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IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: A PROGRESS UPDATE

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BEFORE THE

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CONTENTS

OPENING STATEMENTS

WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: A PROGRESS UPDATE

THURSDAY, DECEMBER 13, 2012

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:12 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Wyden, Cantwell, Nelson, Carper, Cardin, Hatch, Grassley, Thune, and Burr.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order. It seems we are going to have to go with the flow here and call audibles as we proceed. Some of the power is on, some of the power is not on. We have lights, but we do not have sound. We will proceed the best we can, and so just let's everybody work together. And if someone cannot hear, would that person—not the audience—raise his or her hand? [Laughter.] That is, if any members of the panel cannot hear somebody's testimony and vice versa, just raise your hand or shout out, "Would you repeat that?" Okay.

President Harry Truman once said, "Difficulties are a challenge to men of determination." And I suppose that would also apply to "women of determination" these days.

On July 30, 1965, President Lyndon Johnson signed monumental legislation creating both Medicare and Medicaid. At long last, the United States had met the challenge of guaranteeing health insurance to elderly and low-income Americans. The bill-signing ceremony took place in Independence, MO. The first Medicare card was given to the Nation's first beneficiary, the 81-year-old former President, Harry S. Truman.

Nearly 50 years later, Medicare and Medicaid continue to provide vital health services to more than 100 million Americans. Nine million of these individuals are part of a subgroup enrolled in both Medicare and Medicaid. These dually-eligible beneficiaries, sometimes called "duals," present unique challenges that were hard to imagine back in 1965.

These folks who are eligible for both Medicare and Medicaid are often thought of as one single group. They are not. People who become eligible for both Medicare and Medicaid do so for many different reasons. A low-income individual who just turned 65 may qualify. A 26-year-old with a disability may be considered dually-

eligible. An 80-year-old who needs long-term care also could qualify.

All pose very unique, individual challenges. They are not the same. These challenges are often complicated because Medicare and Medicaid do not always work very well together. Some rules are written by the States, others by the Federal Government. Acute care is paid for by Medicare. Long-term care is paid for by Medicaid.

Incentives become misaligned, with too much red tape across both programs. Vulnerable Americans are lost in the middle. As a result, some of these folks receive poor health care, and we have the data that proves this.

Half have three or more chronic conditions. More than half have a mental impairment. As a consequence of their poorer health status, dually-eligible beneficiaries are more than twice as likely as other beneficiaries to die during any given year.

The government also spends disproportionately high amounts on this population. While 18 percent of Medicare beneficiaries are dually-eligible, they account for 31 percent of Medicare spending. Fifteen percent of Medicaid beneficiaries are duals, but they account for 39 percent of total Medicaid spending. Last year, States and the Federal Government spent nearly $300 billion on care for people who qualify for both Medicare and Medicaid.

The nonpartisan Congressional Budget Office tells us that 40 percent of the long-term growth in Federal health care programs is due to the growth in health care costs. But 60 percent can be linked to the aging of our population. In fact, 10,000 Americans will turn 65 each day over the next 2 decades.

We cannot stop the aging of America, but we can work to lower health care costs. Streamlining Medicare and Medicaid so they work better together will pay dividends. It will improve the health of vulnerable Americans, and increasing efficiency will also save the Federal Government money.

How are we going to increase efficiency? First, we need to rework our payment models so that providers, States, and the Federal Government have incentives to work toward the same goal. Let us remove incentives for providers to game the system; we need to put beneficiaries first. Everyone should be rewarded for lower costs as well as held accountable for poor or unnecessary care.

Second, we need to coordinate care so that doctors, hospitals, and other providers are working together as a team. Dually-eligible folks often have multiple chronic diseases, requiring multiple doctors. If providers do not communicate, they can deliver unnecessary care. This leads to increased costs and can harm patients.

Third, we need to get rid of conflicting rules and cut red tape in the areas where Medicare and Medicaid interact. For instance, when a dually-eligible person needs a wheelchair, Medicare and Medicaid have two very different rules. These rules are complicated and at times delay needed care.

Accomplishing these goals will go a long way in improving care and saving money.

Our witnesses are here today to discuss efforts to streamline these two programs. Last year, Melanie Bella, the Director of the office at CMS responsible for dually-eligible beneficiaries, testified

before the Finance Committee. She outlined CMS's plans for a demonstration project where States would test new ways to provide health care to duals.

Today, the committee is following up. We look forward to an update on these efforts from Director Bella and three States participating in the demonstration project: Washington, Arizona, and Ohio. As these demonstrations move forward, we need to keep in mind three key principles.

One, the focus cannot be on cost-cutting alone. We must focus on streamlining Medicare and Medicaid in a smart way to improve how care is delivered.

Two, we must maintain or strengthen the protections beneficiaries already enjoy today. Let me repeat that: we must maintain or strengthen the protections beneficiaries enjoy today.

And three, we need to rigorously evaluate the projects to learn what worked and what did not.

So let us focus on these principles, streamline the programs, and improve care for these vulnerable American citizens. And, as President Truman advised, if we act with determination, these difficulties will only be challenges to solve.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you, Mr. Chairman, for holding this hearing. It will allow us to get a progress update on efforts to improve the care for beneficiaries who are eligible for Medicare and Medicaid. In an otherwise partisan atmosphere, today's topic is refreshing. It represents an area where we can achieve some real bipartisan agreement to lower health care costs and improve patient care.

There are more than 9 million Americans—commonly known as "duals"—who are eligible for both the Medicare and Medicaid programs. These patients often suffer, as the distinguished chairman has said, from multiple chronic conditions and have complex medical needs. The $300 billion spent on this type of care every year is generally separated by complicated Medicare and Medicaid payment rules. Unfortunately, the system is not serving taxpayers well, and it is not serving patients well either.

I would note that many promising efforts have been made to address these needs, such as various State-driven efforts, the Special Needs Plans in Medicare Advantage, and the Program of All-Inclusive Care for the Elderly, which is known as "PACE." While these approaches have made a huge difference, there is much more work to be done.

I know that our first witness, Melanie Bella from CMS, has been working hard to solve these problems, and I have a very high opinion of Melanie Bella and the work that she is doing. We want to help you to the extent that we can, and you need to give us some help yourself by giving us instructions on what we can do to help you.

Ms. Bella has led the Financial Alignment Initiative to encourage States to design solutions that integrate care delivery and funding streams for dually-eligible beneficiaries. She is actively working with 25 States to approve and implement these proposals. Today, we will hear from two States with approved proposals—Washington and Ohio—and another—Arizona—whose proposal is under review.

I am supportive of State-designed efforts generally, and I applaud Ms. Bella for her pragmatic and compassionate approach to a very, very difficult task. However, I do want to make sure that we get the details right. In order to ensure these demonstrations are successful, I and six other members of this committee sent a letter to CMS in June outlining three priorities.

First, the demonstrations should be of a size and scope that gives Congress data upon which to base future policymaking. Second, these proposals should be consistent with good government principles so that contracts are competitively bid on cost and quality across a level playing field. And, finally, we need to be sure that these demonstrations protect the integrity of the Medicare Part D program.

Again, Mr. Chairman, I want to thank you for scheduling this important and timely discussion, and I do, as always, look forward to working with you on these issues.

Now, one final thing. Mr. Chairman, I am really concerned about this fiscal cliff. This is the committee of jurisdiction, and, frankly, I think we ought to haul the Secretary of the Treasury up here one more time just so that we can ask some very pertinent questions about what really is going to go on and what can we do and what does he really want to do, because I cannot imagine him wanting to come up and present the program that he did present, which I found pretty insulting. But it would be a great thing if we could do that, and I know that you and I have worked together on these things, and maybe that is the way of getting that done. Maybe you can push things forward. I do not know.

The CHAIRMAN. Well, Senator, I appreciate your opening statement, and I also know you speak for all of us when you say you are concerned about the fiscal cliff. We are also concerned about making sure that it is resolved, and resolved as expeditiously as possible. We need certainty and predictability in our country, stable markets, et cetera, and our goal should be just that. I will be working to do what we possibly can to help us and not to be taking actions that might be disruptive, so we appreciate your concern in this.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. We are very honored to have you, Melanie. Oh, now they are working. At least our lights are working. That is the first step.

Ms. BELLA. I will just try to speak loudly.

The CHAIRMAN. Try it again. Is there a light that goes on?

Ms. BELLA. A red light, not green.

The CHAIRMAN. A red light? We want red.

Ms. BELLA. We have red. [Laughter.]

Senator HATCH. We can hear you.

The CHAIRMAN. We will raise our hands if we cannot hear you.

STATEMENT OF MELANIE BELLA, DIRECTOR, MEDICARE-MEDICAID COORDINATION OFFICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Ms. BELLA. Thank you. Chairman Baucus, Ranking Member Hatch, and members of the committee, thank you for the invitation to continue our discussion about CMS's efforts to improve care for low-income seniors and people with disabilities who are enrolled in both the Medicare and Medicaid programs. My name is Melanie Bella, and I am the Director of the Medicare-Medicaid Coordination Office. I appreciate your ongoing interest in the work of the office, and thank you for the opportunity to be here today.

For decades, there has been much discussion about better coordination for this population, and, through the Affordable Care Act and the leadership of this committee, Congress has given CMS the necessary tools to make things better.

The Medicare-Medicaid Coordination Office continues to focus its work in three areas: program alignment, data analytics, and models and demonstrations. Together these areas provide a platform for developing integrated programs that help achieve our goal of increasing access to seamless, person-centered care that is high quality for all Medicare-Medicaid enrollees. Today, I would like to update you on the progress we have made since I last testified before this committee.

Although established at the same time, Medicare and Medicaid were designed with distinct purposes, with little forethought as to how the two would work together. As a result, the two programs often work at cross-purposes. We are actively working to address the areas where the programs bump up against each other, and I just want to share with you a few concrete examples.

The number-one issue we get asked about from both beneficiaries and providers relates to billing. So, earlier this year, we issued guidance to make it clear that the providers may not balance-bill Medicare-Medicaid enrollees, and we plan to continue to work aggressively in this area.

Another area of frustration we hear about frequently is appeals.

The CHAIRMAN. By "balance-bill," you mean charge the beneficiary.

Ms. BELLA. Charge the beneficiary the difference, yes.

The CHAIRMAN. I want to make sure everybody understands that.

Ms. BELLA. Another area of frustration is the appeals. We are finalizing what is called a Combined Integrated Notice of Denial of Payment that is the first step in integrating the appeals process between the two programs for beneficiaries, providers, and payers who must navigate both.

Lastly, there has always been widespread interest in expanding the Program of All-Inclusive Care for the Elderly, or the PACE program. We have convened a cross-agency work group to explore how to increase flexibilities in PACE using our sub-regulatory or regulatory vehicles that the agency has at its discretion.

There are many opportunities to improve the coordination of rules, requirements, and policies between the two programs. This

critical work is ongoing for us and fundamental to creating a more seamless, high-quality, cost-effective system of care.

As we have discussed in the past, a thorough understanding of the Medicare-Medicaid population and its subpopulations is critical to everything we do and drives our efforts, including new beneficiary outreach and engagement models, new quality measures, care models, and payment models, just to name a few.

I am happy to report that CMS now has an integrated Medicare-Medicaid data set. This will allow States and policymakers and others to better understand the population and support opportunities for improved care coordination. This work takes our efforts in providing States access to Medicare data for care coordination purposes and expands it by allowing States to also now receive the integrated data that they can be using to support their care coordination efforts.

Also exciting are enhancements to CMS's Chronic Condition Data Warehouse to include new diagnostic conditions flags for conditions prevalent among Medicare-Medicaid enrollees, such as schizophrenia. Given the widespread use of this research database to inform policy and program decisions, it is a huge step forward to be adding conditions that will further inform our understanding of this population.

In June, as part of our mandate to serve as a resource to States, policymakers, researchers, Congress, and others, we released profiles on Medicare-Medicaid enrollees nationally and for each of the 50 States and the District of Columbia. The State-level profiles contain demographic characteristics, utilization and spending patterns, and will be updated annually.

Supplementing this work, this month CMS launched the State Data Resource Center. This center is open to all States to help guide them in their use of Medicare data across CMS programs and in the development of their coordinated care initiatives.

Moving on to our final area, models and demonstrations, CMS has approved financial alignment demonstrations in Massachusetts, Washington, and Ohio. These States will become our first partners to test the integration of services and financing, with the ultimate goal of improving the care experience for beneficiaries. The new programs will use a benefits-plus approach, meaning beneficiaries will receive all the current services and benefits they do today from Medicare and Medicaid with added protections, care coordination, and access to seamless enhanced services. Our work with States and stakeholders to better care for this population will continue with a strong commitment to transparency——

The CHAIRMAN. Ms. Bella, ordinarily we give 5 minutes per witness, but I am going to give you 10, so go ahead.

Ms. BELLA. Oh, I am almost through. Thank you.

The CHAIRMAN. Well, if you want to take more, you can take it.

Ms. BELLA. Okay. Thank you.

The CHAIRMAN. Just say what you want to say.

Ms. BELLA. Okay. Thank you.

Just to finish up on our demonstrations, it is important to reiterate that our work will continue with a strong commitment to transparency, beneficiary protections, and public input.

We are also pleased to have launched our initiative to reduce avoidable hospitalizations among nursing home residents. In September, we announced the selection of organizations in seven States—those being Alabama, Indiana, Missouri, Nevada, Nebraska, New York, and Pennsylvania—to partner with States to reduce avoidable hospitalizations which are both harmful to people and costly to taxpayers. We are very excited that that initiative will begin touching beneficiaries early in 2013 around the February time frame.

In conclusion, this testimony represents just some of the ways we are working to strengthen the Medicare and Medicaid programs and improve the everyday lives of individuals who depend on them. We will continue to work to align the programs, to better understand the population, and to test new models to provide better care, better health, and lower costs through improvement.

I want to thank the committee for its continued interest in improving care for Medicare-Medicaid enrollees. With your continued support, we will keep working with States and other partners to advance high-quality, coordinated care for these individuals who depend on us the most.

Thank you very much.

[The prepared statement of Ms. Bella appears in the appendix.]

The CHAIRMAN. Well, thank you, Ms. Bella.

How many States, realistically, are going to participate in demonstration projects? And have you lined them up so they are different, not the same, and that they have criteria which are going to make sure there is no reduction in coverage for beneficiaries while at the same time achieving efficiencies for the Federal Government?

Ms. BELLA. As you know, we had great interest in the demonstration models when we put them out, and we are working with 25 States that are interested either in the capitated model or the managed fee-for-service model. We have three States that are interested in an alternative approach, because it appears that one of the other two models is not going to be a good fit for them. So of the 25, 13 of them are interested in moving ahead in 2013, and 14 of them are interested in moving ahead in 2014. And you are probably asking why those numbers do not add up to 25. That is because two of the States are pursuing both of the models. So it is——

The CHAIRMAN. Do you have a sense among the fee-for-service on the one hand or the managed care on the other—we do not want to prejudge it, but which might show more promise?

Ms. BELLA. Well, they both hold great promise because they will be tailored to fit the delivery systems of the States, and so we felt that that was very important to be able to work with the States in the types of programs they had today.

The capitated model provides up-front savings in the way the financing is constructed for both the State and the Federal Government. The managed fee-for-service model looks at savings on a retrospective basis. Both of them require quality thresholds to be met, so we are ensuring that it is not just a cost-cutting effort.

Just to go back to your earlier point, the standards that we have in place will not let any model go forward that takes away something from a beneficiary.

The CHAIRMAN. How are the capitation levels set in these States? What is the dollar amount, and who determines that amount?

Ms. BELLA. We set a Medicaid and a Medicare component of the capitated rate. Part D stays, we use the national average bid for Part D. But the Medicaid and Medicare components are—first, we derive a baseline for each of them, looking at what spending would have been in the absence of the demonstration. We also are doing an analysis, and then those amounts are risk-adjusted to take into account the population. At the same time, we are looking at what we think the savings opportunity is through improved care coordination, through reduced duplication and inefficiencies, and through administrative simplification. And we look at the projected spending, and we look at the expected savings, and then a cap rate is developed, and the State and Federal Government each contribute their proportion to that rate that is then passed on to a health plan.

We withhold a portion of that capitation rate to ensure that the plan meets certain quality standards, and that is how it is set. There is a lot more detailed information about that available on our website, and I am happy to provide any follow-up or——

The CHAIRMAN. But essentially it is negotiated between you, CMS, and the States primarily?

Ms. BELLA. So, on the CMS side——

The CHAIRMAN. Or the plan has to be involved? So what is the negotiation here, or determination?

Ms. BELLA. We do not expect to have a negotiation with the plan. CMS, we work closely with our Office of the Actuary to determine the Medicare baseline and to validate the Medicaid baseline. We have external actuaries who are helping us as well, and then the State and its actuaries provide analysis on the Medicaid component.

The CHAIRMAN. So who sets it?

Ms. BELLA. Ultimately, CMS sets the rate with, again, input on the Medicaid side from the State——

The CHAIRMAN. Right, and so what is the difference between what CMS is setting in these capitation States, on the one hand, and what you expect the costs to be otherwise?

Ms. BELLA. Well, we set the rate assuming a savings amount to occur as a result of the integration through the demonstration.

The CHAIRMAN. Do you have a percentage savings expectation? And how do you know how much you want to save?

Ms. BELLA. Well, as you know, Mr. Chairman, we have not set a national savings target because, for us, this is about improving quality and care coordination that should lead to reduced costs.

What we have done is look for where we think there are savings opportunities, and, for example, on the Medicare side, we think there are tremendous opportunities for saving on hospital admissions, on readmissions, on better medication management. On the Medicaid side, the lion's share of savings comes from rebalancing and making sure we are providing more care in the community as opposed to institutions.

The CHAIRMAN. What are you doing to help minimize providers' gaming the system? Because, you know, the patients are put here, or there, you know, just to make more money.

Ms. BELLA. Well, I think that——

The CHAIRMAN. We are not, I guess, making more money, but we are—there is a lot of gaming going on, I suspect, which is part of the problem.

Ms. BELLA. It is part of the problem, and what we are trying to do is establish accountability for the dollars and expect to hold an entity accountable for providing all the services. So, today, they might be able to sort of play Medicaid and Medicare off each other in an area like home health or durable medical equipment because both programs cover them and have different rules. But when they are responsible, and they have one pot of money to manage that, you take away some of those incentives for gaming between the two payers.

The CHAIRMAN. Okay. My time has expired. Thank you.

Senator Hatch?

Senator HATCH. Mr. Chairman, I am going to allow Senator Grassley to go ahead of me, since he has another commitment. So I will just take my turn later.

The CHAIRMAN. Sure. Senator Grassley?

Senator GRASSLEY. Yes, thank you, Mr. Chairman, and thank you especially, Senator Hatch.

I appreciate your being here, and I know you have a very tough job, particularly as we deal with dual-eligibles. They are a very expensive part of health care. They are about 10 percent of all Medicare and Medicaid beneficiaries, but account for more spending than either people eligible for Medicare only or people eligible for Medicaid only. We must find better ways to coordinate care and lower the costs for dual-eligibles.

That said, dual-eligibles are a complex population. I have a chart here that will explain this better. While 62 percent are eligible, 38 percent are under the age of 65. Sixty-two percent are elderly; 28 percent under 65. While some are expensive and need extensive long-term support and services, there are dual-eligibles who are relatively low-cost. More importantly, though, is, not all expensive Medicare beneficiaries are dual-eligibles.

So take a look at the chart. These are the most expensive beneficiaries in Medicare. These are beneficiaries who have multiple chronic conditions and functional impairments. Fifty-seven percent of them are eligible for Medicare only; 43 percent of them are dually-eligible for Medicare and Medicaid.

So the question I ask is, but do not answer yet: Why are we splitting up the two groups? These are two groups of similarly situated individuals. They all have a need for better coordinated care. They all have multiple conditions that are expensive. So I have four kind of rhetorical questions I would like to have you address. I will state all four of them.

Why do we tell some people, you get Medicare solely because you have income, and then we tell some people, you should get Medicaid solely because you do not have enough income? And why is it a good idea to give States control over low-income beneficiaries? Why should low-income beneficiaries get one of 50 different models,

meaning 50 different State models, to coordinate their care, and people with incomes then get Medicare, which is only one approach and that is a national approach? Why are we pushing States to take a greater role with a complex, expensive population when they also are being asked to find resources to cover poor individuals in Medicaid and develop exchanges to cover people in the private market?

I would like to listen to you at this point, and I am very concerned that splitting these individuals makes no sense.

Ms. BELLA. Thank you for those questions. I will do my best to respond.

I think, first, we are fortunate that you all created this office to focus on people who get both Medicare and Medicaid, and we are actively working on solutions, new care models, to focus on people who have exactly the kind of care and cost profile that you represent today. And our hope is that what we are learning will be transferable, it will be transferable to the other 57 percent of those in Medicare. And similarly in Medicaid, the folks who are dual-eligibles with disabilities look very similar to people with Medicaid only who have disabilities. And so, what we learn in those care models should be transferable as well.

So I hope you see the investment in this office as a way to leverage those resources to be able to shed best practices that can be applied to all high-cost patients across both Medicaid and Medicare.

And you raise important questions about States and the role of States. From my perspective, Senator, what we are trying to do is to create person-centered, high-quality, accountable systems of care. And this is not a one-size-fits-all approach. This is a very heterogeneous population, and we have to recognize that States are our partners in the delivery and financing of this care.

So, we have focused on starting with States with a goal of, again, creating financial accountability and aligning incentives in the system, not so much with the goal of deciding whether Medicaid or Medicare should be the one driving that system.

I think what is important and what gets to your point about, you know, why do people with higher incomes have Medicare and then they have variation if they also have Medicaid, the important thing to remember is that, in these demonstrations, we are not taking away anything that Medicare provides today to people who are dually-eligible for both programs. They are getting the best of both programs. We are taking both programs—each of them has their own strengths—looking at putting those strengths together, and then adding on to that.

So, for example, in the Ohio and Massachusetts and Washington programs, beneficiaries are getting new services. They are getting protection from cost sharing that they do not have today. They are getting new resources.

And I guess the last thing I would say is, you are exactly right that States have a lot on their plate right now, but this is an option that we have put out there for States. And States that have decided this population is a priority, we find that they are really committed to trying to work with us to make this happen. And I think

one of the reasons is because we are trying to make it tailored and flexible to their needs.

Senator GRASSLEY. If I could have 10 seconds just for a rhetorical comment. I appreciate what you said, but I just have to point out that CMS is working for Accountable Care Organizations, working on that, which presumably targets the 57 percent of the high-cost beneficiaries while you encourage States to target the 43 percent of high-cost beneficiaries. So I have to ask a question that I do not expect an answer to at this point, but it is as much for my colleagues: Who is in charge of making sure that we find the best solutions for the 100 percent of the population?

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman, and good morning to you, Ms. Bella. I also respect what you are doing, and you are working on the most complex problem that health care has to offer, in my judgment, and it is yet unsettled.

Let me just say I am not going to have time to ask the questions, a series of rapid-fire questions, so let me just say that my overall concern is that HHS is saying certain things that they are doing as a matter of policy, but, when it comes to the MOUs with the States, it is changing. There is slip-back. And I will follow up with written questions to you on this.

To me, Medicare-Medicaid managed care is a model that has not been shown to work for even small numbers of dual-eligibles because of the varying range of intensity of services required to meet their special care needs. Why aren't new and innovative models of care actually being developed? Why aren't, for example, you testing a Medicare-only option for duals?

I am going to continue. We should be letting the policy—providing high-quality, better coordinated care for duals—determine what our approach is, not cost saving. Not cost saving. It is very clear.

Why is CMS pushing for an arbitrary savings target for dual-eligibles under the capitated model in each State and letting that drive the policy? Now, that expands in complexity when you say, for example, with the State of Arizona, where there is a demonstration project you are looking at, Arizona is enrolling nearly 82 percent of their folks, duals, and Washington is enrolling nearly 92 percent. And it just baffles me. Where is the robust evaluation plan for these State demonstrations? How can you do it? If you have that many people involved in a demonstration project, it is not a demonstration project. It is the inevitable formulation of policy. And I do not think that is what a demonstration effort is meant to bring out.

