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DUALLY-ELIGIBLE BENEFICIARIES: IMPROVING CARE WHILE LOWERING COSTS

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CONTENTS

OPENING STATEMENTS

WITNESS

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

DUALLY-ELIGIBLE BENEFICIARIES: IMPROVING CARE WHILE LOWERING COSTS

WEDNESDAY, SEPTEMBER 21, 2011

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 Bingaman, Wyden, Carper, Cardin, Hatch, and Grassley.

Also present: Democratic Staff: Russ Sullivan, Staff Director; David Schwartz, Chief Health Counsel; Kelly Whitener, Professional Staff; and Matt Kazan, Professional Staff. Republican Staff: Chris Campbell, Staff Director; Rodney Whitlock, Health Policy Advisor; and Stephanie Carlton, Health Policy Advisor.

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

The CHAIRMAN. The committee will come to order.

Mahatma Gandhi said, "A measure of a country's greatness should be based on how well it cares for its most vulnerable populations." Last year, 9 million Americans were enrolled in both Medicare and Medicaid. These are often seniors or individuals with disabilities whose incomes are low enough to also qualify for Medicaid.

Most of these dually-eligible beneficiaries live below the poverty line, often with severe disabilities or chronic diseases. They are some of the most vulnerable people in our health care system and often require expensive care.

In 2009, these patients made up 18 percent of the Medicaid population, but nearly half of Medicaid's total spending. States and the Federal government spend more than $300 billion each year on these dually-eligible beneficiaries.

Unfortunately for all of these patients and for taxpayers, Medicare and Medicaid often do not work well together. Each program pays for different types of services. Medicare pays for hospital stays, while Medicaid pays for nursing home care. States set most of their own Medicaid rules, while the Federal government sets Medicare rules. Sometimes these rules conflict.

The beneficiary is often left on his or her own trying to navigate not one, but two, complex health care programs. No one wins in this scenario. The Federal government pays too much for care. States spend precious dollars on long-term care that could have

been prevented. Doctors and hospitals find it difficult to work together. And the patient receives inadequate care.

Congress and those who run Medicare and Medicaid have too often overlooked dually-eligible beneficiaries. There has been little attention paid to the areas where Medicare and Medicaid overlap into the populations served by both programs. In health reform, we began to fix this problem and create better outcomes for patients while saving taxpayer dollars. The health care reform law created an office to focus exclusively on the dually-eligible population, the Medicare-Medicaid Coordination Office. For the first time, Medicare and Medicaid will have to work together.

Some States are creating their own exciting new delivery models. As we will learn from our witness today, these examples show that coordinated care can lower costs and improve care. Massachusetts is working with private health plans to integrate Medicare and Medicaid. North Carolina's Medicaid program has been on the forefront of care coordination. Oklahoma is looking to expand the Program of All-inclusive Care for the Elderly (PACE), a provider-based integration system, to the entire State. These initiatives are promising, but they only affect a small fraction of all dually-eligible beneficiaries.

As we work to improve the quality of care while reducing costs, we should keep in mind four principles.

(1) Medicaid and Medicare funding should be coordinated. Both programs should have the incentive to lower overall costs, not shift costs from one program to the other.

(2) The full range of health care services, from hospital care to long-term care to prescription drugs to mental health care, should be coordinated among all providers.

(3) Providers in States that improve the health of beneficiaries and lower costs should be rewarded financially.

(4) Patient protections should be transparent and comprehensive.

We must provide dually-eligible beneficiaries with choices that meet their health care needs while affording them access to the full range of services they require. We took a first key step in health reform, but we have much more to do to ensure that the most vulnerable beneficiaries are no longer overlooked.

Ms. Bella, I am eager to hear the progress your office has made, and I thank you for all your work. I look forward to learning how you think Congress could improve Medicare and Medicaid so that the two programs work more efficiently.

Many of the States represented on this committee on both sides of the aisle are eager to find new ways to care for these beneficiaries, so let us work together to improve. Let us make the health care system more efficient, and remember what Mahatma Ghandi said: this is the true test of how well our country cares for its most vulnerable, the true test of the greatness of our country.

[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, Chairman Baucus, for holding this hearing. I believe our topic today represents an area where we can achieve some real bipartisan solutions that will lower health care costs and save lives. There are more than 9 million Americans who are eligible for both the Medicare and Medicaid programs, commonly known as dually-eligibles. These patients typically suffer from multiple chronic conditions and also have long-term care needs as well.

In addition to complicated medical issues, payment for their care is generally siloed between complex Medicare and Medicaid payment rules, and this creates inefficiencies and many unnecessary complications. Care for these individuals is also very expensive, with annual spending topping $300 billion in Medicare and Medicaid dollars.

In my home State of Utah, just 10 percent of Medicaid beneficiaries are duals, but 26 percent of the State's Medicaid expenditures go toward care of these patients. Many States have taken the lead to develop innovative solutions for dually-eligibles, such as the Community Care of North Carolina model, or the Star Plus program in Texas. We need to help them build on these successes.

The Federal government has also designed models to address care for dually-eligibles, such as special needs plans in Medicare Advantage or the program of all-inclusive care for the elderly which is known as PACE. And while these approaches have made a difference, there is much more work to do to ensure that every dual-eligible gets better care, and that taxpayers get better value for their dollars. I look forward to hearing from Melanie Bella, the Director of the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services.

Ms. Bella has taken both a pragmatic approach to problem-solving and a compassionate approach to improving patient care. As Congress contemplates reforms to lower our entitlement program spending and to improve the quality of care, the topic of this hearing is an important place to start. Clearly, the status quo is not serving taxpayers well and it is not serving patients well, either. We can do better, and I believe that we can do it in a bipartisan way.

So again, Mr. Chairman, I want to thank you for scheduling this important and timely discussion, and I look forward to working with you on these issues.

The CHAIRMAN. Thank you, Senator. I am very pleased you are here.

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

The CHAIRMAN. Today we hear from the Director of the newly established Medicare-Medicaid Coordination Office, Melanie Bella.

Ms. Bella, just as a reminder, your full statement will be included in the record, and I would encourage you to say whatever you want to say for 5, 6 minutes.

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

Ms. BELLA. I could talk for hours, but I will stick to 5 or 6 minutes. Good morning, Chairman Baucus.

The CHAIRMAN. And let her rip. Say what you want to say. [Laughter.]

Ms. BELLA. Good morning, Mr. Chairman, Ranking Member Hatch, and members of the committee. Thank you for the invitation to participate today. My name is Melanie Bella. I serve as Director of the Federal Coordinated Health Care Office at CMS. This office is what we are referring to as the Medicare-Medicaid Coordination Office, to better explain our mission.

Our single focus is the topic of the hearing today. Medicare and Medicaid enrollees, also referred to as dual-eligibles, are a very heterogenous group. They include low-income seniors, individuals with disabilities, as well as those with serious and persistent mental illness.

The pathway to becoming a Medicare/Medicaid enrollee can vary depending on an individual's health and set of financial circumstances. Some individuals start on Medicaid and age into Medicare; others start on Medicare and have a functional and financial decline that makes them Medicaid-eligible.

As a group, these enrollees have very complex health care needs. Sixty percent have multiple chronic conditions, such as diabetes or congestive heart failure. Almost half have at least one mental or cognitive impairment, such as dementia or Alzheimer's disease. Not surprisingly, given their higher-than-average health care needs, the cost of providing coverage for these individuals is significant, but we believe that provides a tremendous opportunity to achieve program efficiencies through better integration and coordination.

Our office is working across programs with States, providers, and stakeholders on a number of key initiatives to ensure better health, better care, and lower cost through improvement. Specifically, our efforts are focused in three main areas: program alignment, data and analytics, and models and demonstrations. I will highlight a few of those efforts this morning, starting with program alignment.

Better coordination for these enrollees begins with improved program alignment. Currently, Medicaid and Medicare enrollees must navigate two separate programs, as was mentioned: Medicare for coverage of basic acute care services and drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services. Medicaid also provides help with Medicare premiums and cost-sharing.

One of the first objectives of our office was to catalog all of the places where Medicare and Medicaid bump up against each other and where these are creating barriers to care. Through internal and external consultation and outreach, we identified opportunities to improve alignment between the two programs and published a list of these opportunities in the Federal Register.

The public solicitation brought in over 100 responses from a variety of stakeholders, including providers, health plans, States, and beneficiary advocates. We were happy that we even received a few comments from Medicare and Medicaid enrollees themselves, tell-

ing us how the program could work better for them. These comments will help inform our future work and help inform our work with Congress as we make recommendations going forward for how to make the programs work better together.

Another key objective of our office is to engage State partners. Improving the quality and cost of care for Medicare and Medicaid enrollees relies on effective partnerships with States because we share the responsibility to both provide and finance care for this population. Our office has recently announced several key initiatives in support of our partnership with States.

One of these initiatives was the establishment of a new process for States to receive Medicare data for care coordination purposes. Lack of timely Medicare data, particularly Part D data, has been a key barrier for States in expanding their care management efforts to Medicaid/Medicare enrollees. These data provide States with a powerful new tool to support their efforts to improve care for this very complex population.

Our office is also partnering with the Center for Medicare and Medicaid Innovation to establish opportunities through demonstration of delivery and payment reform models to improve the quality and cost-effectiveness of care for Medicare and Medicaid enrollees. A critical aspect of these demonstrations is the expectation from CMS that they include strong beneficiary protections and are informed by meaningful stakeholder engagement at every step.

I will highlight two of these demonstration opportunities this morning. The first is the State demonstrations to integrate care for dual-eligibles, under which 15 States were competitively selected to design new approaches to better coordinate care for Medicare and Medicaid enrollees. I must say, several committee members' States are represented in the group of 15, and so we are very pleased with the interest of States in that regard.

Through these design contracts, CMS is providing funding to the States to support their efforts to design person-centered approaches to fully coordinate care involving primary, acute, behavioral health, prescription drugs, and long-term supports and services. The goal of this initiative is to identify and validate new delivery and payment models that can be tested and replicated in other States.

Early work with these 15 States confirms that a key component of a fully integrated system is testing new payment models. As such, we recently developed and announced a financial alignment initiative that will test new payment and service delivery models, and, importantly, these models are open to all States. We believe that it is important for CMS and for our office to reach out to all States that are interested in improving care for this population.

Specifically, under this demonstration initiative, CMS is making a capitated model available which involves a 3-way contract among CMS, a State, and a health plan, and a managed fee-for-service model available which involves a recognition of sharing savings with a State if Medicaid savings result as a result of improved care management.

A critical link in our partnership with States, both in demonstrations and in our greater efforts, is to be a technical assistance resource to all who are interested in improving care for this population. To that end, we have recently established an Integrated

Care Resource Center, and I am making that resource available, again, to all States.

Lastly, it is worth noting we also recently announced a new demonstration focused on improving quality of care for nursing home residents by reducing preventable hospitalizations. Through this initiative, CMS will select organizations to partner with and will implement interventions to reduce readmission rates and improve the quality of care for those in nursing homes.

In closing, a high priority for our office is to significantly increase the number of Medicare and Medicaid enrollees who have access to seamless coordinated care. We will get there by eliminating barriers to integration; effectively partnering with States, providers, and other stakeholders; and developing new delivery system and payment models.

The programs I mentioned today are just examples of the work that we have begun. Together, in partnership with States, providers, and other stakeholders, and along with your continued support, we can move forward to a more coordinated system that provides higher quality and more cost-effective care for individuals who need it the most.

Thank you very much.

The CHAIRMAN. Thank you very much, Ms. Bella. Clearly, we have selected the right person for the job.

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

The CHAIRMAN. There are a lot of questions all of us have. One for me is, what sort of goals have you set for yourself? What metrics? What is quantified? For example, I understand, at least for the 2008–2009 data, that 16 percent of Medicare participants were dual-eligibles, about 16 percent, but that accounted for about 25 percent of Medicare spending. That same year, 2009, 18 percent of Medicaid patients were duals, but that accounted for about 46 percent of Medicaid spending.

Then there are all kinds of areas looked at, like complexity, whether it is a complexity metric or whatnot. I am wondering if you have set goals for yourself; that is, by a certain date you would like to achieve a certain result that is quantifiable. Could you just talk about that a little bit, please?

Ms. BELLA. Sure. It is a great question. We believe that the inefficiencies in care that are harming both quality and are driving costs in the system result from the fragmentation, so our ultimate goal is to ensure more beneficiaries are served in integrated systems that coordinate all of the benefits and that very importantly align the financing between the two programs.

So our ultimate metric is, how many people can we serve in integrated and coordinated systems? Of the 9 million duals that exist today, we believe about 100,000 of them are in such a system where it is fully integrated and an entity is accountable, clinically and financially, for their care.

So for 2012, our goal is to have 1 million of the 9 million duals into a coordinated, integrated system of care and then to keep building year after year, particularly through our demonstrations and our work with States as we are able to expand the efforts to build these accountable systems of care.

So at the highest metric, that is what we are holding ourselves accountable for, and then it flows down from that in terms of, how are we going to do that, how many States do we want to have in demonstrations, how are we going to share more data, what types of program alignment are we going to address? But it all rolls up to that ultimate metric.

The CHAIRMAN. Right. That is very interesting. Let us say you are successful and you get more people in the coordinated care environment. Have you done any calculations of how that will address the disparity between the population and costs in both Medicare and Medicaid?

Ms. BELLA. We certainly believe that there are three main buckets that we have an opportunity to achieve savings in. One is better care, so, by integrating the care, we are actually going to see an improvement in the utilization of care. The second is, we believe there is duplication inefficiency in the system in what is being provided today, so that represents an opportunity. The third is, there are administrative and operational inefficiencies by the lack of interaction of the two programs.

Quantifying that is a bit difficult at this stage just because we are in the early stages of working with States on putting together demonstrations, but broadly that should give you a sense of where we are going and where we think the cost savings opportunities are that will begin to address the inequity, as you say, between the proportion of people in the program and the spending on those folks in the program. That is what we are working toward over time as we get more specific with States on actual new delivery and payment models.

The CHAIRMAN. I think everybody agrees with the direction we have to move. How much can you do on your own administratively and how much requires legislation? Let me ask it differently: what can you do administratively and what can you not do administratively that you think should be addressed, but would require legislation?

Ms. BELLA. That was part of the purpose of our alignment initiative, to understand that. Many of the areas where there could be greater alignment can be addressed administratively or through the regulatory process. There are some things that will require statutory change. In terms of permanent program changes, those would likely be things that we would need to come back to Congress to support. We have an opportunity on an annual basis to provide you with recommendations in that regard.

Right now, we are in pretty good shape in terms of doing the testing that we need to do to be able to make informed recommendations going forward, by virtue of being able to partner with the Innovation Center and use that new resource to test some of the delivery system and payment models, which ultimately is where we would need congressional support going forward to make permanent changes.

The CHAIRMAN. My time has expired. I will have more questions.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

You know, as a long-time advocate for giving States the flexibility to implement solutions that work for their citizens, I person-

ally appreciate the approach that you have taken on getting ideas from the States to design innovative models for the care of dually-eligible beneficiaries.

However, I am concerned that this will take quite some time, and, while we can always benefit from more ideas, many States have already implemented innovative approaches to better care for duals through various waivers. Now, based on your experience as the former State Medicaid Director in Indiana and your work now at CMS, what kind of legislative proposals do you recommend we evaluate to advance better care delivery for dually-eligible beneficiaries?

Ms. BELLA. We are doing our best to work with States to offer streamlined approaches so that we can get new products and demonstrations out in the field faster and learn what works, and then disseminate those to other States. At this point we have the tools internally to be able to work with States in a flexible manner. One of the main reasons we put out a State Medicaid director letter that I referenced earlier was to announce two new demonstrations for all States.

It basically puts it just one step away, almost, from doing it in a State plan format, because it is a streamlined approach that is very clear on how States can take advantage of these opportunities with us. For now, we feel like we have the tools we need to do the testing to be able to come back to you with informed recommendations down the road as to what sort of statutory changes might be needed in the future.

Senator HATCH. All right. As I understand it, your financial alignment initiative consists of two approaches. Under the first, there would be, I think, a 3-way contract where a plan receives a prospective blended rate. Could you detail for us how that rate would be determined? Then, under the second, a State would benefit from shared savings under their unique approach. Now, how would payments to States and savings be determined here?

Ms. BELLA. Sure. Those are both very good questions. Under the capitated approach—and I should say, this is kind of version II of a prior meta-demonstration that happened several years ago, where Massachusetts actually had a 3-way contract. Minnesota and Wisconsin also participated. But we have had some experience with this model.

Essentially what we are doing is, we are looking at building—let us say that it is me, I am the dually-eligible beneficiary. We are building a rate based on my needs. We are understanding all of the services based on historical utilization and expected future utilization, looking at what that rate would be, and then determining the Federal/State sharing in the funding of that capitation rate and passing that rate to the health plan. But we are doing it in such a way that it assumes efficiencies in those three areas that I mentioned earlier.

