THOMAS J. BETLACH
DIRECTOR
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

IMPROVING CARE
FOR DUALLY-ELIGIBLE BENEFICIARIES

TESTIMONY BEFORE THE U.S. SENATE FINANCE COMMITTEE

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

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

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

In Arizona, 82 percent of our elderly and physically disabled population that is at risk of institutionalization is dually eligible. The model of care for this population in many states is nursing home placement. Over the past decade, AHCCCS and its health plans have progressed from 40 percent of its members in the home or community to 73 percent, saving $300 million this past year. For members at risk of institutionalization with a developmental disability, 98 percent live at home or in the community, contributing to Arizona's number one ranking by United Cerebral Palsy.

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

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

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

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

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

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

It is frustrating to hear Medicaid managed care dismissed by some as an option for duals while others suggest that states are either ill-intentioned or incapable of achieving success for this population. This is not about achieving a budget target. States like Arizona want to move the system forward, improve care for our citizens and be responsible with the taxpayers' dollars.

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

Equally disconcerting is this notion that states are moving too fast and the demonstrations are too big. We have had 47 years of fragmentation. We have decades of comparison data that show the shortcomings of the existing system. We know what is not working for the people we serve and the taxpayers who are footing the bill. The current system is indefensible and unsustainable; we should not wait any longer to build upon a proven model.

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

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

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

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

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

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