So how can the demonstrations be effectively evaluated if the vast majority of a State's dual population is enrolled, as is the case in many examples? Ohio has taken theirs down from 82 to 60 percent recently, but that brings up a new series of problems.

So could you just sort of speak to those for a second?

Ms. BELLA. Sure, I can start with your last question first. We have an external evaluator, RTI. We plan to have a very rigorous evaluation of the demonstrations, both across the demonstrations

and within each State. We have a commitment to having an ability to evaluate people in the demonstration with a comparison of people not in the demonstration.

Senator ROCKEFELLER. But what if most people are in the demonstration?

Ms. BELLA. We work closely with our evaluators to establish appropriate out-of-State comparison groups, looking at a variety of factors that enables us to feel like we have an ability to detect what was really the result of the demonstration.

Senator ROCKEFELLER. Ms. Bella, I respect your words and I respect you, but I am not comforted by your words, by your answer. We have to have a way of breaking it down. It is just an enormous mass of people, in fact, up to one-third of the entire 9.4 million dual population in the country. And I do not think you can tell me that you can take a huge demonstration project with hundreds of thousands of people in it, and then sort of break it down within that huge number. It does not make sense to me. But you can explain that to me either now or later.

Ms. BELLA. Sure. Your preference. I am happy to also come and talk to staff and sit down and share with you our evaluation plans. We have to have a rigorous evaluation. We have a rigorous evaluation. We have external folks helping us do that, and no State is going to get approved where we do not feel like we can rigorously evaluate it.

And so that is a commitment that we have made, and we are happy to provide additional detail as to how that might play out.

Senator ROCKEFELLER. What about the cost-saving factor?

Ms. BELLA. These are not driven by cost savings. If this was a cost-savings initiative, we would have had a national savings target. We would have a savings target now. We do not. We have an obligation to learn what works for this population and to do it in a way that puts people first.

And our other interest is in not continuing demonstrations in perpetuity, and the Innovation Center allows us to test and learn and modify and begin to take things to scale. But for those who go to scale, we have to see improvements in quality and cost. And so, cost is there. It is sort of that elephant in the room. It is always there. It is not driving our efforts. Never have we spoken of these as cost-containment vehicles. We see them as opportunities to improve coordination and quality, which should lead to cost efficiencies. But cost is not the driver here.

Senator ROCKEFELLER. My time is up. I will need to follow up with you on your answers so far.

Ms. BELLA. Certainly.

Senator ROCKEFELLER. And there is another round of questions.

Ms. BELLA. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

I want to start by applauding you and those who work with you for all the hard work you have done to improve care for those patients eligible for both Medicare and Medicaid. We all know we can do better than the status quo, but changing the status quo is always a tremendous challenge, and you are making your best efforts

to do it. And I want to thank you for both the thoughtful solutions and the tremendous energy that you have invested in this important task. Now, I do not want to continue to praise you for fear it might hurt you. [Laughter.] But I think you get the point. I think you are great.

While I am supportive of the goals of the demonstrations, in order for them to be truly successful, I want to make sure we get a few things right. While we are solving problems for the duals, I want to make sure that we are not creating problems elsewhere.

Medicare Part D has been a huge success in offering beneficiaries a choice of plans to fit their needs as well as a competitive bidding structure to keep costs in check. Now, Ms. Bella, under the demonstrations, prescription drug benefits will be paid for with a risk-adjusted, predetermined rate which would be based on the national average Part D bid amount. I am concerned that moving millions of duals out of the competitive bidding system could undermine the integrity of the Part D program, and this is especially concerning because the opportunity to deliver benefits to the duals population is an incentive for drug plans to place competitive bids.

Earlier this year, the Medicare Payment Advisory Commission, or MedPAC, sent a letter to CMS expressing concerns to this effect. Why did CMS decide not to require demonstration plans to submit competitive bids in the same way that other Part D plans do, including PACE and dual-eligible Special Needs Plans? Would CMS consider implementing a process for drug plans to begin submitting competitive bids by the second or third year of the demonstration?

I just wonder if you could answer those questions for me.

Ms. BELLA. It is an important area for us to be watching, certainly: Part D. I mean, Part D is something that we have kept intact for these demonstrations in terms of all the beneficiary protections and in terms of how we integrate that financing stream into the rate.

I would say your concern about, are we undermining the market, is one that we are watching. We believe there are still incentives for drug companies to bid competitively, because they still want to be under the benchmark to receive low-income-subsidy individuals, or dual-eligibles who opt out, or any Medicare beneficiary who is not in those categories who still wants to look for lower premiums. So, we do think the competitive reason, the competitive incentive, is still there, but we are in close consultation with our Office of the Actuary and our colleagues in the Medicare components to ensure that the demonstrations are doing no harm to the financial competitiveness of that program. That is something that we are monitoring.

If we do see that it is having an unintended effect other than what we had expected, then we will have to make modifications to ensure that it is effective for both the demos and for the rest of the Part D program outside of the demonstrations.

Senator HATCH. Let me just ask you this question. CMS has now approved demonstration proposals from three States, with MOUs signed with Massachusetts, Washington, and Ohio. A big incentive for States to implement these demonstrations is the opportunity for States to share in the savings that come from better care management.

Now, could you walk us through exactly how that financing of shared savings would work, and also how CMS plans to monitor the savings as the demonstrations are really implemented?

Ms. BELLA. Sure. Are you interested in both models? Okay. In the capitated model, what we do is, we look at where we think the savings are by integrating care and coordinating and reducing inefficiencies, and we develop a savings target. That savings target is applied to the amount that each payer would contribute, and so, while you might expect savings to accrue from Medicare maybe in the earlier years, you start to expect savings from Medicare in the later years of the demo.

By putting the savings target available to both payers up front, you create a system where they work together in a way where the timing works together of when you expect to see savings in the program. And so there are no Medicare dollars going to States in this model. Simply, each payer is paying less toward the capitated rate than they would have otherwise.

In the managed fee-for-service model, what we do is, we have a formula that looks at expected Medicare savings. We have a threshold for expected Medicare savings. We look to see if States met that threshold. We look to see what their Medicaid increases were, so we offset any Medicare savings with any increase in Federal Medicaid expenditures, so we make sure we are not creating opportunities to game the trust fund. And then, if quality thresholds are met, States can share in a portion of the savings that accrued to Medicare as a result of the investment the State made in Medicaid.

Senator HATCH. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Bingaman?

Senator BINGAMAN. Thank you very much, and thanks for being here to testify.

Let me ask about this Initiative to Reduce Avoidable Hospitalizations that you have. I am trying to just understand: are there things about being a dual-eligible beneficiary that increase the likelihood that you will be hospitalized even though you do not need to be hospitalized?

Ms. BELLA. I think this is the poster child case for misaligned incentives in the program, when you have Medicare paying for the hospitalization and Medicaid paying for the nursing home stay, and when there is an incentive for someone to have a 3-day stay in a hospital to come back out and receive the higher Medicare rate when they go back into the nursing home. So we do feel that the way the two programs are misaligned does increase the likelihood or increase the incentive for unnecessary transfers between hospital and nursing home settings for Medicare-Medicaid enrollees.

Senator BINGAMAN. Let me understand that a little better. You are saying that there is an incentive to move the patient from the nursing home to the hospital because of higher reimbursement, or the other way around? How does that work?

Ms. BELLA. I should say I am not such a cynic that I think that that is the all-driving force, but I think it is a pretty powerful force. Let us say that there are things in the nursing home that you

would like to think would be taken care of in the nursing home, like pressure ulcers or dehydration or things like that. Oftentimes, people with those conditions are taken to a hospital instead of provided care at the nursing home. When they go into the hospital, if they are in the hospital for 3 days and they come back out and they go back into that nursing home, they get the Medicare rate, which is higher than the Medicaid rate. And so, there is an incentive to see a bit of a churning going on. And what we are trying to do in this initiative is support the use of care management resources on site in the nursing facility that can take care of those problems so people are not going back and forth.

Senator BINGAMAN. So there is an incentive for the people who are running the nursing home to have that patient moved out of the nursing home to the hospital for 3 days in order that, when they come back, they are under the Medicare rate? Is that what you are saying?

Ms. BELLA. Correct.

Senator BINGAMAN. Okay. And what is needed to fix that problem? Is that something we have to study for 6 years before we can fix it? Or is this something that you can fix by saying, this cannot happen anymore?

Ms. BELLA. Let us hope we do not need 6 years. I think this is a start, by seeing how much of it is driven by the fact that we need more care resources on-site in the facilities, and then how much can we do—when can we make changes in payment policies that take away those incentives for this churning that we are seeing? And so, this initiative will offer us an opportunity to do both of those things.

In addition, in our demonstrations, when we make one entity responsible for both sets of dollars, we take away that incentive for that shifting. And so, to the extent that people in nursing homes are participating in these demonstrations that we have been talking about, we should be able to address it that way as well.

Senator BINGAMAN. The concern I have—I represent New Mexico; we are not in your group of States that are participating in the demonstration. So I guess 25 States are, 25 States are not. States like my State that are not, are you still able to assist them in solving a problem like the one we just discussed or not?

Ms. BELLA. Absolutely. Our job is to be a resource for all States. So we have our office; we have something called an Integrated Care Resource Center, which is available to help States share best practices, get in touch with other States, those sorts of things; and we have this State Data Resource Center. All three of those sets of resources are available to all States.

We actually have had conversations with Julie Weinberg, the Medicaid Director in your State, about, even though we are not working together in a demonstration, how can we work to support some of the efforts that New Mexico is trying to advance? So the short answer is "yes," that is a job of this office, and when we learn things—for example, in the Nursing Facility Initiative, especially because this is rapid learning—we are not going to wait 3½ years to know what works or not, we will be pushing that information out, encouraging adoption in other States.

Senator BINGAMAN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Let me ask, when this hypothetical patient goes back to the nursing home and receives the higher Medicare payment, how many days does that patient receive the higher Medicare payment? And what is, on average, the differential in amount?

Ms. BELLA. The differential, I would have to get back to you.

The CHAIRMAN. Rough guess?

Ms. BELLA. A third? Probably a third or more.

The CHAIRMAN. And how many days is that——

Ms. BELLA. One hundred.

The CHAIRMAN. One hundred days extra. A third more for 100 days. That is a problem. Okay.

Next is Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Chairman, I asked for a minute before my 5 minutes begins on Medicaid to discuss the plans of Senator Bingaman, because I think we all respect him so much, and we have been discussing his accomplishments over the last few days. But everybody wants to know what Senator Bingaman is going to do next. [Laughter.]

I think we learned a lot last night because, for those of us who saw him on Colbert last night, this is a man with a future in comedy. [Laughter.]

Because all over America, people are tweeting this morning about where they can get to see Senator Bingaman in action. And I just want to take a minute, because I know everybody is asking about his plans, but I urge you to go to YouTube. It was hilarious. It was truly hilarious. [Laughter.]

So to begin my 5 minutes, if I may——

The CHAIRMAN. I might say, Senator, if you ask Senator Conrad about Senator Bingaman's plans, Senator Conrad will tell you that Senator Bingaman has invited all of us out to his house in Santa Fe when he leaves, and we are all to visit him in Santa Fe.

Senator NELSON. Can he put us all up?

The CHAIRMAN. I think he can. [Laughter.]

Thank you. Go ahead.

Senator WYDEN. Thank you very much, Mr. Chairman.

Ms. Bella, first of all, we want you to know we appreciate your good work, in Oregon especially, because of the transformational waiver that we got where, in effect, we are going to be able to beef up quality at reduced cost. And, as you know, Oregon has really financially committed to that agenda.

That is why I want to examine with you where we are with respect to these demonstrations for the duals, because Oregon has come to the conclusion that it is not financially viable for them to be part of the demonstration, and they note—and they say this specifically—that your technical advisory group that you had for the duals, not one person thought, as part of that technical advisory group, that the system could work for a low-cost State, a State with low fee-for-service reimbursement rates and high Medicare Advantage rates.

So we now have the situation where there is no flexibility for a State like ours where spending is less than the States that are here today, and, in effect, we are going to be put at a disadvantage when calculating the baseline for these demonstrations, the very

States that are the future, the States that are most innovative and most creative, as you see with the application for our Medicare waiver.

My sense is that you very much want to help States like ours, but that there is essentially almost a bias at OMB against these kind of innovative efforts.

What is your thought about how we are going to get around this? Because, if we are in a situation where your own technical advisory group says that the baseline support is not going to work for a low-cost State, and you all to your credit are recognizing that we are in the vanguard, how do we get out of this vise?

Ms. BELLA. We knew when we were developing these models that they would not work for all States, and I think we have discovered that the financing for a low Medicare fee-for-service State such as Oregon is a challenge. And the health plans there look at what they receive today through Medicare Advantage, which is considerably higher than fee-for-service or what they would receive through these demonstrations, and so we understand that.

I think what we need to do—Minnesota finds itself in a similar position. We have been working with Minnesota on some administrative and regulatory efficiencies that do not address the payment issue at this point. Senator Wyden, we are early in learning, I think, and doing this analysis and validating the hypothesis as far as some of the challenges for a State like Oregon. And what I can commit to you is to continue working with the State to make sure that they have opportunities, and certainly opportunities that recognize the potential for quality and cost in that State.

Senator WYDEN. I look forward to that, and I hope we can get this cleared out, because it almost undermines the initial thinking behind the transformational waiver. In other words, Oregon got that waiver, Oregon wanted to build the next step, and to face this kind of discrimination literally for doing a good job and doing a better job, in effect, than the States that got the green light, just does not make any sense.

You referenced a negative impact with respect to policy for the duals when you were here before: the multiple cards for Medicare and Medicaid. Last year, Senator Kirk of Illinois and I introduced the Medicare Common Access Card Act. It is legislation that has been supported by senior groups, by the tech sector. It would upgrade the Medicare card seniors use by employing smart card technology, pretty much like the one that is used by the Department of Defense personnel.

Would you have an opinion on generally the proposition of trying to move in this kind of direction and the fact that this could particularly be of benefit to the duals population, given what you said before?

Ms. BELLA. Certainly, we are interested in ways to use technology to streamline and make systems easier for beneficiaries. I would be happy to go back and learn more about your legislation and then make a comment for the record.

Senator WYDEN. Great. One last question, if I might. You also talked about State access to Medicare data, and I am very much in favor of that. The States are having to jump through hoops to gain access to it. Senator Grassley and I have introduced legisla-

tion that would open up the Medicare database so that the public, free of charge, could have that information, and obviously that would be another way to get it to the States. Wouldn't that be, again, consistent with your philosophy of trying to empower States to use this data?

Ms. BELLA. We certainly are trying to do everything we can to put data and tools into States' hands, making sure we protect the privacy of the beneficiaries.

Senator WYDEN. Very good.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Burr?

Senator BURR. Thank you, Mr. Chairman.

Ms. Bella, welcome. I think you are very familiar with North Carolina's Community Care Program, and for my colleagues, Community Care is a demonstration or a waiver under the Medicaid program now serving 1.3 million North Carolinians in a patient-centered approach that has achieved significant savings over the life of it. And it extends a proven medical home model to dual-eligibles that we are currently in the process of trying to get the approvals for from CMS.

Let me ask you, Ms. Bella, what would disqualify a State from participating in the demonstration program? Is there something out there that is an automatic disqualifier?

Ms. BELLA. There is no automatic disqualifier. I think one of the fundamental things we need to see in these programs is total integration of services. So we need to see that the medical, the behavioral health, the long-term care, the substance use, all of those things, are together. That is a challenge in some States.

Senator BURR. If there is not a disqualifier, is it possible for a State not to be disqualified for a demonstration project but not be approved for a project that they have proposed?

Ms. BELLA. It is certainly possible that all of these 25 States will not be approved. I mean, there are things that—there are reasons why the financing does not work, for example. There are some States that, quite frankly, are not doing the appropriate job engaging stakeholders, and so they do not have any buy-in into what they are doing, and that weighs a lot with us. There are some States that are not fully integrating the set of services. So there are reasons why States would not move forward, but there are no automatic disqualifiers. At least in the States that, where they are today, if they were going to automatically be disqualified, they would have already been disqualified. But we do have something called a set of standards and conditions that we expect all States to meet.

Senator BURR. And North Carolina submitted their plan in May, and I commend CMS. They continue to discuss with North Carolina, negotiate about a way to move forward.

I think I heard you say earlier to my colleague Chuck Grassley that we need to translate what is working, because the needs of a dual-eligible with a disability are similar to the needs of a Medicare beneficiary under the age of 65 with a disability.

Ms. BELLA. I said a Medicaid individual under 65, a Medicaid-only.

Senator BURR. So if North Carolina currently covers the under-65 with a disability under the Community Care, what would be so troublesome on the part of approving a plan that now covers the same population that is over 65?

Ms. BELLA. So the challenge with these State proposals is they take time. This is complex. You know, in North Carolina's case, there are lots of other issues we are working on with North Carolina, and North Carolina was involved with CMS on a 646 demonstration that involved duals, and there had to be discussions about, does that demonstration continue or how does it work with our demonstration?

In North Carolina's case, the biggest difference in taking what they are doing for Medicaid-only today is understanding how the networks and Community Care of North Carolina are going to bring in the Medicare piece, because that has been a difference.

Senator BURR. So let me ask you this. It seems like there is a way for a State like North Carolina—I will not comment on Oregon; I do not know it. You discussed this process that CMS goes through to determine, here is what we would have spent, here is what we think you are going to spend, and, if the differential is great enough, we are willing to try this. There are other conditions, I realize, but strictly from a cost standpoint, why would you not say to a State like North Carolina, "Here is what we are willing to spend for this population. Go ahead and implement your plan. And, if you go over our amount, then you are stuck with the tab. If you save money, we split the savings."

Ms. BELLA. Well, North Carolina has not indicated to us that it wants to go at risk in that way. North Carolina has asked, could it participate in Medicare savings, and so we are going through this process with North Carolina to make sure that the protections to the trust fund, when we are going to make a payment to a State, and the quality mechanisms, are in place.

Senator BURR. Well, I am trying to suggest to you possibly a new line of thought to break through with some of the States that are out there. They have not been disqualified. They have legitimate plans. They have not been approved. You are hearing, from members on both sides of the aisle, the frustration over the cost. And in North Carolina's case, I can only say this—and I think those at CMS would agree: the success of Community Care has not only saved significant amounts of money, it has changed the health outcome of the individuals who are under the plan. It has brought what every member says is the future of health care, and that is a medical home model, to 1.3 million people, and we would like now to expand it to dual-eligibles.

So I would encourage you to maybe throw some new things on the table. Maybe North Carolina will accept a risk-based proposal to do it. If they feel strongly enough in implementing the plan, it is worth a try, but to sit and not do either continues to eat up more money, continues not to achieve the health outcomes that we want, does not implement the medical home model. And I think you hear, in a bipartisan way, we want to move this thing forward. We do not want to do anything that jeopardizes the system. But where we are is not a comfortable place.

Thank you.

Ms. BELLA. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

Ms. Bella, you mentioned the rebalancing in your testimony, and one of the things I am interested in—well first, you know, about this discussion in general, I like to say this is Washington, and people like to regulate. But in Washington, my Washington, we like to innovate. And the innovation that we are doing in health care is not just about savings for us. I mean, we have had to do it over decades, and we have proven that innovation does drive better outcomes and lower costs.

So what we want is, we do not want to be held back because we have had to do it to guarantee care. So I just want my colleagues to know, as challenging as these things might seem to us, it is an ethos now. It is beyond an ethos. We have proven success. We want to move forward, and we hope the rest of the country will do the same, because we are tired of paying for more expensive health care for the rest of the Nation as well and having our system jeopardized by the fact that we get paid less and so people do not want to practice there. But we have still innovated.

Anyway, my point is, the rebalancing that you mentioned to community-based care and the provisions of the Affordable Care Act, we have already shown savings in rebalancing from nursing home care to community-based care. How do you think that rebalancing fits with this concept of the dual-eligibles? How would you integrate those two?

Ms. BELLA. Well, the rebalancing is a critical part of what we are doing here. The point is, the system has an institutional bias, and so what we are trying to do is make sure we kind of take that head-on and promote models that are able to have financial accountability, but also flexibility to provide services to people in settings that are least restrictive and most appropriate and in line with their choices.

Senator CANTWELL. So this would be like you would coordinate with the rebalancing?

Ms. BELLA. Well, if you are talking about the formal programs——

Senator CANTWELL. Yes, the formal programs.

Ms. BELLA [continuing]. And rebalancing incentives and all of the other programs coming out of Medicaid, yes. In any given State, we want to make sure that this is all coordinated and that we are looking at the same types of measures to look at indicators of success and understand that we are measuring dollars the same way as far as what is flowing to the community and what is flowing to institutions. So we are aligned with our colleagues back at CMS who are implementing the other more formal rebalancing programs. It is a goal of these demonstrations, though, and it is a measure that we look at as an outcome measure, to understand how these demonstrations made an impact in terms of home- and community-based services.

Senator CANTWELL. And so, for some place like Washington State that did rebalancing 20 years ago or something like that, we would

be able to better integrate immediately a program on dual eligibility because the rebalancing is already so built into our system.

Ms. BELLA. Correct. And this goes into looking at the State-specific approaches. When we work with MaryAnne and others back in Washington, the opportunity for savings from rebalancing is different in a State like Washington that has been doing it longer than in other States. And so we have to take all of that into account when we develop these models so we understand how we are improving both quality in the rebalancing and the cost perspective.

Senator CANTWELL. Okay. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman.

Ms. Bella, thank you very much for your work. I want to follow up on the comments that have been made about incentives that lead to more expensive care. The point that you raised about the incentive to use hospital care over nursing home care because of the reimbursement structure is certainly troublesome. Over half of the cost of dual-eligibles is in long-term care, so I want to talk a little bit about long-term care.

The incentives for a dual-eligible beneficiary tend to steer them toward nursing home care, when less intensive care may be appropriate and acceptable. Because of the reimbursement structure and their financial capacity, many beneficiaries have no option besides a nursing home. I know of other Medicare-eligible beneficiaries with alternative resources; they will use assisted living or even home care, which is less costly, because they have the ability to do that.

So what can we do within the Medicare and Medicaid systems to provide greater incentives for less intensive services for dual-eligibles? Every time we try to deal with this as a separate issue, CBO scores it as providing more services to the financially challenged, and, therefore, it is scored as a cost rather than a savings. How does this issue fit into your game plan?

Ms. BELLA. That is a great question, and it goes back to what we were talking about with the rebalancing. States have made great strides in terms of providing home- and community-based services—supportive services, assisted living, home care, personal care, respite care—so that more and more people are able to be served in the community. And that is what Medicaid brings to this: the ability to fund those services in a way that Medicare does not. And so you see in the States, over time, the spending for the less costly services in the home and community increasing, while the institutional costs are decreasing because we are transitioning or keeping people out of those facilities.

The incentives are still misaligned, though, in terms of, oftentimes those are not automatic in Medicaid, and you have a certain number of waiver slots which translates into the number of people that can be served, whereas the nursing home is a mandatory benefit. And so we still have some work to do in that regard.

How it factors into these programs is just that it is a fundamental underpinning and expectation that these demonstrations

are going to make a dent in the spending between institutional and home- and community-based care, and we are measuring that, we are monitoring that, and we expect States to commit to certain outcomes where we are going to make those changes in that spending curve.

Senator CARDIN. I would just say you also have a fundamental problem if you start to move toward assisted living, which is how you deal with the directed costs of health care and housing, whereas, in nursing home care, that is not an issue. So it does require a creative approach.

Ms. BELLA. Yes.

Senator CARDIN. Let me raise a related problem. We have a program in Maryland called HouseCalls, which is run by XLHealth. It is not part of a demonstration project. HouseCalls sends nurses to the homes of patients with chronic conditions soon after their discharge from a hospital or nursing facility, so that they can ensure compliance with discharge instructions and identify any issues that might lead to readmission. HouseCalls has been able to successfully reduce the readmission rate for their patients. In the under-65 private health plans, insurers are providing a similar benefit, because they know they can reduce hospital readmissions by giving better services to those who are vulnerable after being discharged.