Therefore, it is a reduced amount than what either the State or Federal government would have paid absent this integrated program. So, essentially, it is a capitated prospective rate that is less than what we would have otherwise paid as the result of the coordination we are expecting.

In the managed fee-for-service model, that is designed where essentially we would set a baseline, a benchmark of what we would expect spending to be absent this program. We would measure the actual experience of the beneficiaries in the demonstration relative to the benchmark. If it hit pre-established savings thresholds that the State and CMS would have worked out, the State would be eligible to share in a percentage of those savings.

There are a couple of key caveats. One is, quality measures have to be attained, so we cannot just have savings occur to the detriment of quality. Also, we are measuring States on impact in Medicaid spending as well because we want to make sure, again, we are not creating new opportunities to cost shift between the two programs.

Senator HATCH. In its June 2011 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that "Medicare's requirement for voluntary enrollment in coordinated care programs is a key limitation to expansion." Do you agree that this is a limitation to expansion of effective models of coordinated care, and would you support models that allow States to enroll their dually-eligible patients into better models for care coordination?

Ms. BELLA. One problem that we have with these models is, these are very complex patients, these are very complex systems, and we have a hard time communicating the benefits of integrated systems of care. So what we are seeking to build are systems that are far superior to what we have in fee-for-service today, and we believe that those systems are ones where beneficiaries would want to receive their care and where they would get better care.

As part of our financial alignment models, we have made public the opportunity for States to request passive enrollment of beneficiaries into these models with an opt-out, with the understanding that these models also carry very critical consumer protections. But to answer your question, States have the opportunity to request passive enrollment with an opt-out, assuming these beneficiaries protections are met.

Senator HATCH. All right. My time is up, Mr. Chairman.

The CHAIRMAN. Do you have more questions?

Senator HATCH. No, my time is up.

The CHAIRMAN. Do you have more questions?

Senator HATCH. I may have some. I am going to ask again.

The CHAIRMAN. All right. Fine.

Next, Senator Bingaman.

Senator BINGAMAN. Thank you for being here.

Let me ask about two issues. I think you mentioned in your testimony that nearly a quarter of all hospitalizations for dual-eligibles are avoidable. I guess a first question would be, in concrete terms, what can you do and your office do to reduce these preventable hospitalizations? I know this is something you are trying to accomplish. I am just not really clear in my own mind what changes in regulations at the Federal level can do to actually reduce the number of people who go into the hospital who do not need to.

Ms. BELLA. That is a great question. Given that the majority of the Medicare and Medicaid enrollees are in fragmented systems, there is no one who is helping them navigate those systems. There is no one who is looking at the medication to ensure that it is what

it needs to be and that there are no contraindications. There is not anyone making sure that the primary care foundation is there. So, all of these factors contribute to why people end up in hospitals: inadequate primary care, medication problems, lack of coordination among the various service providers.

So what our office is doing is trying to put together care models and other programs that focus on care coordination for folks, on medication management, on care transitions when people are going between settings, because we believe that those provide the foundation of keeping people out of the hospital when they do not need to be in the hospital. I would say, I would just take your point one step further.

Where this is even more compelling is for beneficiaries who are in nursing homes. We actually believe there is a 40-percent preventable hospitalization rate for beneficiaries in nursing homes. One of the things we are doing, as I mentioned, is a demonstration specifically targeted at that population to stop this churn that we see that is going on that is very bad for patients. It is very, very costly, and it should not be happening.

Senator BINGAMAN. A related issue is the problem of hospital-acquired conditions. I think the health care that folks in this group—since an awful lot of these dually-eligibles wind up going into the hospital at some time during the year, their need to stay there or return or whatever is sometimes increased because of the conditions that they acquire in the hospital.

What are you able to do in your office to deal with that problem?

Ms. BELLA. Well, fortunately there are many department and agency initiatives under way that target that very thing. So the Partnership for Patients, which you may be aware of, is looking at a reduction in patient safety of 40 percent on top of also looking at readmissions. So there are several initiatives that are bringing together partnerships in States with providers, hospitals, and payers to get at that very issue.

So fortunately, the dual-eligible population is such a high priority that it is a target population within these initiatives that are under way. So we have an ability now within the agency to advocate for this population and make sure that they are included in all of these initiatives, especially when it comes to payment incentives and really focusing on and measuring the impacts specifically on this population.

Senator BINGAMAN. This Partnership for Patients program is funded at $1 billion, I guess, or there is a $1-billion fund that has been set aside for this. How much of the dual-eligible population is being reached or in any way impacted by this?

Ms. BELLA. I can give you sort of a qualitative answer, and then I will be happy to provide some follow-up. Broadly, the Partnership for Patients is looking generally at the relationship of the hospitals, and then we have the Care Transitions Initiative that was part of health reform. Many of the dual-eligibles will likely be part of the Care Transitions Initiative, which is really focused on community-based organizations, really trying to work to prevent errors and re-hospitalizations.

So, broadly speaking, it is a small population, the duals, but they have a high percentage of the things that the Partnership for Pa-

tients campaign is targeting. Therefore, we believe that the campaign will have a huge impact in terms of the number of duals that it touches and the spending that it can possibly help control. And like I said, I would be happy to get back to you with some more quantifiable information.

Senator BINGAMAN. Yes. Anything you could give us that would document the extent of the savings, the extent of the reduction in these hospital-acquired conditions, that would be great.

Ms. BELLA. Certainly.

[The information appears in the appendix on p. 55.]

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

Ms. Bella, if anybody was designing a system from scratch, that person obviously would not create a system like we have today for dual-eligibles. Medicare and Medicaid pass responsibility for dual-eligibles back and forth between Federal and State governments in a way that is more likely to discourage than encourage coordination.

Ideas like giving the Federal government complete responsibility for duals through a comprehensive Medigap policy purchased with State contributions or giving the States responsibility for duals with the use of Federal dollars to pay the acute care would eliminate the counter-productive Medicare and Medicaid relationship.

So my question to you is: could you give me any good reason that we ought to continue the Federal/State partnership for this population without significant restructuring?

Ms. BELLA. That is, I think, the million-dollar question. It is a very good one. The challenge that we face is that the system that we have today has evolved over 45 years, so our efforts over the past year have been to try to become more informed to answer questions like yours.

So, for example, with the program alignment initiative, we are trying to really understand the differences in all areas—enrollment, eligibility, marketing, grievances and appeals, financing, performance measurement—between Medicaid and Medicare, to understand how they got the way they are today and what they would look like in a better system, and "better" being from the perspective of serving beneficiaries better, as well as serving the taxpayers better. So, that is an example.

The second area is the data and analytics. We do not know enough about this population to understand the drivers to know how to design a more effective solution for 9 million of them who are very diverse, so the analytic activities we are undertaking again will inform that question.

Lastly, the models and demonstrations are going to be telling. There are many folks out there who believe that the Federal government could do a better job, and just as many who believe the States could do a better job. There are good things in each program, but each program misses key elements as well.

So the demonstrations and models should really help to inform, how would we take the best of both and put them together in a

way that, again, is better from a beneficiary perspective and better from a taxpayer, a State and Federal government, perspective?

Senator GRASSLEY. Have you done enough study to know whether there is progress being made that you can see light at the end of the tunnel for restructuring so we can get away from the mess that we are in?

Ms. BELLA. I think we definitely believe there is light at the end of the tunnel. The question is, how quickly can we get there? The challenge we face today is, even when we have seen some promising solutions, it takes a while to get those to scale. That is due to a couple of factors. One is, this is a very complex population, and the types of care they need, it is not the same as being able to expand, for example, to a population of fairly healthy moms and kids.

The second is just having the capacity in the field to be able to provide the types of services that are needed. There is a lot that needs to be done on the long-term support and services side, and building that capacity takes time. So, there is light at the end of the tunnel.

I think we certainly see opportunities for alignment between the two programs. We have identified where there is major cost-shifting, and we are trying to put our fingers on those holes, and then again be able to continue to work with Congress and others on how to take those more broadly and inform future program changes.

Senator GRASSLEY. We have a study published in the September issue of *Health Affairs* by Gina Livermore showing that there was $63 billion in 2008 in Medicare spending on working-age people, meaning those mostly with disabilities. That was roughly 14 percent of Medicare spending. Medicaid spending on working-aged people with disabilities in 2008 was $88, almost $89 billion. That means a very large portion of Medicare spending on working-age individuals would have been for people who are dual-eligibles.

Do you think that the senior duals and working-age duals are separable populations and should be treated differently in any solution to improve coverage and coordination for dual-eligibles?

Ms. BELLA. Another very good question. Even if you just split the population at those over 65 and those under 65 with disabilities, there is still so much diversity, and there is commonality even above and below that line, that it makes it very difficult to give you a "yes" or "no" answer to that question.

I think what I would like to say is, with the analytic work we are doing, again, to drill down into this population, a lot, Senator, depends on folks in both of those groups being in institutional settings. That changes a lot of things and would change the way that I might answer that question. If there is mental illness or dementia involved, all of those things would influence the answer to that question.

As we do more analytics and really drill down into the subsets of the population, I think we would be able to come back to you with a very informed answer and a set of at least some analytic work that might help inform some thoughtful choices about how to best organize the delivery system around the very heterogeneous population.

Senator GRASSLEY. Just a short answer to this: are you thinking in the direction of some division along the lines of my question or have you not reached that point yet?

Ms. BELLA. We have not reached that point yet.

Senator GRASSLEY. All right.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Ms. Bella, I know you have a long record of advocating for these folks, folks who are eligible for Medicare and Medicaid, so I think that gives me a certain leeway to speak bluntly about where we are with respect to this issue.

My own view is, we have been treading water on this question literally for decades. I look back, when I was co-director of the Oregon Gray Panthers, and we were doing exactly what we are doing now: we are talking about demonstration projects, small-scale kinds of studies. We knew that this was a group that was sort of precisely fitted for essentially the house-call arrangement kind of approach, a team approach—doctors, nurse practitioners, a multidisciplinary approach.

Here we are today in pretty much the same place. As you know, I, and a big bipartisan group, authored the Independence at Home portion of the Affordable Care Act. The same issue. We wanted to have a large group of people, but everybody kept ratcheting it down. Now we are talking about a demonstration of 10,000 people. That is where we are. Essentially that is about where we were 3 decades ago when I had a full head of hair and rugged good looks and I was director of the Gray Panthers and we were talking about exactly the same issue.

So here is my question: since we passed the Affordable Care Act, we have another demonstration. My colleagues are absolutely right about these State experiments. Two very important things have taken place. As you know, the VA has come out with this blockbuster study where they showed, for their group that they were taken care of at home, they reduced hospital stays by 62 percent, nursing home days by 88 percent, the costs by 24 percent.

Those folks are almost exactly in the same spot as folks who are eligible for Medicare and Medicaid, except for the fact they are even sicker. They have 5 chronic conditions and co-morbidities. In addition to that, the experts at the University of Pennsylvania have said that if you had a fully operational independence at home program you could save somewhere in the vicinity of $30 billion annually for Medicare.

So my question to you is, what is going to have to be done to take this program, writ large? As you know, there are millions of eligible people. We have these demonstration projects. There is provider capacity, according to what we have seen, for about 2 million people, not the whole 9 million you talked about. What is it going to take to get this beyond the small groups and get to the point where we can get more people care where they want to be at a cheaper price?

Ms. BELLA. It is a great question. I agree with you that the Independence at Home model and the home visits are an important one for a subset of the population that has those needs. Part of what

we seek to learn from Independence at Home is how to bring the Medicaid piece in there as well, since to date the demonstrations have been Medicare-focused. So we want to make sure we are bringing all of that together for the population.

We have early experience along those lines, service provided in the home with the PACE program also, which, as you know, has remained small as well. I guess I am neither hopeful nor naive that by creating this office there is a force that might be able to push for a broader and faster expansion than we have been able to do in the past. No one has ever had the luxury of only having this population to worry about and being able to sort of lobby for that population.

Senator WYDEN. Because time is short, with the advocacy you are doing, in 5 years how many of these folks will we have in programs at home with the kinds of models that we are talking about? Are we going to be able to get to a million within 5 years? I mean, the provider capacity is 2 million. You said there are 9 million eligible people. I would like to get your sense so at least we have a target and we can say we are going to make this sort of where we want to go and get beyond these demonstrations. What are we going to be able to do in terms of 5 years from now?

Ms. BELLA. Sure. We like to have targets as well. What I would like to do is get back to you. I would like to go back and make sure that—because that type of program, everyone would not fall into those criteria. So what I would like to do is go back, look at how many of the 9 million we think would be appropriate, and come back to you with a quantifiable target that matches our 1 million to have in broad systems by 2012.

Senator WYDEN. But just do take a look at that VA model, because they are essentially, those folks, exactly like the people whom we sought to address in the legislation with Independence at Home, except they are even sicker.

Ms. BELLA. All right.

Senator WYDEN. So that is why we have a model.

Thank you, Mr. Chairman.

Ms. BELLA. Thank you very much.

[The information appears in the appendix on p. 55.]

The CHAIRMAN. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Well, thank you, Mr. Chairman. Let me thank you for your testimony. I want to follow up on Senator Wyden's point because I think he is absolutely correct. I served for many years in the State, and I know it is extremely difficult to get the States to move forward on programs that will save them money, when they have to invest to save. Particularly in these budget times, it is difficult to just point out Medicaid savings and say therefore, yes, let us get on board when they know that they have to invest in order to do that.

What Senator Wyden was asking, and I want to follow up on that, is, we need bolder proposals. The demonstration programs are fine, but again, there is an inconsistency in the use of the demonstration programs. So I think we are looking for bolder approaches to sort of get more of the dual-eligibles under a managed program where they have access to care that they have not tradi-

tionally had. We need bold proposals that recognize that a large number of the dual-eligibles did not get access to care earlier in life that has complicated their medical needs today.

We need bolder proposals that understand that a large number have challenges in the mental health area. So, are you looking at ways that we can really make a significant change in the way that the dual-eligible population has access to care under the Medicare and Medicaid programs?

Ms. BELLA. We are. I recognize it is frustrating that I am going to use the word demonstration, but the demonstrations we are doing, the financial alignment demonstrations, actually target 2 million beneficiaries, so their target time frame is 2012. We are looking for 2 million of the 9 million, which is more aggressive than we have ever been able to be in the past.

We do have challenges with State bandwidth right now, as well as States being able to make an up-front investment, so we are trying to support States so they can take us up on these models. We do want to expand faster than we have done in the past, but this is a complex population, and putting the two programs together and getting the care and the financing aligned correctly is a complex thing, so we want to make sure that we are doing it in a way that actually is going to achieve the outcomes that you discuss and not actually drive costs to the system, either at the State or Federal level, over time.

Also, some States are going pretty boldly in focusing on populations with serious mental illness or focusing on different populations, so we also believe we will have a variety of approaches that, again, allows us to get a good sense of what things we might want to take to even broader populations.

Senator CARDIN. Do you have a good analysis as to why the dual-eligible population, on a per-person basis, is more expensive in their needs than the general Medicare population?

Ms. BELLA. We do. I mean, there are many factors that contribute to that. Part of it is the complexity, the number of conditions, the prevalence of mental illness, the number of medications that they take, their lower socioeconomic status. There are higher levels of cognitive impairment. We have a higher proportion of racial and ethnic minority populations served. We have a fair amount of that, and I would be happy to provide follow-up.

Senator CARDIN. And that is consistent with some of the information that I have reviewed and my staff has provided to me.

It seems to me that, if we are going to take bold steps forward, these are the type of issues we have to address: the racial disparities, the poverty issues, socioeconomic issues, the mental health issues. If we are going to make significant progress on the dual-eligibles, we have to understand the reason why we have higher cost issues and then have programs that aggressively deal with it. So it is not just the delivery model, it is dealing with how we are going to overcome those type of disparities we have had in the past.

Ms. BELLA. Yes.

Senator CARDIN. Are you doing that?

Ms. BELLA. Yes. Part of what we are doing is a lot of analysis to drill down on all the factors that are driving the cost to understand the subsets of the population and use that to inform our

work to design new care models and delivery systems that address the gaps and the care opportunities specific to sub-populations.

Senator CARDIN. So the Affordable Care Act provided for the Office of Minority Health and Health Disparities, as well as a center within NIH. Are you working with them to deal with the fact that the dual-eligibles are a higher proportion of minorities? Are you working in that regard?

Ms. BELLA. We are working with them. We will be requiring our States to help us understand how their demonstrations will feed into the disparities targets that we have set at the Federal level, and as an agency.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Carper?

Senator CARPER. Thanks. Do you pronounce your last name Bella?

Ms. BELLA. Bella.

Senator CARPER. Like Bella Abzug?

Ms. BELLA. Like what? [Laughter.]

Senator CARPER. Former Congresswoman.

Ms. BELLA. Oh.

Senator CARPER. All right.

I want to ask a question about PACE, if I could. If somebody just dropped out of the sky, they had no idea what this PACE program was about, just knew nothing, how would you explain it very simply so they could actually understand it?

Ms. BELLA. With the PACE program, someone who has very serious needs and is very frail would be able to get their needs met through the PACE program by going to a certain side of care for their medical and social needs.

