S. HRG. 105–58

TORN BETWEEN TWO SYSTEMS: IMPROVING CHRONIC CARE IN MEDICARE AND MEDICAID

HEARING

BEFORE THE

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UNITED STATES SENATE

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TUESDAY, APRIL 29, 1997

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

The committee met, pursuant to notice, at 9:36 a.m., in room SH–216, Hart Senate Office Building, Hon. Charles Grassley (chairman of the committee) presiding.

Present: Senators Grassley, Warner, Hagel, Collins, Breaux, Reid, Feingold, and Wyden.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Good morning, everybody. We appreciate all of you for participating, and obviously, this turnout for this meeting shows a very strong interest in the issues that I and my colleagues are going to discuss with you this morning. I am going to give an opportunity to each one of my colleagues to make an opening statement, because some of my colleagues have conflicts with other committee meetings and will not be able to stay here for the entire meeting. I do appreciate my colleagues' attendance at these hearings, and so, I want to work with them, even if we have to go out of order to make it possible for them to make their statements, because they deserve to be heard as well.

The Senate Special Committee on Aging convenes to have this hearing on improving chronic care in Medicare and Medicaid. I appreciate all of you being here today to discuss the potential of improving this setup that does not work so well for Americans who are dually qualified. I am especially grateful to our distinguished panel of witnesses, many of whom have traveled a great distance to be here. Today's witnesses and most of the people in the hearing room are here because they are concerned about our Nation's health care system.

I would like to add a special thanks to those here today who have come because they are caring for an individual with Alzheimer's disease. Today's hearing will explore the barriers in the health care system that stand in the way of most efficiently serving persons with chronic conditions. Individuals and family members coping with Alzheimer's disease can experience additional hardships due to the fragmentation in the system, particularly in Medicare and Medicaid programs. We hope to identify these particular barriers so that we can work on appropriate corrective measures.

For many years Alzheimer's groups have educated members of Congress about important health care issues and about important advancements in medical research, and I appreciate the attendance and participation of those here today. For millions of elderly Americans, quality health care is one of the most important things in their lives. They depend on Medicare and Medicaid for health care coverage. For this reason, we must work to preserve and improve these programs.

Today's hearings will examine Medicare and Medicaid. We will hear from experts who will discuss challenges in administering services to elderly people with chronic conditions who are eligible for both programs. A discussion about this group of elderly Americans has several layers. First, we know that elderly persons who are dually eligible for Medicare and Medicaid have poorer health than Medicare-only beneficiaries. They often have chronic conditions, such as Alzheimer's disease, diabetes, cancer, arthritis, mental illness, and chronic heart problems. These health conditions require special attention. It takes the coordination of the individual families, doctors, nurses and other health experts to cope with these conditions. Fortunately, advances in medicine have provided many ways of managing these conditions. Yet, it is too often the case that elderly Americans with chronic conditions do not receive the appropriate medical and social services they desperately need.

Without proper care, chronic conditions can quickly worsen. In such instances, the results can be very costly. What seems like a minor problem of health care can turn into a major one. This results in ongoing trips to doctors or hospitals. Today, you will hear from one witness about how a minor fall precipitated a series of events well beyond that which was expected. Before being hospitalized due to a fall, this individual was living independently at home with her husband of 51 years. Seven months later, after 16 moves and $126,000 of Medicare costs, the same individual is now living in a nursing home. Her dementia has advanced significantly, and she does not always recognize her family.

Not only can fragmented care lead to a decline in an individual's well-being, but it can mean skyrocketing costs to an individual or family. Today, average nursing home care can cost $40,000 per year. Home health care can range from $50 to $200 per day. When paid by an individual, such health care expenses can quickly exhaust a lifetime of family savings, and when paid by Medicare and Medicaid, program costs reach into the billions. The matter of costs is important to address, and we will talk today about costs to the individual and also to the Medicare and Medicaid programs.

If you would look at these two charts over here, you will see that the first chart, the one on my left, that the dual eligible population accounts for approximately 30 percent of the spending in both Medicare and Medicaid, even though the percentage of the population is a much, much smaller percentage. The second chart shows that, on average, dual eligibles have higher Medicare expenditures, especially with respect to home health and skilled nursing facility services. So, we are here today to recognize the special care needed for the seniors with chronic conditions, and we are going to look at ways that the health care system can better serve individuals with

chronic conditions and become more efficient, so that we can save health care dollars.