The difficulty again here is scoring. If these services are not part of a capitated plan or a demonstration project, how can we offer incentives to provide that level of care, which we know will reduce the number of readmissions, but which the Congressional Budget Office will not score as savings when we try to do it? Do you have any suggestions as to how we can implement that type of policy other than as part of a specific demonstration project?

Ms. BELLA. That is a very good question. I think we are increasingly finding opportunities to do things like that, that do not score in non-capitated environments, through some of the Accountable Care Organizations, through the bundled payments, and through other mechanisms.

An array of the Center for Medicare and Medicaid Innovation (Innovation Center) initiatives—Independence at Home, Comprehensive Primary Care, Multi-Payer Advanced Primary Care, and many others—will help us build the evidence base to determine whether such models are effective at lowering costs and improving care. The Innovation Center commitment to rapid-cycle evaluation is unprecedented and provides CMS a new opportunity to share results with Congress and others, allowing them to make evidence-informed decisions about the health and long-term care changes that are critical to improving outcomes while lowering costs. As evidence from these models becomes available, CMS is happy to work with you and your staff on your policy proposals.

Senator CARDIN. I know there is interest in Maryland in moving forward on that. We have a good track record with the under-65 population showing that savings can be achieved. And I would appreciate further discussion on this to figure out creative ways that we can advance these ideas.

Thank you.

Ms. BELLA. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman.

Welcome, Ms. Bella. It is great to see you. Thank you for your service and thanks for being here with us today.

Senator Hatch, earlier in the hearing you mentioned to the chairman your interest in maybe bringing the Secretary of the Treasury to talk with us a little bit about the fiscal cliff.

Senator HATCH. It would be great if we could.

Senator CARPER. I think one of the things that most of us know in this room is that whatever agreement is struck by the President and the Speaker—my hope is that they will reach an agreement—it is going to involve trying to find ways to get better health care results for less money or better health care results for the same amount of money. And the other half of the bargain is going to be to figure out how to raise some revenues and at the same time do it in a way that fosters economic growth.

This hearing—and this program—is really a poster child for better health care results for less money and answering the question, can we actually get better health care results for less money or the same amount of money? I think the answer is "yes." And to the extent that we can do it in this particular program, we help the States. As an old Governor, I can tell you the States are getting killed on Medicaid costs. It is just sucking away money from K–12. It is sucking away money from post-secondary education, and we have to find ways to stem that loss.

We operate under two imperatives—well, more than two, but at least two that I want to focus on. One of those is a moral imperative, and the moral imperative is to look out for the least of these. And the relevant description, in the Book of Matthew, the least of these it refers to is, you know, "When I was hungry, when I was sick, when I was thirsty, when I was naked, or imprisoned, did you visit me?" Well, the Bible does not say anything about duals, the dual-eligibles being the least of these, but they are, and we have a moral imperative to look out for them.

At the same time, even if the President and the Speaker strike a deal and we are able to come in with legislation to back it up next year, we are still going to have huge budget deficits. Huge budget deficits. And everything that we do in the Federal Government, whether it is health care, whether it is transportation, it is defense, it is education, it is housing, virtually everything we do, we are going to have to look at it through that prism. How do we get better results for less money or the same amount of money?

As I put on my old hat—and former Governor Rockefeller wore this hat at one time—we know that the States are the laboratories of democracy. You have 50 States, and I used to say to my own cabinet when I was Governor, some State somewhere, whatever problem we are wrestling with, some State somewhere has figured out how to solve this problem. And the challenge for us in Delaware was to find out who solved it, and to find out how they solved it, and is that solution transferable, replicable, exportable back to my State and to other States?

We actually created within the National Governors Association a mechanism called the Center for Best Practices. It is a clearinghouse for good ideas. And if, say, Utah has an idea on this or some

other subject that actually works for you, well, we could find out about it. We could find out who to contact in Utah, learning about it, is it replicable, is it exportable, and so forth.

That is a great incentive for States. States compete with one another in a very fruitful way. But one of the ways we compete is for jobs, and we want to grow jobs and economic opportunities in my State. One of the key factors for job growth, and companies wanting to be located in States, is health care costs. It is other things. It is regulations, it is taxes, it is all kinds of things. But it is inclusive. Quality health care outcomes for less money. So there is a great competition for States. As States are trying to balance their budgets, compete for jobs, and so forth, there are all kinds of market forces that are really encouraging States to look for better results and to be our partner.

Here is my first question. That was a long preamble. My first question is, what are we doing or what are we not doing that can help us actually foster more participation, more successful participation, in these programs? How can we be a better partner in the legislative branch? Please start with that.

Ms. BELLA. Well for us, you have done the greatest service by creating this office and by giving us the opportunity to try to dabble in many different areas—program alignment, data and analytics, and models and demonstrations—and to just give us this opportunity to continue to inform you along the way as the work progresses and as we learn things that we think might be worthy of permanent change.

Senator CARPER. We had a hearing in the Homeland Security and Governmental Affairs Committee about a year ago. We had the Medicaid Directors from several States in, and one of the questions we asked of them was: In Medicare, we are doing a pretty good job, a better job every year, of going out in recovery audit contracting, and monies that are mis-paid, mistaken payments and so forth in Medicare, we are going out and recovering them and returning that money to the Medicare program. We are doing almost nothing in Medicaid. And we asked a question of the Medicaid Directors: Why is that? The guy from New York who runs the Medicaid program there came back and said, "Well, you only gave us like 60 days to go out and recover the money, and that is really not enough time. We need more time." I said, "How much? Six months? What do you need?" He said, "A year." So that is what we did. Guess what? They are starting to recover money for the Medicaid programs. Half of it comes back to the Federal Government, half of it comes back to the State governments. That is the kind of thing I am looking for. That is the kind of thing that I am looking for, and whether you have ideas here or not, that is what we need.

The other thing I wanted to say is, where is the nexus between what we are doing here with the PACE program and what we are doing here with the duals? What is the nexus with the federally qualified community health programs? How do they intersect? And how are we making sure that we are maximizing utility from both, the contribution from both?

Ms. BELLA. Well certainly, the Federally Qualified Health Centers are important parts of the safety net system and the delivery system in States. Some States rely more heavily on them than oth-

ers, and so, as we develop these models and these demonstrations with States, the FQHCs will have a different role to play in each of them, but we expect that they are a vital part of the delivery system for States in putting together these demonstrations.

Senator CARPER. I would urge you to think about that some more beyond this, and my hope is your staff here will be thinking about that.

The other thing is, in Delaware, federally qualified community health centers are all using electronic health records. They have the ability to go back and forth with our acute-care hospitals for the most part, and to better coordinate the delivery of health care. I just want to make sure that we are taking every advantage of those kinds of opportunities.

And lastly, Albert Einstein, Mr. Chairman, used to say, "In adversity lies opportunity." There is a huge amount of adversity here, a lot of churning here, trying to figure out how do we work with this new law, how do we work with the States and coordinate with the providers and so forth, but there is great opportunity here. There is great opportunity. We have to seize the day, which we say in Latin, "Carpe diem," but which we say in Delaware, "Carper diem." [Laughter.]

The CHAIRMAN. Every day is "Carper diem" in Delaware, as well as in this committee and in the Senate.

I think Senator Rockefeller would like to ask a couple more questions.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Ms. Bella, I think what, sort of generally, I am worried about is that MedPAC, for example, wrote a letter in July, stating, "Even if the Commission agrees with CMS's stated guidelines, there is no assurance that the final structure of the demonstration within any given State will be fully consistent with CMS's guidelines."

I care a lot about CMS's guidelines. I want to make sure that they are enforced, and that gets into the question, you know, in North Carolina and other States we can save a lot of money if we do this or if we do that. That is not the primary role at the beginning as demonstration projects are evaluated.

Then you have sort of transparency here, you know. CMS has to be the model that sets the standards that every State or parts of States or demonstration variations reach.

Now, you have large numbers of people enrolled in certain States, and then you said, well, we have this third-party group that comes in and sort of evaluates what they are doing. But that does not tell me that CMS is putting out or laying down what the standards have to be before States start doing these experimentations and demonstration projects. I mean, I really think that is important. And then MedPAC does, too, and I have a lot of respect for them.

Let me just give you an example. Maria is going to be furious at me. Lock-ins, consumer protections—fifty-eight percent of duals have cognitive impairments. Now, this is the question of people making the decision whether they are going to be a part of it or not. Numerous duals face language barriers, do not understand. They have low literacy rates, or they are blind. And yet only nine

States plan to provide access to independent advocates to make decisions, help people make decisions and navigate changes.

Now, again, everything comes back to CMS guidelines, meeting that standard. That is what, you know, the Secretary says, and that is what the deal is.

In Texas, people are writing all kinds of responses, which are being totally ignored by Texas, and I think by CMS, because Texas is kind of staying away from all of that.

One of the things that is going on in Washington, as I understand it—and with all due respect to one of the great, great States of America—is a lock-in plan. Not true? Okay. Well then, can you further take me to the fact that there will not be, either at the beginning of the process or at the end of the process, a lock-in plan involved in this whole process?

Ms. BELLA. There is no lock-in in these demonstrations. States may propose them. CMS has said, and will continue to say, there will be no lock-in to this demonstration. People can opt out of the demonstration, or change a plan in the demonstration, monthly. Just like dual-eligibles have that opportunity to do so today.

And to your point on—I just want to assure you CMS has guidelines, and we have put those guidelines out. We have further memorialized them in the MOU. They cover Medicare——

Senator ROCKEFELLER. How do you do that?

Ms. BELLA. The MOU is pretty clear on what our guidelines are. What we have not been able to talk about today is, we have a readiness review process that is very rigorous. I would be happy to share it with you. It is 73 pages of things that plans have to do to prove to us they are ready. That gets into network adequacy and provider accessibility. It gets into call centers to make sure that they can address all the folks you were just talking about. In addition, the readiness review happens before plans can accept enrollment. But we do not stop there. We have implementation monitoring. So there are milestones that have to be met before the next round of beneficiaries goes into demonstration plans. This is not like Part D where everybody goes in one day and the whole population is in. We phase it in because we want to be careful and deliberate about it. We want to make sure these milestones are hit.

Then we have ongoing implementation monitoring, where the State and CMS share this role, but it is a very rigorous process. The combined demonstration that we have here is much more rigorous than what we have independently today for these dual-eligibles where no one is helping coordinate or navigate their care. And to the extent that this provides you any comfort, I mean, States are expected to provide new resources. Those come in the forms of independent enrollment brokers—independent choice counselors. We are supporting, CMS is supporting, funding for State Children's Health Insurance Programs and Aging and Disability Resource Centers to help beneficiaries. States are expected to use ombudsman. As you see in Ohio, it is very specific about the role of an ombudsman for this program and then all of the other resources that exist. But these programs will not succeed if we are not effective at reaching beneficiaries, and so I can assure you CMS has standards, and we have expectations, and I am not sure what

number of States you were referencing there, but expect to see all of these demonstrations contain those important provisions.

Senator ROCKEFELLER. Okay. Well, my time is up. I will follow up with a series of questions with you, and we can talk and all the rest of it. You know, 9.4 million dual-eligibles, the most complicated subject in health care, and then the assumption that States are just going to kind of do the great job they have, or have all kinds of creative ideas, you know—Medicaid has worked pretty well, but this is an example where the Federal Government has to lay down standards. And you are doing that, but I just worry, with this enormous proliferation of populations and then breakdowns of demonstrations within populations, that these standards will not be met. And it is not, how much will they cost? What will have to be done to this program will be much more expensive than what goes on today. But that is okay to know that at the beginning, because then we have to make adjustments to that. But guidelines, quality guidelines, have to be the commanding principle. That is all I am saying.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you, Senator.

I just found this interesting. We had an earlier discussion about the differential between Medicare reimbursement and Medicaid reimbursement for patients in nursing homes. The data I have is from MedPAC. On a per day basis, Medicare pays between $427 and $395 a day to nursing home patients. Medicaid pays—the national average is $160. So it is about 2½ times difference between the two.

Okay. Now I will call the second panel. Thank you, Ms. Bella, very, very much. I really appreciate that.

Senator ROCKEFELLER. And you did not answer my "all Medicare" question—that was my first question.

The CHAIRMAN. She will for the record. Thank you.

[The information appears in the appendix on p. 63.]

The CHAIRMAN. Okay. I would like to call up the next panel, and I would like to introduce them as they come up to the table, asking each to restrict his or her statement to 3 minutes to enable us to ask questions—for the panelists to speak, for members of the committee to ask questions—because I think there is a vote scheduled at 12 o'clock.

The second panel includes: Tom Betlach, the Director of the Arizona Health Care Cost Containment System; MaryAnne Lindeblad, Director of the Washington State Health Care Authority; and John McCarthy, Director of the Ohio Department of Job and Family Services, Office of Health Plans.

Senator Cantwell, I believe you want to make an introduction.

Senator CANTWELL. I will go quickly, Mr. Chairman, because I know we want to get to those questions. I just want to introduce and thank Ms. MaryAnne Lindeblad for being here today from Washington State. As many of you know, this dual-eligible issue and innovation I think go hand in hand, and Washington is a State with Microsoft and Boeing, and we always think a lot about innovation, but we also have Group Health and the Everett Clinic. And Ms. Lindeblad, who is Director of the Washington State Health Care Authority, has many years of experience and a master's in

public health from the University of Washington, and she has had time in her career at DSHS in our State, and, in her current role, she has served as Assistant Secretary for the Aging and Disability Administration in the Department of Social and Health Services.

So I am just thrilled that she is here today to add to this discussion with her many years of experience. I thank her for her chairmanship of the current Medicaid Managed Care Technical Advisory Group and the Executive Committee for the National Academy of State Health Policy and Long-Term Care. And I would just add 98118 is the most diverse zip code in all of the United States, and that is Washington State. So when it comes to this issue of language and it comes to the communication issue, I guarantee you, we are on top of it. We have to be.

Thank you. Thank you, Mr. Chairman. And again, thank you, Ms. Lindeblad, for traveling here to testify.

The CHAIRMAN. Yes, thank you, Senator, very much.

Okay. Mr. Betlach, you are first.

STATEMENT OF THOMAS J. BETLACH, DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, PHOENIX, AZ

Mr. BETLACH. Thank you, Mr. Chairman, members of the 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. Arizona has maintained a system of managed care for its entire membership, including dual-eligible members, since joining Medicaid in 1982. Arizona also offers the unique perspective of a State that has one-third, or 40,000, of its dual-eligibles in their Medicaid health plan for both Medicare and Medicaid.

Thirty years of experience have shown it is precisely our frailest members who are most in need of the care coordination managed care offers. Medicare managed care for dual-eligible members is not an experiment but, rather, a documented success. In Arizona, 82 percent of our elderly and physically disabled population that is at the risk of institutionalization is dually-eligible. The model of care for this population in many States is nursing home placement. Over the past decade, Access and its health plans have progressed from 40 percent of its members in the home or community to 73 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-one ranking by United Cerebral Palsy.

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

Recently, Avalere Health compared national data for duals enrolled in traditional Medicare fee-for-service to dual-eligibles served by Access Health Plan for both Medicare and Medicaid. Aligned Access duals exhibited a 31-percent lower rate of hospitalization, a 43-percent lower rate of days spent in a hospital, 9-percent lower emergency room use, and 21-percent lower readmission rates.

Alignment works. Equally important, Arizona has proven passive enrollment works. When Medicare Part D was created, Arizona en-

couraged its Medicaid plans to become Medicare Advantage Special Needs Plans. In 2006, approximately 39,000 members were passively enrolled in their Medicaid plan to provide better continuity of care for Part D implementation. Arizona's strong transition planning and protocols successfully ensured member protections with minimal disruption during this process.

Given our documented success in improving the delivery system for dual-eligibles, Arizona enthusiastically participated in the dual demonstration initiative. After extensive stakeholder engagement, Arizona submitted a proposal that sought to increase dual alignment from 40,000 to 100,000 beneficiaries on January 1, 2014. I applaud the passionate and consistent leadership Melanie Bella has provided to bring about change. Despite her efforts, the process has moved slowly.

The current system is indefensible and unsustainable. We should not wait any longer to build upon a proven model. One of the significant concerns we have is what happens when we are successful 3 years from now. Forty-seven years ago, Congress designed a system of care that required low-income elderly and disabled Americans to receive their health care from two distinct massive and complicated systems. The result is what one would expect: a fragmented, complicated, bureaucratic delivery system with higher costs, poorer outcomes, and no single point of accountability.

As we rapidly approach the golden anniversary for Medicaid and Medicare, it is time for Congress to act in partnership with the States to develop a new system that will eliminate fragmentation and confusion while better meeting the needs of dual-eligible members and their families.

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

[The prepared statement of Mr. Betlach appears in the appendix.]

Senator ROCKEFELLER [presiding]. Please, go ahead.

STATEMENT OF MARYANNE LINDEBLAD, DIRECTOR, WASHINGTON STATE HEALTH CARE AUTHORITY, OLYMPIA, WA

Ms. LINDEBLAD. Thank you. Chairman Baucus, committee members, and distinguished guests, it is my great pleasure and distinct honor to report on Washington State's HealthPathWashington, which is a forward-looking Medicare-Medicaid initiative aimed at integrating primary and acute care, behavioral health, and long-term care services and supports. It is a more cost-effective structure that will save Medicaid dollars, but its real purpose is to improve care and the overall health status of our clients.

The initial strategy will begin in April next year with newly developed and community-based health homes for up to 30,000 of the State's highest-need dual-eligibles. While the dual-eligibles only account for 13 percent of our State's Medicaid caseload, they account for 30 percent of our costs, so this is a priority project on several levels, including the need to provide more effective care for this population. Many, if not most, experience significant challenges caused by disability, mental illness and/or chemical dependence, which complicate delivery and payment mechanisms.

Today, Washington is already moving forward to implement HealthPathWashington's multi-pronged approach to improve beneficiary experience in accessing care, promote person-centered health action planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right care at the right time and place, reduce health disparities, improve transition among care settings, and achieve cost savings for the State and Federal Government through improvements in health and functional outcomes.

By using two financial models, our first strategy will focus on incorporating high-risk dual-eligibles into health homes as part of a managed fee-for-service financial demonstration.

The second strategy, which is still being negotiated with CMS and with counties that are going to take a leadership role, will offer dual-eligibles a fully capitated combined Medicare-Medicaid managed care benefit. Both strategies will rely on a predictive modeling system called PRISM. It stands for Predictive Risk Intelligence System. PRISM is a system developed by our State to sift health care data and assign risk scores that identify those clients in need of chronic care management and timely interventions that will provide more effective care.

Stakeholders have been invited to participate in our program through a number of methods. We have included them in a variety of ways—interviews, forums, presentations, focus groups, webinars—and have asked them to submit written comment on our draft design plan and to continue to comment.

Of particular importance to all was the preservation of consumer choice and development of adequate consumer protections. For example, while both of the State's strategies rely on passive enrollment, they also support optional disenrollment at any time. We will continue to work with stakeholders and other interested and impacted parties as the work on the project now moves from the design phase to the implementation and planning phase. Materials for outreach, education, and training will be developed and shared with our HealthPathWashington advisory team, a group of 35 members representing advocates, providers, health plans, and beneficiaries that continues to meet regularly to assist with the implementation of this financial demonstration.

Concern about duals is not new. Since Governor Gregoire chaired the National Governors Association, the NGA has included, as part of its standing health policy, language in support of State-Federal coordination with respect to duals. As recently as this month, members of the NGA Executive Committee met with President Obama and Vice President Biden at the White House and raised the importance of working together on dual-eligibles.

In a nutshell, the problem that duals face traces back to the fact that almost all care and payment for Medicare and Medicaid beneficiaries are handled through separate systems and financial models. Services are fragmented, care is not well-coordinated, and there exists a lack of accountability to make sure that healthy outcomes are measured or achieved and that individuals receive the right care at the right time and place.

HealthPathWashington targets these concerns and provides realistic solutions—a better-planned, better-coordinated, cost-effective

system that will provide a healthier dual-eligible population, significant cost savings, and an improved care structure.

Thank you.

[The prepared statement of Ms. Lindeblad appears in the appendix.]

Senator ROCKEFELLER. I thank you.

Mr. McCarthy?

STATEMENT OF JOHN B. McCARTHY, DIRECTOR, OHIO DEPARTMENT OF JOB AND FAMILY SERVICES, OFFICE OF HEALTH PLANS, COLUMBUS, OH

Mr. MCCARTHY. Chairman Baucus and members of the committee, thank you for the invitation to discuss Ohio's ongoing effort to create and implement an Integrated Care Delivery System for Medicare and Medicaid enrollees.

My name is John McCarthy, and I oversee the Office of Medical Assistance as Medicaid Director for the State of Ohio. An office within the Ohio Department of Job and Family Services, OMA is currently in the process of becoming our State's first cabinet-level Medicaid agency—a move aimed at bringing comprehensive reform and quality improvement to Ohio's health care landscape. Better care planning and coordination for Medicaid's dual-eligible population is central to this work.

Approximately 182,000 Ohioans are covered by both Medicare and Medicaid. However, the absence of any significant degree of coordination in the delivery of benefits between the two programs has contributed to a diminished quality of care. Frankly, the current system is confusing and difficult to navigate, and no single entity is accountable for the whole person. Additionally, despite substantial investments, Ohio's long-term care services and supports remain in the third quartile of States, and such spending will prove unsustainable with the rapid aging of Ohio's population. This has led to the fact that individuals enrolled in both programs make up 14 percent of Ohio's Medicaid enrollment, but they account for 34 percent of all expenditures. Clearly a "hot spot" in the discussion involving care quality and cost containment, the time has come to improve coverage for individuals enrolled in both Medicare and Medicaid.

In its efforts, Ohio is hoping to achieve the following: one central point of contact for enrollees, person-centered care that is maintained seamlessly across services and settings of care, and a system that is easy to navigate for both enrollees and providers.

Of course, in order for any initiative of this kind to prove effective, it must place the individual first. That is why we have made every effort to emphasize the need for real person-centered care that moves seamlessly across services and care settings alike.

A series of enrollee protections have also been included to ensure that high standards for care are maintained on a consistent basis. With at least two plans in all regions, beneficiaries will have the power to choose what avenue of care best fits their needs. Eligible individuals also reserve the ability to opt out of the Medicare portion of the initiative if they so choose. ICDS plan member advisory groups will also be established and a unified grievance and appeal process will be implemented in order to further assure individuals

that their needs and concerns are being heard. Finally, strong safeguards will be put into action to ensure quality management and proper oversight over all aspects of this initiative.

However, the number-one protection for individuals in the program is that they are guaranteed continuity of care for 1 year with all providers, except for assisted living and nursing facility providers, where they are guaranteed 3 years. Providers have also been protected from rate reductions from the Medicaid rates for those same periods.

The power of choice for beneficiaries is a common theme throughout the proposal, and that is no different in the enrollment stage. Individuals will have opportunities to make choices during the process, such as consulting over the phone with an enrollment contractor, during regional education and enrollment forums, or through one-on-one in-person enrollment counseling.

It is important to note that Ohio has engaged with stakeholders and advocates throughout the design and development phases of this demonstration project. In order to ensure success and maintain a truly collaborative process, we will continue to reach out to providers, advocates, and individuals throughout the implementation and operational phases of this project.

Thank you again.

[The prepared statement of Mr. McCarthy appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, all of you, for being here and for the work that you do on the real front lines, called "the rest of America."

I am not going to deviate from my previous line of questioning because I am not satisfied with the responses that I got, so I am going to try it out on you all. And it is this business of lock-in. People can get locked in without having it a rule because they passively become a part of it simply because they qualify or they meet certain criteria. But they do not know because—you know, I mentioned they do not speak English or they are blind or have different impairments. They do not really know what this is all about, even dual-eligibles. I probably could give a rather short statement about what it actually means to them. And I brought up Senator Cantwell's Washington, and I said there are lock-ins in there, and I was pushed back strongly on that.

But I am not sure that I am wrong, because, if people are passively included simply because they meet certain criteria, that does not mean that they are there because they want to be there or that they have the chance to opt out either at the beginning of the program, which would be less likely for those who have some of the disabilities that I referred to, or as the demonstration developed more in its work with CMS.