Senator CARPER. All right.

I am told, and you have talked a little bit about this, that the PACE program contains some difficult age, health, geographic, and investment requirements that will often discourage patients and health care providers from participating in the program. My staff tells me there are just barely 20,000 people, I think, nationally who participate in the PACE programs. The potential for actually getting a better result for less money, or a better result for the same amount of money, is actually pretty good, but that is not many people to be participating.

In your view of the PACE program, what have you learned about the program's effectiveness in improving health care outcomes and reducing costs? Would you just please share with us your recommendations for how to improve the PACE program and how it may overhaul the eligibility requirements to encourage more patients and more providers to participate in the program?

As you prepare to answer that question, one of the things I have focused on is how to get better results for less money. Dr. Alan Blinder, former Vice Chairman of the Federal Reserve, sat right where you are sitting a couple of months ago on a panel on deficit reduction. He said unless we do something to reign in health care, the growth in health care costs, we are doomed as a Nation on the deficit side.

So I asked him later in the Q&A, so what should we do about those health care costs, Dr. Blinder? He said, "I am not an expert on this stuff. All I know is, find out what works, and do more of that." That is what he said: "Find out what works, and do more of that." I wonder if PACE could be one of those things where, if we find out what works, we could do more of that. But how do we do more of this?

Ms. BELLA. Sure. Great questions. So the PACE program, as it is currently structured——

Senator CARPER. Do you think this committee probably asks more great questions than most committees you go before? [Laughter.]

Ms. BELLA. No. I think, though, that——

The CHAIRMAN. I was going to say, that is my impression. I have never heard a witness——

Ms. BELLA. Oh, you do not understand. This is my favorite subject in the whole world, so all the questions, I love them. I am a bit obsessed with the topic, so I love them all.

The PACE program, as it is currently designed, is for a very frail population, as you allude to. But the care model is also geared toward a very frail population, so when we make changes in the eligibility standards, for example, we just need to look at how we might make changes in the care model, in the financing of all that, just to make sure that is all aligned.

So, for example, if we brought in the eligibility standards, we may want to change a little bit about how we pay for it and how the teams are structured, because you do not want to pay at the same level for such a complex population. So, bearing all those things in mind, there is great interest in a couple of things, the first, I would say, being dropping the eligibility age, so now you have to be 55 or older. There has been a lot of talk about, should we make that available to a younger population that has disabilities, for example? Again, thinking through that, it is worth considering as long as we think about, are there other changes we would make to the care model, for example?

As far as the providers go, again, some flexibilities that have been brought to our office have to do with kind of relaxing a little bit the need to have all the services provided right there. One of the issues is whether a patient can continue the relationship with the current provider. So we are trying to figure out, how do you take the PACE concept and allow it to work with some community contract providers, for example, without violating the integrity of the model?

So, is it something that works? Yes, it works very well for this population. As we look at changing the composition of the population, we would have to look at, how do we make it work to broaden it and make it scaleable? Those are things that are appropriate for our office to do, and things that we are doing with the National PACE Association through its recommendations, as well as with our colleagues in CMS.

Senator CARPER. That was a good answer. [Laughter.]

Ms. BELLA. Thank you.

Senator CARPER. All right. Let us talk about one more last, quick question. I think the Simpson-Bowles Deficit Reduction Commis-

sion recommended, among other things, a policy that would include all dual-eligibles enrolling in Medicaid managed care. Even though some States currently do not have any Medicaid managed care operations, Delaware is one that does. Many States are planning to move their managed care beneficiaries into managed care programs as a way to get better results for less money.

Here is my question: is the increased use of Medicare managed care programs for dual-eligibles an effective way of providing health care services at a lower cost, and how could the States and the Federal government work together to ensure that Medicaid managed care programs deliver high-quality and coordinated health care services to dual-eligibles?

Ms. BELLA. So, just as we think PACE is a viable option, we think managed care is a viable option. We also know that there are States that do not have managed care, so they need options as well. The important thing, I think, in your question is that the entity that is providing the services has the responsibility and the accountability for both Medicaid and Medicare, and that is what is important about the proposals we are putting forward.

So the managed care approach we are putting forward combines both Medicaid and Medicare in ways that you would not get the benefits of that integration if we focused on a proposal that only advocates Medicaid managed care, for example, or Medicare managed care. Importantly, though, there will be States that will not have managed care for any number of reasons, and that is why we have put forward also a managed fee-for-service alternative, again, because we need duals in those States to also be in more integrated systems for all the reasons we have discussed: quality, cost, all those things.

Senator CARPER. All right. Thank you very much.

The CHAIRMAN. Thank you, Senator.

I think to some degree, when a lot of us think about this problem, at least I do, it seems like the whole thing is inherently unstable. We have Medicaid, we have Medicare, totally different payment systems, totally different structures, totally different culture. We are trying to fit a round peg in a square hole to some degree.

If you had a magic wand and you could enact anything you wanted—you know a lot about this problem. I mean, thinking big, there are no constraints on you, what would you do? Would you follow the VA model? Would you abolish all this stuff and set up a third category of elderly poor and a third totally separate pool? What would you do? Forget about statutes needing to be changed. Forget about anything else. What makes sense?

We are all kind of frustrated that we have been at this for a long time. There has been some progress, but it is costly, it is inefficient in care, people just are not getting the care that they really should get, is my understanding. I am asking the question a little bit at length so you can think. [Laughter.]

So you can come up with whatever you want to come up with. But this is Melanie Bella, and I can do whatever I want to do.

Ms. BELLA. And anything I say does not leave the room, right?

The CHAIRMAN. I am sorry?

Ms. BELLA. Nothing I say leaves the room.

The CHAIRMAN. Nothing you say. Just carte blanche. Just, what should we do here?

Ms. BELLA. So, fundamentally, the problems are, there is no—again, I will use myself as an example. Pretend I am a dual-eligible. I have a separate prescription drug plan, I have separate Medicare and separate Medicaid. Nobody is responsible for making sure I have what I need in the most cost-effective and the least-restrictive setting, so the first principle has to be, we have to have all the services together and some type of accountability for the services.

The second principle has to be, we have to figure out a way that, regardless if we shifted out of the Federal government or shifted out of the State government, it is hard for me to believe, even with a magic wand, we would ever let one or the other off the hook from a payment perspective. So we have to figure out how we get the funding aligned as you figure out how you might develop a new system.

So I do not have an answer for you. I know what the system has to have in it, and it is those two characteristics. There are different ways that we could design it depending on various other opportunities or constraints as work proceeds, both with our office and I know with the super committee and the various other efforts under way.

The CHAIRMAN. All right. Well, let us not throw a bomb in all this. Let us keep to the system we have. How can we help you move more quickly, more efficiently to accomplish the things you are trying to accomplish? What can we do to help you?

Ms. BELLA. Well, you have made a great——

The CHAIRMAN. Should we give you quantifiable goals, or should you come up with those goals and tell us what they should be? Do you want us to just harangue you? What works?

Ms. BELLA. We can commit to—we have a pretty good set of goals, and we want to hold ourselves accountable for this, and we certainly will continue to do so with this committee and your colleagues. You have done a great thing by creating this office, and I think what we need to do right now is, we need a little bit more time to finish some of the exercises we are going through, looking at the data and the alignment and then the models and demonstrations.

Really, what we would like is to be able to continue to, I think, have a dialogue on an ongoing basis about what we are learning and changes that we might be able to make along the way. The Secretary will be providing an annual report to you. We have done one; we will do this annually. Each time that we uncover potential statutory needs or recommendations, those will be included.

So I feel like we have a good vehicle for communicating with you. What we are trying to do right now is be able to put some activities in place that allow us to come back with very concrete and informed responses to your question about, how can you continue to help us even more as we evolve?

The CHAIRMAN. So, when is the next sort of decision point? When is the next sort of benchmark as you look down the road in the next several months? That is, a time when we can come back and talk again.

Ms. BELLA. Well, I do not think you will want to talk to me this close, but October 1st is a big date for us. All the States that are interested in doing one of our financial alignment demonstrations submit a letter of intent by that date, so we will have a very good idea of take-up and the number of beneficiaries that we could perhaps begin testing in these models. By the end of the year we will have a pretty good sense of when the start date for those will be.

I think early 2012, we would have a very good update on where we are with our alignment initiative, with our data efforts, and we would have a much better picture of the States that we will be working with and the number of beneficiaries they hope to serve in these new models.

The CHAIRMAN. So what would you like to accomplish by early 2012?

Ms. BELLA. I would love to have a large number of States that are going forward with us in one of these payment models that gets us close to the 1 to 2 million beneficiaries range. We would like to have the majority of our analytic work undertaken so that we can talk to you about some of the subpopulation analysis and answer questions like Senator Grassley is asking. We would like to have recommendations.

We would have, again, presented a second annual report to Congress by that time, and we would have an update for you on some of the areas that have a greater opportunity for alignment, and which of those things we have been able to tackle administratively or through regulation and which things would require statute.

The CHAIRMAN. All right. Well, why do we not do that? Why do we not get together sometime in 2012?

Ms. BELLA. All right.

The CHAIRMAN. We will have a follow-up hearing to just see what we have accomplished, how we can help, the areas where we have slipped a little bit. Maybe we will be surprised because you have gone a lot further than we expected.

Ms. BELLA. I will hope to surprise you, yes.

The CHAIRMAN. All right.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Just one other question if I could, Ms. Bella. On page 8 of your testimony you say, "Access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for their highest-cost beneficiaries." Senator Grassley and I have introduced a bill to make that Medicare data available to the public. Would that not be helpful as well here for families and others to have that kind of data as we try to work to get that 1 to 2 million population served as quickly as possible?

Ms. BELLA. Certainly we know there is great interest in getting access to these data. Those data are at the beneficiary level, so it is pretty personal.

Senator WYDEN. Well, all of this, and all the reform proposals, take everybody's name, ID, any of that sort of thing off.

Ms. BELLA. Exactly. This does not though, because it is beneficiary-level so that it can get in the hands of providers and care managers to truly be used to develop their care plans and help them do navigation. So I certainly understand the interest in tak-

ing aggregate data and getting it out in the hands of folks who can use it to help make sure people are getting better care. I just would say the distinction in what is in the testimony and what we are giving to States is beneficiary-level for the very purpose of being used for specific care coordination programs.

Senator WYDEN. Well, I will send you the bill, and, for the record, I would like a written response, because I think it is exactly the same thing. I mean, your point about making sure that it is bullet-proof in terms of protecting the privacy of patients and individuals is spot-on. I think Senator Grassley has had a longstanding interest in this, and I have done that. So I would like your response for the record because, if this data is useful to the States, it seems to me it ought to be available to the public because it goes right to the point that you are saying: this kind of data can help coordinate care, improve quality, and control the costs. So, if you would respond in writing, that would be great.

Thank you, Mr. Chairman.

[The information appears in the appendix on p. 56.]

The CHAIRMAN. Thank you, Senator.

Thanks, Ms. Bella. I really appreciate your very hard work. You are clearly dedicated. I would just urge you to obviously keep at it. If you need help from this committee, just let us know.

Ms. BELLA. All right. Thank you very much.

The CHAIRMAN. It is all teamwork. Thank you.

Ms. BELLA. Thank you.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 11:15 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Enrollees in Both Medicare and Medicaid

Mahatma Gandhi said, "The measure of a country's greatness should be based on how well it cares for its most vulnerable populations."

Last year, nine million Americans were enrolled in both Medicare and Medicaid. These are often seniors or individuals with disabilities whose incomes are low enough to also qualify for Medicaid.

Most of these dually-eligible beneficiaries live below the poverty line, often with severe disabilities or chronic diseases. They are some of the most vulnerable people in our health care system and often require expensive care.

In 2009, these patients made up 18 percent of the Medicaid population, but nearly half of Medicaid's total spending. States and the federal government spend more than $300 billion each year on these dually-eligible beneficiaries.

Unfortunately for all these patients – and for taxpayers – Medicare and Medicaid often do not work well together. Each program pays for different types of services. Medicare pays for hospital stays, while Medicaid pays for nursing home care.

States set most of their own Medicaid rules, while the federal government sets Medicare rules. Sometimes these rules conflict and the beneficiary is often left on his or her own trying to navigate not one, but two, complex health care programs.

No one wins in this scenario. The federal government pays too much for care. States spend precious dollars on long-term care that could have been prevented. Doctors and hospitals find it difficult to work together. The patient receives inadequate care.

Congress and those who run Medicare and Medicaid have too often overlooked the dually-eligible. There has been little attention paid to the areas where Medicare and Medicaid overlap, and to the populations served by both programs.

In health reform, we began to fix this problem and create better outcomes for patients while saving taxpayer dollars. The health reform law created an office to focus exclusively on the dually-eligible

population: The Medicare-Medicaid Coordination Office. For the first time, Medicare and Medicaid will have to work together.

Some states are creating their own exciting new delivery models. As we'll learn from our witness today, these examples show that coordinated care can lower costs and improve care.

Massachusetts is working with private health plans to integrate Medicare and Medicaid. North Carolina's Medicaid program has been on the forefront of care coordination. And Oklahoma is looking to expand PACE, a provider-based integrated system, to the entire state. These initiatives are promising, but they only affect a small fraction of all dually-eligible beneficiaries.

As we work to improve the quality of care while reducing costs, we should keep in mind four principles.

First, Medicaid and Medicare funding should be coordinated. Both programs should have the incentive to lower overall costs, not shift costs from one program to the other.

Second, the full range of health care services – from hospital care, to long-term care, to prescription drugs, to mental health care – should be coordinated among all providers.

Third, providers and states that improve the health of beneficiaries and lower costs should be rewarded financially.

And fourth, patient protections should be transparent and comprehensive.

We must provide dually-eligible beneficiaries with choices that meet their health care needs while affording them access to the full range of services they require. We took a key first step in health reform, but we have more to do to ensure the most vulnerable beneficiaries are no longer overlooked.

Ms. Bella, I am eager to hear the progress your office has made. I look forward to learning how you think Congress could improve Medicare and Medicaid so that the two programs work more efficiently.

Many of the states represented on this Committee, on both sides of the aisle, are eager to find new ways to care for these beneficiaries.

So let us work together to improve Medicare and Medicaid to better serve dually-eligible beneficiaries. Let us make our health care system more efficient. And let us work to better care for our most vulnerable population.

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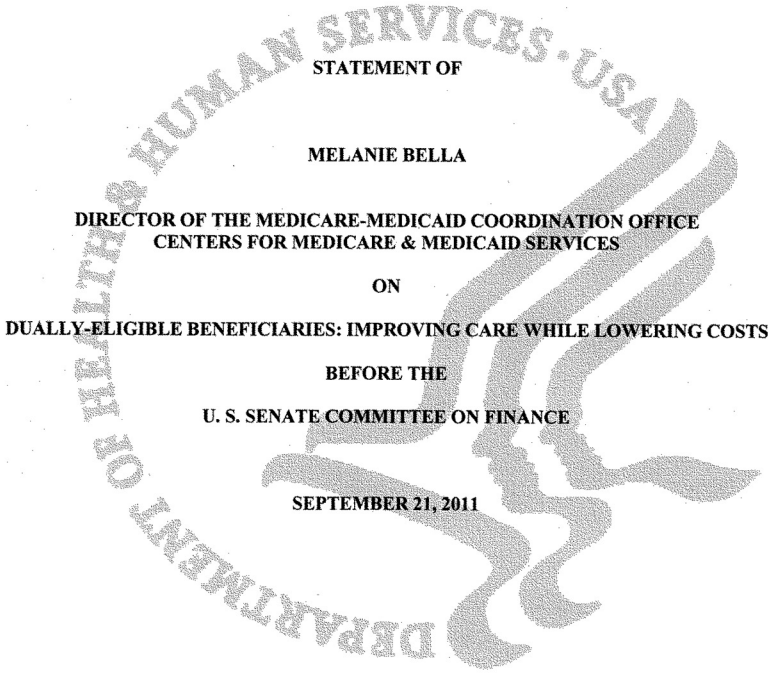

STATEMENT OF

MELANIE BELLA

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

ON

DUALLY-ELIGIBLE BENEFICIARIES: IMPROVING CARE WHILE LOWERING COSTS

BEFORE THE

U. S. SENATE COMMITTEE ON FINANCE

SEPTEMBER 21, 2011

U.S. Senate Committee on Finance

Dually-Eligible Beneficiaries: Improving Care While Lowering Costs

September 21, 2011

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to discuss the Center for Medicare & Medicaid Services' (CMS) efforts to improve and integrate care for individuals who are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). The Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, was established by Section 2602 of the Affordable Care Act to more effectively integrate the Medicare and Medicaid benefits and to improve the coordination between the Federal and State governments for individuals enrolled in both the Medicare and Medicaid programs. A Federal Register notice officially establishing the Medicare-Medicaid Coordination Office was published on December 30, 2010.