I now turn to my distinguished ranking member, Senator Breaux of Louisiana.

[The prepared statement of Chairman Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good morning ladies and gentlemen. The Senate Special Committee on Aging will come to order. I appreciate all of you being here today to discuss the potential for improving chronic care for elderly Americans. I am especially grateful to our distinguished panel of witnesses—many of whom have traveled a great distance to be here this morning.

Today's witnesses and most of the people in the hearing room today are here because they are concerned about our country's health care system.

I'd like to add a special thanks to those here today who have come because they are caring for an individual with Alzheimer's disease. Today's hearing will explore the barriers in the health care system that stand in the way of most efficiently serving persons with chronic conditions. Individuals and family members coping with Alzheimer's disease can experience additional hardships due to the fragmentation in the system, particularly in the Medicare and Medicaid programs.

We hope to identify these particular barriers so that we can work at appropriate corrective measures.

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Today's hearing will examine Medicare and Medicaid. We will hear from experts who will discuss challenges in administering services to elderly people with chronic conditions who are eligible for both Medicare and Medicaid.

A discussion about this group of elderly Americans has several layers.

First, we know that elderly persons who are dually eligible for Medicare and Medicaid have poorer health than Medicare-only beneficiaries. They often have chronic conditions, such as Alzheimer's disease, diabetes, cancer, arthritis, mental illness, and chronic heart conditions.

These health conditions require special attention. It takes the coordination of the individual, families, doctors, nurses and other health experts to cope with these conditions. Fortunately, advances in medicine have provided many ways of managing these conditions.

Yet, it is too often the case that elderly Americans with chronic conditions do not receive the appropriate medical and social services they desperately need.

Without proper care, chronic conditions can quickly worsen. In such instances, the results can be very costly. What seems like a minor health care problem can turn into a major problem. This results in ongoing trips to the doctor or hospital.

Today you will hear from one witness about how a minor fall precipitated a series of events well beyond that which was expected. Before being hospitalized due to a fall, this individual was living independently at home with her husband of 51 years. Seven months later, after 16 moves and $126,000 in Medicare costs, this same individual is now living in a nursing home. Her dementia has advanced significantly and she does not always recognize her family.

Not only can fragmented care lead to the decline in an individual's well-being, but it can mean skyrocketing costs to an individual or family. Today, average nursing home care can cost $40,000 per year. Home health care can range from $50 to $200 per day. When paid by an individual, such health care expenses can quickly exhaust a lifetime of personal and family savings. When paid by Medicare and Medicaid, program costs reach into the billions.

This matter of costs is important to address and we will talk more about costs to the individual and also to the Medicare and Medicaid programs. If you look at the two charts in front of me, you will see on the first chart that the dual eligible population accounts for approximately 30 percent of spending in both Medicare and Medicaid. The second chart shows that on average, dual eligibles have higher Medicare expenditures, especially with respect to home health and skilled nursing facility services.

We are here today to recognize the special care needed for seniors with chronic conditions. We're going to look at ways the health care system can better serve indi-

viduals with chronic conditions and become more efficient so that we can save health care dollars.

Before we hear from the witnesses, I'd like to share a story with you about an Iowan. To me, this is a success story. It makes a point about what we are here to talk about today. That is, working to improve health care for seniors so that they have access to services that keep them healthy. Reaching this goal is an ongoing mission for health professionals. It should be an ongoing mission for policymakers as well.

This success story is about a 77-year-old woman from Waterloo, IA which is near my home. She has been diagnosed with multiple health conditions, including mental illness, arthritis, cataracts, and vascular disease. This is an awful lot for one person to manage alone.

Being over age 65, she is eligible for Medicare. She is also eligible for Medicaid. In Iowa, we have a Medicaid waiver for frail elderly seniors. Under this program, she was assigned a case-manager, who made it possible for this woman to stay at home and receive the care she needs.

First, under Medicaid, she was assigned a prescription card that allows her to take her medications consistently. This is vital to here well-being due to her mental illness and vascular disease. Under Medicare-only, there is no assistance with medications.

Now, she also receives home delivered meals, nursing visits twice a week and personal care assistance. She has been assigned a Senior Companion who helps her with money management and mental health counseling.

By looking to community supports, the case manager also assisted in acquiring a furnace through the community action agency (CDBG), energy assistance, a property tax credit, and transportation provided by church members.