Can you talk with me about how you work as States with CMS on the question of guidelines and on questions like lock-in/lock-out passive enrollment? How do you do that? Anybody?

Ms. LINDEBLAD. I would be happy to answer what Washington is doing, and I think it is unique in its own right. So, one of the things that we have done with the program that we are starting in April next year is that, while individuals are passively enrolled—and we use that term—there has to be a face-to-face inter-

action with that individual before they are really officially enrolled. So, when we talk about these health homes, a health home coordinator needs to meet with the individual, develop their health action plan. So that first step, that is a cooperative development between the individual and the care coordinator. They set their individual health care goals during that assessment. And at that point, that assessment is billed for, and that is when the person is truly enrolled.

So, until they have that face-to-face, until they have a better understanding of the program—and if someone has limited English speaking, there will be interpreters there. We will help them through that. But they will have that face-to-face with an individual whom we are hoping will have had some connection with the client, even in the past.

So, when we do this passive enrollment and assign a person to a care-coordinating entity, that care-coordinating entity will have history on that individual, will know which community of resources that individual is already accessing, and try to link them with a care coordinator who is part of that. So for us, it is really important that the member is engaged in that decision about whether they want to be in the program or not.

Senator ROCKEFELLER. But you do have interpreters available?

Ms. LINDEBLAD. Absolutely. We have a very strong——

Senator ROCKEFELLER. And you do have people, maybe they do not need interpreters, but they are confused about the program, and you have people available.

Ms. LINDEBLAD. People to help them.

Senator ROCKEFELLER. That is my point, you see? And Senator Cantwell—and we tease about this, but Washington is a superior State. You always have been.

Ms. LINDEBLAD. We think so.

Senator ROCKEFELLER. You are. [Laughter.]

I mean, you have services, you are innovative, you are ahead. Oregon is the same way. In many ways, Minnesota and Wisconsin are very advanced in their thinking, et cetera. But most States are not. All States are going to face huge budget cuts, because we are facing them here, and that will be passed on down to you, and maybe some of those interpreters will disappear—not because you want them to, but because you do not have the money to pay them. And that is where we are doing demonstrations and trying to pick out what works best.

And then I further asked, if you have a big population in one demonstration, how is it that, within that population, you pick out a variety of approaches and then treat each of those as something that you can hold up to CMS standards but then hold back to CMS for approval?

Ms. LINDEBLAD. And just let me clarify that too. We do not think that we will have more than 50 percent of our duals population actually enrolled in one of the programs. So, with this first initiative that we are starting in April of 2013, we hope up to 30,000 individuals will enroll in that out of 115,000; and then with the second, probably, again, at most maybe 20,000 additional. So we are not looking at even more than half the population of the dual-eligibles being enrolled. We are going to be taking a very targeted approach.

Senator ROCKEFELLER. Okay. In my final few seconds, could you help me understand how you pick out an approach for this group and a different approach for that group in a demonstration as a way of finding how to make the dual-eligible coordination work best? How do you do that? I mean, 20,000 is a lot of people; 600,000 is a lot of people.

Ms. LINDEBLAD. Well, again, in Washington, what we are doing is looking at two different models, as I mentioned, and so looking at one that is——

Senator ROCKEFELLER. Models that you have come up with yourself?

Ms. LINDEBLAD. That we have developed, right. One is more of a fee-for-service health home model; the other model will be through fully integrated managed care. So we have something to compare and look to.

Mr. BETLACH. In Arizona, we are also developing different models based upon the population, so we will have a different model for individuals who are at risk of institutionalization who require home- and community-based services and long-term care support services. We will have a different approach in terms of the model of how we want to deal with members who have serious mental illness in terms of how we want to approach that population. So we are obviously looking at the fact that this is not a homogeneous group of individuals, and we need to target the development of our delivery system based upon the needs of that population.

Senator ROCKEFELLER. And my final interruption. How are you made aware of and how do you use, if they have been sent to you, the standards that CMS insists on?

Mr. BETLACH. Well, in terms of Arizona, we have not gotten to the level of specificity for the memorandum of understanding to see how that fits within our overall structure. But in terms of having some preliminary conversations, they understand the model and approach that we want to use with the different populations that we are serving.

Senator ROCKEFELLER. So a verbal back-and-forth.

Mr. BETLACH. So far. We just had the initial conversations around the MOU. I mean, we are a 2014 State. We are not as far along as Washington and Ohio.

Mr. MCCARTHY. In Ohio, we have been working with them on all of the measurements going back and forth, and they proposed some measurements. We actually proposed more than they had given to us. And we have been working very collaboratively between the two to set up what is it we are going to be measuring along the way for health outcomes, nursing home diversion, and other areas. Right now it is over 40 measures that we are going to be measuring as we move through the program.

Senator ROCKEFELLER. Okay. My time is way more than up. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman, and thank you for your line of questioning. I know you really are trying to be a guardian for the less fortunate here, and I think one of my most memorable Senate moments will be, you know, your 3 a.m. speech before the health care committee on the passing of that legislation about exactly how these policies do affect individuals. So I take

your line of questioning as welcoming, because I think we certainly understand the challenge. And there are challenges. I mean, Washington would be the first to admit it.

Ms. Lindeblad, when we talk about communication to this population, we get that it is a challenge, right?

Ms. LINDEBLAD. It is.

Senator CANTWELL. I mean, are we talking about 72 different languages in our State? Or is it more than 72?

Ms. LINDEBLAD. It is something like that, and what we do is, we will be targeting the top 10 or 12 where most of the population is and then bring in interpreters as needed for other languages, but making sure that all materials are translated into the top languages, and then assisting folks if it is a very unusual or rare language, absolutely.

Senator CANTWELL. But when we say communication, we get that this is—it is huge for us.

Ms. LINDEBLAD. It is.

Senator CANTWELL. It is. As I said, we are the most diverse zip code in the entire country, and some of these school districts have already struggled with it when it comes to the delivery system. But isn't the point here that right now, for the Medicaid population, they are not being managed in the sense of you basically get, as you were saying, a medical home or a caregiver to take a Medicaid enrollee who could be a youth who is, you know, on SSI and not doing a very good job of managing their own care? I guarantee you they are probably not. And all of a sudden, now they have an advocate. Is that——

Ms. LINDEBLAD. That is absolutely true. And, when you think about the diversity of the population, not just in language but in a variety of other ways in terms of what their health care needs are in the system, you are right, now they will have an advocate, someone who can help them navigate through often a very complicated, difficult system.

Senator CANTWELL. So I would say that, currently, they are being bumbled around. They do not have anybody. They are knocking their heads against the wall many times on this.

Mr. Betlach, you mentioned that Arizona saved $300 million in your switch to community-based care, going from 40 percent of your community-based care to 73 percent.

Mr. BETLACH. For the elderly and physically disabled, that is correct, Senator.

Senator CANTWELL. Which is great. You know, we wish all States would move toward that rebalancing. But you were mentioning that to think that Medicare alone could be the sole answer for these dual-eligibles, you basically think that is wrong, because there is no way, dealing with this Medicaid population, particularly as it relates to community-based care——

Mr. BETLACH. It is not a Medicare skill set in terms of, it is something that the States have developed through their Medicaid programs for home- and community-based placement and support. Behavioral health is similar, where especially members with serious mental illness, that is more a Medicaid skill set in terms of knowing what is needed for community supports, and also providing an array of other services for individuals.

Senator CANTWELL. Thank you.

So I think, Mr. Chairman, that these questions are the right questions. You are right: some States are further ahead, but I think we should ask them about how to guarantee those safeguards. But I think this is one of our biggest challenges, but also biggest opportunities to deliver better care and to be more cost-effective in how we deliver it. So I hope that we will build in whatever safeguards we need to build in, and I think you are right: build them in. But even in our rebalancing proposal that was part of the health care law, I think now, what are we, up to like 8 or 9 States that have now said, okay, we want to try to do rebalancing, and some of them I never would have predicted. So the good news is that we have models that we can follow, and we can keep pushing the envelope in various stages here. So I thank the chair.

The CHAIRMAN. Thank you, Senator.

Senator Carper, I understand you have another question.

Senator CARPER. I do. And has the vote started? I think the vote may have started.

The CHAIRMAN. It has started.

Senator CARPER. Okay. First of all, Mr. McCarthy, where do you live?

Mr. MCCARTHY. I live in Dublin, OH.

Senator CARPER. Okay. Are there any Ohio State fans around there?

Mr. MCCARTHY. I am surrounded by them. [Laughter.]

Senator CARPER. Do they have any idea you are from Indiana undergraduate and graduate school?

Mr. MCCARTHY. Yes, they know that, and I have had numerous discussions with the Governor about that. [Laughter.] The State of Indiana has three number-one college teams as of today.

Senator CARPER. That is great. All right. I will not get into why Montana—we are 1–AA in Delaware, and we lose to teams like Eastern Washington University, which I never heard of until 2 years ago. And I am not sure—this is a team that plays on a red football field, and they managed to win a national championship. I do not get it. They beat Montana; they beat us. It is not fair.

Okay. Let me talk about greater—first of all, thanks a lot for being here, and thank you for being some of the laboratories for democracy. As an old Buckeye myself, we are delighted that you are here.

Greater care coordination and care managers, or at least patient navigators, are important folks, as we know, in the patient-centered medical homes and Accountable Care Organizations. And let me just ask how you are working in your own States to integrate your innovative programs for duals with medical homes and with the Accountable Care Organizations. Can you all take a shot at that?

Mr. MCCARTHY. Sure. In Ohio, we took the path of going down the road of patient-centered medical homes for individuals with severe and persistent mental illness first because, actually, what we were concerned about as we were bringing up medical homes for people with chronic conditions, what we saw was individuals' practices were looking at how to get the behavioral health providers

into the acute-care providers' offices to provide services. But, as we know, looking through our data, that is not where a person with behavioral health issues goes for services, because, when you look at it, if a person has serious and persistent mental illness and a chronic condition, they are not getting the services.

So what we did in Ohio is, we brought up behavioral health health homes first, where the behavioral health providers are actually out front and they are bringing the acute-care providers into their offices. We have incorporated that model into our proposal that we have put forward, because we know many of the individuals whom we are going to be serving—I know we have talked about the elderly, but many of them have behavioral health issues. And so that is an integral part of our project.

Senator CARPER. Okay, good. Please?

Ms. LINDEBLAD. And certainly for Washington, our first model is absolutely predicated on the use of health homes, medical homes, and we have experience in some pilots that we have done over the last few years, both on the behavioral health side and on disabled, under-65 disabled, where we have had great successes using a health home model in terms of not only bending the cost curve, but I think, interestingly enough, finding statistically significant differences in the mortality of the individuals whom we served in those programs.

Mr. BETLACH. It is a must in Arizona as well. You know, we——

Senator CARPER. Sorry. State that again?

Mr. BETLACH. It is a must in Arizona as well. We mandate it from our health plans in terms of the structure to work with, not only a primary care physician, but also to be a critical tool in terms of providing information back to those providers. So the managed care system is really doing the most in terms of leveraging care coordination and care management, particularly for the populations like the high-cost behavioral health population as well as specifically the long-term care population. So it is a must in terms of our structure and our delivery system.

Senator CARPER. Okay. Thanks.

How do you all plan to ensure that your demonstration programs will include the most high-risk and high-cost duals in your States? That is my first question.

The second half of that would be: would it be beneficial to your respective programs to have the option of including coordinated care models such as the PACE programs for your duals?

Mr. BETLACH. Well, in Arizona, we leverage managed care, so we do not have the PACE model in Arizona. And just to give a comparison, I think the PACE numbers nationally are about 25,000 members. In Arizona, we have 40,000 alone who are aligned in terms of getting both their Medicare and their Medicaid from the Medicaid plan. So, just to give you some idea of the scope of that. And, obviously, by having that alignment, the plans have all the data on who their high-cost members are. Because you have that information, you can see who is using the emergency department too much; you can see who has. And it was in my data in terms of where you can stem the readmissions in the hospital.

So we all talked about fragmentation, and clearly, by having that single point of accountability, you really then can leverage the

managed care organization to drive better outcomes for the member.

Senator CARPER. All right.

Ms. LINDEBLAD. And I think in Washington, when I talked about the PRISM system, that is a predictive——

Senator CARPER. About the prison system?

Ms. LINDEBLAD. PRISM system.

Senator CARPER. Okay.

Ms. LINDEBLAD. Not prison. PRISM. [Laughter.]

The PRISM system. That is actually a tool, a predictive modeling tool, that we have developed in Washington that will help us focus—and we actually will be managing those highest-cost individuals or those individuals whom we are predicting will be 50-percent higher cost using this model. And we have used this model for a number of years in various settings, and the care management strategy is predicated on identifying individuals, so absolutely, they will be the highest-cost, highest-need individuals to be served in our program.

Senator CARPER. Okay. Last word, Mr. McCarthy?

Mr. MCCARTHY. And in Ohio, we actually left the PACE program outside of our proposal because, as Senator Rockefeller was talking about, it gives a person—you can opt out of our duals proposal into the PACE program, and so it is another way to do an evaluation of what is going on. We have two PACE programs in Ohio currently, one in the Cleveland area and one in the Cincinnati area.

Senator CARPER. Okay, thanks.

Mr. Chairman, this was great. Thanks.

The CHAIRMAN. It was a very good hearing, and I thank all of you so much. You traveled distances and suffered inconvenience to get here, even temporarily no lights, but thank you very much for your participation. And I thank the Senators too. There are about 4 minutes left on the vote.

The hearing is adjourned. Thank you.

[Whereupon, at 12:12 p.m., the committee was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Ways to Improve Care for "Dually-Eligible" Beneficiaries

President Harry Truman once said, "Difficulties are a challenge to men of determination."

On July 30, 1965, President Lyndon Johnson signed monumental legislation creating both Medicare and Medicaid. At long last, the United States had met the challenge of guaranteeing health insurance to elderly and low-income Americans. The bill-signing ceremony took place in Independence, Missouri. The first Medicare card was given to the nation's first beneficiary, the 81 year-old former President, Harry S. Truman.

Nearly 50 years later, Medicare and Medicaid continue to provide vital health services to more than 100 million Americans. Nine million of these individuals are part of a subgroup enrolled in both Medicare and Medicaid. These dually-eligible beneficiaries, called "duals," present unique challenges that were hard to imagine back in 1965.

These folks eligible for both Medicare and Medicaid are often thought of as one single group. They are not. People who become eligible for both Medicare and Medicaid do so for many different reasons. A low-income individual who just turned 65 may qualify. A 26-year-old with a disability may be considered dually-eligible. An 80-year-old who needs long term care could qualify.

All pose very unique, individual challenges. These challenges are often complicated because Medicare and Medicaid do not always work well together.

Some rules are written by the states; others by the federal government. Acute care is paid for by Medicare. Long term care is paid for by Medicaid.

Incentives become misaligned, there's too much red tape across both programs, and these vulnerable Americans are lost in the middle. As a result, some of these folks receive poor health care, and we have the data that proves this.

Half have three or more chronic conditions. More than half have a mental impairment. As a consequence of their poorer health status, dually-eligible beneficiaries are more than twice as likely as other beneficiaries to die during any given year.

The government also spends disproportionately high amounts on this population. While 18 percent of Medicare beneficiaries are dually-eligible, they account for 31 percent of Medicare spending. Fifteen percent of Medicaid beneficiaries are duals, but they account for 39 percent of total Medicaid spending. Last year, states and the federal government spent nearly $300 billion on care for people who qualify for both Medicare and Medicaid.

The non-partisan Congressional Budget Office tells us that 40 percent of the long term growth in federal health care programs is due to the growth in health care costs. But 60 percent can be linked to the aging of population. In fact, 10,000 Americans will turn 65 each day over the next two decades.

We cannot stop the aging of America, but we can work to lower health care costs.

Streamlining Medicare and Medicaid so they work better together will pay dividends. It will improve the health of vulnerable Americans, and increasing efficiency will also save the federal government money.

How are we going to increase efficiency? First, we need to rework our payment models so providers, states and the federal government have incentives to work towards the same goal. We need to remove incentives for providers to game the system. Everyone should be rewarded for lower costs as well as held accountable for poor or unnecessary care.

Second, we need to coordinate care so that doctors, hospitals and other providers are working together as a team. Dually-eligible folks often have multiple chronic diseases, requiring multiple doctors. If providers don't communicate, they can deliver unnecessary care. This leads to increased costs and can harm patients.

Third, we need to get rid of conflicting rules and cut red tape in the areas where Medicare and Medicaid interact. For instance, when a dual needs a wheelchair, Medicare and Medicaid have two very different rules. These rules are complicated and at times delay needed care.

Accomplishing these goals will go a long way in improving care and saving money.

Our witnesses are here today to discuss efforts to streamline these two programs. Last year, Melanie Bella, the director of the office at CMS responsible for dually-eligible beneficiaries, testified before the Finance Committee. She outlined CMS's plans for a demonstration project where states would test new ways to provide health care to duals.

Today, the Committee looks forward to an update on these efforts from Director Bella and three states participating in the demonstration project: Washington, Arizona and Ohio. As these demonstrations move forward, we need to keep in mind three key principles.

One, the focus can't be on cost cutting alone. We must focus on streamlining Medicare and Medicaid in a smart way to improve how care is delivered. If we do this right, duals will be healthier and the programs will save money.

Two, we must maintain or strengthen the protections beneficiaries enjoy today. Let me repeat that: We must maintain or strengthen the protections beneficiaries enjoy today.

Three, we need to rigorously evaluate the projects to learn what worked and what didn't.

So let us focus on these principles. Let us streamline these programs and improve care for these vulnerable Americans. And as President Truman advised, if we act with determination, these difficulties will only be challenges to solve.

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STATEMENT OF

MELANIE BELLA

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

ON

"IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: A PROGRESS UPDATE"

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON FINANCE

DECEMBER 13, 2012

U.S. Senate Committee on Finance

"Improving Care for Dually-Eligible Beneficiaries: A Progress Update"

December 13, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to continue our discussion about 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), commonly referred to as "dual eligibles." I appreciate your ongoing interest in the work of the CMS Medicare-Medicaid Coordination Office to provide high quality, coordinated care for Medicare-Medicaid enrollees.

I am pleased to report that CMS continues to make progress in our efforts to create a more streamlined system that delivers appropriate, quality, cost-effective care. The Medicare-Medicaid Coordination Office has been working on a variety of initiatives to meet its mandate and to further partner with States and other stakeholders to improve access, coordination, and cost of care for Medicare-Medicaid enrollees. Since I last appeared before this Committee on September 21, 2011, CMS has announced agreements with States to test new models to better align the Medicare and Medicaid programs and undertaken numerous initiatives to further its work to improve care coordination and quality of care for Medicare-Medicaid enrollees, including providing new tools to gain a better understanding of the population, increasing access to Medicare data, and partnering with organizations to reduce avoidable hospitalizations.

Background

The Medicare and Medicaid programs were originally established in 1965 as separate programs with different purposes. Medicare provides health insurance for qualified individuals over the age 65 and people with disabilities. Medicaid provides coverage for low-income families including children, pregnant women, parents, seniors and people with disabilities. While Medicare and Medicaid are separate programs, a growing number of people depend on both programs for their care, creating a greater need for both programs to work together. 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. In many cases, they are among the poorest and sickest people covered by either program.[2] 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 payers and providers, resulting in cost-shifting, unnecessary spending and an inefficient system of care.

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

A major focus of our work is to improve beneficiaries' experience with both the Medicare and Medicaid programs. To that end, 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 with these organizations on a regular basis, CMS partnered with California, New Mexico, New York, Oregon, Pennsylvania, and Wisconsin to conduct beneficiary focus groups to assess and increase understanding of the beneficiary experience and needs in both programs. As we work to better coordinate services and improve beneficiary health outcomes, CMS will continue to work with these organizations and other stakeholders to ensure the beneficiary perspective is always informing every aspect of our work.

Financial Alignment Initiative

In July 2011, CMS launched the Financial Alignment Initiative to more effectively integrate the Medicare and Medicaid programs to improve the quality and costs of care, as well as the overall

[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.

beneficiary experience. Through this Initiative, CMS offers States the opportunity to test two models to align payment and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. 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 under which a State and CMS will enter into an agreement by which the State would invest in care coordination and be eligible to benefit from savings resulting from such initiatives that improve quality and costs. Both models are designed to help beneficiaries by improving health care delivery, encouraging high-quality, efficient care and better streamlining services and achieving State and Federal health care savings.

All approved Demonstrations will include critical beneficiary protections that will ensure high-quality care is delivered. In addition, for the prescription drug benefit, approved Demonstrations will be required to meet all Medicare Part D requirements regarding beneficiary protections, protected classes, and network adequacy. No participating States will be permitted to alter Demonstration standards in a manner that is less beneficiary-friendly or reduces access.

CMS recognizes the diversity of States in serving the Medicare-Medicaid enrollee population, and the Demonstrations afford an opportunity to test better coordination of services in a multitude of settings. Since the Committee's previous hearing on this issue, CMS has announced agreements with the first States to test models to improve health care for Medicare-Medicaid enrollees. CMS is partnering with Massachusetts[3] to provide care under the capitated model and with the State of Washington[4] under the managed-fee-for-service payment model. CMS continues to work with 23 other States[5] that have submitted proposals.

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[3] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

[4] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMEFSMOU.pdf

[5] At the time this testimony was submitted, both Washington and Massachusetts have approved Demonstration agreements. CMS continues to work with the following States on their coordinated care approaches: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin.

To support these Demonstrations, on August 23, 2012,[6] CMS announced a new funding opportunity for participating States to provide support through Aging and Disability Resource Centers (ADRC) and State Health Insurance Assistance Program (SHIP) infrastructure for direct person-centered counseling and State information-sharing over a three-year period. This opportunity is being jointly coordinated by CMS and the Administration for Community Living.

Massachusetts – Capitated Medicare-Medicaid Demonstration

On August 23, 2012, Secretary Sebelius announced that Massachusetts is the first State to partner with CMS in this Demonstration to test the capitated model and provide Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. Massachusetts and CMS will contract with Integrated Care Organizations (ICOs) to oversee and be accountable for the delivery of Medicare, Medicaid, and expanded services, such as dental care, vision and durable medical equipment, as well as behavioral health services and community supports, for participating Medicare-Medicaid enrollees aged 21 to 64. The new program is scheduled to launch in 2013, and will help provide 110,000 Medicare-Medicaid enrollees with access to these expanded services. In addition, all ICOs will include Medicare-Medicaid enrollee participation in their governance structure.

Medicare-Medicaid enrollees participating in the new demonstration will have the ability to shape and direct their care through a person-centered model built around their needs and preferences. Care will be delivered through teams that include a primary care provider, care coordinator, independent long-term services and supports coordinator, and other care providers at the discretion of each beneficiary. The beneficiary and his/her team will develop, implement and maintain individualized care plans. Medicare-Medicaid enrollees will have access to the new and enhanced services previously described to promote alternatives to long-term institutional services.

Washington State – Managed FFS Medicare-Medicaid Demonstration

On October 25, 2012, CMS announced that the State of Washington would become the first State partner to test the Managed FFS Demonstration model, building on its planned Medicaid Health

[6] http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4437&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

homes to provide better coordinated care and enhanced services for Medicare-Medicaid enrollees with chronic health conditions or a serious and persistent mental health condition. More than 20,000 Medicare-Medicaid enrollees in Washington will be eligible to receive improved care through integrated service delivery across primary, acute, prescription drugs, behavioral health and long-term services and supports. Washington will be eligible to receive a performance payment depending on its performance on beneficiary experience, quality and savings criteria.

Leveraging its innovative predictive risk model,[7] Washington will be able to identify Medicare-Medicaid enrollees' health care needs and target those with chronic conditions or serious and persistent mental health conditions. Medicare-Medicaid enrollees will be able to shape and direct their care with access to a care coordinator, working with a multidisciplinary care team, who is responsible for their overall care coordination and comprehensive care management. Enrollees will be free to choose whether to receive these new services, and will continue to have access to the same Medicare and Medicaid benefits.