Background

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment. Over the past 40 years, the Medicare and Medicaid programs have remained separate systems despite a growing number of people who depend on both programs for their health care. Many of these Americans become eligible for Medicare first because of their age or disability, and then qualify for Medicaid as a result of an income-changing event. Others qualify for Medicaid initially and then become eligible for Medicare. As the number of people who rely on both programs for their coverage grows, there is an increasing need to align these programs so that they better serve enrollees.

Today, more than 9 million Americans are enrolled in both the Medicare and Medicaid programs; two-thirds of this population are low-income elderly, and one-third are people who are under 65 and are disabled.[1] Additionally, Medicare-Medicaid enrollees include higher proportions of women, African-Americans, and Hispanics than in the Medicare-only population.

[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.

Medicare-Medicaid enrollees must navigate two separate programs for their care—Medicare for coverage of basic acute health care services and prescription drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services. Medicaid also provides help to those with low incomes to pay their Medicare premiums and cost-sharing. A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for Medicare-Medicaid enrollees and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees.

People enrolled in both Medicare and Medicaid tend to have the most complex, chronic illnesses, and therefore they are some of the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care is estimated at $300 billion across both programs. In the Medicaid program, these people represent 15 percent of enrollees but 39 percent of all Medicaid expenditures.[2] In Medicare, they represent 16 percent of enrollees and 27 percent of program expenditures.[3] Medicare-Medicaid enrollees' health costs are nearly five times greater than all other people with Medicare. Compared with all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly 6 times greater. They are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.[4] These statistics demonstrate the tremendous opportunities available to improve the individual care experience by raising quality and lowering costs through improved health outcomes for this population.

Too often, the care delivered to Medicare-Medicaid enrollees is fragmented and uncoordinated which can result in poor health outcomes. These Americans could benefit the most from more integrated systems of care that ensure all their needs – primary, acute, long-term care, behavioral and social – are met in a high quality, cost effective manner. Better alignment of the administrative, regulatory, statutory, and financing aspects of these two programs promises to improve the quality and cost of care for this complex population.

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[2] Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011. Available at: http://www.kff.org/medicare/upload/8138.pdf

[3] The Medicare Payment Advisory Committee (MedPAC), A Data Book: Healthcare spending and the Medicare program, June 2010. Available at: http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

[4] Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. Available at: http://www.kff.org/medicaid/upload/8081.pdf

The Medicare-Medicaid Coordination Office's mission is to address and improve the experiences, access to care, quality of care, and cost of benefits for individuals enrolled in both the Medicare and Medicaid programs. To that end, the Medicare-Medicaid Coordination Office is engaged in ongoing discussions with key internal and external stakeholders, including beneficiary advocates, provider organizations, Medicare Payment Advisory Commission (MedPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC),and State Medicaid agencies, to work together to advance high quality, seamless care for Medicare-Medicaid enrollees. The Office is also working to improve collaboration and communication between Medicare and Medicaid program offices within CMS and across other Federal agencies.

The Need for Coordinated Care

Partnerships with the States

The 9 million Medicare-Medicaid enrollees accounted for approximately $120 billion in combined Medicaid Federal and State spending in 2007 – almost twice as much as Medicaid spent on all 29 million children it covered in that year.[5] While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 26 States. These numbers demonstrate the critical need to build, sustain and strengthen Federal-State partnerships by improving care coordination for this population.

State Medicaid programs alone spent more than $50 billion in 2007 to support the health and long-term care costs of people enrolled in Medicare. The average Medicaid spending per beneficiary on Medicare-Medicaid enrollees was $15,459 in 2007, more than six times higher than the comparable cost of a non-disabled adult covered by Medicaid ($2,541).[6] This spending mostly reflects the significant costs associated with a population with low income and high health care needs; however, there are opportunities for savings through improved care coordination, simplification, and alignment of some Medicare and Medicaid rules.

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[5] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm

[6] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm

Too often, the current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it. We are collaborating with States to find real solutions that, through better care coordination, will improve the experience and quality of care for beneficiaries and reduce costs. The Medicare-Medicaid Coordination Office is working to facilitate innovation by nurturing these vital State-Federal relationships.

Better Care for People

The Medicare-Medicaid Coordination Office has been working to improve Medicare-Medicaid enrollees' satisfaction, program awareness, health, functional status, and well-being. Most individuals enrolled in both Medicare and Medicaid are not receiving coordinated care. Our goal is to assure that Medicare-Medicaid enrollees are receiving high quality and person-centered acute, behavioral, and long-term care services and supports.

To further this mission, our Office has worked in concert with the new Medicare and Medicaid Innovation Center, the Center for Medicaid, CHIP and Survey & Certification, and the Center for Medicare within CMS to foster significant reforms across the health care delivery system that will improve the coordination of care for all patients, including low-income beneficiaries, many of whom are Medicare-Medicaid enrollees. One example of such an initiative is the Partnership for Patients, an investment of up to $1 billion in patient safety initiatives that are designed to improve coordination of care and reduce preventable hospital-acquired conditions. The Partnership for Patients hopes to take these safety efforts to scale, which could save tens of thousands of lives, avoid millions of preventable injuries, and save Medicare and Medicaid billions of dollars over time.

The Partnership for Patients, which aims to prevent hospital readmissions and hospital-acquired conditions, will help drive better care for Medicare-Medicaid enrollees. In a recent CMS study, 27 percent of the Medicare-Medicaid enrollees were hospitalized at least once during the year,

totaling almost 2.7 million hospitalizations.[7] More than a quarter of these hospital admissions may have been avoidable, either because the condition itself could have been prevented (e.g., a urinary tract infection), or the condition could have been treated in a less costly and more appropriate setting (e.g., chronic obstructive pulmonary disease). This also includes hospitalizations from skilled nursing facilities, the setting from which potentially avoidable hospitalizations were most likely to occur. The study projects that the total costs for potentially avoidable hospitalizations for Medicare-Medicaid enrollees will be between $7 and $8 billion for 2011.[7] Providing appropriate, coordinated and integrated care may be able to prevent unnecessary hospitalizations, which would allow individuals to remain independently at home while saving scarce health care resources. Our office is furthering work to prevent inpatient hospitalizations from nursing facilities through a new demonstration project, which will be discussed in the *Models and Demonstrations* section of this testimony.

Benefits of Integrated Care

A real-life example of the significant benefits of integrated care for people enrolled in both Medicare and Medicaid is evident in the care of a 77 year old woman named Mattie. Mattie is a fiercely independent woman who lives alone but requires significant personal assistance to maintain independence. She has diabetes, depression, and hypertension, and over the years has suffered three strokes, resulting in weakness and limited mobility. Before receiving care in an integrated program, she fell frequently, had inadequate food intake, and suffered three potentially avoidable hospitalizations that resulted from poorly controlled diabetes. In addition, she faced difficulties making her medical appointments because of mobility limitations, challenges accessing and managing personal care attendant services, and problems obtaining mental health services. In order to receive routine medical care, Mattie had to navigate and manage three separate health care systems—one for Medicare, one for her prescription drug coverage, and one for Medicaid. She had multiple care providers that rarely communicated with one another, and her health care decisions were rarely coordinated and were not made from a patient-centered

[7] Centers for Medicare & Medicaid Services, Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations, 2011. Available at: http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf.

perspective. As a result of these challenges, her care was fragmented and she was considering nursing home care.

Fortunately, Mattie was able to enroll in a special program that integrates her Medicare and Medicaid covered services and which has at its core a multi-disciplinary care team that assumes full responsibility for all of her care needs. She now has access to the full range of services to meet her needs and keep her at home, including necessary nutrition support, mental health services, and durable medical equipment. In this program, Mattie only has to manage one set of benefits, and has a single insurance card. One year after enrolling in this program her health has improved, and her care costs have been reduced: she has had no falls, achieved diabetic control, improved her mobility, reduced her personal care attendant support needs, and has had no hospital or emergency department contacts since enrollment in the program. Coordinated care has meant that Mattie can maintain her independence and receive high quality care, while Medicare and Medicaid have avoided the high costs of preventable hospitalizations and nursing home care. These outcomes are the care we want to make available to everyone.

Initiatives to Date

The Medicare-Medicaid Coordination Office has already launched a variety of initiatives to meet its Congressional charge to improve access, coordination and cost of care for Medicare-Medicaid enrollees. Our work falls into the following broad areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

Program Alignment

On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs.[8] As stated previously, the lack of alignment between the programs too often leads to fragmented or episodic care for people enrolled in Medicare and Medicaid, which can reduce quality and raise costs. For example, Medicare and Medicaid have different coverage standards

[8] http://www.cms.gov/medicare-medicaid-coordination/07_AlignmentInitiative.asp#TopOfPage

for those accessing durable medical equipment. These differences can lead to fragmented care and coverage gaps that could result in patients losing access to the treatments and equipment that help them live at home or in the community. Even temporary coverage gaps can be disruptive and potentially even life-threatening if patients no longer have coverage for wheelchairs or other medical care.

The Alignment Initiative is not simply an effort to catalogue the differences between Medicare and Medicaid, or to make the two programs identical. Rather, it is an effort to advance beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

The first step in the Alignment Initiative was to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a wide-ranging list of opportunities for legislative and regulatory alignment on areas identified through numerous stakeholder discussions. Those areas fall into the following broad categories: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment, and appeals. This list was published in the Federal Register on May 16, 2011 and the public comment period closed on July 11, 2011.

Through the Alignment Initiative, we facilitated a national conversation on improving care for Medicare-Medicaid enrollees. The public solicitation for comments brought in over 100 responses from beneficiaries, advocates, professional health associations, plans and States. In addition, CMS conducted local listening sessions, which were attended by over 500 stakeholders. These sessions provided stakeholders an opportunity to contribute their experiences and suggestions to the discussion. Section 2602(c) of the Affordable Care Act established specific goals for our office, and the Alignment Initiative has provided an effective means to engage the public to ensure that these goals are met. We are committed to being open and transparent in our efforts to better streamline these programs to ensure more efficient and effective care, and will continue to engage the public as we move forward on this Initiative.

Data to Support Goals

On May 11, 2011, the Medicare-Medicaid Coordination Office also announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid.[9] Access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for their highest cost beneficiaries. Already, CMS has actively engaged and begun to work with many States on accessing Medicare data, creating new State pathways to better integrate care for Medicare-Medicaid enrollees. For example, a State that wants to expand its long-term care and behavioral health care management program to serve low-income seniors and people with disabilities needs data on its Medicare-covered hospital, physician, and prescription drug use. With Medicare data, States can identify high risk and high cost individuals, determine their primary health risks, and provide comprehensive Medicare-Medicaid enrollee profiles to their care management contractors to tailor interventions. The ability to access the entire spectrum of information on Medicare-Medicaid enrollees enables States to better analyze, understand, and coordinate a person's experience within the Medicare and Medicaid programs.

The Medicare-Medicaid Coordination Office has been focused on understanding the utilization profiles and care experience of individuals eligible for Medicare and Medicaid. As a foundation for this goal, we will be preparing an analysis of individuals eligible for Medicare and Medicaid in each State, including demographics, service utilization, and availability of benefits. Our Office also seeks to go beyond data and actually speak with beneficiaries to gain a better understanding of their experiences from their perspectives. To build on ongoing efforts to better understand the needs of Medicare beneficiaries under the age of 65, we are in the process of conducting focus groups across the country with individuals with disabilities enrolled in both Medicare and Medicaid to understand the impact of integrated care on beneficiary experience and health outcomes. Finally, the Medicare-Medicaid Coordination Office will monitor and report on issues from a national viewpoint, including annual total expenditures, health outcomes, and access to benefits for individuals enrolled in Medicare and Medicaid.

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[9] http://www.cms.gov/medicare-medicaid-coordination/06_MedicareDataforStates.asp#TopOfPage

Models and Demonstrations

The Medicare-Medicaid Coordination Office is working to support improvements in the quality and cost of care for Medicare-Medicaid enrollees. To that end, the Medicare-Medicaid Coordination Office recently announced several opportunities through demonstrations of delivery and payment models to improve the quality of care Medicare-Medicaid enrollees receive by expanding access to seamless, integrated programs, and better care management.

The first demonstration supports this objective by allowing States to coordinate and align Medicare and Medicaid benefits. Partnering with the Center for Medicare and Medicaid Innovation (Innovation Center), the Medicare-Medicaid Coordination Office has awarded contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for Medicare-Medicaid enrollees.[10] The 15 States selected for the design contracts are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The overall goal of this contracting opportunity is to identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other States. CMS will work with the States to develop models and interventions that can be implemented in future phases.

It is important to note, however, that a CMS contract with a State to design a coordinated care model does not confer authority to implement, or endorsement of, the particular model. Only after a State has submitted a coordinated care model design that meets CMS' specifications and is consistent with its contract will the model receive further consideration by CMS for implementation. We will also take recommendations that MedPAC has shared with us into consideration. These include testing capitated payment models, collecting consistent quality and cost data across demonstrations, assessing ways to increase enrollment, preserving beneficiary protections, and promoting the appropriate use of Federal funds. We will assess State proposals

[10] http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

with these concerns in mind to ensure models that are tested improve the quality of care while ensuring appropriate use of program funding.

On July 8, 2011, the Medicare-Medicaid Coordination Office, again in partnership with the Innovation Center, announced the *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees.* Through this financial alignment initiative, CMS provided initial guidance on two streamlined approaches for States interested in testing models to align financing between the Medicare and Medicaid programs.[11] Our early work with the 15 States selected for design contracts confirms that a key component of a fully integrated system will be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between the programs.

The financial alignment initiative will test two new payment and service delivery models to reduce program expenditures under Medicare and Medicaid, while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. Through the first model, a State, CMS, and health plan enter into a three-way contract wherein the health plan receives a prospective blended payment to provide comprehensive, coordinated care. In the second model, a State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from managed fee-for-service initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. We will evaluate whether these models improve care for this population while also lowering costs. All States are eligible for this initiative; however, in order to be considered, States must submit letters of intent for these two models by close of business on October 1, 2011. States meeting the necessary criteria will have an option to pursue either or both of these financial alignment models. Beyond these models, technical assistance will be available to all States through the Integrated Care Resource Center, which will support our State partners as they develop models that better serve Medicare-Medicaid enrollees.

A third initiative, also announced July 8, 2011, is a new demonstration focused on improving the quality of care received by nursing home residents by reducing preventable inpatient

[11] http://www.cms.gov/medicare-medicaid-coordination/08_FinancialModelstoSupportStatesEffortsinCareCoordination.asp#TopOfPage

hospitalizations. As previously stated, hospitalizations are often expensive, disorienting, and dangerous for frail elders and people with disabilities, and cost Medicare billions of dollars each year. Starting this fall, CMS will competitively select independent organizations to partner with and implement evidence-based interventions at interested nursing facilities. This demonstration supports the Administration's Partnership for Patients goal of reducing hospital readmission rates by 20 percent by the end of 2013 and furthers our work in improving quality for Medicare-Medicaid enrollees.

Collaborative Efforts

The Medicare-Medicaid Coordination Office is also facilitating a collaborative effort across the Medicare and Medicaid programs, and with external partners, to evaluate and promote the development of quality measures to better assess beneficiary access to care to reflect the unique circumstances of individuals eligible for Medicare and Medicaid. CMS will engage partners to review the availability of appropriate quality and access measures, and assist in the development of measures which accurately reflect the quality of care received by individuals eligible for Medicare and Medicaid. Our partners will move forward in strategic development of such measures in a manner that streamlines quality measurement across Medicare and Medicaid for individuals receiving care under both programs.

Additionally, the Medicare-Medicaid Coordination Office has consulted and coordinated with both the MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC), including presenting at the MACPAC public meeting in October 2010. The Medicare-Medicaid Coordination Office will continue to collaborate with staff and members of both Commissions on important issues related to data analysis, care model demonstrations, and policy alignment opportunities for Medicare-Medicaid enrollees.

Conclusion

CMS, through the Medicare-Medicaid Coordination Office, is working to ensure better health, better care, and lower costs for individuals that are enrolled in both Medicare and Medicaid. Over the years, a lack of coordination for this population has led to fragmented and episodic care, which can lead to lower quality and higher costs. With the creation of the Office, we have

a tremendous opportunity to better integrate the programs and better serve this population. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals who need it the most.

United States Senate Committee on Finance
Public Hearing
"Dually-Eligible Beneficiaries: Improving Care While Lowering Costs"
September 21, 2011

Questions Submitted for the Record

Senator Max Baucus

Questions for the Record:

Deficit Reduction and Dually-Eligible Beneficiaries

States and the federal governments currently spend about $300 billion annually on dually-eligible beneficiaries (duals). Duals make up a relatively small proportion of Medicare and Medicaid enrollees, but represent a high proportion of program spending. About 16 percent of Medicare beneficiaries in 2009 were duals, and they accounted for about 25 percent of Medicare spending. The distribution of enrolment and spending is similar for Medicaid, which duals making up about 18 percent of total enrollees in 2009, and 46 percent of total spending.

As you know, a special congressional committee is charged with recommending policies that will reduce the deficit. You note in your testimony that the dually-eligible population costs states and the federal government a lot of money.