Even with all these services, the costs are lower than if she were living in a nursing home, where she could also receive good care. Most of all, she is able to keep living at home and going to church, which is important to her. To me, this is a real success story, and much of the credit is due to here caseworker, who is here today.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Senator Grassley, and thank you for arranging to have this hearing. I can tell you that I have been in Congress for over 25 years, and in all of those years, I have never, ever attended a hearing which had such a large audience of concerned citizens from throughout our country. I congratulate all of you for taking the time, the effort and the expense in traveling here to Washington, many of you from out of State; many of you from my home State of Louisiana. I welcome all of you. I hope that you learn as much, as we do from participating and listening to the witnesses at this hearing. As members of the Aging Committee, we are members who are trying to learn as much as we possibly can about the particular and special problems that affect the millions and millions of senior citizens in our country, we try to explore ways to solve some of the problems that you face each day.

Health care reform has been a very prominent issue for Congressmen and women over the last several years, and I believe we have to have one guiding principle: health care reform is not just about cutting costs. Health care reform is about getting a better deal at a better price for all of our citizens. It is much more than just finding ways to reduce the costs of the health care; it is very important to make sure that we also find ways to deliver better health care for all of our citizens.

I think one very important point is that people cannot be like a tennis ball bouncing back and forth between health care services. The amount and quality of health care people receive should not be determined by what program you happen to fall under. The hearings this morning will show us that too many times, too many

people are bounced back and forth like that tennis ball, just because of what programs someone else figured they may fit best into, and that is not how the system should work. The system should be providing quality health care, regardless of the program that the person happens to fit into, and providers cannot use these programs to try and finesse individuals when really, we ought to be trying to find out how we can get the best quality health care for everyone.

So, I think this morning, we are going to learn a great deal about these problems. I am interested in exploring, perhaps, how managed care can be better utilized to help senior citizens because only a very small number of the elderly are in managed care programs. Managed care programs, in my opinion, have to be more involved in treating seriously ill people instead of being encouraged to pick and choose healthy citizens to enroll in their programs. So, hopefully, Mr. Chairman, the witnesses that we have selected will give us that type of information, in order for us to make the right decisions for the people whom we represent, and I thank all of this very large audience for being with us. It is an exciting day, and we thank you for being with us.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Any serious attempt to hold down Medicare and Medicaid costs must take the needs of the dually eligible—the elderly and disabled poor—into account. They are the most expensive of the Medicare and Medicaid beneficiaries. They account for a disproportionately large share of spending in both Medicare and Medicaid. As 16 percent of the Medicare population, they account for 30 percent of its expenditures. As 17 percent of the Medicaid population, they consume 35 percent of its payments. Overall, $106 billion was spent in 1995 on the dual eligibles. This amounts to 9 times more money than was spent nationally on medical research.

As only 2 percent of the Nation's population, they account for 10 percent of the country's health care spending. They are also the two fastest growing segments of the Medicare population. These groups—the nonelderly disabled and individuals 85 years and older—are the two groups most likely to be dually eligible.

The current financing and delivery of health care between the Medicare and Medicaid programs is fragmented, not cost effective, and fails to serve the beneficiaries' health needs well.

For example, Medicare, which pays for acute care, encourages hospitals to discharge the elderly quickly to nursing homes or home care facilities. Medicaid, which pays for many of the long term needs of the elderly, encourages nursing homes to discharge high cost and high service-using residents to hospitals where Medicare picks up the tab. We will hear today about the enormous financial costs that result to taxpayers and personal costs to family members to this shifting between the two systems.

Managed care, with its integration of health care services, has enormous potential to combine both the Medicare and the Medicaid programs' funding streams and provide coordinated health care for this population.

But while the Medicare and Medicaid programs are beginning to hold down costs through managed care arrangements, the dually eligible beneficiaries are *not* participating in these plans. While 77 percent of workers nationwide are enrolled in managed care plans, only 3 percent of dually eligible individuals are enrolled. Only 7 percent of all Medicare HMO enrollees are dually eligible.

Traditional managed care, with its emphasis on acute care and preventative medicine, is not equipped to handle the long term and chronic care needs of this population. In addition, flat payment rates give HMO's an incentive to avoid high cost patients. The dually eligible beneficiaries—the most expensive—are therefore patients left behind in fee-for-service medicine, where costs are skyrocketing.