Open and Transparent Development of Proposals for the Financial Alignment Initiative

CMS is fully committed to an open and transparent process for these 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 website for a subsequent 30-day public comment period in order to solicit stakeholder feedback. CMS continues to accept and discuss public comments on the development of these Demonstrations proposals. All Memoranda of Understanding and Final Demonstration Agreements will be made public and CMS will continue to engage with the public on this work.[8]

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[7]Washington's modeling system is calledPredictive Risk Intelligence System (PRISM). More information is available here: http://www.agingwashington.org/docs/strategic-planning/PRISM-Explained.pdf

[8] Massachusetts: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

Evaluation of the Demonstrations

CMS is funding and managing the evaluation of each approved Demonstration. CMS has contracted with an external independent evaluator, RTI International, to measure, monitor, and evaluate the overall impact of the demonstrations, including impacts on Medicare-Medicaid enrollees, expenditures and service utilization. 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. The MOUs for Massachusetts and Washington provide examples of the types of areas that will be measured in all Demonstrations, including beneficiary experience of care, care coordination, care transitions, support of community living, access to services, and the caregiver experience, among many others. The evaluations in Washington and Massachusetts will also use comparison groups to identify and analyze the impact of the Demonstrations.

In addition, in the capitated model, a CMS-State contract management team will ensure access, quality, program integrity, and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking quick corrective action when necessary. 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.

Initiative to Reduce Preventable Hospitalization among Nursing Facility Residents

On March 15, 2012, the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation announced the *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*. Through this initiative, CMS is partnering with seven organizations[9]

Washington: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf

[9]For a full list of the selected participants in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, please go to: http://www.innovations.cms.gov/Files/fact-sheet/rahnfr-factsheet.pdf

to implement strategies to reduce avoidable hospitalizations for Medicare-Medicaid enrollees who are long-stay residents of nursing facilities.

These avoidable hospitalizations can be disruptive, dangerous and costly. Research shows that nearly 45 percent of hospitalizations among Medicare-Medicaid enrollees in nursing facilities are potentially avoidable, meaning they could have been prevented with adequate monitoring and treatment in the nursing facility setting.[10]

The initiative directly supports CMS' ongoing work to reduce avoidable hospitalizations for Medicare-Medicaid enrollees. The goals of this initiative are to:

- Reduce the number of and frequency of avoidable hospital admissions and readmissions;
- Improve beneficiary health outcomes;
- Provide better transition of care for beneficiaries between inpatient hospitals and nursing facilities; and
- Promote better care at lower costs while preserving access to beneficiary care and providers.

On September 27, 2012 CMS announced the seven selected organizations, including two universities, hospital networks, and other professional organizations, to participate in the program. The selected organizations are partnering with CMS to implement evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a 4-year period. In addition, each organization is required to partner with a minimum of 15 Medicare-Medicaid certified nursing facilities in the same State where the intervention will be implemented. Nursing facility participation is voluntary.

The initiative did not prescribe a specific clinical model for these interventions. However, all interventions must:

- Improve beneficiary safety by better coordinating management of prescription drugs
- Bring onsite staff to collaborate and coordinate with existing providers, including residents' primary care providers and the staff of the nursing facility.

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[10]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.

- Demonstrate a strong evidence base for the proposed intervention and potential for replication and sustainability in other communities and institutions across the country.
- Supplement (rather than replace) existing care provided by nursing facility staff.
- Allow for participation by nursing facility residents without any need for residents or their families to change providers or enroll in a health plan. Residents will be able to opt-out from participating, if they choose.

As an example, one selected organization, HealthInsight of Nevada, will use tools to assess beneficiaries' risk levels to assign each beneficiary the appropriate level of enhanced care and attention in order to reduce acute care transfers. It expects to implement an intervention in 25 nursing facilities across the State. Another organization, the Alabama Quality Assurance Foundation, will implement an intervention in 23 facilities by supplementing the facilities' staff with registered nurses who will train staff on managing workplace demands and increasing awareness of residents' status and needs. Upon implementation, we estimate the awarded interventions will initially reach more than 17,000 beneficiaries over the four years of the initiative. As with the Financial Alignment Initiative, CMS has contracted with an external independent evaluator to measure and evaluate the overall impact of this demonstration on the quality of care received by Medicare-Medicaid beneficiaries and the costs to the two programs.

Fostering a Better Understanding of Medicare-Medicaid Enrollees

In the last year, CMS has undertaken numerous efforts to improve access to and the quality of data that exists to support better care for Medicare-Medicaid enrollees. A lack of such data has been a long-standing barrier to care coordination.

New Tools to Support Better Research to Understand Medicare-Medicaid Enrollees

The Chronic Condition Data Warehouse (CCW) is a research database designed to make Medicare, Medicaid, Assessment, and Part D Prescription Drug Event data readily available to support research designed to improve the quality of care and reduce costs and utilization. Traditionally, researchers and both Federal and State governments use the CCW to understand beneficiaries' utilization, demographics, spending and other key factors to support a more efficient delivery of services.

This November, CMS made available new diagnostic conditions flags[11] (coding used to identify characteristics/demographics) to represent those conditions prevalent among Medicare-Medicaid enrollees. These diagnostic condition flags facilitate and streamline research on beneficiary conditions and allow for a more targeted use of resources.

Historically, conditions focused on prevalent characteristics in the Medicare-only, over-65 population. With the newly released condition flags, both State and Federal policymakers will be able to focus efforts on mental health conditions more prevalent among Medicare-Medicaid enrollees, as well as better understand the population with intellectual and developmental disabilities. For example, bipolar disorder and schizophrenia are newly added condition flags that can now be used to better understand this population and take into account the full beneficiary experience.

Integrated Medicare-Medicaid Data Set

In addition, CMS developed a new Medicare-Medicaid integrated data set.[12] This data set supports all States by providing preliminary tools to determine and understand new opportunities for care coordination, including information on eligibility, enrollment, beneficiary conditions, service use and expenditures for both the Medicare and Medicaid programs. The data set will better assist researchers, as well as Federal and State policymakers, to identify regions, populations or necessary interventions to improve the quality of care for Medicare-Medicaid enrollees.

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[11] These new condition flags are: 1) Attention deficit, hyperactivity, and conduct disorders, 2) Anxiety disorders, 3) Bipolar disorder, 4) Type 1 major depression and Type 2 depressive disorders,5) Personality disorders, 6) Post-traumatic stress disorders, 7) Schizophrenia 8) Schizophrenia and other psychotic disorders, and 9) Tobacco use disorders. http://www.ccwdata.org/chronic-conditions/index.htm#NewAlgos

[12] The Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) http://www.ccwdata.org/data-dictionaries/index.htm#linkedfiles.

Medicare-Medicaid Enrollee State Profiles

As part of these improved data efforts, CMS released Medicare-Medicaid Enrollee State Profiles (State Profiles).[13] CMS hopes these State Profiles will help provide policymakers, researchers, and other interested parties with yet another opportunity 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. The national summary provides a composite sketch of the population 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.

Medicare Data to States to Support Care Coordination

State access to Medicare data facilitates more informed policy and program decisions for Medicare-Medicaid enrollees.

To that end, CMS established a process for States 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.[14] To date, 28 States have received or are in the process of actively seeking Medicare Parts A and B data,[15] and 24 States are in the same position regarding Medicare Part D data.[16] Other States continue to request access and are working with CMS to receive data use agreements.

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

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

[15] As of November 20, 2012, these States are Arkansas, California, Colorado, Connecticut, Indiana, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Maine, Michigan, Minnesota, Missouri, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.

[16] As of November 20, 2012, these States are Arizona, California, Connecticut, Massachusetts, Maine, Michigan, Missouri, North Carolina, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.

Supplementing this work, this month, CMS has made available the State Data Resource Center (SDRC) to provide more tools to support data use. This Center furthers work from the Integrated Care Resource Center (ICRC), and expands resources and efforts to guide States in their use of the Medicare data. The SDRC is open to all States and will further support States in their development of coordinated care initiatives.

The Integrated Care Resource Center

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 meet States' 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.[17]

Conclusion

The Medicare-Medicaid Coordination Office has been diligently working to improve the beneficiary experience with the Medicare and Medicaid programs as well as the partnership with States and other stakeholders to improve the quality, coordination, and cost-effectiveness of care for this vulnerable population. These initiatives have been designed to enhance care coordination and advance person-centered care programs, focus on increased access to needed beneficiary services, promote keeping individuals in their homes 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 is a part of this effort, CMS is also working to improve and enhance existing care programs that serve this population. A major part

[17] http://www.integratedcareresourcecenter.com/

of this effort is supporting and developing a better understanding of the Medicare-Medicaid enrollee population and the current programs that serve them. In doing so, CMS seeks to improve care for Medicare-Medicaid enrollees by providing Congress, States, and other policymakers with more robust information about the beneficiary experience, quality, and spending. We are committed to continuing to work with Congress, States, advocates, and other key stakeholders in furtherance of this needed work.

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

United States Senate Committee on Finance
Public Hearing
"Improving Care for Dually-Eligible Beneficiaries: A Progress Update"
December 13, 2012

Questions Submitted for the Record for Melanie Bella

Senator Max Baucus

Scope of Demonstrations

Duals are a highly vulnerable group with complex medical needs and high costs. Stakeholders are concerned the demonstration is too large. Most states have proposed to enroll all or the majority of their duals in the demonstrations. If all of these state proposals are approved, approximately three million of the nine million duals will be enrolled in the demonstration, but CMS is aiming to limit enrollment to two million duals.

Many of the states that originally submitted demonstration proposals to your office planned to enroll all or most of the duals in their state in the project. This raises concerns that the demonstrations are too large to really be demonstrations.

1. **How many states will start their demonstrations in 2013? How many duals will be included in the demonstration?**

Answer: CMS and States are proceeding at a measured pace for each State, and implementing safeguards that will ensure the demonstrations protect and enhance beneficiaries' access to high quality care. To date, CMS has approved demonstrations in three States, including capitated models in Massachusetts and Ohio and the managed fee-for-service model in Washington. The earliest enrollment for any capitated Demonstration model is expected in July of 2013 in Massachusetts.

The actual number of states with demonstrations that would begin serving beneficiaries in 2013, and the total eligible populations within those States, is dependent on CMS review and approval of Demonstration proposals.

In addition to the three States that have already been approved for a Demonstration, there are 20 States with Demonstration proposals before CMS for review. Two of these States are primarily interested in testing better alignment for beneficiaries in capitated programs, but without pursuing any increases in enrollment relative to existing programs in those States. Of the remaining 18 States, three (CA, IL, WI) are pursuing capitated demonstrations in 2013 and six (NC, NY, CO, MO, OK, CT) are seeking to implement the managed fee-for-service models in 2013.

In our experience to date, the start dates for each Demonstration have moved later than originally proposed to be responsive to public feedback and allow sufficient time for preparation, outreach, and education.

2. **How many states will start their demonstrations in 2014? How many duals will be included in the demonstration?**

Answer: Following from our discussion above, 10 states are proposing to start a Demonstration in 2014. In addition, Washington and New York are pursuing both a capitated and managed fee-for-service model, and will be pursuing the capitated model in 2014 and managed fee-for-service model in 2013. As above, the actual number of states that move forward is subject to CMS review and approval. CMS has committed to a cap of 2 million beneficiaries in the Demonstrations. We believe this is a reasonable limit to balance concerns with size and the ability to test models across the nation in different delivery systems, States, and target populations.

3. **How can we ensure that the demonstrations are truly testing different models and not creating a whole new way of doing business?**

Answer: To better serve people who are dually eligible for Medicare and Medicaid, we need to develop and test delivery system changes that improve the quality and coordination of care. The Demonstrations recognize the diversity across the States in serving the Medicare-Medicaid enrollee population, and afford an opportunity to test better coordination of services in a multitude of settings. The Demonstrations have been established to test different models, consistent with the parameters and conditions set forth in the Affordable Care Act and incorporate the strongest aspects from both Medicare and Medicaid to best meet the needs of Medicare-Medicaid enrollees, their caregivers, and providers. To that end, each Demonstration Memorandum of Understanding (MOU) sets clear end dates and procedures for termination or phase-out, should the demonstration fall short of stated objectives. Additionally, CMS has established a rapid-cycle evaluation process for all Demonstrations and has contracted with an independent evaluator to measure, monitor, and evaluate the overall impact of the demonstrations.

<u>Savings from Managed Care</u>

Most of the states that submitted proposals to participate in the demonstration will rely on managed care plans to coordinate care for duals. Under a managed care arrangement, Medicaid and Medicare would pay managed care plans one combined payment each month to provide medical services to duals. The managed care plan is responsible for negotiating with and paying the individual providers in its network. There is uncertainty as to whether savings to the federal and state governments will be achieved by this approach. If savings are achieved, there is further uncertainty if these savings will be a result of actual care coordination and greater efficiency or if managed care plans would simply cut provider payments. Savings from greater coordination and efficiency is the goal, but it's unclear how we will know the source of the savings.

4. **When evaluating demonstrations that use managed care, can you be certain savings will be achieved through increased efficiency and care coordination rather than simple cuts to provider payments?**

Answer: Improving the quality of care for beneficiaries is the highest priority of these demonstrations. Demonstrations are designed to improve the quality of care while maintaining access to benefits and ensuring robust provider networks. Demonstration plans will undergo a rigorous review to determine provider networks are sufficient to the needs of Medicare-Medicaid enrollees using the strongest of either Medicare or Medicaid standards; we believe such robust networks will only be achievable with payment of adequate provider rates.

CMS' monitoring and evaluation efforts will be able to assess the effects of the integrated financing and delivery model versus rate changes through multiple mechanisms:

- CMS will collect encounter data from the plans to assess changes in utilization patterns over time.
- Our evaluator will conduct key informant interviews with State staff and stakeholders, site visits to health plans, and case studies to further understand the interventions in each Demonstration, including gains made through efficiencies and care coordination.

Auto Enrollment/Opt-out

Almost all of the states participating in the demonstration proposed to auto-enroll dually-eligible beneficiaries into managed care plans, with an option for beneficiaries to then opt-out of the managed care plan if they choose. This means dually-eligible beneficiaries are identified and then randomly assigned to a managed care plan. After this enrollment occurs, beneficiaries would have a limited time period to dis-enroll from the assigned plan. Beneficiary advocates and some Democrats are very concerned this policy tramples on beneficiaries' rights and protections. They argue that duals' access to their doctors will be limited and confusion among duals will occur. Staff believes these concerns may be legitimate, but testing auto-enrollment/opt-out to determine its effectiveness is warranted through this demo.

5. **How will the auto-enrollment work from a beneficiary's perspective?**

Answer: Beneficiaries in States pursuing the capitated model will be notified at least 60 days prior to potential enrollment to select a new integrated health plan under the Demonstration and of their ability to choose not to participate. Beneficiaries who do not make an active choice will be enrolled in a health plan.. Medicare-Medicaid enrollees will retain the same rights they have under Medicare Part D and Medicare Advantage programs to disenroll at any time from the Demonstration and exercise their choice to enroll in original Medicare with a Prescription Drug Plan or a Medicare Advantage plan not participating in the Demonstration.

6. **What protections are you putting into place to ensure duals' rights are not trampled?**

Answer: The Demonstrations will incorporate the most robust beneficiary protections from Medicare and Medicaid and will integrate and enhance the current protections to create a more accessible, seamless system of care for Medicare-Medicaid enrollees. Continuity of care provisions will ensure beneficiaries have access to their existing doctors and other providers for a specified period of time while they transition into demonstration plans, and Demonstration enrollees will retain all Medicare Part D beneficiary protections.

In addition, beneficiaries will receive clear, understandable notices that have been reviewed by advocacy organizations and field tested with beneficiaries. Outreach and education will proceed through multiple channels at multiple points in time and will take into account the prevalence of cognitive impairments and mental illness in this population as well as the incidence of limited English proficiency. Independent resources, such as choice counselors and enrollment brokers, will assist beneficiaries in making enrollment choices. We will also leverage existing resources, such as State Health Insurance Programs and Aging and Disability Resource Centers, to provide one-on-one counseling on enrollment options. Special training for 1-800-Medicare operators will enable them to effectively assist beneficiaries.

Evaluation Process

A major goal of the demonstration projects is to evaluate what works and what doesn't work when caring for duals. CMS has stated that every demonstration program will be evaluated on the program's ability to improve quality and reduce costs. An important part of analyzing a program's success is comparing two similarly situated groups – one that received the new intervention and one that did not. However, there may not be sufficient number of duals in each state to serve as a comparison group during the evaluation of the demonstrations, especially if most or all beneficiaries in a state are enrolled in demonstrations. Additionally, CMS must evaluate on an ongoing basis and must impartially assess what policies are not viable.

7. **How will CMS evaluate whether demonstration projects are working?**

Answer: CMS is funding and managing the evaluation of each approved Demonstration. CMS has contracted with an external independent evaluator, RTI International, to measure, monitor, and evaluate the overall impact of the Demonstrations, including impacts on Medicare-Medicaid enrollees, expenditures, and service utilization. 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. The evaluation will use a mixed methods approach to capture and analyze quantitative and qualitative information.

The Memorandums of Understanding for Massachusetts, Ohio, and Washington provide examples of the types of areas that will be measured in all Demonstrations, including beneficiary experience of care, care transitions, support of community living, access to services, and shifts in service utilization patterns, among many others. Additional quality measures, as well as qualitative evaluation components such as beneficiary focus groups and key informant interviews, will be included in the State-specific evaluation plans. CMS will apply Medicare Part D requirements regarding oversight, monitoring, and program integrity to Demonstration plans in the same way they are currently applied for Medicare Part D for sponsors.

8. **Will you have a comparison group of duals who are not participating in the demo?**

Answer: The evaluation contractor will compare pre- and post-demonstration changes in outcomes of interest for the demonstration group with pre- and post-demonstration changes in a comparison group. The approach to comparison group identification will be State-specific; all comparison groups will be comprised of Medicare-Medicaid enrollees not participating in the Demonstration.

The evaluation contractor will draw a comparison group of Medicare-Medicaid enrollees from statistically similar regions of the Demonstration State, or from one or more comparison States. Where comparison States are used, the evaluation contractor will use cluster analysis to identify the potential comparison States that are most similar to the Demonstration State.

9. **Will the evaluation process be on-going?**

Answer: Yes. The Center for Medicare and Medicaid Innovation has assembled the Rapid-cycle Evaluation Group to ensure that evaluations of CMS Demonstrations and models are designed to rapidly assess program effectiveness and evaluate the impact on the outcomes, quality, and cost of care. The Financial Alignment Demonstration evaluation will involve ongoing reporting and analysis throughout the Demonstration period, as well as a final impact analysis that will be performed at its conclusion.

10. **How will CMS determine if the demonstrations are succeeding or failing and what will CMS do in either event?**

Answer: The evaluation process described in the responses above, plus a wide array of day-to-day monitoring mechanisms, will inform CMS' determination on the success or failure of each demonstration.

Under Section 3021 of the Affordable Care Act, the Secretary of Health and Human Services may expand the scope and duration of the testing of a model if she finds that a model reduces spending without reducing the quality of care, or improves the quality of care without increasing spending, and would not deny or limit the coverage or provision of benefits. The chief actuary of CMS must certify that such expansion would reduce (or not increase) net program spending. Additionally, the Affordable Care Act requires that the Secretary terminate or modify any demonstration failing to meet those objectives.

In addition, each approved Demonstration MOU specifies terms under which CMS and the State may extend or terminate the Demonstration if they are succeeding or failing. For examples, please see: Ohio MOU, page 16 available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf; and Washington MOU, page 24 available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf.

Rural Challenges

About 30% of duals live in rural areas. One model for the demonstration gives states the option of a capitated payment model, where the state, the federal government and a managed care plan enter into a three-way contract to provide benefits to duals. Managed care and other care coordination models may not be available in rural areas. For example, in Montana, there is not a comprehensive network of Medicaid managed care plans. Therefore, proposals that would require duals to enroll in Medicaid managed care would not work in Montana. Proposals to improve care for duals should keep the challenges that rural areas present in mind.

11. **What do we need to keep in mind to make sure the needs of rural dually-eligible beneficiaries are also met?**

Answer: In September 2011 and August 2012, staff from the Medicare-Medicaid Coordination Office participated in rural health listening sessions on issues related to dual eligibility. The session highlighted several important themes to keep in mind, including:

- Supporting the informal caregivers who play a critical role in helping people maintain their independence in the community
- Recognizing the challenges of travelling long distances to see providers, and considering alternatives such as telemedicine;
- Exploring current flexibilities within current integrated, person-centered care programs, to better serve Medicare-Medicaid enrollees in rural communities; and
- Engaging with rural providers to better understand capacity issues related to specialty and HCBS providers in providing coordinated care for beneficiaries.

12. **Should we look for delivery models other than managed care in rural areas?**

Answer: The managed fee-for-service financial alignment Demonstration model is designed to promote greater coordination of care in fee-for-service environments. Fee-for-service financing is especially prevalent in rural areas. Our first approved managed fee-for-service Demonstration model is in Washington State and it includes the rural areas of the state.

Takeaways from the Demonstration

CMS announced the financial alignment demonstration in July 2011. States that are participating will begin in either 2013 or 2014. These demonstrations are set to

run for three years. CMS's stated goals of the demonstration are to improve the quality of care and the overall beneficiary experience and to reduce costs. Some have raised concerns that this demonstration will continue after the initial three years at the request of states and managed care plans.

13. What should we be watching as the demos progress?

Answer: CMS will have formal internal and external evaluation and oversight mechanisms in place that will capture critical information for CMS, Congress, and other stakeholders to be watching as the Demonstrations' progress.

Key objectives of the Demonstration are to improve the beneficiary experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination. In addition to these key objectives, we should also be looking for changes in the State-Federal dynamic – from one where each payor is trying to cost shift to the other to one where the programs are aligned in a manner that is most beneficiary friendly and programmatically efficient. Additionally, we should be looking at the way advocates, providers, and other interested stakeholders feel they are able to interact with CMS and the States, with the expectation being that the demonstrations are transparent and there are multiple and meaningful mechanisms for obtaining ongoing stakeholder (including beneficiary) input.

14. At the conclusion of these demonstrations, what do you hope to learn? How will you help Congress make policy for duals?

Answer: At the conclusion of the Demonstrations, CMS hopes to learn many new things that will help increase access to person-centered, seamless care programs for Medicare-Medicaid enrollees such as:

- How and what it takes to improve the beneficiary's care experience with the Medicare and Medicaid programs;
- Effective methods of communication with beneficiaries to increase their awareness of and satisfaction with the programs;
- Through the capitated Demonstration model, test the hypothesis that holding one entity accountable – from a delivery and payment perspective – leads to better beneficiary experience and improved outcomes, and a better understanding of the elements that contribute to such a testing;
- In the Managed fee-for-service model, test the hypothesis that aligning the incentives between Medicare and Medicaid so that Medicare-Medicaid beneficiaries - who have traditionally been excluded from care management programs - receive coordinated care that leads to a better beneficiary experience and improved outcomes, and determine which elements contribute to such a testing; and
- In both models, further our understanding about how to apply different care models to different subpopulations depending on their needs and determining how best to scale.

This list is not exhaustive, and as the Demonstration progresses, there will likely be new things that develop that we will want to learn more from during its course.

The Medicare-Medicaid Coordination Office will work with Congress as it learns from the Demonstrations, as well as with the efforts outside the Demonstrations to better align the incentives across the two programs. As promising practices are identified, the Medicare-Medicaid Coordination Office will be in a better position to assess possible approaches for improved integration of the Medicare and Medicaid programs.

Nursing Home

Avoidable hospitalizations are disruptive, dangerous and costly. Approximately, 45 percent of hospitalizations of duals are potentially avoidable with adequate monitoring and treatment by nursing facilities. CMS is partnering with seven organizations to implement strategies to reduce avoidable hospitalization for beneficiaries who are long-stay residents of nursing facilities.

15. When does the nursing home program begin?

Answer: The *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents* will begin serving Medicare-Medicaid enrollees in February of 2013.