1. **What are some smart ways to improve care for duals and save money?**

Answer: The majority of individuals eligible for Medicare and Medicaid are not receiving any type of coordinated care today and no one is accountable for meeting their needs in the most cost effective manner. As a result, care improvement and cost savings opportunities that may prevent unnecessary hospitalizations or adverse drug interactions or improve discharge planning and provide home based supportive services are missed. We know there are significant opportunities to improve care and in turn costs in the areas of unnecessary hospital admissions/readmissions; medication management; care transitions; home and community-based care; fall prevention; patient data exchange; and care coordination.

A person-centered approach to care, accountability for coordinating and integrating both Medicare and Medicaid benefits, and coordination between the Federal and State governments offer good opportunities to improve the care and costs for Medicare-Medicaid eligible individuals.

2. **Are there some changes that we should be careful about because they may jeopardize the care duals receive?**

Answer: Medicare-Medicaid eligible individuals are a heterogeneous group of individuals, with arguably the most complex care needs in the health care system. The needs of this population are not uniform from person to person or even State to State. Understanding the various subsets of the population and their different care needs plays an important role in making any changes to the delivery mechanisms for this population. The Medicare-Medicaid Coordination Office is working closely with States and others to develop care models and programs tailored to the needs of the beneficiaries. We are thinking carefully to ensure that the new models and programs that are being developed and tested recognize the importance of both medical and non-medical services and are developed in a way that involves beneficiaries and their caregivers.

Caring for Dually-Eligible Beneficiaries in Rural Areas

About 30% of duals live in rural areas. Efforts to improve care for duals usually focus on managed care and other care coordination models that 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.

As you know, beneficiaries living in big cities have different needs and access to care than beneficiaries living in rural areas.

3. Based on your expertise, what do we need to keep in mind to make sure the needs of rural dually-eligible beneficiaries are also met?

Answer: We are committed to improving care for all Medicare-Medicaid eligible beneficiaries and we recognize the need to be sensitive to urban and rural differences. While rural areas are less likely to have capitated managed care plans, there are other models of coordinated care to consider. For example, Montana Medicaid has offered coordinated care statewide via its Passport to Health primary care case management program (PCCM) since 1993. Other States have used PCCM as well as medical home and health home models to provide those in rural areas with the advantages and benefits of coordinated care. They also offer additional support, e.g. Montana's "Nurse First" advice line that reduces burden on physicians by providing beneficiaries with access to a nurse who can help screen those who are unsure if their symptoms require medical treatment. However, as with capitated programs, States have often excluded Medicare-Medicaid eligible beneficiaries because they believe much of the upfront savings accrue to Medicare. We are excited about the potential for our Financial Alignment Initiative's fee-for-service model to bring Medicare-Medicaid eligible beneficiaries into coordinated care programs in rural areas.

Oversight of Medicare-Medicaid Coordination Office

In April, the Medicare-Medicaid Coordination Office announced that 15 states would each receive a $1 million grant to plan and design new integrated health care models for all or a portion of each state's dually-eligible beneficiaries. The fifteen states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina,

Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. Once the planning phase is over, each state is expected to move forward with its plan beginning in 2012.

Seven states represented on this Committee got one million dollar planning grants each to improve care for duals.

4. Can you tell us more about what states will be doing with this planning money?

Answer: The 15 States are partnering with CMS to develop a proposal to structure, implement, and evaluate a model aimed at improving the quality, coordination and cost-effectiveness of care for Medicare-Medicaid enrollees. The $1 million is funding a design phase. States are using the funds to support activities critical to the design of their integrated models, including staffing and contractors, analytic support, actuarial analysis, and stakeholder engagement. More information about this initiative can be found on the CMS website at the following link: http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

5. How have you worked with states to make sure that the money is well spent?

Answer: CMS is working closely with each of the 15 States that have received design contracts, including assigning a Medicare-Medicaid Coordination Office "staff lead" to conduct regular calls with each State to discuss progress and work on an ongoing basis. In addition, States are required, as part of their contracts with CMS, to submit interim and final progress reports providing detail on the development process and budget modifications.

6. When do you expect their plans to turn into real changes to help beneficiaries?

Answer: States are required to submit a detailed demonstration proposal to CMS 12 months after the contract award (i.e. late April/early May 2012 depending on the State contract) with implementation of any approved demonstrations beginning in 2012. We anticipate enrollment of beneficiaries into these three-year demonstrations to begin in the latter half of 2012.

Senator Jay Rockefeller

Questions for the Record:

Role of Medicare in Care Improvement for Dually-Eligible Beneficiaries

I am encouraged that the Medicare-Medicaid Coordination Office announced a new demonstration to help reduce preventable hospital admissions from nursing facilities for Medicare-Medicaid beneficiaries.

1. **What more can the Medicare program be doing to specifically address the needs of dually-eligible beneficiaries?**

Answer: We appreciate your interest in the Demonstration to Reduce Preventable Hospitalizations among Nursing Facility Residents. We have designed this demonstration to test whether implementing evidence-based interventions in nursing facilities can improve the quality of care for residents of these facilities. Hospitalizations are often expensive, disruptive, disorienting, and dangerous for frail elders and people with disabilities, and cost Medicare billions of dollars each year. CMS-funded research on Medicare-Medicaid eligible nursing facility residents in 2005 found that approximately 45 percent of hospital admissions were preventable, accounting for 314,000 potentially avoidable hospitalizations, and $2.6 billion in Medicare expenditures. As part of the demonstration, CMS will initiate a competitive process to select independent organizations to partner with and implement evidence-based interventions at participating nursing facilities. These interventions could include using nurse practitioners in nursing facilities, supporting transitions between hospitals and nursing facilities, and implementing best practices to prevent falls, pressure ulcers, urinary tract infections, or other events that lead to poor health outcomes and expensive hospitalizations.

In addition to this demonstration, under the Affordable Care Act CMS is implementing several other initiatives to improve the quality and safety of care for people with Medicare and Medicaid, which will also benefit Medicare-Medicaid enrollees. For example, the Partnership for Patients is a partnership to reduce harm and error in care that has already engaged more than 2,000 hospitals. The Partnership's goals include reducing hospital readmissions by 20 percent and reducing preventable hospital-acquired conditions by 40 percent, which over the next decade could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings. With the Centers for Disease Control and Prevention, CMS recently launched the Million Hearts Campaign™, which will work to prevent one million heart attacks and strokes over the next five years. Both of these initiatives will improve care for Medicare-Medicaid enrollees.

2. **How are the needs of dually-eligible beneficiaries being taken into account whenever new delivery system and payment reforms are implemented in the Medicare program?**

Answer: The Medicare-Medicaid Coordination Office works closely with the Medicare and Medicaid components within CMS as well as other CMS offices to ensure policies are developed with Medicare-Medicaid enrollees in mind. This collaboration includes development of regulations, administrative policies, and demonstrations. For example, within CMS our Office is working with Center for Medicare, Center for Medicaid and CHIP Services, and the Center for Medicare and Medicaid Innovation in developing the Demonstration to Reduce Preventable Hospitalizations Among Nursing Facility Residents. It coordinates with the Partnership for Patients efforts and Community Based Care Transitions Program, which also strive to reduce hospital readmissions. In addition, the Office is pursuing an initiative to identify opportunities for alignments between the Medicare and Medicaid programs.

3. **Are there existing opportunities for the Medicare program to prevent functional decline and other precipitating events that result in the need for Medicaid enrollment among current Medicare beneficiaries?**

Answer: CMS is implementing several initiatives to strengthen primary care infrastructure to reduce adverse events that can lead to the need for nursing facility and other institutionalized care and eventual Medicaid eligibility. Examples include the Multi-payer Advanced Primary Care Practice Demonstration and Medicare Shared Savings Program. The Center for Medicare and Medicaid Innovation is leading several efforts, including the Pioneer ACO Model, the Partnership for Patients, the Million Hearts Campaign, and the recently announced Comprehensive Primary Care Initiative, which will promote coordinated care among primary care doctors and other providers to prevent and better manage chronic disease.

The Demonstration to Reduce Preventable Hospitalizations Among Nursing Facility Residents is another example. This demonstration will implement clinical interventions to improve quality of care in nursing facilities. It will target nursing facilities with high hospitalization rates and a high concentration of residents who are Medicare-Medicaid enrollees. These interventions should have an impact on the overall care provided in nursing facilities, including for those residents who are Medicare beneficiaries but are not enrolled in Medicaid.

Accountability and consumer protections in integrated care models

Considering that the federal government funds over 75% of the cost of care for dually-eligible beneficiaries, accountability for federal dollars is critical in any new care model being developed for dually-eligible beneficiaries. MedPAC has called for "carefully designed transparency mechanisms to ensure program integrity" in care integration models that allow states to fully manage all Medicare and Medicaid funds. MedPAC has noted that "This approach raises concerns about how Medicare funds would be used… states would have a financial incentive to use Medicare funds to reduce their own spending and Medicare would not receive any savings."

1. **What accountability measures and consumer protections does CMS plan to put in place as it moves forward with state demonstrations to integrate care for dually-eligible beneficiaries?**

Answer: CMS understands that these new approaches must be implemented in a way that is fair and accountable; preserves beneficiary rights and ensures continued access to guaranteed benefits; and protects Medicare's finances. Through the Center for Medicare & Medicaid Innovation, we intend to evaluate the demonstrations to ensure that the strategies are not only appropriate for improving beneficiaries' care but also a wise investment of Federal resources. Further, the new financial models protect both beneficiaries and Medicare funding by setting clear limits and protections. States interested in pursuing the new financial alignment demonstrations will be required to meet or exceed certain standards and conditions before they are able to move forward with implementation. These standards and conditions include a number of beneficiary protection provisions aimed at ensuring beneficiary health, safety and access to

high quality health and supportive services, including notice and appeal rights as well as network and accessibility standards.

Senator Ron Wyden

Questions for the Record:

Early Innovator Grants for States

1. **How does CMS plan to set the rates for duals for those states who have secured one of the 15 grants?**

Answer: The 15 States selected to receive design contracts are in the process of developing person-centered approaches to coordinate care across primary, acute, behavioral health, and long-term supports and services for Medicare-Medicaid enrollees. The primary deliverable of the contract is a demonstration proposal that outlines how the State would structure and implement its proposed approach. CMS anticipates that a number of the States with design contracts will take advantage of the new capitated financial alignment model, under which an actuarially developed, blended Medicare-Medicaid rate would be set accordingly.

2. **How will CMS account for states with historically low Medicare FFS rates?**

Answer: Our goal with these demonstrations is to improve quality and reduce costs through improved coordination. As we work with States on State-specific models and demonstrations, we will be taking a number of factors into account, including historical spending in Medicare for Medicare-Medicaid enrollees.

Senator Maria Cantwell

Questions for the Record:

Activities of Daily Living Assistance

Many of the current models of care coordination, which hold such promise for improving quality while reducing cost, are focused exclusively on primary care and not on long-term services and supports. Yet, we know that 52 percent of individuals with dual eligibility need assistance with one or more activities of daily living (ADLs): 23 percent need assistance with 1-2 Activities of Daily Living and 29 percent need assistance with 3-6 Activities of Daily Living.

1. **Could you comment on what plans the Medicare-Medicaid Coordination Office has for encouraging the incorporation of long-term care services, specifically home care workers, into care coordination for dual eligibles?**

Answer: The Medicare-Medicaid Coordination Office works to advance systems of care that provide all of the necessary services and supports to meet an individual's needs, including long-term care services. Through our demonstrations, we work with each State to develop care models that fully integrate the entire range of Medicare and Medicaid benefits, including long term care supports and services, that are needed by an individual. We recognize that long-term services and supports are instrumental in improving the overall quality of care received by an individual and the valuable role home care workers and other supportive service providers play in making sure individuals continue to receive the services they need.

2. **If we were to move toward full-integration of Medicare and Medicaid services who do envision as the best entity to administer the program?**

Answer: The Federal and State governments have joint responsibility for individuals eligible for both Medicare and Medicaid. As we move toward a fully integrated system, there are some who believe we should federalize such a program and others who believe States would be the best entities to administer a fully integrated program. The most critical piece of any effort to coordinate care for Medicare-Medicaid eligible individuals is to establish accountability for delivering Medicare and Medicaid services in a cost effective manner and to ensure the entity responsible for doing so has the necessary expertise and network/provider capacity (across primary, acute, behavioral, prescription drugs and long-term supports and services) to do so.

The Office is committed to working with Congress, States, beneficiaries and their advocates, providers, and other stakeholders to develop and test accountable entities that reflect Federal and State delivery system and payment variation and best meet the heterogeneous health care needs of this complex beneficiary population.

Preventing Chronic Conditions

3. **Since most dual-eligible individuals tend to be those with chronic conditions, what are some preventive steps that can be taken to maintain both the physical and financial health of individuals that can help them remain in their homes and communities and keep prevent them from becoming dually-eligible?**

Answer: We share your interest in promoting preventive steps that can help maintain the physical, functional and financial status of Medicare-Medicaid enrollees or individuals at risk of becoming Medicare-Medicaid eligible. Opportunity areas include: fall prevention and home modifications (falls in the home are a leading cause of institutional placement); medication management to avoid drug-drug interactions, polypharmacy, contraindications, etc.; comprehensive and early intervention discharge planning and care transition strategies among all transition points (home, acute, post-acute, etc.); person-centered care management/navigation that helps beneficiaries receive services in the least restrictive setting; and data exchange among providers to ensure all are informed of the care being provided and to avoid conflicting and/or

potentially adverse treatment regimens. Ensuring appropriate access to home and community based services is also critical, and is a key component of the integrated models CMS is working with States to develop.

CMS is implementing several initiatives to strengthen the primary care infrastructure to reduce adverse events that can lead to the need for nursing facility and other institutionalized care and eventual Medicaid eligibility. Examples include the Multi-payer Advanced Primary Care Practice Demonstration and Medicare Shared Savings. The Center for Medicare and Medicaid Innovation is leading several efforts, including the Pioneer ACO Model, the Partnership for Patients, the Million Hearts Campaign™, and the recently announced Comprehensive Primary Care Initiative, which will promote coordinated care among primary care doctors and other providers to prevent and better manage chronic disease.

National Care Coordination Models

4. Are there examples of states whose practices of care coordination are national models or can be set forth as "best practices" for care coordination of dual-eligible individuals?

Answer: Collaboration between States and CMS has built the foundation for care coordination. Early pioneer States such as Massachusetts, Minnesota and Wisconsin were leaders in improving coordination for Medicare-Medicaid eligible individuals and their efforts have created basic principles and practices for future models and demonstrations to follow. For more in-depth information on these pioneer States and others, see the following reports:

- Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Need Plans, A Report to MedPAC, Mathematica Policy Research, June 2011; and
- Profiles of State Innovation: A Roadmap for Improving Systems of Care for Dual Eligible Individuals, Center for Health Care Strategies, November 2010.

Mandatory Versus Voluntary Enrollment

5. What is your approach on mandatory versus voluntary enrollment for dual-eligible individuals in a coordinated care program and how would you maintain patient choice for dual-eligible individuals?

Answer: States are permitted to request passive enrollment with an opt-out in the new capitated financial alignment model. Providing individuals with an opportunity to opt-out of any coordinated care program is an important right and protection for beneficiaries.

Administrative Alignment

6. What have you learned so far from feedback regarding administrative alignment? Which rules make the most sense for the dual-eligible population?

Answer: The feedback we received on the Alignment Initiative confirms that there is broad support for aligning Medicare and Medicaid rules. The responses we received were thoughtful

and insightful, and reflect some consensus on a number of requirements and incentives that misalign. The comments also reflect a strong desire to address some of the systemic issues that often frustrate Medicare-Medicaid eligible beneficiaries, their providers and payers. These issues, which include cost-sharing, home health, durable medical equipment and appeals processes, are ones that we continue to focus on as we work with our CMS colleagues across Medicare and Medicaid. Finally, the feedback we received confirms the value of transparency in our work and clear channels of communication between our office and stakeholders. To that end, we continue to hold and schedule listening sessions throughout the country to capture as clearly as possible public input, which will help inform our work as we move forward with efforts to better align and coordinate the programs.

7. **How do you propose that states and providers best work together to align incentives and share savings to promote innovation and best outcomes for the dual-eligible population?**

Answer: A good first step would be to work from the same starting point, which is a person-centered approach to care with accountability for making sure individuals receive their Medicare and Medicaid services in a coordinated, seamless and efficient fashion. CMS can create an appropriate environment and incentives for States, providers and payers to innovate and invest in ways that will provide the best outcomes for Medicare-Medicaid eligible beneficiaries. For example, the recently announced Financial Alignment Initiative seeks to provide appropriate flexibilities and incentives for the provision of high-quality care to Medicare-Medicaid eligible beneficiaries.

Senator Michael Enzi:

Questions for the Record:

Mandatory Enrollment in Integrated Managed Care Programs

Ms. Bella, according to your own research, only 120,000 dual eligible beneficiaries are enrolled in fully integrated managed care programs.

