of New York's FIDA demonstration proposal that we believe can and should be replicated in other states.

- **We support allowing existing models of care to coexist alongside new demonstration models.** New York proposes to create a fully capitated managed care plan for dual eligible beneficiaries; it also proposes to create a managed fee-for-service health home. Other existing models, PACE, Accountable Care Organizations (ACOs) and enhanced Primary Care Case Management (PCCM), are preserved. And in fact, PACE and ACO members will not be automatically decanted into a fully capitated plan. Allowing and supporting a number of care integration models will help ensure that states and MMCO can compare multiple models of care and determine which achieved the best outcomes for dual eligible beneficiaries.

- **We support the creation of an independent participant Ombudsman with broad authority to assist consumers.** An unbiased consumer ombudsman is needed given the enormous task of shifting dually eligible beneficiaries to new care models and care delivery systems at the speed at which these changes are proposed to take place. As proposed by New York State, the independent ombudsman must be adequately funded to provide information and counseling to beneficiaries regarding FIDA plan coverage and advocate on behalf of aggrieved beneficiaries with plans and other providers.

- **We support the creation of work groups to assist states in developing these new programs.** New York, like California, created three work groups which will include a variety of stakeholders, including consumer advocates, to address several key areas, including integrated appeals, plan quality, and plan payment methodology. We strongly recommend that other states follow suit and that New York and other states create additional work groups regarding notice to beneficiaries, and monitoring and oversight.

We appreciate the opportunity to provide testimony on this critical issue for Medicare beneficiaries. We look forward to working with Congress and with MMCO as these demonstration proposals evolve and are implemented.

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July 18, 2012

Hearing of the Senate Special Committee on Aging
Examining Medicare and Medicaid Coordination for Dual Eligibles
Chairman-Senator Herb Kohl (Wisconsin)
Ranking Member-Senator Bob Corker (Tennessee)

Chairman Kohl, Senator Corker:

The **National Association of Nutrition and Aging Services Programs (NANASP)** along with the **National Caucus and Center on Black Aged (NCBA), National Family Caregivers Association, Older Women's League (OWL)** and **Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE)** are writing to register some concerns over proposed changes which could impact those older adults who are also dual eligibles.

We are writing also as organizations who either directly serves or are advocates for duals. In the case of NANASP, our nutrition programs are targeted to serving the elderly in the greatest economic and/or social need which include the duals.

We also collectively subscribe to the **Dual Eligible Principles** which were communicated by the Leadership Council of Aging Organizations (LCAO). We especially support the right of duals to have full choice in receiving care and avoiding any disruptions which could be caused by removal from existing health and prescription drug plans. We support the right of duals to have access to a full range of benefits and providers and we want to see a full commitment to quality care in any new programs or policies advanced which would affect this especially vulnerable population.

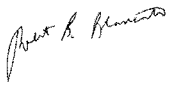
Our concerns of course relate to the recently published guidance for the implementation of new programs for the duals. There are a number of important goals inherent in this guidance that we endorse including improving care coordination and to extend critical patient protections from Medicare Part D prescription drug plans into state run programs. However one of our concerns is that existing Part D plan formularies also be extended into new state programs and not substituted.

We have additional concerns related to ensuring that CMS does proper oversight to ensure quality in any new state managed care programs which may be established for the duals. Finally we want to make sure that the enduring reality of Medicare's universality is not compromised in any new policies related to the duals.

We believe that these issues are sufficiently serious to be addressed prior to any final implementation done by CMS of this guidance. We believe one sensible approach would be to convene a comprehensive stakeholders meeting to allow CMS to hear first-hand the concerns we raise and we know are being raised by others. CMS has done effective if not outstanding outreach in the past and this is a crucial opportunity to do it again.

Thank you for your consideration of our views.

Sincerely,



Bob Blancato
NANASP Executive Director

Co-Signers

National Caucus and Center on Black Aged (NCBA)
National Family Caregivers Association
Older Women's League (OWL)
Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE)

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U.S. Senate Special Committee on Aging

Medicare and Medicaid Coordination for Dual Eligibles

Wednesday, July 18, 2012

The National Senior Citizen Law Center (NSCLC) and the National Committee to Preserve Social Security and Medicare (NCPSSM) thank the members of the U.S. Senate Special Committee on Aging for holding this important hearing regarding Medicare and Medicaid coordination for dual eligible individuals. On July 18, we joined 31 national aging and disability organizations in a letter to Melanie Bella, Director of the Medicare-Medicaid Coordination Office (MMCO), that raised consumer concerns and made recommendations for the demonstrations. A list of those organizations is attached. As beneficiary advocates, we support MMCO's goal of ensuring that dual eligible individuals have seamless access to high quality care. We believe that the integrated care program demonstrations offer tremendous promise for states to develop innovative, person-centered systems of care, and we are hopeful that the demonstrations will succeed. There are, however, several key issues that we believe require attention to prevent negative outcomes for beneficiaries and for the overall success of the demonstrations. The letter to Director Bella, available at http://www.ncpssm.org/Portals/0/pdf/dual-eligible-demonstrations.pdf , details each of these concerns, which we will summarize here:

Specificity and clarity of the proposal: The Centers for Medicare and Medicaid Services (CMS) is currently reviewing the state demonstration proposals for integrated care. The public had an opportunity to comment on the proposals at the state and federal level; however, many are frustratingly vague in critical areas, like beneficiary protections and plan accountability. Further, some proposals lack specificity on plan assignment, education of enrollees to help them make appropriate decisions, plan capacity, and network adequacy. This lack of clarity leaves advocates concerned about what this will mean when the demonstration is operational. Finally, many states are proposing to work out the details of the demonstration through Memoranda of Understanding (MOU), which are not guaranteed to include stakeholder input or public transparency. CMS should require that the MOUs development process be transparent and include stakeholder input.

Size and scope: CMS established a target of enrolling two million of the nine million dual eligibles nationwide into integrated programs, mostly through managed care organizations (MCOs). We are concerned that for an initiative operating under demonstration authority, this is much larger than a typical Medicare demonstration, raising concerns about unrealistic rapid growth, lack of control groups, and inability to account for other demonstrations. We urge MMCO to approve more genuine demonstrations, and limit the total demonstration population nationally to no more than one million beneficiaries. We ask that MMCO not allow states to enroll all dual eligibles, or all dual eligibles in a large metro area, into a demonstration, and that MMCO ensure that each state and metro area have a clearly identifiable, size appropriate, control group. In areas where other significant delivery reform efforts are underway, dual eligible integration demonstrations should be scaled back or should exclude duals participating in those other initiatives. Before implementation, each demonstration must have a strategy to avoid contamination of other payment and delivery system reform demonstrations and initiatives so that the impact of the demonstration can be accurately evaluated.

Enrollment: We urge CMS to require voluntary (opt-in) enrollment as we oppose state proposals to passively enroll beneficiaries into the demonstrations. Passive enrollment allows plans guaranteed enrollment without demonstrating that their product is worth having. Free choice of provider has been a tenet of the Medicare program since its beginning and people dually eligible for Medicare and Medicaid have been protected by statute from mandatory Medicaid managed care enrollment except when that right is explicitly waived through a statutorily-defined process. We support the CMS position that beneficiaries may not be locked into a demonstration for any period of time. We believe the enrollment process should be facilitated by an independent enrollment broker in all the demonstrations. We further request that adequate funding be provided to community-based organizations to educate beneficiaries about their enrollment options. The enrollment process should be supported by linguistic and culturally competent written materials that are also available in alternative formats, such as Braille, CD, large-font print and sign language translation.

State readiness: The aggressive timeline that many states are proposing for enrolling large number of dual eligibles (beginning in 2013) raises several concerns about state readiness. We ask CMS to slow down the demonstrations, as noted in the size and scope discussion. CMS should require states to provide CMS with a detailed statement/assessment of readiness and to demonstrate their expertise, prior experience, and current and future capacity (such as staff and financial resources) to adequately undertake their oversight responsibilities in managing new care models for the dual eligible population. This statement should be made public and should

identify the different approaches that the state will use to oversee service to diverse groups of dual eligibles, such as those requiring long-term services and supports.

Plan readiness: There are many unanswered questions about whether the plans will have the experience, network adequacy, access protections, and integrated long-term services and supports (LTSS) necessary to successfully integrate care for dually eligible individuals. Dual eligibles are a complex, heterogeneous group, whose only unifying characteristic is that they are eligible for two publicly-financed health insurance programs. Developing effective models of care for dual eligibles takes an intensive, long-term commitment from providers, payers, and beneficiaries of the services. Because the population is diverse with high needs, plans must have robust networks of providers, including primary care providers, specialists in conditions that affect the population, LTSS providers, and other services to address their needs. Networks must be physically and programmatically accessible to persons with disabilities in terms of facilities, equipment and scheduling, and be linguistically and culturally competent.

There is real concern that states and plans that are unfamiliar with LTSS systems may deny or reduce LTSS because lack of familiarity with LTSS needs. States and plans may also reduce LTSS in order to achieve quick savings instead of investing in services that improve health and reduce costs over time. States must require and plans must demonstrate verifiable proposals to ensure access to LTSS funded through Medicare and Medicaid, with sufficient appeals, advocacy, and ombudsperson options for consumers that are specifically tailored to LTSS..

Plan quality: The integration of long-term services and supports, other Medicaid services and Medicare is a complex and delicate task that requires extensive knowledge of local resources and the ability to provide quality care. Only plans with a proven track record of providing high quality Medicare and/or Medicaid services should be permitted to participate in the demonstration. Medicare plans that are poor performing—any plan below three stars—should not be included.