16. What impact do you expect it will have on improving care for duals and reducing unnecessary costs?

Answer: The *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents* is testing evidence-based interventions that reduce avoidable hospitalizations and improve beneficiary care. The goals of this Initiative are to: (1) reduce the number of and frequency of avoidable hospital admissions and readmissions; (2) improve beneficiary health outcomes; (3) provide better transition of care for beneficiaries between inpatient hospitals and nursing facilities; and (4) promote better care at lower costs while preserving access to beneficiary care and providers. CMS expects that all seven of the partnering organizations will improve quality and safety, and generate savings achieved from a reduction in the number of avoidable hospitalizations.

Senator Orrin G. Hatch

Shared Savings

CMS has now approved demonstration proposals from three states with MOUs signed with Massachusetts, Washington, and Ohio. A big incentive for states to implement these demonstrations is the opportunity for states to share in the savings that come from better care management.

1. **Could you walk us through exactly how that financing of shared savings will work and also how CMS plans to monitor the savings as the demonstrations are implemented?**

Answer: CMS projects that the Demonstrations can achieve overall savings through improved care coordination, reduction of unnecessary or duplicative services, administrative efficiencies, and better access to community support services. In the capitated financial alignment Demonstration model, we apply a savings factor to the Medicare Parts A and B and Medicaid baseline components of the rate (the estimate of what would have been spent on Medicare Parts A and B and Medicaid services for the Demonstration population if the Demonstration did not exist). This approach is designed to allow both payers to share proportionally on their respective contribution to the capitation rate and in the savings achieved through the Demonstration. Our evaluation will track factors such as enrollment mix and risk adjustment to measure actual savings. Savings targets will not be applied to the Medicare Part D component of the rate.

In the managed fee-for-service model, States will invest in new interventions for the targeted Demonstration population. If those interventions result in savings to the Medicare program and net overall Federal savings, after accounting for any increases to Medicaid spending, the State qualifies for a retrospective performance payment, subject to meeting certain quality standards.

In all approved Demonstrations, shared savings will be reduced if patient quality is not at least maintained for the Demonstration population. Our external evaluator will monitor for savings and all savings will be subject to review by the CMS Office of the Actuary.

Data Evaluation

I am supportive of the goals of these state demonstrations, but I do want to make sure that Congress gets good data from them in order for us to make policy decisions in the future. So it is critical that we carefully monitor what happens with the demonstrations.

2. **I know that CMS has contracted with R-T-I International to evaluate the overall impact of the demonstrations, but could you give us the details of exactly what R-T-I will be monitoring and what CMS will be looking for?**

Answer: Each Demonstration will have its own State-specific evaluation plan. All of the State-specific plans will include a core set of quality measures to enable cross-State comparisons where possible.

RTI will be monitoring and analyzing both qualitative and quantitative information throughout the Demonstration. It will monitor and evaluate the extent to which each State's Demonstration was implemented as designed, which will include Demonstration design features that reflect service delivery and financial integration. Beneficiary satisfaction and access to care will be evaluated through mixed (quantitative and qualitative) methods as well to capture beneficiary experience and perception of care received. Analysis of service utilization data will provide insight to changes in beneficiaries' access to and use of Medicare and Medicaid services. RTI will examine a

set of core quality measures focused on the needs of Medicare-Medicaid enrollees, such as follow-up after hospitalization for mental illness and screening for depression. Costs will be examined to learn whether certain types of intervention approaches save more than other types of approaches, or whether costs are lower in the Demonstration group compared with a comparison group for certain subgroups, such as the individuals with severe and persistent mental illness.

3. **Your testimony notes that both Washington and Massachusetts will have comparison groups to analyze the impact of the demonstrations, but will that be the case for every state that gets a demonstration approved by C-M-S?**

Answer: The evaluation contractor will compare pre- and post-demonstration changes in outcomes of interest for the demonstration group with pre- and post-demonstration changes in a comparison group. The approach to comparison group identification will be State-specific; all comparison groups will be comprised of Medicare-Medicaid enrollees not participating in the Demonstration.

Senator Jay Rockefeller

1. **Why isn't the Medicare-Medicaid Coordination Office testing a fully federalized model of care for dually eligible beneficiaries?**

Answer: The Federal government and the States are full partners in the delivery and financing of care for dual eligibles. Our Demonstrations are structured to leverage and strengthen that partnership with a focus on creating accountability and aligning incentives between the payors as opposed to focusing on turning the program over to one payor or the other.

2. **Will the Coordination Office pilot a Medicare-only demonstration (that includes coverage of long-term care, supports and services) for dually eligible beneficiaries?**

Answer: As noted above, we are focusing on creating accountability and aligning incentives between the payors, as opposed to focusing on turning the program over to one payor or the other. States are our partners in the delivery and financing of care for this population, so we have focused our efforts on working with States to design these new models of care. That said, these Demonstrations are a full partnership between Medicare and Medicaid and are designed in a manner that incorporates the strongest aspects from both Medicare and Medicaid to best meet the needs of Medicare-Medicaid enrollees, their caregivers, and providers. Improving the quality of care for beneficiaries is the highest priority of these Demonstrations.

Demonstration Size

According to MedPAC, the Financial Alignment Initiative could include as many as 3 million dually eligible beneficiaries if CMS allows all 26 states to move forward

with their proposals. That is nearly one-third of the entire dually eligible population (9.4 million)—far too large for a program that purports to be a "demonstration." CMS has claimed they plan to enroll a lower, yet still excessive, number of beneficiaries (2 million) and will limit the size and scope of state demonstrations that reach too far.

3. **What specific enforcement mechanisms will CMS use to guarantee the size of state demonstrations do not exceed target thresholds?**

Answer: CMS has committed to a cap of 2 million beneficiaries in the Demonstrations. We believe this is a reasonable limit to balance concerns with size and the ability to test models across the nation in different delivery systems, States, and target populations. This approach will allow CMS to provide Congress and others with information to scale and advance integrated care for this population. We are proceeding judiciously on a State-by-State basis and enrollment will be phased in to ensure it is carefully conducted. To that end, CMS has established oversight and monitoring mechanisms as well as operational and implementation milestones to ensure the Demonstration will preserve and strengthen Medicare-Medicaid enrollees' access to care, quality of care, and benefits. CMS ultimately controls how many beneficiaries will be approved to be enrolled in a given Demonstration

4. **How can we be sure that health plans will not continue to enroll more and more beneficiaries even after targets have been reached?**

Answer: CMS will consider the total number of expected Demonstration participants as part of the approval process. In addition, CMS and the States will manage the enrollment process. Thus, we do not anticipate any ability for individual health plans to enroll numbers of beneficiaries in ways that would result in exceeding our overall limit of 2 million beneficiaries.

Lock-In Policy

The prospect of locking dually eligible beneficiaries into plans they did not select for themselves due to passive enrollment raises a number of concerns. While the three MOUs CMS has approved do not include a lock-in policy, a number of pending state proposals have lock-in periods that last up to 6 months.

5. **Can you confirm that CMS will not allow a lock-in policy to be used in any state demonstration moving forward?**

Answer: Beneficiaries can opt-out of these Demonstrations at any time.

6. **What specific steps is CMS taking to prevent "practical lock-ins" that may occur even if CMS does not technically approve a lock-in policy due to beneficiaries' lack of awareness about their ability to opt-out or a change in their health plan resulting from passive enrollment?**

Answer: CMS will work with States to help ensure that robust enrollment assistance and options counseling services are available before and during enrollment into any Demonstration, and to ensure that beneficiary materials clearly articulate the right to opt out. Again, beneficiaries can opt-out of these Demonstrations at any time.

Educating Beneficiaries

I am very concerned that the high prevalence of cognitive impairment, limited English proficiency and literacy, blindness and mental health conditions among the dually eligible population will create challenges in educating and informing beneficiaries about potentially drastic changes to their health coverage.

7. **In addition to the resources being made available to State Health Insurance Programs (SHIPs) to support counseling and education for beneficiaries in the demonstrations, what more is the Medicare-Medicaid Coordination Office doing to build a network of *conflict free* supportive services—such as options counseling, enrollment brokers, the SHIPs, ombudsman programs and community-based organizations—for those enrolled in the demonstrations?**

Answer: Beneficiaries will receive clear, understandable notices that have been reviewed by advocacy organizations and field tested with beneficiaries. Outreach and education will proceed through multiple channels at multiple points in time and will take into account the prevalence of cognitive impairments and mental illness in this population as well as the incidence of limited English proficiency. Independent resources, such as choice counselors and enrollment brokers, will assist beneficiaries in making enrollment choices. We will also leverage existing resources, such as State Health Insurance Programs and Aging and Disability Resource Centers, to provide one-on-one counseling on enrollment options. Special training for 1-800-Medicare operators will enable them to effectively assist beneficiaries. Finally, we anticipate providing support such as technical assistance and training for independent Ombudsman services, which will provide additional support and advocacy for beneficiaries and systemic oversight.

8. **What steps are states and CMS taking to ensure these organizations are conflict free? And how will the Medicare-Medicaid Coordination Office and participating State Agencies guarantee access to real-time information and resources about the participating plans to inform this network?**

Answer: CMS and States will use different approaches to verify and ensure that enrollment broker, Ombudsman, and options counseling organizations are independent and conflict free, largely through existing and new contracting requirements.

CMS will require all plans to report performance and quality information to both CMS and States. This information will be shared, as appropriate, with Ombudsman and options counseling partners.

Removing Beneficiaries from Part D

I am concerned that removing millions of duals from Medicare's prescription drug benefit (Part D) will limit plan choices for vulnerable populations with complex prescription drug needs. It may also reduce incentives for plans to bid low in the competitive bidding process to become eligible to automatically enroll LIS beneficiaries, thus having cost ramifications for all Medicare beneficiaries.

9. **Why can't you give beneficiaries the option of maintaining enrollment in their current Part D plan, or require plans participating in the demonstration to submit Part D bids, as PACE and Dual Eligible-Special Needs Plans already do?**

Answer: All beneficiaries will have the option to maintain enrollment in their current Medicare Part D plan. However, for those beneficiaries in the capitated model, Medicare Part D services will be integrated in the Demonstration health plan, as with all other Medicare and Medicaid services. We believe this is critical to maximizing the opportunities and incentives for care coordination, and it creates for a more seamless beneficiary experience. The capitation rates paid to Demonstration plans will reflect the results of the competitive bidding process, although the plans themselves will not bid in the same way. Moreover, the Demonstrations preserve Part D requirements including the strong beneficiary protections, network standards and protected classes. Medicare-Medicaid enrollees will retain the right to disenroll from demonstration plans on a month-to-month basis throughout the entire duration of the Demonstrations.

In the managed fee-for-service model, beneficiaries will select a Part D plan as they do today.

10. **You stated in your testimony before the Committee that the CMS Actuaries will be monitoring the Part D market for any problems and that you may have to reassess if issues arise. But why wait for a problem to develop before doing something about it when there are clear steps your office can take to prevent issues from arising in the first place?**

Answer: The Demonstrations have been designed in a way that preserves and protects the Medicare Part D program, and we are working with the Center for Medicare and the Office of the Actuary to monitor closely for this effect as the Demonstrations progress.

There are a number of countervailing factors that may mitigate concerns about negative disruptions in the Part D market. In States where Demonstration plans go into effect, Part D plans will still have strong incentives to bid low in order to offer competitive premiums to the majority of Medicare beneficiaries who do not receive the low-income subsidy (LIS). Low-bidding plans will also be able to receive auto-assignment of LIS beneficiaries who are not full dual eligible beneficiaries (those who applied for LIS through the Social Security Administration and those deemed into LIS through enrollment in Medicare Savings Programs) if the plan bid is below the regional benchmark for the low-income premium subsidy amount. Plans with bids below the

benchmarks will also be able to offer zero-premium Part D coverage to full dual eligible beneficiaries who opt out or are otherwise excluded from the Demonstration.

Voluntary Enrollment

11. Given the limited experience among States Agencies and health plans with integrating care between Medicare and Medicaid, wouldn't it make more sense to use voluntary enrollment along with a robust outreach campaign to allow beneficiaries to opt in?

Answer: State agencies and health plans have a range of experience with integrating care between Medicare and Medicaid. CMS will partner with States on coordinated outreach activities, and anticipates that many beneficiaries will assertively choose to participate in the new integrated care programs through the Demonstrations. All approved Demonstration plans will undergo a robust review process to help ensure preparedness and readiness to enroll and serve beneficiaries. Beneficiaries who choose to opt out may do so at any time. CMS will continue to work with its State partners and contracted plans to monitor beneficiary enrollment and disenrollment, and will make any adjustments that are necessary to support beneficiary needs.

12. Why can't states use voluntary enrollment for an initial period of time to reach enrollment targets before resorting to passive enrollment?

Answer: States can use opt-in enrollment for an initial period of time prior to passive enrollment. Both of the capitated Demonstrations approved to date (in Massachusetts and Ohio) include an initial opt-in enrollment period.

Readiness

The Financial Alignment Initiative strives to do too much too quickly. There seems to be an extremely short timeline for designing and launching the state demonstrations, despite the complexity or coordinating care for the dually eligible population. Assessing health plan readiness—from network adequacy to organizational infrastructure to in-depth assessment tools and staffing—is a complex task that must be carefully done. Many of the health plans participating in these demonstrations will have little to no experience managing care for this population.

13. How can CMS really guarantee that plans will be ready to enroll people—especially those with the most complex health needs—on day one?

Answer: As part of the Medicare-Medicaid capitated Financial Alignment model, CMS and States want to ensure that every selected Medicare/Medicaid plan (MMP) is ready to accept enrollment, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the Medicare-Medicaid population. As such, plans must first meet core Medicare and Medicaid requirements, State procurements standards and State insurance rules (as applicable). Every selected MMP must also pass a comprehensive joint CMS/State readiness review.

CMS and Massachusetts developed a State-specific readiness review tool, based on the MOU signed on August 22, 2012, applicable Medicare and Medicaid regulations, the Commonwealth's Request for Responses from Integrated Care Organizations, and stakeholder feedback. The readiness review protocol is available on our website at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

CMS is following a similar process with each State participating in the Demonstration. The readiness review process includes desk reviews, site visits, validations of the provider and pharmacy networks, review of key subcontracted entities, and validation of systems and capacity to ensure that each MMP has the ability to offer high-quality, coordinated care while adhering to all federal and State requirements. Importantly, there will be a specific focus on those areas and processes that directly impact the beneficiary's care including assessment processes, care coordination, provider network development and maintenance, and the MMP's staffing and staff training.

Stakeholder Involvement

Stakeholder involvement will be crucial both as states design their programs and throughout the life of the demonstrations. While the Medicare-Medicaid Coordination Office has facilitated stakeholder engagement throughout the design process, there seems to be no requirement that this level of engagement will continue throughout the entire demonstration. This is a necessary form of oversight that will provide early warnings about flaws or concerns with state programs.

14. **Will you require all states and plans to regularly seek input from beneficiaries (and those that represent them) and demonstrate how they incorporated this input even after implementation is underway?**

Answer: Yes. CMS will continue to require that all States and participating Demonstration plans regularly seek input from stakeholders. CMS and States will require regular meetings with beneficiary stakeholders and continued opportunities for feedback on Demonstration operations. Additionally, plans are required to have beneficiary participation on advisory or governing bodies. In the Massachusetts Demonstration, for example, the State has established an implementation council through which beneficiaries and advocates have a critical role in Demonstration implementation and we will encourage other States to implement a similar role for beneficiaries.

15. **How is the Coordination Office responding to states that appear to be ignoring stakeholder input throughout the design process?**

Answer: A robust stakeholder process is a core standard and condition for approval. States not engaging with stakeholders will not move forward with a Demonstration until they do so.

Savings

The Medicare-Medicaid Coordination Office has repeatedly touted that CMS has not set a national savings target for the Financial Alignment Initiative. However, I remain concerned that the demonstration programs are more focused on reducing costs than improving quality—even though improving quality and care delivery was the express intent of the authorizing legislation. Under the capitated model, CMS will not allow a demonstration to move forward if it fails to produce upfront savings by a state-specific threshold established in the MOU. The Ohio MOU projects that the demonstration will achieve savings even in its first year. Please identify the savings targets for years one, two and three for all approved state MOUs that are based on the capitated model.

Answer: The savings targets for years one, two and three for approved MOUs based on the capitated model are available at:

Massachusetts MOU, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, page 40 and 46. *Available* at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf ; and Ohio MOU, Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, page 39. *Available* at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf .

16. **Since the vast majority of the states are pursuing the capitated model, is this not establishing a national savings target by default?**

Answer: CMS projects that each approved Demonstration can achieve overall savings through improved care management and administrative efficiencies. There will be different savings opportunities across states and within each Demonstration model (capitated and managed fee-for-service). CMS has not set forth a national savings target.

17. **What are these projections based upon?**

Answer: CMS projects that the Demonstrations can achieve overall savings through improved care coordination, reduction of unnecessary or duplicative services, administrative efficiencies, and better access to community support services. Savings opportunities will vary by State depending on a number of factors, as described above. Analytic work, together with input from States and others, will inform the selection of a savings estimate. While some States may have lower or higher savings potential than other States, CMS anticipates applying consistent savings factors across States with comparable ranges of potential savings.

18. **Given that there will be significant start-up costs involved in setting up systems and getting beneficiaries stabilized, are year one savings realistic?**

Answer: We recognize there are indeed upfront costs for organizations to prepare for implementation, even before any beneficiaries enroll; however, there are also significant areas of inefficiency and overlap and immediate care coordination opportunities, which are the basis for anticipating that modest savings are achievable in year one.

19. Can the Coordination Office and state agencies provide more detailed breakdowns of expected savings?

Answer: We have structured the capitated financing model to achieve proportional savings, on a percentage basis, to Medicaid and Medicare Parts A/B. We do not apply any savings factor to Part D payment. The savings factors applied in each Demonstration are included in the Memorandums of Understandings (MOUs) posted on our website[1].

Risk Adjustment

About 20% of the duals population needs substantial amounts of long-term services and supports. Clearly, we want to limit the financial incentives for plans to make a profit by under-serving these beneficiaries—particularly since participating plans will not be subject to a medical loss ratio (MLR) requirement. And, yet, at least in the Massachusetts demonstration, reinsurance is only available for the first year.

20. Why aren't you using a reinsurance structure – including risk corridors and high-cost risk pools—for the full course of the demonstration?

Answer: The payment provisions, including the use of a reinsurance structure, reflect the unique circumstances that prevail in each State. In the Massachusetts Demonstration, the State uses a risk corridor for the first 18 months of experience to protect against excessive loss or gains by the participating health plans. In Ohio, participating plans in the Demonstration are subject to an MLR requirement. In all approved Demonstrations, we will use risk adjustment techniques to match payment to risk and mitigate any differences among plans in the proportion of their enrollees who have high costs. And in all approved Demonstrations, CMS will apply risk corridors and reinsurance provisions and reconcile Medicare Part D expenditures, just as we do today. Collectively, these measures help balance interests by protecting and stabilizing the marketplace while also incentivizing plans to manage risk and invest in the types of interventions that help people live independently and avoid costly adverse outcomes.

21. What are you doing to start improving risk adjustment by collecting data on beneficiaries' "functional status" (e.g., do they need assistance with dressing, bathing, feeding etc.)?

Answer: The Demonstrations present an opportunity to capture functional status information on a systematic basis and develop methods to apply it to risk adjustment. CMS is at the early stages in exploring how to better use this information data to foster improvement through use of data on beneficiaries' functional status, and will continue to work with Congress and others as progress is made to ensure risk is properly adjusted and

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

beneficiaries receive necessary long-term services and supports. Massachusetts, for example, will capture functional status information in a uniform assessment applicable for all demonstration enrollees.

Senator Charles Schumer

Improving Care for Dually-Eligible Beneficiaries

As you know, many individuals dually eligible for Medicaid suffer from multiple chronic conditions, including severe mental illness and cognitive impairments, such as traumatic brain injury. Some states are proposing to fold existing home and community-based (HCBS) waiver programs serving individuals who have complex medical and behavioral conditions into their integrated care demonstrations. This must be done carefully to ensure that persons already receiving long-term services and supports and service coordination continue to have access to these services and care management tailored to meet their specific needs.

1. **Can you please tell the Committee if the Medicare-Medicaid Coordination Office is using objective criteria to evaluate the proposed inclusion of HCBS waiver populations into the duals demonstrations, or is requiring states to develop such criteria for participating health plans?**

    a. **If the answer is yes, would it be possible to provide the Senate Finance Committee with more details about how such criteria is being developed and applied?**

Answer: Yes. CMS is using the standards and conditions required to participate in this Demonstration as the consistent starting point for determining whether HCBS waiver populations will be included in a State Demonstration, when States have proposed to include them. Additional applicable criteria may differ by State, to account for different State proposals and pre-Demonstration circumstances.

CMS will use a range of approaches to monitor and evaluate the performance of the Demonstration for HCBS waiver populations, as well as other key sub-populations. While some of the criteria and approaches will be State-specific, monitoring and analysis for all States will include access to and utilization of HCBS – as well as HCBS relative to facility-based care. Quantitative data will be stratified by HCBS waiver populations where applicable, and focus group and key informant interview questions will ensure that actual beneficiary and stakeholder experiences provide context for the data.

    b. **If the answer is no, can you please explain how your office is evaluating whether inclusion of these waiver populations would either improve care and reduce costs or, at the very least, produce savings without putting these individuals at risk of receiving inferior care?**

2. **For states proposing to include Medicare-Medicaid enrollees currently receiving home and community-based (HCBS) waiver services in their capitated financial alignment demonstrations, are you requiring them to maintain the same set of services in the demonstration?**

    a. **If yes, are you also requiring that states ensure continued access to this set of services for enrollees who choose to opt out of the demonstration? My concern is to make sure that everyone who currently has access to HCBS services or who could qualify to receive them in the future -- allowing them to remain in their homes and live independently – will not lose access if they choose not to participate in the demonstration.**

Answer: Under the Demonstration beneficiaries will receive current Medicare and Medicaid services, as well as new and/or enhanced care coordination, protections, and services. To that end, beneficiaries in the Demonstration will not lose their access to current HCBS services, and in many cases will receive enhanced HCBS services as a result of the Demonstration. For example, in Ohio, participating beneficiaries will have access to a more robust set of HCBS benefits and services than they do today.

Senator Bill Nelson

Bad Debt

Medicare bad debt payment help to reimburse skilled nursing facilities (SNFs) and hospitals for any unpaid deductibles or other costs incurred while caring for a dual-eligible beneficiary. Medicaid is meant to "wrap-around" Medicare for dual-eligibles and pay the Medicare deductibles and copays for these enrollees, who by definition have limited financial resources. However, many states pay less than the Medicare reimbursement levels and therefore do not pay providers these cost-sharing obligations.

Medicare bad payments are crucial to providers serving dual-eligible beneficiaries. Beginning October 1, Medicare is no longer reimbursing skilled nursing facilities for 100 percent of this uncompensated care. Facilities in Florida are particularly affected by the phase-down in bad debt reimbursement.

1. **In states like mine where Medicaid does not pay for dual eligible SNF co-pay, what recourse does the provider have?**

Answer: Federal law allows State Medicaid agencies the option not to pay the Medicare cost sharing in certain circumstances. In States that choose this option, SNFs typically receive Medicare bad debt payments. CMS is aware of provider difficulties in securing payment for services and is continually working with internal and external partners on more fully addressing this issue.

Senator Tom Carper

PACE

My core principle in reforming our country's health care system is finding ways to get better health outcomes while lowering costs. Better health outcomes are especially important for duals because these patients, who are often the most vulnerable of our Medicare and Medicaid populations, also receive substandard and misaligned health care. Among all the programs to help duals, the PACE program stands out by consistently providing high quality, team-based care for a set cost. Fortunately, states and PACE programs are interested in expanding the program by changing requirements that could help PACE to serve more duals.

1. **Are you and your colleagues trying to expand the PACE program?**

Answer: CMS is committed to partnering with Congress, States, caregivers, providers and others to explore new ways to better coordinate services and improve health outcomes for Medicare-Medicaid enrollees. CMS continues to engage in various conversations regarding the PACE program with a number of States and the National PACE Association through regulatory and sub-regulatory policies. Furthermore, the Medicare-Medicaid Coordination Office's FY 2011 Report to Congress suggested potential approaches for expanded flexibilities within the PACE program.