1. **Is your office examining the concept of mandatory enrollment for dual eligibles in an integrated managed care program?**

Answer: States already have an ability to require enrollment into Medicaid managed care programs, subject to certain requirements. As indicated in the July 8, 2011 State Medicaid Director letter announcing the new financial alignment model demonstrations, CMS is willing to consider passive enrollment with an opt-out into the new capitated model. CMS would be open to this policy as long as appropriate beneficiary safeguards are in place, and these enrollment flexibilities would only be available to plans or models that showed the promise of improving care coordination, quality, and costs of care for Medicare-Medicaid eligible beneficiaries.

2. **Would this type of program, if it included an opt-out policy, improve care coordination and integration for dual eligible beneficiaries?**

Answer: We believe that a program responsible for primary, acute, behavioral health, prescription drugs, and long term supports and services would improve care coordination and integration for this population. As noted above, we would only passively enroll (with an ability to opt-out) Medicare-Medicaid eligible beneficiaries into plans that demonstrate they would coordinate care and integrate benefits across the two programs through a single, seamless delivery system.

Special Needs Plans in Medicare Advantage

3. **Has your office reviewed any data on special needs plans in Medicare Advantage that are specifically designed to meet the needs of dual eligible beneficiaries?**

Answer: We have reviewed available data on Medicare Advantage Special Needs Plans (SNPs). We are also encouraged by the new requirement, starting in 2012, that Medicare Advantage plans, including Special Needs Plans, submit encounter data to CMS, and believe that these data will continue to inform the picture of how these plans are meeting the needs of Medicare-Medicaid eligible beneficiaries.

4. **Is your office working to adopt the best practices for care integration from these policies?**

Answer: The Medicare-Medicaid Coordination Office has been working with our colleagues in Medicare to incent and promote best practices for care integration within SNPs. For example, CMS has announced a proposed initiative to allow certain high quality Special Needs Plans greater flexibility to provide supplemental benefits.[1]

Metrics

5. **Please describe in more detail the metrics and process for conducting the quality evaluations that are required for the new financial model demonstrations. What type of measures will be used?**

Answer: These demonstrations will be evaluated as to their ability to improve beneficiary experiences and quality of care and costs for Medicare-Medicaid eligible individuals. We are working with an external evaluator to develop the specific measures for the evaluation.

CMS Office of the Actuary

6. **Please describe in more detail how the CMS Office of the Actuary will certify the estimates of expected savings for a state that seeks to participate in one of the new financial model demonstrations. Will these estimates and methodology be made public?**

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-10-11/pdf/2011-25844.pdf

Answer: CMS will review each State demonstration proposal to determine its ability to meet certain standards and conditions, including achievable savings targets. The CMS Office of the Actuary will be part of the review process and will evaluate savings assumptions in the proposed demonstration. No State will be allowed to participate in the demonstrations if the CMS Office of the Actuary does not agree that the State's proposal will generate savings for the federal government.

Expanded Implementation

7. How does CMS plan to expand implementation of State coordinated care models that have demonstrated success at integrating care and lowering costs for the Medicare and Medicaid program? Does CMS have a national strategy to scale up successful models?

Answer: The goal of the CMS State demonstrations is to rapidly test, develop and, upon successful implementation, expand and disseminate to other States. To that end, we are supporting States with extensive, in-depth technical assistance (TA) and facilitating State-to-State learning collaboratives to share and expand best practices across the country. In addition, all State demonstrations will undergo rigorous, rapid-cycle evaluation to assess the programs' effectiveness in order to ensure efficient use of Federal resources. Additionally, we have developed a provider TA strategy to further efforts to identify, replicate and scale best practices in coordinated care delivery for this complex population. Finally, pursuant to the Affordable Care Act,[2] the Secretary has statutory authority to, through rulemaking, expand (including implementation on a nationwide basis) the duration and scope of a model that is being tested if cost and quality criteria are met. We hope to be able to use the experiences from the initial demonstrations to disseminate and inform future efforts across the country.

Senator Tom Coburn

Questions for the Record:

President's Fiscal Commission

I served as a member of the President's Fiscal Commission. We recommended giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs. Medicare would continue to pay its share of the costs, reimbursing Medicaid.

1. Do you agree with this approach?

Answer: We have reviewed the fiscal commission report and appreciate that the Commission recognized the importance of integrating care for Medicare-Medicaid eligible individuals as well as the benefit that such integration will have on improved quality of care for these beneficiaries. We recently solicited and received State proposals to design new integrated care

[2] Section 1115A(c) of the Social Security Act, as established by Section 3021 of the Affordable Care Act.

models for people enrolled in Medicare and Medicaid. The proposals from the States include a variety of different delivery system approaches to provide an integrated set of services to Medicare-Medicaid eligible individuals in their State, including arrangements with health plans. In the newly announced financial alignment demonstrations, States are permitted to request passive enrollment with an opt-out in the capitated model. Providing individuals with an opportunity to opt-out of any coordinated care program is an important right and protection for beneficiaries. Our work with our State partners will provide us with critical data and information to continue evaluating models to identify those with the greatest potential to improve care and coverage for Medicare-Medicaid eligible individuals, without increasing system costs.

2. Should we amend the law to give states the authority to auto-enroll duals into managed care?

Answer: A number of considerations should be taken into account when considering auto-enrollment for Medicare-Medicaid eligible individuals into managed care, two of the most important being beneficiary protections and provider network capacity. As noted above, in the newly announced financial alignment demonstrations, States are permitted to request passive enrollment with an opt-out in the capitated model. Providing individuals with an opportunity to opt-out of any coordinated care program is an important right and protection for beneficiaries. These demonstrations will yield great insight into our work on enrollment strategies for Medicare-Medicaid eligible individuals.

State's Role in Medicaid

There's been a lot of discussion in Washington, DC in recent months about the States role in managing the Medicaid program. I am glad to see you empowering states with different approaches and sharing data with them.

3. Should States have the flexibility to adopt proven solutions without having to first ask CMS for permission?

Answer: The State-Federal partnership is of vital importance to the Medicaid program and providing States with the support necessary to manage their Medicaid programs is a top priority for the Administration. Federal law currently requires States to have approved Medicaid program plans (referred to as "State plans") or waivers to operate their programs. We appreciate the attention Members of Congress have paid over time to increase flexibility and administrative simplification in the Medicaid program. Over the past decade Congress has acted to provide States with flexibility to implement meaningful changes to their programs. For example, learning from State experiences with various demonstration programs, Congress has created several new State plan options so that States no longer need to submit a waiver to CMS to implement certain benefits and services. Learning from State experiences helps CMS increase flexibility for States while also ensuring that Federal resources are used wisely and that beneficiaries' access to services is protected.

Our office is working extensively with my colleagues in CMS to ensure that States have the flexibility they need to best coordinate and efficiently provide coverage for Medicare-Medicaid

eligible individuals, while also ensuring that adequate beneficiary and financial protections are in place. We are working now in our demonstrations and Alignment Initiative to examine proven solutions that States may utilize to accomplish this shared goal. We look forward to sharing our work with you and other Members of Congress as it progresses.

4. Is there anything you believe States are incapable of doing to successfully manage the duals population?

Answer: Currently, Medicare-Medicaid eligible individuals must navigate two separate programs: Medicare for coverage of basic acute care services and drugs, and Medicaid for coverage of supplemental benefits, such as long-term care supports and services. Medicaid also provides help with Medicare premiums and cost-sharing. While States play a key role delivering care to Medicaid beneficiaries, the Federal government operates Medicare and sets guidelines for the acute care that Medicare-Medicaid enrollees receive. The current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government, making effective partnership between the two essential. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it. Our office is working with a wide range of States to test new ways to better coordinate care within the existing system, and explore opportunities to improve financial alignment between Medicare and Medicaid in ways that will help improve care management for people enrolled in both programs.

Care Coordination

There is abundant data showing that care coordination can help lower costs and improve outcomes.

5. Can you talk a little bit about what models you have seen for duals that use a "care coordinator" successfully, and what differentiates successful approaches from unsuccessful ones?

Answer: Collaboration between States and CMS has built the foundation for care coordination. Early pioneer States such as Massachusetts, Minnesota and Wisconsin were leaders in improving coordination for Medicare-Medicaid enrollees and their efforts have created basic principles and practices for future models and demonstrations to follow. In addition to these States, research has been conducted on general background and central components of care coordination models.

6. What research and studies in the literature would you identify as "recommended reading"?

Answer: Recommended reading on this topic may include the following studies and information:

- Center for Health Care Strategies, Integrating Care for Dual Eligibles: An Online Toolkit, *available at* http://www.chcs.org/publications3960/publications_ show.htm? doc_ id= 606732; and

- Brandeis University, Medicare Special Needs Plans: Lessons from Dual-Eligible Demonstrations for CMS, States, Health Plans, and Providers (March 2007). *Available at*: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver percent20Renewal/Brandeis percent20Duals percent20Demo percent20Report percent200307.pdf.

- Profiles of State Innovation: A Roadmap for Improving Systems of Care for Dual Eligible Individuals, Center for Health Care Strategies, November 2010. *Available at:* http://www.chcs.org/usr_doc/Duals_Roadmap_112210.pdf.

- **General Presentations:**
  - "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." Presentation. Washington, DC: AARP National Health Policy Council, Health and Long-Term Care Committee, July 2009, Deborah Peikes, Randall Brown, Greg Peterson, and Jennifer Schore.

  - "Features of Successful Care Coordination Programs." Presentation. Robert Wood Johnson Foundation Webinar on Care Management of Patients with Complex Health Care Needs, December 2009, Randy Brown, Debbie Peikes, and Greg Peterson.

- **State Reports:**
  - Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Need Plans, A Report to MedPAC, Mathematica Policy Research, June 2011.

State Demonstrations

CMS has given more data to states and is funding several demonstrations. But, over the years MANY approaches have been tried and costs continue to rise.

7. What do you think it takes for best practices to gel and lawmakers and program administrators to reach some kind of general consensuses about the proven solutions?

Answer: Our Office is committed to an open, transparent and collaborative process around these core components that will lead to widespread implementation of best practices and consensus around such practices. To that end, information on all the initiatives of the Medicare-Medicaid Coordination office can be found at: http://www.cms.gov/medicare-medicaid-coordination/.

Our office recently created The Integrated Care Resource Center[3] to identify and catalogue best practices and provide all States with technical assistance and support to better meet the needs of complex, high-cost beneficiaries. The Center is a key tool to sharing and implementing best practices as well as building the necessary consensus among our State partners.

Through the Alignment Initiative, we facilitated a national conversation on improving care for Medicare-Medicaid eligible individuals. The public solicitation for comments brought in over 100 responses from beneficiaries, advocates, professional health associations, plans and States. In addition, CMS conducted local listening sessions, which were attended by over 500 stakeholders. These sessions provided stakeholders an opportunity to contribute their experiences and suggestions to the discussion. Partnering with States, health care providers, caregivers and beneficiaries on efforts like our Alignment Initiative creates a national dialogue to identify best practices and emerging opportunities to improve care and health outcomes for Medicare-Medicaid eligible individuals.

We are also excited to be partnering with the CMS Innovation Center to award States across the country with contracts to design and test new approaches to coordinating care. As we learn from these demonstrations, we look forward to sharing our findings with Congress so that successful new approaches to improving care for individuals enrolled in both Medicare and Medicaid can inform Federal policymaking.

Federal Regulations

President Obama recently public acknowledged that too often well-intended regulations can be overly burdensome, constrictive, or counter-productive.

8. Have you ever surveyed State Medicaid directors, Governors, and health secretaries to ask what regulations in the Medicaid program they find problematic?

Answer: As part of the Administration's efforts to streamline, improve and create more efficient administrative processes, our office launched the Alignment Initiative, which examined regulations, as well as laws and operating guidance, in the Medicaid and Medicare programs as an effort to better align the two programs. As a first step in the Alignment Initiative, our office compiled the Opportunities for Alignment List which was published in the Federal Register on May 16, 2011 as a solicitation for public comments. The public solicitation for comments brought in over 100 responses from beneficiaries, advocates, professional health associations, plans and States. We conducted local listening sessions to facilitate the discussion on improving program administration, involving over 500 stakeholders in host States California, New York and Kansas. In addition, stakeholders from the following States participated by phone: Arizona, Nevada, New Jersey, Nebraska, Iowa, Missouri, and some of the territories. We received written feedback from Arizona, Colorado, Massachusetts, Michigan, Minnesota, Tennessee, Texas, Washington and Wisconsin.

[3] http://www.cms.gov/medicare-medicaid-coordination/10_IntegratedCareResourceCenterAvailabletoAllStates.asp

In addition to this effort, we established The Integrated Care Resource Center to provide all States with technical assistance and support to better meet the needs of complex, high-cost beneficiaries. We anticipate receiving further feedback from States through this Center.

9. What do States say?

Answer: Reflecting different perspectives and experiences, State comments were fairly diverse. One common theme among States who submitted feedback was the need for greater State flexibility to offer fully integrated plans that would follow a streamlined set of Medicare and Medicaid requirements. States also commented on alignment of benefits and eligibility rules for Medicare and Medicaid, payment flexibilities, and the need to simplify and combine Medicare and Medicaid materials for Medicare-Medicaid eligible individuals. In line with that need, as part of the Administration's efforts to streamline, improve and create more efficient administrative processes, our office launched the Alignment Initiative, which examined regulations, as well as laws and operating guidance, in the Medicaid and Medicare programs as an effort to better align the two programs.

Many comments identified financial misalignment between Medicare and Medicaid as a major barrier to seamless, coordinated care for Medicare-Medicaid eligible individuals. In an effort to address this issue, we announced a new opportunity for States to participate in financial alignment model demonstrations designed to improve the quality and costs of care for this population. To date, 37 States and the District of Columbia have expressed an interest in the demonstrations, which underscores the widespread State interest in this area.

10. Are there any Medicaid regulations you are considering reducing, or eliminating?

Answer: The Administration is committed to reducing and eliminating burdensome regulations government-wide. This year, the President outlined his plan to create a twenty-first century regulatory system and called for an unprecedented review of regulations already on the books. Under this initiative, CMS will propose reforms in Medicare and Medicaid regulations to increase the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or divert activities away from providing high quality patient care.

As part of the Administration's work to reduce and eliminate burdensome regulations, as noted in prior questions, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, our effort to more effectively align the Medicare and Medicaid programs. The goal of the Alignment Initiative is to improve the integration of the Medicare and Medicaid programs for Medicare-Medicaid eligible individuals. As a first step in the Alignment Initiative, my office compiled the Opportunities for Alignment List, which includes a broad range of content areas in which the Medicare and Medicaid programs have conflicting statutory, regulatory, or policy requirements or create incentives that may prevent Medicare-Medicaid eligible individuals from receiving seamless, high quality care. The Opportunities for Alignment List was published as a request for public comment in the Federal Register on May 16, 2011, and we received over 100 responses from beneficiaries, advocates, professional health associations, plans and States. In addition, CMS conducted local listening sessions, which were attended by over 500

stakeholders. CMS continues to work to address misalignments and will keep Congress and all stakeholders updated on our progress as we address these issues.

Medicare-Medicaid Care Coordination Office

While I generally oppose creating new government offices or programs, your office has an important task in seeking to increase coordination on the costliest, sickest patients in Medicare and Medicaid.

11. However, given the persistent problems with this population, can the problems of high cost and fragmented care duals face really be fixed through the work of your office?

Answer: In creating the Medicare-Medicaid Coordination Office, Congress established an office with responsibility for improving the care for Medicare-Medicaid eligible individuals. Prior to the office's creation, there had not been a dedicated resource within the agency whose sole focus was to assess and address barriers and/or fragmentation between Medicare and Medicaid as well as States and the Federal government. We are optimistic that the office will be a critical bridge between the Medicare and Medicaid programs – as well as the Federal and State governments - and serve as a catalyst for improving care coordination, fragmentation and financial misalignment between the programs.

12. What can you tell me that will give me reason to believe it may be different/better this time?

Answer: Work underway to promote increased coordination and efficient, effective care for persons with Medicare and Medicaid demonstrates our commitment to meeting our Congressional goals to improving outcomes for the people we serve. As stated in my written testimony, since our creation last year, we have successfully rolled out an Alignment Initiative to identify and begin addressing unintentional conflicts between the Medicare and Medicaid programs. Additionally, we made available to States more timely access to Medicare data to support care coordination efforts. We have also selected 15 States to receive contracts to design new integrated care models for people enrolled in Medicare and Medicaid and launched the Financial Alignment Demonstrations to align the financing between the Medicare and Medicaid programs, providing options for States to align financing in their fee-for-service or managed care systems. Finally, we are sponsoring a nursing home demonstration, in line with the broader Partnership for Patients campaign, to help reduce preventable hospital readmissions among residents of nursing facilities. Over time, we expect that all of these efforts will yield valuable results that will further our efforts to improve and quality and cost effectiveness of care for individuals enrolled in Medicaid and Medicare.

Follow-Up Items

Senator Jeff Bingaman

- Ms. Bella agreed to follow up on the number of dually-eligible individuals who may be involved in the Partnership for Patients initiative and the potential for savings.