Even injecting competition into the Medicare managed care marketplace, as under the FEHBP model I have proposed, will not help reduce the costs of these needy beneficiaries enrolled in fee-for-service plans. We must focus more attention on how

to adapt the cost-saving mechanisms of managed care to the needs of our most expensive, most vulnerable citizens.

This hearing will showcase some new, innovative managed care projects that are proving it is possible to offer better health care to our seniors *and* save money. We will hear about ideas like case management, where a provider coordinates the health care for these seniors, making sure they are receiving the care they need, not the care Medicare or Medicaid decides it will pay for or has cost shifted to the other program.

We will hear from representatives from two States, who have developed new ways to combine Medicare and Medicaid to offer their elderly poor a wide range of health care services.

But we will also hear about problems with these arrangements. The dually eligible are not a healthy population, and they need high quality care. Per capita caps and block grants, for example, pose special problems for the dually eligible. Capping Federal payments to States in Medicaid will make it extremely difficult for programs that coordinate care to exist—they will not be able to afford it.

In fact, a per capita cap will reproduce the same negative incentives that lead HMO's which receive a flat payment and to avoid high-cost, chronically ill people. We need to move slowly, but with an open mind and an eye for new ideas. These are our most vulnerable citizens, and we owe them the best of our Nation's health care.

The CHAIRMAN. Senator Collins, then Senator Reid, then Senator Feingold, and then Senator Wyden.

Senator COLLINS.

STATEMENT OF SENATOR SUSAN COLLINS

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

I want to thank you for calling this important hearing today and for elevating my seniority so considerably on this committee. [Laughter.]

Senator COLLINS. I think that is the fastest ascent of any freshman, and I really appreciate it, particularly since we have a witness from Maine here today.

While Medicare and Medicaid are financed and administered separately, as the chairman has pointed out, the programs often share in the delivery of services to frail elderly and disabled patients. These dually eligible individuals are generally poor, often institutionalized and usually have serious, chronic health conditions and very specialized health care needs. While the population is small, about 6 million people, it accounts for a disproportionate share of both Medicare and Medicaid spending, as the chairman's charts so well demonstrate.

In 1995, it cost an estimated $106 billion to cover all of the health care needs of dually eligible individuals. While they make up just 2 percent of our population, they account for more than 10 percent of all health care spending. Furthermore, the two groups most likely to be eligible under both programs—the non-elderly disabled and beneficiaries 85 or older—are the fastest growing segments of the Medicare population. Any attempt to hold down the costs of these programs must take their special needs into account.

Dually eligible individuals generally depend upon Medicare and Medicaid to coordinate the financing and delivery of their care. However, as we will hear this morning, all too often, there is very little coordination between the programs, and, as a result, care is fragmented. Financial and other benefit differences between the Medicare and Medicaid programs create conflicting incentives, so that the care that a patient receives and who delivers it may have

more to do with who is paying for it than what the patient actually needs or what the total cost to the health care system would be.

An example of these conflicting incentives and lack of coordination was recently brought to my attention by one of my constituents, Dorothy Seekins of Bucksport, ME. Ms. Seekins wrote to express her concern about a situation involving her mother. Her mother was dually eligible and had been transferred from a local nursing home to a board and care home because Medicaid had determined that she did not need the level of skilled care that the nursing home provided. Ms. Seekins was told that the board and care home would be less expensive, and it was, but only as far as Medicaid was concerned. Her mother was a diabetic, and the cost of her insulin shots and supplies had to be covered by Medicaid as part of an $88 daily nursing home rate. However—and here is the catch-22—since no one on the staff of the board and care home was trained to give injections, a home health nurse was brought in twice a day, a cost that was covered by Medicare. As a result, while the move saved Medicaid $810 a month, Medicare costs increased by $6,300. All together, the total cost of her care jumped from $2,640 a month to $8,130.

As Ms. Seekins observed, what this amounts to is the right hand does not know what the left hand is doing. Fortunately, Maine's Bureau of Elderly and Adult Services is on its toes, and the situation was quickly corrected by teaching the workers in the board and care home to administer injections. However, as those who have been in the situation know, not all such problems are corrected so quickly, and this is a prime example of what can go wrong and why it is so important that there be better coordination between Medicare and Medicaid when dealing with these vulnerable patients.