Continuity of Care and Transitions: The relationship between dual eligible beneficiaries and their providers must be preserved during the demonstration plan transition period in order to avoid disruptions in care. Dual eligibles who are undergoing a course of treatment, whether short-term or longer-term, or who have a plan of care for long-term services and supports should not have an interruption in care because a provider is not in their network. To promote safe transitions, plans must identify all current providers for each enrollee and invite them to join the network; inform enrollees, in writing and orally, which of their providers are not in the network and the period of time they have to complete transitions to network

providers; allow up to 12 months of continued coverage with pre-existing non-network providers and allow for the completion of an on-going treatment plan; provide transition supplies of pre-existing prescription drugs at the same cost-sharing level for at least 90 days; and continue any service, supply or drug that was authorized prior to enrollment in the demonstration under the same terms and conditions.

Quality measurement: It is essential that quality be monitored continually throughout the demonstration to ensure that, at the very least, minimal standards are met, and to assess whether promised improvements in quality occur. Existing quality measures are limited, especially for the dual eligible population and for long-term supports and services. Moreover, even the best measures can only provide a limited picture of patient care. These demonstrations are an opportunity to develop better measures, and must go beyond traditional metrics, with existing Medicare quality standards as a floor for quality measurement.

We suggest domains where CMS, states and plans should go further to develop specialized measures. These domains are: 1) care coordination, 2) access/availability, 3) patient-centered care, 4) prevention, and 5) effectiveness of care. We have additional thoughts on specific measures within each domain. All data should also be publicly reported and stratified by demographic group, to allow transparency and monitoring. Where no good measures exist, CMS must use the demonstrations as an opportunity to work aggressively to develop them.

Appeals: We urge CMS to require states to create a single appeal process relying on the most beneficiary-friendly elements from both Medicare and Medicaid systems. The beneficiary should continue receiving benefits pending the outcome of the appeal. Dual eligibles are not in a financial position to pay for their care while an appeal is processed. This is true whether the service is covered by Medicare or Medicaid.

Oversight and evaluation: We believe that quality oversight of the demonstrations depends on the timely collection, review and public availability of data. Data collection must capture whether the plans are limiting access to care or providing low quality care. The data must measure evidence to determine if the demonstrations are improving overall quality and lowering cost. Data collection and evaluation should include a comparable control group to determine if the intervention was successful. The state should collect data sufficient to determine if the plans are maintaining or expanding access to care, providing high quality-care, addressing health disparities, and lowering costs.

Oversight should occur at multiple levels and involve consumers and their

caregivers. To guard against limits to care, all plans should report to an independent state ombudsperson. The state should fund the ombudsperson program to receive and respond to complaints and to monitor overall demonstration activity. CMS should require all data collection, evaluation and oversight efforts to be timely, transparent, and available to the public.

Rebalancing and reinvestment of savings: Medicare and Medicaid integration provides opportunities to promote greater rebalancing of long-term services and supports from institutional settings to home and community-based services. While most states clearly articulate goals to rebalance, proposals are often vague about financial incentives to promote rebalancing. We encourage CMS to ensure meaningful aging and disability stakeholder engagement in developing financial incentives to rebalance. CMS should also encourage states to offer options for self-direction of home and community-based services. Finally, some states have proposed carving out long-term services and supports in nursing homes and other institutional settings. This will significantly decrease their ability to incentivize rebalancing and preventable hospital admissions from such facilities. CMS should not approve demonstrations that carve out nursing home and institutional services.

As states and CMS determine savings targets, we ask that CMS not require the demonstrations to show savings in the first year. We also ask that states be encouraged to use demonstration savings to reinvest in home and community-based services and supports.

NSCLC and NCPSSM value CMS' effort to better coordinate care for dual eligibles and appreciate the Aging Committee's attention to the demonstration. Thank you for the opportunity to submit our recommendations on this issue.

If any questions arise about this submission, please contact Fay Gordon, fgordon@nsclc.org, or Brenda Sulick, sulickb@ncpssm.org.

Consumer Advocate Organizations
Signed-on to July 18, 2012 letter to MMCO

1. American Association on Health and Disability
2. Association of University Centers on Disabilities (AUCD)
3. American Network of Community Options and Resources
4. B'nai B'rith International
5. Center for Medicare Advocacy, Inc.
6. Community Catalyst
7. Direct Care Alliance
8. Disability Rights Education and Defense Fund
9. Easter Seals
10. Families USA
11. Leading Age
12. Lutheran Services of America Disability Network
13. Medicare Rights Center
14. Mental Health America
15. National Alliance on Mental Illness
16. National Academy of Elder Law Attorneys
17. National Association of Area Agencies on Aging
18. National Association for Hispanic Elders
19. National Association of Nutrition and Aging Services Programs
20. National Association of Professional Geriatric Care Managers
21. National Association of State Long-Term Ombudsman Programs
22. National Caucus and Center on Black Aged, Inc.
23. National Council for Community Behavioral Healthcare
24. National Council on Aging
25. National Committee to Preserve Social Security and Medicare
26. National Health Law Program
27. National Senior Citizens Law Center
28. Older Women's League
29. PHI – Quality Care through Quality Jobs
30. Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE)
31. The Arc
32. The National Consumer Voice for Quality Long-Term Care
33. United Spinal Association

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