The Partnership for Patients (P4P) works to better care and lower costs through a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. Specifically, P4P seeks to reduce hospital readmission rates by 20 percent by the end of 2013. Approximately 33 percent of hospitalizations were for full or partial dual-eligibles and the 30-day all-cause readmission rate for the combined population of full and partial dual-eligibles was 22 percent, compared to a rate of 16 percent for Medicare non-dual-eligibles, and a rate of 18 percent for all Medicare patients.[1] Based on these figures and assuming the full goals of P4P are met, we estimate that the potential savings of reducing hospital acquired conditions and readmissions in the dual-eligible population is roughly $18 billion from 2011-2020.

The P4P focuses on two clinical improvement areas—patient safety and care transitions—that are central to the care experience of dual-eligibles. For example, care transitions are notoriously problematic for dual-eligibles, who often have chronic conditions that increase their risk of readmission, and who face special problems with care coordination across settings—problems that the Partnership for Patients explicitly targets. Additionally, most or all dual-eligibles, regardless of their specific medical condition, would be at risk during their hospital admission for several "core" adverse events targeted by the P4P, such as pressure ulcers, falls, and adverse drug events. As a result, we would expect a participating hospital that has seriously engaged in both of these program focus areas to provide improved care to every dual-eligible patient it admits.

Senator Ron Wyden

- Ms. Bella agreed to follow up with Senator Wyden on a target for how many dually-eligible beneficiaries can be served in a home based setting in 5 years.

CMS strives to ensure that any beneficiary who would be best served by living in the community has the opportunity to do so. The Affordable Care Act provides important new tools to help States make this possible for Medicaid beneficiaries, including duals. These tools include expansion of the MFP demonstration and new and enhanced State Plan Options that will enable States to build their HCBS infrastructure and capacity. This is vital because States that have a more developed support infrastructure have a more balanced long-term care system.

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[1] These results exclude hospitalizations from Inpatient Psychiatric Facilities, certain specialty hospitals (e.g., cancer, children's), Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals. (Under a more expansive definition of hospitalization that included these types of providers, these excluded hospitalizations would account for roughly 20 percent of the total.) These rates include both partial and full dual-eligibles.

Because States have the freedom to design their individual Medicaid programs and HCBS is an optional service, CMS does not have a reliable estimate of how many Medicare-Medicaid beneficiaries can be served in a home-based setting within five years.

- Ms. Bella agreed to follow up on the Administration's position on Senator Wyden's bill to make Medicare data available to the public.

CMS and HHS have reviewed S. 756, the "Medicare Data Access for Transparency and Accountability Act," and provided technical assistance to Senators Grassley and Wyden on this legislation. However, it is my understanding that the Department has not taken any formal position on the proposed legislation. As introduced, the bill does not have any provisions that would impact dual-eligible beneficiaries in ways distinct from other Medicare beneficiaries.

Senate Finance Committee Hearing
"Dually-Eligible Beneficiaries: Improving Care While Lowering Costs"

Statement for the Record
Senator Mike Enzi

Mr. Chairman, the recent debate over raising our nation's debt ceiling has brought renewed attention to the issue of controlling health care costs. Spending on health care in particular is a significant element of national spending. National health expenditures totaled $2.5 trillion in 2009, an amount equal to 17.6 percent of our GDP. We need to get a handle on these costs if we ever hope to be able to significantly reduce our long-term deficit. Reining in federal government spending is vital to preserving the country's capacity for economic growth and protecting our children and grandchildren's futures.

Any serious effort to address rising health care costs must focus on the health care entitlement programs like Medicare and Medicaid, whose costs are growing at a rate far above the rest of our economy. That is why I introduced a bill this summer to close a Medicaid loophole in the Affordable Care Act that would have Americans with similar incomes, ages and medical histories paying very different amounts for private health insurance. This bill is expected to save $13 billion by ensuring that all income and eligibility for both Medicaid and insurance subsidies is counted under the new law. Earlier this year Medicare's Chief Actuary, Richard Foster, noted that millions of early retirees would be eligible for Medicaid coverage because of a loophole in the recently passed health care law, which he said "just doesn't make sense." I completely agree. Additionally, while saving our nation billions of dollars, this measure would not increase the number of uninsured Americans.

Spending on individuals who are eligible for both Medicare and Medicaid, also known as the "dual eligible" population, is one of the biggest drivers of overall Medicare and Medicaid spending. Working to address the needs of this unique population could have a significant impact on slowing the rate of growth in health care costs.

Improving access to managed care services for dual eligibles is one possible avenue for controlling costs. Dual eligible individuals tend to suffer from chronic diseases or complex illnesses that require more intensive care and greater access to services. In addition, dual eligibles must navigate both Medicare and Medicaid to obtain health care coverage. Extending and improving managed care services for this population could increase care coordination and integration and reduce overlaps in coverage. These benefits would result in more efficient, higher quality care for a population of individuals that most needs the help.

I appreciate the steps that CMS has taken to improve care coordination and integration and to develop new models of payment that may improve incentives for providers to provide better care for dual eligible beneficiaries.

Mr. Chairman, I thank you for holding this hearing today.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF SEPTEMBER 21, 2011
DUALLY-ELIGIBLE BENEFICIARIES: IMPROVING CARE WHILE LOWERING COSTS

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining innovative solutions 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. I believe our topic today represents an area where we can achieve some real bipartisan solutions that will lower health care costs and save lives.

There are more than 9 million Americans who are eligible for both the Medicare and Medicaid programs, commonly known as the *dual-eligibles*.

These patients typically suffer from multiple chronic conditions and also have long-term care needs.

In addition to complicated medical issues, payment for their care is generally siloed between complex Medicare and Medicaid payment rules, and this creates inefficiencies and many unnecessary complications.

Care for these individuals is also very expensive with annual spending topping $300 billion in Medicare and Medicaid dollars.

In my home state of Utah, just 10 percent of Medicaid beneficiaries are duals, but 26 percent of the state's Medicaid expenditures go for care of these patients.

Many states have taken the lead to develop innovative solutions for dual-eligibles, such as the Community Care of North Carolina model or the Star Plus program in Texas. We need to help them build on these successes.

The federal government has also designed models to address care for dual-eligibles, such as Special Needs Plans in Medicare Advantage or the Program of All-Inclusive Care for the Elderly, which is known as PACE.

While these approaches have made a difference, there is much more work to do to ensure that every dual-eligible gets better care and that taxpayers get better value for their dollars.

I look forward to hearing from Melanie Bella, Director of the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services (CMS). Ms. Bella has taken both a pragmatic approach to problem-solving and a compassionate approach to improving patient care.

As Congress contemplates reforms to lower our entitlement program spending and to improve the quality of care, the topic of this hearing is an important place to start.

Clearly, the status quo isn't serving taxpayers well and it isn't serving patients well. We can do better, and I believe that we can do that in a bipartisan way.

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

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Statement of Senator John D. Rockefeller IV
Senate Committee on Finance
Hearing on Dually-Eligible Beneficiaries: Improving Care While Lowering Costs
September 21, 2011

Mr. Chairman:

Thank you for holding this important hearing on improving the care for the 9.2 million beneficiaries who currently receive health care coverage through both Medicare and Medicaid. These people – elderly, disabled, low-income, many living with cognitive impairments such as Alzheimer's – are burdened with serious health issues and the need to navigate a complex health care system. West Virginia alone serves 80,000 dually-eligible beneficiaries, the majority of whom live on no more than $7,900 in annual income with virtually no assets.

For years, we have heard about the unique problems faced by dually-eligible beneficiaries, who tend to be poorer and sicker than other beneficiaries. They are three times more likely to have a disability and have overall higher rates of diabetes, pulmonary disease, stroke, and mental illness. Adding insult to injury, these complex health needs are often poorly managed as dually-eligible beneficiaries are forced to navigate a complex health care system with different eligibility rules, coverage standards, and benefits between the Medicare and Medicaid programs. This lack of coordination can result in fragmented care and coverage gaps, increasing the need for costly acute treatment that might have been avoided. While we still have much to learn about the best way forward, our goal is clear: we simply must improve our health and long-term care systems to meet the needs of current and future dually-eligible beneficiaries.

To help health and long-term care providers in our Medicare and Medicaid programs deliver better care to dually-eligible beneficiaries, I was pleased that the health reform law included a provision I authored creating the Federal Coordinated Health Care Office (now called the Medicare-Medicaid Coordination Office), which is the first-ever central office at the Centers for Medicare and Medicaid Services charged with making significant improvements in the quality of care for dually-eligible beneficiaries. The office has already begun the important work necessary to move our health and long-term care systems forward to make sure that people with the most complex health care problems receive the highest-possible quality of care. This includes identifying ways to test and replicate best practices across the country, streamlining rules and regulations, and conducting new demonstration programs to help reduce preventable hospitalizations among nursing home residents. This work is critical to improving our health care system, and I look forward to hearing more about the important strides this office has already made towards improving the quality of care for dually-eligible beneficiaries.

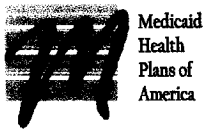
The good news when it comes to dually-eligible beneficiaries is that there is so much potential to provide them with higher-quality, coordinated care. In doing so, we can not only improve their health and quality of life – we may even be able to reduce the rate of preventable, but costly, health care problems. Indeed, as we continue the difficult discussions about the status of our national deficit and the best ways to contain rising health care costs, it is perhaps inevitable that the currently fragmented care for dually-eligible beneficiaries has become part of the discussion. Total annual spending for dually-eligible beneficiaries is estimated at $300 billion across both programs, and we spend nearly five and six times more on care for dually-eligible beneficiaries than for other Medicare and Medicaid enrollees, respectively. It is imperative that we work together to identify those measures that both improve health outcomes and have the potential to make health care less expensive for everybody. However, in exploring cost-saving measures, we must draw a distinction between the right and wrong ways to save federal and state dollars. It is our responsibility to be sure that our actions protect beneficiaries and do not endanger the care they depend on.

As we move forward, therefore, we must avoid proposals that simply shift health care costs between the federal government and the states or raise out-of-pocket health care costs for dually-eligible beneficiaries. With incomes of less than $10,000, dually-eligible beneficiaries simply cannot be expected to shoulder additional health care or long-term care costs, nor can they afford to lose essential services. Strong beneficiary protections are essential as we move forward.

To that end, it is essential to provide the necessary time to allow the Medicare-Medicaid Coordination Office and others to critically assess the best ways to provide integrated care to dually-eligible beneficiaries, assure robust consumer protections, and guarantee accountability for the use of federal and state dollars. Given that the federal government funds over three-quarters of the care of dually-eligible beneficiaries, it is also critical that new delivery system reforms in the Medicare program specifically address their needs.

For the beneficiaries who struggle with complicated health care problems day in and day out, the work of the Medicare-Medicaid Coordination Office could not be more important. Ms. Bella, I look forward to working with you and your office to continue to promote quality and access to care for dually-eligible beneficiaries. I thank the Chair.

COMMUNICATIONS



Statement for the Record
From Medicaid Health Plans of America and the Association for Community Affiliated Plans
On the hearing entitled
Dual-Eligible Beneficiaries: Improving Care While Lowering Costs
Senate Committee on Finance
Wednesday, September 21, 2011

Chairman Baucus, Ranking Member Hatch, and members of the Committee, the Association for Community Affiliated Plans (ACAP) and Medicaid Health Plans of America (MHPA) are pleased to submit the following statement for the record regarding the important role that coordinated care can serve for people who are dually eligible for Medicare and Medicaid.

Together, ACAP and MHPA represent 143 health plans that serve more than 22 million Medicaid beneficiaries – one of every 3 Americans who receive health care coverage through Medicaid.

MHPA and ACAP recognize America's current fiscal crisis and understand the need to address the national debt. We also understand that Medicare and Medicaid are two of the largest programs in the Federal government and are responsible for a significant amount of government spending. Getting the country back on the right fiscal path will require changes to address these two programs.

However, ACAP and MHPA believe the debate should be about policies that improve the programs for beneficiaries and should not be driven by the budget. Arbitrary budget cuts that strangle these programs will only serve to undermine the larger effort as costs are shifted to health plans, providers, and beneficiaries with little consideration of improvement in the quality and coordination of care.

To achieve meaningful program improvements while saving significant dollars, MHPA and ACAP believe that expanding the flexibility of states for those populations dually eligible for Medicare and Medicaid will help to produce innovative models of care integration. While this expanded flexibility should not come at the expense of reducing coverage for vulnerable populations, we do believe that giving the states options to expand coordinated care will help improve the quality of care for dual eligibles.

The attached report from The Lewin Group entitled "*Increasing Use of the Capitated Model for Dual Eligibles: Cost Saving Estimates and Public Policy Opportunities*" finds that Medicaid health plans are well positioned to effectively serve the dual eligible population. Lewin finds that:

"Many MCOs – as well as many state Medicaid agencies – now have extensive experience serving high-need populations through an integrated care model, and the "industry's" sophistication in designing, implementing and overseeing such programs has improved substantially throughout the past decade. Historically, few coordinated care programs for high-need subgroups existed, and the "coordinated care" aspects of these programs focused on assigning individuals to a "medical home" primary care provider, encouraging proper use of the MCO's provider delivery system, and deploying utilization review practices such as prior authorization for expensive services. While these techniques remain in use and of value, current Medicaid MCO programs for high-need subgroups (e.g., the Medicaid-only SSI population) typically go far beyond this traditional approach...

For example, states now often require Medicaid MCOs to demonstrate an effective process for assessing each new high-need enrollee's health care needs, housing situation, family structure and social support system, then developing and continually adjusting individualized treatment and care coordination plans. Care coordination has advanced to provide more individualized care planning and effective approaches to identify emerging health conditions in order to avoid crisis based interventions. Such requirements and coordinated care techniques do not exist in the fee-for-service environment across the acute, chronic and long term care parts of the health system.

States have also become increasingly adept at putting effective MCO contract requirements in place for high-need subgroups, and monitoring MCO performance aggressively."

In addition, the report finds that:

"...large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. The clinical and eligibility characteristics of the dual eligibles population are exceptionally well-matched to the strengths of a fully integrated care program operated by at-risk health plans. For any given dual eligibles subgroup moved into a capitated setting, encompassing the fully benefits package of Medicare and Medicaid covered services, we estimate initial... net savings (across the Medicare and Medicaid programs) of approximately 3% per year, growing to nearly 6% per year as of CY2024. Given the large baseline size of the per capita spending on dual eligibles (more than $7 trillion nationwide across the upcoming 15 years), these relatively modest percentage savings translate into rather massive dollar amounts. Nationally, each percentage point reduction in dual eligibles' spending will yield more than $70 billion in savings across the 2010-2024 timeframe."

Given the findings of this report, we believe that policy changes that expand care coordination for dual eligibles will yield significant savings to both Medicare and Medicaid while also providing high quality care for this population.

We do recognize concerns among some advocates about the expanded use of health plans to serve dual eligibles and we stand prepared to work, side-by-side, with patient advocates to expand the use of coordinated care while also protecting choice, access to care, and benefits for the most vulnerable among us. We should not let such differences prevent us from improving the services provided to these populations.

Thank you for your consideration of this statement. Please do not hesitate to contact us if we can be of any further assistance to you.

Margaret A. Murray, CEO
Association for Community Affiliated Plans

Thomas Johnson, CEO
Medicaid Health Plans of America

Dually-Eligible Beneficiaries and Palliative Care:
Improving Care While Lowering Costs
September 21, 2011

Diane E. Meier MD and R.S. Morrison MD

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Dually-eligible Medicare and Medicaid beneficiaries account for highly disproportionate shares of both budgets. As a group these beneficiaries are much more likely to be poor, functionally and cognitively disabled, and to require high-cost hospital and nursing home care. Many travel a revolving door path between Medicare-funded hospital stays and Medicaid-funded long-term care stays with neither setting able to comprehensively meet needs of these patients in an efficient and effective manner.

An unrecognized but powerful solution to this problem is the integration of palliative care focused on intensive symptom management, communication and goal setting, as well as continuity across the settings where dually-eligible beneficiaries receive care. The testimony to follow will explain how palliative care is ideally positioned to break this costly and dysfunctional pattern of fragmentation: it focuses on patient and family-centered goals and values; it improves both quality and length of life; it reduces both Medicare and Medicaid spending; and, importantly, it is already widely available across the country.

- Palliative care is medical care focused on relief of pain and other symptoms; matching treatments to patient and family preferences about achievable goals of care; and coordination across settings.
- Palliative care is not end of life care. Unlike hospice, palliative care is appropriate from the point of diagnosis of serious and chronic illness and is delivered at the same time as life-prolonging or curative care.
- Palliative care can prolong life and improve its quality for both patients and family caregivers.