2. **What can my colleagues and I do to help CMS increase access to PACE?**

Answer: Potential areas for Congressional exploration were reported in the Medicare-Medicaid Coordination Office's FY 2011 Report to Congress, and include: issues of eligibility, additional operational partners, alternative settings, and tailored multidisciplinary teams within the PACE program.

Community Health Centers

I'm especially interested in the role that community health centers play in serving our nation's most vulnerable populations. I know health centers in Delaware provide comprehensive primary and preventive care to their patients, in addition to meeting many of patients' additional needs, such as management of chronic diseases and health education, to help their patients stay out of costly care settings like the emergency room. This full spectrum of care is important for all patients, but especially our dually eligible patients whose resources are limited and whose health needs grow more complex as they age.

3. **As health centers serve a significant and growing number of duals, what role do you see health centers playing now and in the future as primary and preventive health care providers to this important population? For example, how are you working to ensure that community health centers will be included in demonstration programs to improve health care for duals?**

Answer: There are a number of ways in which Community Health Centers will be a part of the Demonstration, depending on the State and the model. In the capitated financial alignment model, CMS is applying network adequacy standards to ensure that all health plans have sufficient number of providers and continuity of care protections to ensure that beneficiaries can continue to see current providers (including those at community health centers) during any transitions into the Demonstration health plan. The managed fee-for-service model presents opportunities for additional resources to be directed to primary care providers through care management payments or enhanced rates. Both examples help CMS ensure that providers such as Community Health Centers are a part of the Demonstration.

Senator John Thune

It is no secret that South Dakota is a very geographically sparse state.

1. **How do you envision a duals demonstration working in a geographically sparse state like South Dakota when there are no Medicaid managed care?**

Answer: The managed fee-for-service financial alignment model is designed to promote greater coordination of care in the fee-for-service environments that are especially prevalent in rural areas. Our first approved managed fee-for-service model is in Washington State and includes the rural areas of the state.

2. **Is there a methodology for forecasting savings in these types of states?**

Answer: In the managed fee-for-service model, States will invest in new interventions for the demonstration population. If those interventions result in savings to the Medicare program and net overall federal savings, the State qualifies for a retrospective performance payment, subject to meeting certain quality standards. We assess the potential for savings on a state-by-state basis, and are informed by state-specific factors such as Medicare and Medicaid expenditures for Medicare-Medicaid enrollees, managed care penetration, long-term care service users by type of provider, and rates of avoidable hospitalization.

3. **How would that methodology account for the fact that those states do not have Medicaid managed care?**

Answer: At its root, our methodology for projecting potential savings from improved care coordination and integrated benefits for Medicare-Medicaid enrollees is based on the prevalence in the current care delivery system of the principal factors driving high cost, suboptimal care, including potentially avoidable hospitalizations, hospital readmissions, and the overuse of institutional care compared to community-based long term care services and supports. We believe these cost drivers can be addressed in all States, including those without Medicaid managed care, through aligning financial incentives across Medicare and Medicare and providing Medicare-Medicaid enrollees with a more integrated, coordinated care delivery system.

THOMAS J. BETLACH
DIRECTOR
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES

TESTIMONY BEFORE THE U.S. SENATE FINANCE COMMITTEE

DECEMBER 13, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Senate Finance 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.

Arizona has maintained a system of managed care for its entire membership, including dual eligible members, since joining Medicaid in 1982. Arizona also offers the unique perspective of a state that has one-third of its dual eligibles in their Medicaid health plan for both Medicare and Medicaid.

Thirty years of experience have shown us it is precisely our frailest members most in need of the care coordination managed care offers. Medicaid managed care for dual eligible members is not an "experiment" but rather a documented success.

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, AHCCCS and its health plans have progressed from 40 percent of its members in the home or community to 73 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 one ranking by United Cerebral Palsy.

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

Recently Avalere Health compared national data for duals enrolled in traditional Medicare fee-for-service to dual eligibles served by an AHCCCS health plan for both Medicare and Medicaid. The aligned AHCCCS duals exhibited:

- 31% lower rate of hospitalization;
- 43% lower rate of days spent in a hospital;
- 9% lower ED use; and
- 21% lower readmission rate.

Alignment works. Equally important, Arizona has proven passive enrollment works. When Medicare Part D was created, Arizona encouraged its Medicaid plans to become Medicare Advantage Special Needs Plans. In 2006, approximately 39,000 members were passively enrolled in their Medicaid plan to provide better continuity of care for Part D implementation. Arizona's strong transition planning and protocols successfully ensured member protections with minimal disruption during this process.

Given our documented success improving the delivery system for dual eligibles, Arizona enthusiastically participated in the Duals Demonstration initiative. After extensive stakeholder engagement, Arizona submitted a proposal that sought to increase dual alignment from 40,000 to 100,000 beneficiaries.

I applaud the passionate and consistent leadership Melanie Bella has provided to bring about change. Despite her best efforts, the process has moved slowly. With over 20 states submitting demonstrations and limited resources, delays are understandable. What is disappointing is the delay stemming from an inability by stakeholders to fully acknowledge the failures in the current system design and the negative impact that has had for this population.

It is frustrating to hear Medicaid managed care dismissed by some as an option for duals while others 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; states 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 47 years of fragmentation. We have decades of comparison data that show the shortcomings of the existing system. 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.

Forty seven years ago Congress designed a system of care that required low-income elderly and disabled Americans to receive their healthcare from two distinct, massive and complicated systems. The result is what one would expect: a fragmented, complicated, bureaucratic delivery system with higher costs, poorer outcomes and no single point of accountability for the beneficiary and their family.

Dr. Alain Enthoven defined "'Fragmentation' in healthcare delivery as the systemic misalignment of incentives, or lack of coordination, that spawns inefficient allocation of resources or harm to patients. Fragmentation adversely impacts quality, cost, and outcomes." In short, we are perpetuating a system that is not only too expensive but is harming patients.

One of my favorite articles is "Hot Spots" by Atul Gawande published in *The New Yorker*. "Hot Spots" describes how Dr. Jeffrey Brenner worked to positively change the health care system for our neediest citizens in a way that improved outcomes and reduced costs. For us as a nation, dual eligible members represent a Hot Spot opportunity.

As we rapidly approach the Golden Anniversary for Medicaid and Medicare, it is time for Congress to act in partnership with the states to develop a new delivery system that will eliminate fragmentation and confusion while better meeting the needs of the dual eligible members and their families.

Congress should create a system that takes into account the fact that this population is not homogenous and some members rely more on critical services provided by Medicaid like long term care support services and behavioral health. The system must ultimately take the best of both Medicare and Medicaid to create a program that determines who will be truly accountable for improving outcomes for these members while bending the cost curve.

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

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF DECEMBER 13, 2012
IMPROVING CARE FOR DUALLY-ELIGIBLE BENEFICIARIES: A PROGRESS UPDATE

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing evaluating efforts to improve care and lower costs for patients who are eligible for both Medicare and Medicaid programs:

Thank you, Chairman Baucus, for holding this hearing. It will allow us to get a progress update on efforts to improve the care for beneficiaries eligible for both Medicare and Medicaid. In an otherwise partisan atmosphere, today's topic is refreshing. It represents an area where we can achieve some real bipartisan agreement to lower health care costs and improve patient care.

There are more than 9 million Americans — commonly known as duals — are eligible for both the Medicare and Medicaid programs.

These patients often suffer from multiple chronic conditions and have complex medical needs. The $300 billion spent on their care every year is generally separated by complicated Medicare and Medicaid payment rules. Unfortunately, the system is not serving taxpayers well, and it is not serving patients well either.

I would note that many promising efforts have been made to address these needs, such as various state-driven efforts, the Special Needs Plans in Medicare Advantage and the Program of All-Inclusive Care for the Elderly, which is known as PACE. While these approaches have made a huge difference, there is much more work to be done.

I know that our first witness, Melanie Bella from CMS, has been working hard to solve these problems.

Ms. Bella has led the Financial Alignment Initiative to encourage states to design solutions that integrate care delivery and funding streams for dually-eligible beneficiaries. She is actively working with 25 states to approve and implement these proposals.

Today, we will hear from two states with approved proposals — Washington and Ohio — and another — Arizona — whose proposal is under review.

I am supportive of state-designed efforts generally, and I applaud Ms. Bella for her pragmatic and compassionate approach to a very difficult task.

However, I do want to make sure that we get the details right. In order to ensure these demonstrations are successful, I and six other Members of this Committee sent a letter to CMS in June outlining three priorities.

First, the demonstrations should be of a size and scope that gives Congress data upon which to base future policy-making. Second, these proposals should be consistent with good government principles so that contracts are competitively bid on cost and quality across a level playing field. And finally, we need to be sure that these demonstrations protect the integrity of the Medicare Part D program.

Again, Mr. Chairman, thank you for scheduling this important and timely discussion. I look forward to working with you on this issue and hearing from our witnesses today.

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Oral testimony for Senate Finance Committee
MaryAnne Lindeblad, Director, Washington State Health Care Authority
10 a.m. December 13, 2012
Dirksen Office Building, Washington. D.C.

Chairman Baucus, Committee members, Distinguished Guests:

It is my great pleasure and distinct honor to report on Washington State's HealthPathWashington – which is a forward-looking Medicare-Medicaid initiative aimed at integrating primary and acute care, behavioral health, and long-term care services and supports. It is a more cost-effective structure that will save Medicaid dollars, but its real purpose is to improve care and the overall health status of these clients.

The initial strategy will begin in April next year with newly developed and community-based Health Homes for up to 30,000 of the state's highest-need "dual eligibles." While the dual eligibles only account for 13 percent of our state's Medicaid caseload, they account for 30 percent of our costs – so this is a priority project on several levels, including the need to provide more effective care to this population.

By definition these are fellow Washingtonians of very low-income and with few financial resources. And there are other concerns.

Many, if not most, experience significant challenges caused by disability, mental illness and/or chemical dependence, which complicate delivery and payment of their care. As a result, this population is made up of people who require a variety of services including medical, mental health, chemical dependency and long term services and supports and therefore are among the most costly segment of the entire beneficiary population.

In April 2011, Washington State was one of 15 states that received a planning grant from the federal government's Centers for Medicare and Medicaid Services (CMS). The grant monies were made available for developing an implementation plan that would lead to innovative ways to integrate and care for individuals who receive services from both Medicare and Medicaid. In the Evergreen state, the number of individuals who are fully eligible for Medicare and Medicaid is approximately 115,000. The proposed implementation plan was submitted to CMS in late April 2012, and our initial strategy was approved by CMS two months ago, in October 2012. Today, Washington is already moving forward to implement HealthPathWashington's multi-pronged approach to:

- Improve beneficiary experience in accessing care.
- Promote person-centered health action planning.
- Promote independence in the community.
- Improve quality of care.
- Assist beneficiaries in getting the right care at the right time and place.
- Reduce health disparities.
- Improve transition among care settings.
- Achieve cost savings for the state and federal government through improvements in health and functional outcomes.

Integrating Medicare and Medicaid services means coordinating the delivery, financing, technology and human touches experienced by dual beneficiaries. By aligning payment, outcome expectations and services, confusion and fragmentation will be diminished. This will improve the beneficiaries' experience with service delivery, improve health outcomes and better control future costs.

Two Financial Models:

- **Washington's first strategy** will focus on incorporating high-risk dual eligibles into Health Homes as part of a Managed Fee-for-Service financial demonstration. (A 90 percent federal match for health home services is available for the first eight fiscal quarters of a State Plan Amendment.)

- **The second strategy** – which is still being negotiated with CMS and with counties that will take a leadership role – will offer dual eligibles a fully capitated combined Medicare-Medicaid Managed Care benefit package in specific counties.

Both strategies will rely on a predictive modeling system called PRISM – it stands for "Predictive Risk Intelligence System". PRISM is a system developed by our state to sift existing health care data and assign risk scores that identify those clients in need of chronic care management and timely interventions that will provide more effective care. (*I've included more information on predictive modeling and PRISM in my written testimony.*)

Currently, payment for health care services is chiefly tied to the provision of distinct services, treatments or interventions and is not oriented to performance-based outcomes. Yet the greatest public expenditures and most preventable health outcomes are associated with complex needs that cut across the disciplines represented by each delivery silo. Washington State intends to demonstrate two distinct solutions, using two separate financial models aimed at integrating care for the dual eligible.

A word about the great stakeholder work that went into our project: The state reached out to a wide array of beneficiaries, providers, health plans and advocates – all of who, provided valuable insight that helped to inform the strategies outlined in our proposal to CMS.

Stakeholders were invited to participate through a number of methods including: interviews, forums, presentations, focus groups and webinars. Individuals and organizations were also asked to submit written comment and feedback on the draft design plan and did so using a variety of communication methods including surveys, letters, email, and in-person meetings. Throughout the development of its design plan, the state shared approaches and sought comments from beneficiaries, their families, advocacy groups, providers, impacted organizations and entities, government entities and other key informants. Of particular importance to all was the preservation of consumer choice and development of adequate consumer protections. For example, while both of the state's strategies rely on passive enrollment, they also support optional dis-enrollment at any time.

This ongoing dialogue – between bureaucrats, the health care industry and the stakeholders – providers, clients, advocates – will be invaluable in shaping the integration strategies as well as identifying operational and implementation issues that can be resolved in the process.

The state will continue to work with stakeholders and other interested and impacted parties as work on the project now moves from the design to the implementation planning phase. Materials for outreach, education, and training will be developed and shared with our HealthPathWashington Advisory Team, a group comprised of 35 members representing advocates, providers, health plans, and beneficiaries that continues to meet regularly to assist with implementation of these Financial Demonstrations.

In final form, HealthPathWashington is not just about a medical model. Rather, it represents a holistic approach – one that embraces different levels and categories of health care – and puts the patient, not the program, at the center of the system.

Washington has a long history of innovation and has achieved progress in rebalancing services and supports away from institutional care.

Concern about duals is not new. Since Governor Gregoire chaired the National Governors Association (NGA) 2010-2011, the NGA has included as part of its standing health policy language to support state-federal coordination with respect to duals. As recently as this month (Tuesday, December. 4), members of the NGA Executive Committee met with President Obama and Vice-President Biden at the White House and raised the importance of working together on dual eligibles.

In a nutshell, the problem that duals face, traces back to the fact that almost all care and payment for Medicare and Medicaid beneficiaries are handled through separate systems and financial models. Services are fragmented, care is not well coordinated, and there exists a lack of accountability to make sure that healthy outcomes are measured or achieved and that individuals receive the right care at the right time and place.

From the beneficiaries' perspectives, there is confusion about navigating the systems, and this can result in significant cost shifting while making it problematic to avoid high cost care in emergency rooms, hospitals, and other institutional settings.

HealthPathWashington targets these concerns and provides realistic solutions – a better planned better coordinated, cost-effective system that will provide a healthier dual eligible population, significant cost savings, and an improved care structure.

JOHN B. McCARTHY
DIRECTOR
OHIO MEDICAID – OFFICE OF MEDICAL ASSISTANCE

CARE DELIVERY COORDINATION THROUGH MEDICAID-MEDICARE INTEGRATION

THURSDAY, DECEMBER 13, 2012

Chairman Baucus, Ranking Member Hatch, and members of the committee, thank you for the invitation to discuss Ohio's ongoing effort to create and implement an Integrated Care Delivery System (ICDS) for Medicare-Medicaid enrollees.

My name is John McCarthy and I oversee the Office of Medical Assistance (OMA) as Medicaid Director for the State of Ohio. An office within the Ohio Department of Job and Family Services, OMA is currently in the process of becoming our state's first cabinet-level Medicaid agency – a move aimed at bringing comprehensive reform and quality improvement to Ohio's health care landscape. Better care planning and coordination for Medicaid's dual eligible population is central to this work.

Approximately 182,000 Ohioans are covered by both Medicare and Medicaid. However, the absence of any significant degree of coordination in the delivery of benefits between the two programs has contributed to a diminished quality of care. Frankly, the current system is confusing and difficult to navigate and no single entity is accountable for the whole person. Additionally, despite substantial investments, Ohio's long term care services and supports remain in the third quartile of states and such spending will prove unsustainable with the rapid aging of Ohio's population. This has led to the fact that individuals enrolled in both programs make up 14 percent of Ohio's Medicaid enrollment, but they account for 34 percent of all expenditures. Clearly a 'hot spot' in the discussion involving care quality and cost-containment, the time has come to improve coverage for individuals enrolled in both Medicaid and Medicare.

In its efforts, Ohio is hoping to achieve the following:

- One central point of contact for enrollees;
- Person-centered care that is maintained seamlessly across services and settings of care;
- A system that is easy to navigate for both enrollees and providers; and
- Lower care costs through wellness, prevention, coordination, and community-based services

On April 2, 2012, Ohio submitted its Integrated Care Delivery System (ICDS) proposal to the Centers for Medicare and Medicaid Services (CMS). Ohio envisions the creation of a fully integrated system of care that provides comprehensive services to individuals enrolled in both programs across the full continuum of Medicare and Medicaid benefits. Through this model, we anticipate that more individuals enrolled in both programs will receive the medical and supportive services they need not only in a more coordinated and integrated fashion, but in their own homes and other community-based settings - rather than in more costly institutional settings.

Ohio has chosen the capitated managed care model offered by CMS. Through this CMS Medicare-Medicaid demonstration program, Ohio will develop a robust care-delivery system capable of managing the full spectrum of benefits made available to individuals, including long term services and supports (LTSS). Our proposed program is a three-year demonstration that will take place in 29 Ohio counties separated into seven geographical regions. This plan will not only improve care for the approximately 114,000 eligible beneficiaries who reside in these counties, but will also play a critical role in reducing duplicative costs and boosting greater efficiency in both programs. Implementation of the program is slated to begin in fall of 2013, pending approval from CMS.

Of course, in order for any initiative of this kind to prove effective, it must place the individual first. That is why we have made every effort to emphasize the need for real person-centered care that moves seamlessly across services and care settings alike.

With that said, Ohio selected five health plans through a competitive process to manage the benefit package for dual eligible beneficiaries under the ICDS demonstration. Selected plans include Aetna, Buckeye, CareSource, Molina, and United. All five of the plans will utilize a variety of care management tools to ensure the proper coordination of services. Ohio's ICDS health plans will have the responsibility to comprehensively manage the delivery of services to individuals enrolled in both programs. Some of the responsibilities include

- Arranging for care and services by specialists, hospitals, and providers of LTSS and other community-based services and supports;
- Allocating increased resources to primary and preventive services in order to reduce utilization of more costly benefits, including institutional services;
- Covering all administrative processes, including consumer engagement, outreach and educational functions, grievances, and appeals;
- Coordinating service plan development and delivery;
- Working cooperatively with a financial management services (FMS) vendor and consumers in cases involving self directed care;

- Using a person-centered care coordination model that promotes an individual's ability to live independently and which includes the individual in the development of their care plan; and

- Utilizing a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

A series of enrollee protections have also been included to ensure that high standards for care are maintained on a consistent basis. With at least two plans in all regions, beneficiaries will have the power to choose what avenue of care best fits their needs. Eligible individuals also reserve the ability to opt out of the Medicare portion of the initiative if they so choose. ICDS plan member advisory groups will also be established and a unified grievance and appeal process will be implemented in order to further assure individuals that their needs and concerns are being heard. Finally, strong safeguards will be put into action to ensure quality management and proper oversight over all aspects of this initiative.

However, the number one protection for individuals in the program is that they are *guaranteed* continuity of care for one year with all providers, except for assisted living and nursing facility providers where they are guaranteed three years. Providers have also been protected from rate reductions from the Medicaid rates for those same periods.

The power of choice for beneficiaries is a common theme throughout our proposal, and that is no different in the enrollment stage. Individuals will have opportunities to make choices during the process, such as consulting over the phone with an enrollment contractor, during regional education and enrollment forums, or through one-on-one in-person enrollment counseling.

All individuals who enroll in the demonstration will be provided with a care manager. Through the use of an *identification strategy*, the ICDS plan will prioritize the order in which individuals will receive a comprehensive health assessment. Comprehensive assessments will include an evaluation of an individual's medical, behavioral, social, and long-term care needs. The Office of Medical Assistance will also prescribe a minimum contact schedule to assess risk acuity and stratification levels.

Of course, one size certainly does not fit all when it comes to health care. That is why every enrollee will be provided with an individualized, integrated care plan based on the results of their comprehensive assessment. Quality assurance will continue throughout the time of care as plans will be required to complete evaluations of the impact and effectiveness that their care management model has on the health outcomes and consumer satisfaction of our beneficiaries. The results of these evaluations will be integrated into the plans' continuous quality improve programs.

Quality will be further assured through the utilization of national measures used by all demonstration projects. Ohio-specific measures focused on transition, diversion and balance will also be derived and used, in addition to standard measures traditionally associated with Home and Community-Based Services.

It is important to note that Ohio has engaged with stakeholders and advocates throughout the design and development phases of this demonstration project. In order to ensure success and maintain a truly collaborative process, we will continue reaching out to providers, advocates, and individuals throughout the implementation and operational phases of the project.

Thank you again Chairman Baucus, Ranking Member Hatch, and members of the committee for the opportunity to explain Ohio's ongoing pursuit of an Integrated Care Delivery System for Medicare-Medicaid eligible individuals.

COMMUNICATIONS

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Statement for Hearing on December 13, 2012
"Improving Care for Dually-Eligible Beneficiaries: A Progress Update"

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) respectfully submits comments to the Senate Finance Committee pertaining to the December 13, 2012 hearing entitled, "Improving Care for Dually-Eligible Beneficiaries: A Progress Update." Thank you for conducting this hearing on an often forgotten group of individuals. We greatly appreciate and share your interest in making sure that this vulnerable population receives the care and support that it needs and deserves. We would welcome the opportunity to work with the Committee on proposals that meet that critical goal.

AHCA/NCAL comments are divided into two categories. First, we offer comments related to unclear or inaccurate statements made by witnesses and ensuing discussions. Second, the Association offers an overview of our ongoing concerns with the Medicare-Medicaid Financial Alignment Initiative. We would welcome the opportunity to discuss our comments with members of the Committee.

Section 1. Corrections and Clarifications in the Record

Below we highlight several points which merit additional inclusion in the record.

- Medicare finances post-acute care in a variety of settings including skilled nursing centers for persons who are eligible for both Medicare and Medicaid as well as for persons who are Medicare-eligible, only. However, in order to be eligible for a Medicare-financed post-acute care stay, these individuals first must have been admitted to a hospital for a minimum of a three-day stay. During the hearing, the mandatory three-day stay was not noted. This point is of key importance (see discussion below).

- Related to the point, above, the need to address so-called "observation stays" also was not addressed. "Observation" is the term used to describe the outpatient status of a patient who is in a hospital, but not as an inpatient. Although the Medicare Manuals limit observation to 24-48 hours, many beneficiaries nationwide are experiencing extended stays in acute care hospitals under observation. A major consequence for beneficiaries of not being classified as an inpatient is that their subsequent stays in a skilled nursing facility are not covered by Medicare. Depending on the type of Medicare-Medicaid eligible, payment for post-acute care becomes questionable and, if not a full Medicare-Medicaid eligible, presents serious financial consequences for beneficiaries and their families. This also is a key issue related to a subsequent discussion (see below).

- In terms of the average length of stay in a skilled nursing facility, maximum number of Medicare-financed post-acute care days is 100. At one point during the hearing a witness stated that the average length of a Medicare post-acute care stay was 100 days. This is incorrect. As noted above, the maximum number of Medicare-covered post-acute care days is 100. Research indicates that the number average number of Medicare-covered post-acute care days in Medicare fee-for-service is 27 days.[1] AHCA/NCAL members indicate that in Medicare Advantage average lengths of stay are lower than in Medicare fee-for-service. However, the outcomes of shorter lengths of stay are as yet unclear. For example, research has just begun to explore the implications of shorter average lengths of stay and preventable re-hospitalizations.