- Palliative care teams focus on the chronically and seriously ill who, though they constitute only 5-10% of patients, account for well over 50% of Medicaid and Medicare spending. Palliative care programs are a solution to this growing quality and cost crisis.
- Palliative care teams are a solution to this growing quality and cost crisis. Palliative care significantly reduces Medicare and Medicaid hospital spending as reported in the March 2011 issue of *Health Affairs* by supporting informed patient and family decisions that often result in more conservative care choices.
- More than 85% of U.S. hospitals with more than 300 beds and more than 63% of all U.S. hospitals with more than 50 beds have a palliative care team.
- A 2010 Lewin Group Report identifying opportunities to improve quality and reduce costs recommends broad implementation of hospital and community palliative care programs as a key strategy.
- Government (State and Federal) can require presence of a palliative care program as a condition of hospital (and NH) participation in Medicare and/or Medicaid, progressing to required demonstration of palliative care delivery to the sickest and most complex beneficiaries as defined by both diagnostic and utilization criteria.
- The National Quality Forum has recently identified palliative care as a national priority area for healthcare quality improvement.
- Technical assistance and support for palliative care delivery in the U.S. is already available through the national organization, the *Center to Advance Palliative Care (www.capc.org)*.

Why palliative care? Despite enormous expenditures, studies demonstrate that patients with serious and chronic illness and their families receive poor quality medical care, characterized by untreated symptoms, inadequate or absent communication about the realities of the illness and the treatment options, unmet personal care needs, high caregiver burden, and low patient and family satisfaction.[1-4] Of the $378.3 billion spent by Medicaid in 2009, 61% ($227 billion) was spent on acute care (hospital) services and a very small proportion -- 4% -- of the sickest Medicaid beneficiaries account for fully 48% of total program spending.[3]

How does palliative care reduce costs? By addressing pain and symptoms that increase hospital complications and lengths of stay, meeting with patients and families to establish clear care goals, withdrawing or not initiating treatments that don't meet those goals, and by developing comprehensive and sustainable discharge plans, palliative care programs reduce hospital costs, readmissions, and emergency department visits. Costs go down because fewer deaths occur in hospital as a consequence of better family support, care coordination, and home care and hospice referrals; more admissions go directly to the palliative care service instead of a high cost ICU bed; patients not benefiting from an ICU setting are transferred out to more appropriate and lower intensity settings; and non-beneficial or futile imaging, laboratory, specialty consultation, and procedures are avoided (Figures 5 and 6). Studies in which patients were randomized to usual care or palliative care[7, 11, 12, 17] and multi-site studies in the U.S. and in NY State suggest that the savings associated with palliative care can be substantial.[21-26]

How does palliative care improve quality? Palliative care programs have been shown to prolong life, and to improve physical and psychological symptoms (Figure 3), family caregiver well-being (Table 1), and consulting physician satisfaction (Figure 4).[7-17] Employing interdisciplinary teams of physicians, nurses, social workers, and additional personnel when needed (chaplains, physical therapists, psychologists), palliative care teams identify and rapidly treat distressing symptoms which have been independently shown to increase medical complications and hospital utilization (Figure 3).[10,16,17] Palliative care teams meet extensively with patients and their families to establish appropriate and realistic goals, support families in crisis, and plan for safe transitions out of hospitals to lower intensity settings (home hospice, nursing home care with hospice, or inpatient hospice care) (Table 1). Finally, because of the assistance that they provide to already time-pressured physicians, palliative care programs are valued and utilized by referring physicians (Figure 4).

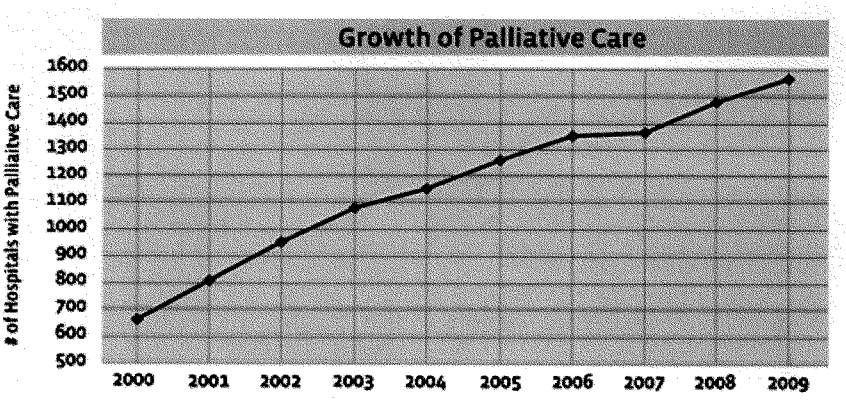
What are the essential elements of quality palliative care? Palliative care is not hospice[5]. Until 10 years ago, palliative care services were typically available only to patients enrolled in hospice. Now, palliative care programs are found increasingly in hospitals – the main site of care for the seriously ill and site of death for 50% of adults on average nation-wide. As of 2009, 63% of all U.S. hospitals and over 85% of U.S. hospitals with more than 300 beds reported the presence of a palliative care team – an increase of 138% from 2000. As outlined by the National Quality Forum[27] and the National Consensus Project for Quality Palliative Care[5], the essential structural elements of hospital palliative care are

- Interdisciplinary team of specialized clinical staff (palliative medicine MD, RN and SW)
- Staffing ratios determined by hospital size
- Staff-trained, credentialed and/or certified in palliative care
  Access and responsiveness 24 hours per day, 7 days per week

Palliative Care provides what people want. According to an April 2011 poll conducted by Public Opinion Strategies[35], once informed, consumers are extremely positive about palliative care and want access to this care if they need it:

- **92%** of respondents say they would be likely to consider palliative care for a loved one if they had a serious illness.
- **92%** of respondents say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families. Response by party was similar across the board with Democrats (96%), Independents (86%), Republicans (89%), and Tea Party Supporters (91%).

Figure 1: Growth of Palliative Care (ref 34)



Source: Center to Advance Palliative Care, March 2011

Figure 2: Impact of hospital palliative care on direct and total costs (ref 22)

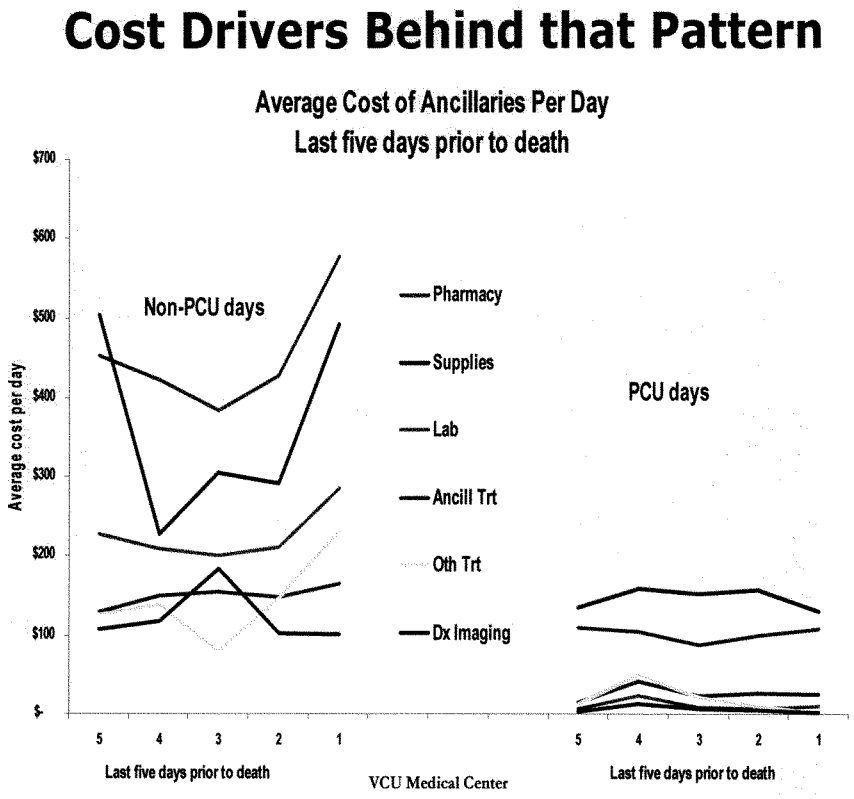
Case Control Study: 60% cost reduction for patients in PCU

Cost per day for EOL care, sample of 38 matched pairs			
	Control, Non-PCU	PCU	*p* value
Direct Costs Per day	$1,441	$632	0.004
Total Costs Per day	$2,538	$1,095	0.0009

Smith et al., JPM, Nov 2003

VCU Medical Center

Figure 3: Effect of hospital palliative care on specific expenditures (ref 22)



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Comments for the Record

United States Senate Committee on Finance

Hearing: Dually-Eligible Beneficiaries: Improving Care While Lowering Costs

September 21, 2011, 10:00 AM
215 Dirksen Senate Office Building

by Michael G. Bindner
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Chairman Baucus and Ranking Member Hatch, thank you for the opportunity to address this topic. We offer our comments on three areas of this topic, program organization, program parity and program funding.

Separating Medicaid into a program for retirees and the disabled and a program for the non-retired working and non-working poor will allow the retiree program to be fully federalized and managed with Medicare, rather than the separate management that occurs now under CMMS, which is part of the problem. That simple step will add clarity to this issue as the senior and disabled Medicare and Medicaid populations can be managed by the same offices, rather than separately. The question then shifts from parity to effective consolidation – at least on the Medicare side. All retirees and the disabled would be treated under parts A, B and D all the time, including while in nursing home care (part E). Rates would require parity in all settings, however.

The issue of parity is especially important in the area of provider limits. It is useful to compare the impact of how provider limits have been dealt with between the Medicare and Medicaid programs.

Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

The Affordable Care Act works toward increasing funds for Medicaid providers, which is necessary to get people out of emergency rooms. The same act, however, counted on assuming that Medicare provider cuts would be implemented – a heroic assumption – in order to pass according to budget rules. Now that the Act is passed, however, the fiction that current law will be maintained can be dispensed with.

Parity between Medicare and Medicaid is desirable, although without mandatory sick leave, it will not keep poor people from having to use emergency room care, although it will benefit nursing home patients who will be able to see a doctor without hospitalization.

There are many ways of achieving parity, however great care must be used so that these don't constitute a race to the bottom. Cost shifting should not be used as a substitute for cost saving, especially if such shifting violates the tenants of social insurance.

The whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, have been suggested to save costs. Without the ACA pre-existing condition reforms, mandates and insurance exchanges, however, premium support will not work because people will have no assurance of affordable coverage. This, of course, assumes that private insurance survives the imposition of pre-existing condition reforms. If it does not, the question of both premium support and the adequacy of provider payments is moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

Resorting to single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Statement for the Record

Continua Health Alliance

U.S. Senate Finance Committee
"Care Coordination for the Dually Eligible"

September 23, 2011

Mr. Chairman, the more than 240 members of the Continua Health Alliance (Continua) thank you for this opportunity to submit a statement for the record concerning individuals who are enrolled in Medicare and Medicaid, the dually eligible. Continua is a non-profit, open industry coalition of health care, technology and medical device companies joining together in collaboration to improve the quality of healthcare through the use of technologies such as telehelath, remote patient monitoring (RPM), electronic care (eCare) , mobile health (mHealth), and other health information technologies which is often referred to as personal connected health care.

Numerous studies have shown remote patient monitoring can reduce costs and improve health care outcomes. For example, the New England Healthcare Institute reported in 2009 that telehealth for remote monitoring of heart failure patients compared with two other heart failure management options resulted in a 50 percent lower rate of hospital readmissions. Given the cost of caring for patients who are dually eligible, and the need to find new payment and delivery models to care for them, it is critical for federal health programs to recognize and test these tools as methods to ensure coordinated.

While Congress has placed enormous importance on health information technology (HIT) concerning electronic health records, it has not placed the same emphasis on HIT as a patient centered tool. Personal connected health care is the foundation of health information technology. HIT is not limited to the mere exchange of electronic health records among providers, but rather encompasses a broader, richer ecosystem that begins with how raw diagnostic data captured from the patient and then derived. Continua is dedicated to establishing interoperable personal connected heath care solutions with the knowledge that extending those solutions into the homes saves money, fosters independence, empowers individuals and provides the opportunity for personalized health and wellness. By creating standards to ensure interoperability, Continua member companies have demonstrated the plug and play efficiencies in terms of deployment time and cost reductions.

On average, dually eligible patients incur almost twice the level of total health expenditures as other Medicare beneficiaries and account for nearly half of all Medicaid spending. Compared to other Medicare beneficiaries, the dually eligible were more than twice as likely to be hospitalized for pressure ulcers, asthma and diabetes, 52 percent more likely to be hospitalized for urinary tract infections and over 30 percent more likely for COPD and bacteria pneumonia. The top

three causes of potentially preventable hospitalizations for dual eligible were bacterial pneumonia, congestive heart failure and COPD.

Particularly for those who are dually eligible, whose care has been fragmented, remote patient monitoring can provide tools that can greatly assist the delivery and the management of appropriate care and provide savings. Personal connected health care can assist in improving medication adherence, medication reconciliation, patient monitoring as well as communications between clinicians, patients and informal caregivers. For example, the Heath Buddy Program integrates a telehealth tool with care management for chronically ill Medicare beneficiaries. A study published in *Health Affairs* in which the Health Buddy telehelath program was used, demonstrated savings between 7.7 percent and 13.3 percent ($312-$542) per person per quarter.

A second example of the use of health information technology as a tool to improve care is a study that demonstrated remarkable improvements in diabetic patients' HbA1C results after they used a cell phone-based software program to communicate constantly with health care providers, as compared to patients who did not have the benefit of the telehealth service. In this case, the alternative to the intensive treatment service delivered via telehealth was no intensive monitoring service at all; the alternative was not an intensive monitoring service rendered face-to-face. This study is typical of current studies of telehealth services published in peer-reviewed journals in that it shows that telehealth services lead to improved clinical outcomes, but it does not compare the results of the telehealth service to a face-to-face service. This study is attached.

The Affordable Care Act provides many opportunities for the use of personal connected health care including in several demonstration projects. However, it is clear that in implementing many of these provisions, CMS has yet to think in terms of an overarching policy about how to incorporate personal connected health across the board. Based on research that has already been completed, remote patient monitoring devices can help all individuals, including the dually eligible, in adherence to at home treatment regimens, and in creating a picture of the patient over time, which can avoid unnecessary physician, emergency department and hospital visits. Remote patient monitoring tools collect accurate data from the patient with minimal training and effort. Physicians and other providers can use the data collected to present to the patient a more accurate picture of how care compliance can assist the patient.

The Office of Federal Coordinated Care can play an important role in ensuring that as our health care system tests delivery and payment models to improve care for the dually eligible patient, personal connected health care is essential and must be included as a requirement for proposals and demonstration project designs. This is true particularly in the area of preventable hospitalizations among the dually eligible. When the New England HealthCare institute examined the use of remote patient monitoring for patients with heart failure, they found the net savings per patient were approximately $3,700 annually versus disease management. This kind of saving translates to a significant return on investment in using these tools.

With the focus on improving post-acute care transitions being driven by an interest in reducing hospital readmissions, Continua points to the evidence that personal connected health care should play a key role in helping dually eligible patients and their caregivers manage their care and prevent readmissions to the hospital.

In June 2010, the Center on Technology and Aging, in collaboration with the Administration on Aging and CMS announced grants with the aim of helping selected states expand the use of technologies for improving post-acute care transitions and reduce avoidable readmissions. While it is too soon to have work from these grants evaluated, it was an important and key step in working with states to begin to incorporate these underutilized technologies.

We would encourage the Office of Federal Coordinated Care to build upon this work now as it looks for way to better coordinate needed care for this vulnerable population. Use of personal connected health care ought to be an automatic criteria included for a vast majority of the work this office initiates. By incorporating remote patient monitoring and telehealth into the care of dually eligible patients, the Federal government would be encouraging providers to incorporate these tools into their practices which would create savings for all patients.

While not in the purview of the Office, the Independence at Home Demonstration Project (IAH) is an example of the kind of work the Office of the Federal coordinated Care could incorporate and build upon. The demonstration project authorized by Section 3024 of the Affordable Care Act, will test a service delivery model that utilizes physicians and nurse practitioners in directed primary care teams to provide services to certain Medicare beneficiaries in their homes. The participating practices will report on quality measures to monitor and evaluate the demonstration, utilize electronic health systems, remote patient monitoring and telehealth. Participating practices will be accountable for providing comprehensive, coordinated and accessible care to high-need populations at home and coordinate healthcare across all treatment settings. Dually eligible patients are not able to enroll in this initiative, however the Office of Federal Coordinated Care could use similar concepts and include technology for dually eligible patients.

The Department of Veteran Affairs (VA) has done extensive work in the area of remote patient monitoring and telehealth. However, the Department of Health and Human Services, in general disregards this work in part because the VA is in essence a health system not an insurer like the Medicare or Medicaid programs. Yet, much of this work is relevant in terms of how to use technology with patients who are often chronically ill. Continua would encourage this committee to review the work of the VA and their successful results in reducing readmissions and other costly care while improving quality of care for veterans as a template for HHS to use for Medicare and Medicaid patients.

We look forward to working with Congress and the Office of Federal Coordinated Care to ensure that these vulnerable patients are not left behind when it comes to innovative uses of HIT that have been proven to improve care and reduce spending.