- Additionally, nursing patients and residents may leave a nursing facility, be readmitted to a hospital as ***inpatients*** and, after a three-day stay, return to a nursing facility which then ***may*** bill Medicare for a Medicare-financed post-acute care stay. Medicare rates are higher than Medicaid rates. Despite CMS official's statement that there is no evidence that nursing homes are engaged in gaming the system by prompting a hospital to nursing facility to hospital revolving door method, discussion ensued that implies that gaming may be occurring. We strongly disagree with such a line of thinking. To suggest skilled nursing center providers are gaming the system in order to maximize Medicare reimbursements is false and fails to appreciate the deep-rooted challenges of caring for such a medically-frail and needy population. First, there is no question that Medicare-Medicaid eligibles are a cost-driver in today's system. Second, as noted by the CMS official, there is no evidence that such gaming is occurring. Third, because of the new Affordable Care Act hospital penalties for preventable readmissions, hospitals have powerful incentives not to re-admit nursing facility patients as inpatients. Instead, it appears they are being taken to emergency rooms or placed in hospitals for observation stays (see above). In this scenario, Medicare financing for a subsequent Medicare-financed post-acute care stay is not be available. Fourth, if a patient already in a Medicare-financed post-acute care stay is re-admitted, a new Medicare stay does not ensue, rather the current post-acute care simply continues. Finally, AHCA/NCAL has initiated a major quality initiative designed in partnership with CMS. A key measure in our quality initiative is "safely reducing hospital readmissions." Our target is that by March 2015 we will reduce the number of hospital readmissions within 30days during a skilled nursing center stay by 15 percent. More information about our quality initiative may be found on our website: www.ahcancal.org.

- During a discussion about rebalancing efforts, a number of comments were made by CMS officials about the merits of home and community-based services (HCBS) over facility-based services. AHCA/NCAL fully supports choice and the full array of long term services and supports. However, to characterize HCBS as

[1] MedPAC. June 2012 Report to Congress.

less costly to public payers and more beneficial to HCBS program participants presents an incomplete picture. nursing centers appear to play a key role in delivering care which better prevents avoidable hospitalizations than HCBS programs for certain populations. Recent research shows that HCBS avoidable hospitalization rates are two times higher than for the general Medicaid population.[2] While the Medicaid data used dates back to 2005, the authors note that little has changed in HCBS program design since that year and they hypothesize the trends remain true. The researchers subdivided the study population into four categories: a) persons with intellectual and developmental disabilities (ID/DD); b) younger persons with disabilities but not ID/DD; c) older adults age 65 and older; and d) other HCBS users who did not fall into any of the preceding categories. Of the four subpopulations, older adults using HCBS had the highest rates of avoidable hospitalizations.[3] Additionally, a **CMS-commissioned study** found that HCBS participants with multiple chronic conditions and who are Medicare-Medicaid eligible had twice the avoidable hospitalization rates than long-stay nursing home residents.[4] AHCA/NCAL applauds state and federal efforts to expand beneficiary choice but also urges state and federal government to closely examine the quality of services and supports delivered in HCBS settings.

Section II. Ongoing Concerns with the Medicare-Medicaid Financial Alignment Effort

On June 6, 2012, AHCA/NCAL transmitted a letter to the CMS Medicare-Medicaid Coordination Office (MMCO) conveying our concerns and offering possible avenues of addressing such challenges. Subsequently, MMCO staff have met with AHCA/NCAL staff twice and addressed in full or in part several of our concerns. We greatly have enjoyed their willingness to engage in an open dialogue. However, a number remain outstanding. Below, we provide an overview of our remaining concerns. Many of these items are echoed by others in the health care community.

1. **Demonstrations projects should not enroll all or the vast majority of any population.** The Medicare-Medicaid Financial Alignment Initiative is characterized as a demonstration and will use demonstration authorities – either included in the Affordable Care Act or long-standing Medicaid demonstration authority. However, many states have proposed enrolling all or the vast majority of their Medicare-Medicaid eligible population in untested

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[2] R. Tamara Konetzka, Sarita L. Karon, and D.E.B. Potter. Users Of Medicaid Home And Community-Based Services Are Especially Vulnerable To Costly Avoidable Hospital Admissions. Health Affairs, 31, NO. 6 (2012): 1167–1175

[3] Fuller-Thomson E, Yu B, Nuru-Jeter A, et al. Basic ADL disability and functional limitation rates among older Americans from 2000-2005: the end of the decline? J Gerontol A Biol Sci Med Sci. 2009;64:1333-1336.

[4] Walsh, E. Ph.D. (August 2010) Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing home, Skilled Nursing home, and Home and Community-Based Services Waiver Programs. Prepared for the Centers for Medicare and Medicaid Services.

programs operated by plans with little or no experience with the needs of this fragile, high-need population. Furthermore, the majority of these plans have very little experience with long term services and supports which are inherently different from acute care services. Long term services and supports provide foster independence and community connection. Acute care services are intended to be restorative and have far more defined outcomes than long term services and supports. Furthermore, the Kaiser Family Foundation released an analysis of research on previous efforts (capitated and managed fee-for-service) aimed at reducing costs associated with full duals. ***The analysis indicates that virtually none of the earlier efforts produced projected savings and raises notable concern about the likelihood of the existing Financial Alignment Initiative to produce projected savings.***[5] The analysis goes on to highlight specific action steps likely necessary to make such savings achievable. AHCA/NCAL strongly believes that CMS should limit enrollment by states to a small percentage of the Medicare-Medicaid population and only allow expansion when certain benchmarks are met (see below).

2. **Consumer protections should be central to any approach.** CMS has worked with the states to make a number of improvements to the demonstration proposals. For example, in the three MOUs, CMS has required states to provide extensive notice to potential enrollees before passively or auto-enrolling them into the demonstration. However, a number of concerns remain. AHCA/NCAL believes that CMS should require: a) tested and streamlined processes for appealing denial of services that are consumer friendly; b) mechanisms to ensure that federal-state contracts are being followed; and c) states should be required to develop a Medicare-Medicaid Ombudsman Office as part of the demonstration possibly co-located in the State Health Insurance Program (SHIP) entity. Already, the Department of Health and Human Services (DHHS) is offering Aging and Disability Resource Center (ADRC) grants aimed at expanding ADRC capacity to support Medicare-Medicaid eligible considering enrollment in an integration program. AHCA/NCAL strongly believes DHHS should build on this effort by requiring states to implement and operate a Medicare-Medicaid Ombudsman Office.

3. **Use of shared savings.** The three MOUs indicate that states may use the shared savings as they see fit. There appears to be no requirement that such funds be reinvested in services or to enhance quality. AHCA/NCAL suggestion that a percentage of savings should be used to improve access to services and enhance quality.

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[5] Brown, R. and Mann, David. Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence. Mathematica Policy Research. October 2012.

4. **State readiness for expansion or implementation.** Only about four percent of older adults are enrolled in Medicaid managed care.[6] And, outside of a handful of states, the managed care marketplace has limited long term services and supports (LTSS) experience. The majority of states pursuing integration demonstrations have little to no experience with enrolling older adults in Medicaid managed care plans. Furthermore, Medicaid managed care plans have very limited experience with LTSS, particularly among nursing homes. As stated during the hearing, the states and CMS are conducting readiness reviews of the plans. However, CMS is not conducting a readiness review of the states implementing the capitated, risk-based model. Based on the single managed fee-for-service (MFFS) approval, it appears that CMS will be conducting a readiness review of Washington State. However, the scope of this review is unclear. AHCA/NCAL believes that for such complex undertakings, regardless of whether a state is using the MFFS or capitated, risk-based approach, that CMS should conduct a readiness review of the state.

5. **The appropriateness of Medicaid and Medicare capitation rates appears unclear.** Research on Medicare and Medicaid capitation rate appropriateness appears to be very mixed and raises concerns. The recently released Ohio MOU appears to have some additional protections, such as the Minimum Medical Loss Ratio (MMLR). However, three examples in states with considerable Medicare-Medicaid experience are particularly troubling:

    - Recently, CMS conducted a rigorous review of the state of Minnesota's integrated Minnesota Senior Health Options programs, one the longest standing Medicare-Medicaid integration arrangements. The investigation was launched because a plan voluntary repaid the state $30 million-plus because they were overpaid using the state's capitation rate setting methodology.
    - Additionally, the Commonwealth of Massachusetts Office of the Inspector General released a report indicating the Medicaid managed care was paying, hospitals for example, over a 100% of fee-for-service rates.
    - Third, Wisconsin commissioned its Legislative Audit Bureau (LAB) to conduct a study in 2010 to determine the adequacy of its MLTSS rates. The LAB analyzed MCOs' financial statements and spending on services and administration, and determined that rates based on the experiences of pilot counties were insufficient for many of the newer MCOs because the participants served by the newer MCOs were generally more costly. Eight of the nine MCOs had operating deficits in 2009, and three of nine had operating deficits in 2010. The report advised Wisconsin to provide newer MCOs with up to five years of additional payments for risk-sharing, as

[6] MACPAC (June 2011) Report to Congress: The Evolution of Managed Care in Medicaid.

well as making other adjustments to capitated payments to ensure MCOs' financial stability.

- As per a provision in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the General Accountability Office was directed to conduct an analysis of CMS' oversight of state managed care capitation rate setting. In 2010, GAO found notable problems with CMS' oversight and states' application of the managed care rules for capitated rate setting. Currently, Congressional leaders again are raising serious questions about CMS' capacity to ensure adequate oversight and have alleged that states are padding capitation rates to increase federal matching.
- Finally, Congress and MedPAC both have repeated expressed concern about Medicare Advantage costs far exceeding Medicare fee-for-service levels.

AHCA/NCAL believes that considerable work should be invested to ensure accurate rate setting that will cover beneficiary needs, be cost effective and ensure network adequacy. Again, such an endeavor would best be achieved by requiring states to slowly phase in the demonstrations.

6. **The demonstrations should ensure adequate services without unnecessary utilization controls or deeper cuts to fragile provider networks still struggling with recession recovery.** Following the most serious economic conditions since the Great Depression, state fiscal conditions improved in 2012 and are projected to continue to improve in 2013. However, such improvements should be considered in the context of the lingering recovery from the recession. Recent research indicates that state fiscal year 2013 general fund revenues are projected to increase by $27.8 billion while additional spending is projected to increase by only $14.6 billion or 2.2 percent.[7] Despite such improvements, state budgetary recovery remains uncertain and mixed. Twenty-three states still are projecting fiscal 2013 general fund revenues below fiscal 2008 levels and, while improved over 2012, the project 2013 state budget cap is $55 billion. Additionally, the impact of the recession and resulting budget gaps are unprecedented in modern history and states already have exhausted most Medicaid cost containment efforts. AHCA/NCAL strongly believes that Congress should ensure the CMS follows through with its promise of focusing on quality and access first through ongoing oversight including General Accountability Office studies on quality and access to services among demonstration participants.

[7] The Fiscal Survey of States: A Report by the National Governors Association and the National Association of State Budget Officers. Spring 2012.

7. **CMS and the states must ensure states have contingency arrangements for plan failure or withdrawal.** Again, this concern relates to our earlier question about state and plan readiness to take on large scale implementation. Such plan failure or withdrawal could have disastrous impacts on beneficiaries and increase costs as states and the federal government scramble to secure providers and coordinate services for people and their families. If capitated rates are inadequate and/or plans operate at deficits for an extended period, they may exit the managed care program or shut down. There have been several instances of such "plan failure" in the Medicaid managed acute care market. However, there is limited research concerning failure of MLTSS plans. The authors of one study found that non-profit and provider-sponsored plans were less likely to exit. They hypothesized that sponsors of these plans may have a sense of social mission or obligation to serve the Medicaid population, making them less likely to exit.[i] However, in many of these expansions, the non-profit plans are partnering with large commercial plans which may not have such a mission focus and might pull out. Finally, yet another study found that if states required Medicaid beneficiaries with disabilities to enroll in managed care, MCOs were more likely to exit, probably because the MCOs found, or feared, that the capitated rates did not reflect the much higher cost of this population. .[ii] AHCA/NCAL believes that CMS must require a state readiness review on the state strategy to address plan failure.

8. **CMS and States must ensure plans reimburse providers in a timely manner that ensures access and overall network operational and financial stability.** Since 2007, many Medicaid providers have not received rate increases while, at the same time, a notable number have experienced Medicaid rate cuts. We are concerned about the potential negative implications for people's access to services and plan capacity to negotiate rates that will be sufficient to attract providers. Many providers are concerned that the demonstrations will focus more on savings targets rather than quality and care coordination. And, the likely target for savings will be provider rates. Further rate reductions could impact access and quality. Blended capitation at the plan level coupled with plan negotiated rates raises serious questions about how providers will be reimbursed particularly where providers have considerably less experience negotiating with plans much less on blended payment rates. Of note, we are especially concerned about Medicare Advantage rates and providers' capacity to negotiate rates that are sufficient to cover costs as well as bad debt. Finally, sustained cash flow is a key concern for LTSS providers which are almost entirely reliant upon

Medicare and Medicaid. In Medicaid managed care states and with MA-PDs, providers already struggle with eligibility verification issues, prior authorizations, and timely payment. AHCA/NCAL urges consideration of inclusion of prompt pay requirements in the three-way contract arrangements.

We would be pleased to discuss our comments or other Committee member concerns and questions. Inquiries should be directed to Michael Cheek, Vice President for Medicaid & Long-Term Care Policy. He may be reached at 202-454-1294 or mcheek@ahca.org.

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[i] Long, Sharon and Alshadye Yemane. "Final Report: Commercial Plans in Medicaid Managed Care: Understanding Who Stays and Who Leaves in a Changing Market." Centers for Medicare and Medicaid Services, September, 2004. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Long2.pdf

[ii] Kaiser Family Foundation (KFF). "Medicaid Managed Care: Key Data, Trends, and Issues." February 2012.

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NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE
And
NATIONAL SENIOR CITIZENS LAW CENTER

Statement for the Record
United States Senate Committee on Finance
Improving Care for Dually-Eligible Beneficiaries: A Progress Update
Thursday, December 13, 2012

The National Committee to Preserve Social Security and Medicare (NCPSSM) and the National Senior Citizens Law Center (NSCLC) thank the members of the U.S. Senate Finance Committee for holding a hearing to discuss progress of Medicare and Medicaid coordination for dual eligible individuals and the state demonstrations. As beneficiary advocates, we support the goals of the Medicare-Medicaid Coordination Office (MMCO) and its efforts to improve the health care provided to dual eligible individuals. We believe that the demonstrations provide an opportunity to design innovative, person-centered systems of care and hope that the demonstrations will fulfill their promise.

Advocates representing dual eligible individuals have met quarterly with the MMCO to share recommendations and concerns about the demonstrations. Most recently, we met with the MMCO regarding a letter *103 national and state aging and disability organizations* sent to the Center for Medicare and Medicaid Services (CMS) requesting each demonstration include a funded, independent ombudsman program. This letter is available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Dual-Eligible-Stakeholder-Request-for-Ombudsmanmanman-in-State-Demonstrations-102312.pdf.

In brief, we believe that each Memorandum of Understanding must include a detailed written plan for establishing and funding an independent ombudsman. Without a plan in writing, we cannot be certain that ombudsman programs will be in put into place. Dual eligible consumers, who are generally very sick and frail, need an advocate that can assist them in accessing needed services, monitor overall demonstration activity, and identify systemic problems in the demonstrations.

Further, it is critical that the ombudsman is independent from the managed care plan and has sufficient financial resources. We believe states should design ombudsman programs appropriate for their needs, and we recommend building an ombudsman program that provides: 1) information and assistance in pursuing complaints and appeals; 2) negotiation and mediation; 3) case advocacy assistance in interpreting relevant law; 4) reporting on patterns of non-compliance by plans as appropriate and 5) individual case advocacy in administrative hearings and court proceedings relating to program benefits. We are encouraged by conversations with MMCO that the office supports the concept of an ombudsman.

In addition to the ombudsman request, advocacy organizations representing dual eligible individuals sent the MMCO a list of issues and recommendations that require attention for the success of the demonstrations. This document, signed by *33 national aging and disability organizations*, is available at http://www.ncpssm.org/Portals/0/pdf/dual-eligible-demonstrations.pdf.

We thank you for your interest in the state demonstrations for dual eligible individuals, and the opportunity to submit a statement to the record on this important topic. For additional information or questions, please contact Fay Gordon, fgordon@nsclc.org, or Brenda Sulick, sulickb@ncpssm.org.

Senate Finance Committee
Hearing on "Improving Care for Dually-Eligible Beneficiaries: A Progress Update"
December 13, 2012 10:00 a.m.

The National Disability Rights Network (NDRN) would like to thank Chairman Baucus, Ranking Member Hatch, and the Senate Finance Committee for holding this important and timely hearing to assess the progress on improving care for dual eligible beneficiaries. We appreciate the opportunity to draw attention to the continuing needs of dual eligibles and how the Protection and Advocacy Network could be used to address the problems currently being encountered by people with disabilities navigating the two systems, ensuring dual eligibles are receiving the services they are entitled to, and helping them negotiate divergent appeals processes. NDRN and the network of Protection and Advocacy Systems have been involved for years with advocating for the health care rights of people with disabilities and monitoring the accessibility of the health care system. Although the United States has made progress in care for dual eligible beneficiaries, there is still much work to be done.

Who Are NDRN and the Protection and Advocacy Systems?

NDRN is the nonprofit membership organization for the federally mandated Protection and Advocacy (P&A) systems for individuals with disabilities. The P&As were established by the United States Congress through eight separate statutes to protect the rights of people with disabilities and their families through legal support, advocacy, referral, and education. P&As are in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Territories (American Samoa, Guam, Northern Mariana Islands, and the US Virgin Islands), and there is a P&A affiliated with the Native American Consortium which includes the Hopi, Navaho and Piute Nations in the Four Corner region of the Southwest. Collectively, the P&A Network is the largest provider of legally based advocacy services to people with disabilities in the United States.

Medicaid Mandatory Managed Care Legal Problems and Issues

NDRN and the P&As believe that the P&A Network is uniquely situated to address the legal issues and problems that have arisen around dual eligibles, and especially through the increased use of Medicaid managed care. We believe the P&As are well situated because first P&As are located in every state and territory of the United States meaning that a P&A agency is in every place a person can access Medicaid services. Second, the P&As continually address issues that arise in both the Medicare and Medicaid programs, which means unlike other organizations, the P&As have the unique internal knowledge to address problems and issues that can and do arise as a person accesses both systems. Third, in addition to the work the P&As do to address

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problems with state and federal health care systems, P&As also work to address issues with private health insurance meaning that the P&As can advocate for the rights of a person throughout the entire health care delivery system. Fourth, P&A agencies already exist, so any additional funding to help perform a task automatically goes into the service that will be provided rather than into starting a program from scratch and building from the ground up. The following examples show ongoing situations the P&As have been, and will be in the future, well situated to address:

1. **PROBLEM:** A Managed Care Organization (MCO) has little experience providing long-term care and lacks access to specialty providers in the MCO network.

SOLUTIONS: P&A agencies work to educate MCOs and state authorities on long-term care and specialty provider issues in their state or territory, as well as helping develop contracts to ensure enrollment procedures and plans allow for the:

- Right to opt-out of a managed care plan for failure to meet long-term care needs as determined by the person with a disability. The plan must have the burden of proving they can meet needs of individual, and the right to opt out must be indefinite not just in initial enrollment phase.

- Right to petition the plan for access to specific specialty providers or suppliers outside of the managed care plan's network (assuming the benefits at issue are covered by Medicaid).

2. **PROBLEM:** The facilities and equipment of an MCO provider are inaccessible.

SOLUTION: P&As help MCOs ensure the accessibility of facilities and equipment, but can also enforce Americans with Disabilities Act requirements governing medical offices and equipment if necessary. Additionally, P&As work to ensure access to sign language interpreters to help individuals with hearing loss access health services. Finally, P&A agencies work to ensure plans provide adequate due process for people to appeal adverse decisions.

3. **PROBLEM**: MCO providers have financial and programmatic disincentives for providing extra time as may be required for individuals with intellectual or developmental disabilities.

SOLUTION: P&As work with MCO's to eliminate financial and programmatic disincentives to help ensure that people with intellectual and developmental disabilities have access to health care services in a manner that they can fully participate.

4. **PROBLEM**: Person-Centered Service Plans must include important non-medical issues to address health issues that MCOs are not familiar with prescribing and providers are not in network, for example:
- Pre-vocational services;

- Transportation related to the provision of covered services;
- Home modifications for accessible and safe living, and
- Respite care services

SOLUTION: P&As help obtain needed coverage for these services through the rehabilitative and habilitative service options and through Medicaid waivers. P&As can also help ensure plans have adequate due process rights to safeguard these important services.

5. **PROBLEM**: Quality measurements used to evaluate the MCOs are not relevant, nor capture, issues related to long-term care. Unfortunately, many MCO quality measurements look at issues like number of heart attacks and diabetic services, but don't often measure quality related to mental illness or intellectual or developmental disabilities services, especially long-term care services.

SOLUTION: P&As help bring together agencies that can design these measures and identify legal requirements to develop these specific quality measures important to people with disabilities.

6. **PROBLEM:** A lack of federal or state monitoring of MCOs to ensure enforcement of legal requirements impacting people with disabilities, as well as nonexistent or poor due process procedures:

SOLUTION: P&As are familiar with all the licensing agencies that need to work together to monitor, assess, and report on the transition and implementation requirements. P&As ensure adequate accessible grievance and appeal procedures to make challenges to health plan decisions timely, meaningful, and easy to pursue for people with disabilities.

Recommendations to Continue to Improve Care for Dual Eligibles

While great strides have been made on improving care for dual eligibles, much work still remains. Specifically, NDRN and the P&A Network make the following recommendations:

1. **When proposing or approving proposals to address the health care needs of dual eligibles, federal and state authorities need to ensure access to accessible facilities and services for people with disabilities.**

   If a person with a disability is unable to fully access a health care provider's facilities or services, then they will be unable to receive needed medical care, or the care they receive will not address the medical needs of the individual because some aspects of the care are inaccessible or not understood. All plans or demonstrations to address dual eligibles need to include accessibility provisions to ensure that people with disabilities are receiving the health care they are entitled.

2. **When proposing or approving proposals to address the health care needs of dual eligibles, federal and state authorities need to ensure appropriate quality measures of care are included to evaluate the care of people with disabilities.**

   P&As have encountered new systems to serve dual eligibles that do not include proper quality measurement requirements that will reflect the level of care people with disabilities are receiving. Without proper measures of care, oversight agencies cannot adequately measure the level of care that people with disabilities are receiving, which means in many cases that people with disabilities are not receiving the care that they deserve or are entitled to receive. All plans or demonstrations to address dual eligibles must include the design and use of proper measurements of care for people with disabilities at the beginning of the process to ensure that the health care needs of people with disabilities are being met by these demonstrations and proposals.

3. **When proposing or approving proposals to address the health care needs of dual eligibles, federal and state authorities need to ensure adequate due process procedures are in place for individuals to appeal adverse decisions. In addition, consideration needs to be given to better coordination of divergent appeals processes faced by dual eligibles.**

   Without the inclusion of adequate due process provisions, dual eligibles face a confusing array of appeals processes across both programs. Consideration needs to be given to creation and coordination of a due process system to help ensure the rights of people with disabilities are protected in any appeals process.

4. **Specific funding needs to be included in proposals and demonstrations regarding dual eligibles to ensure appropriate advocacy systems are in place to protect the rights of people with disabilities.**

   The ability to serve the health care needs of dual eligibles is complicated by the fact that they are eligible for two systems of health care with different requirements, including appeals processes. In order to ensure that the systems designed to serve dual eligibles are truly helping this population receive proper health care services funding needs to be included to allow for the provision of advocacy services. NDRN and the P&A Network believe that the P&A agencies are uniquely qualified to provide these advocacy services, but to ensure that such advocacy services exist in every state and territory

without reducing services already being provided to other populations requires a dedicated source of funding. To ensure that every P&A agency has the capacity to respond to and assist dual eligibles in a variety of ways, Congress and CMS should provide dedicated resources toward expanding the capacity of the P&A network in this area.

We appreciate the opportunity to provide testimony regarding the work of the Protection and Advocacy Network to assist dual eligibles in accessing health care systems. If you would like further information, please contact Eric Buehlmann at (202) 408-9514, 121.