Mr. Chairman, I would note that cost, while an important issue, is not the only issue. This lack of coordination and fragmentation of services takes a human toll as well. We will hear later in this hearing from one of my constituents, Sue Paul, who has traveled from Augusta, ME, today to tell us about her family's frustration in trying to coordinate care for her later father-in-law. As Ms. Paul will tell us, her father-in-law was tossed back and forth between the Medicare and Medicaid systems. In the last year of his life, he was forced, over the objections of both his family and his doctor, to move a total of 11 times between a hospital, a nursing home, and a residential care facility. Like too many other frail elderly individuals, Mr. Paul was simply lost in a bureaucratic maze.

Again, I want to thank the chairman for holding this very important hearing, and I look forward to welcoming my constituent to the committee. Thank you.

The CHAIRMAN. Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator REID. Mr. Chairman, I have to be excused. We have the full Appropriations Committee at 10 this morning to mark up our supplemental emergency appropriation bill. However, I am very happy to be here today. I have reviewed the testimony and been briefed by my staff, and I think it is going to be an outstanding

panel and a very difficult area that a lot of work needs to be done on.

I am pleased that we are holding this hearing and dedicating the committee's time and effort to our citizens who are eligible for both Medicare and Medicaid. These people, sometimes referred to as dual eligibles, have been described by some as politically invisible. They are poor and often quite sick. This population tends to be female, and they tend to live alone. By definition, they are low income. Most dual eligibles are minorities. Many experience cognitive impairment or mental health disorders. In short, they are among our most vulnerable citizens.

About 6 million indigent Medicare beneficiaries have some level of supplemental coverage under Medicaid. It is estimated that another 3 to 4 million are eligible but not enrolled. Because they are sicker and a more vulnerable population, dual eligibles consume a disproportionate amount of resources under both Medicare and Medicaid. In 1995, while dual eligibles constituted only about 17 percent of Medicaid beneficiaries, they accounted for about 35 percent of total Medicaid expenditures, largely due to long-term care costs. This group represents only 16 percent of total Medicare beneficiaries but accounts for about 30 percent of total Medicare spending. In 1995, health care costs for dual eligibles reached over $100 billion, frankly, about $106 billion.

In far too many cases, as we will hear today, dual eligibles are often denied effective treatment, because the system that will pay the bills often becomes a more important issue to providers than the actual care required by the patient. While unintentional, appropriate care for the patient becomes secondary, and maneuvering through the health care maze becomes primary.

This is inexcusable. We can and must do better. Let any one of us walk a mile in the shoes of our first two witnesses, and I think we would see all too clearly that our current system is in dire need of reform. We must seek an integrated system that provides case management or disease management with the goals of quality service, patient/family satisfaction, and cost containment being pursued simultaneously. Care must be provided on an integrated continuum. Health care for our most vulnerable citizens should not be left to chance but pursued vigorously to ensure that it is the best it can be. Unnecessarily shifting costs from system to system or shifting the patient from facility to facility is not the American way, and we will hear today that this happens many times and has in many instances become the American way.

With the number of dual eligible beneficiaries expected to grow over time, the time to pursue solutions to this complex challenge is now. In the State of Nevada, we have nearly 11,000 people who are dually eligible for Medicare and Medicaid. For their benefit and the benefit of those whose taxes support these programs, I look forward to today's testimony and sincerely hope that we will gain ideas about how to pursue reform.

In my view, reform presents us with a win-win situation: a win for beneficiaries, who, through an integrated system, will receive the care they need, where they need it, when they need it, as well as a win for the taxpayer, who will be assured that much-needed

emphasis is placed on cost containment and the prevention of unnecessary duplication and cost shifting.

We must put the individual patient and their concerns first instead of the system that will ultimately be billed for the service. I am confident and hopeful that the hearing this morning will shed some light on how we can accomplish this vital task. I am reminded of a comment once made by Dr. Robert Butler, the geriatrician who was founding director of the National Institute on Aging. He said—and I paraphrase what he said—the best way to have a good system of health care for older Americans is for each of us to think of ourselves as someday being a frail, old person and then work to make sure that the system we want is in place when it is our turn to be old.

I think this is sound advice as we listen today about the plight of dual eligibles. So, I encourage all of my colleagues on the committee to ask themselves: Is this the system we want in place when it is our turn to be old?

Thank you, Mr. Chairman.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

Good morning, Mr. Chairman, members of the Committee, and distinguished panelists. I am pleased that we are holding this hearing this morning and dedicating our committee's time and effort to our citizens who are eligible for both Medicare and Medicaid. This group, sometimes referred to as dual-eligibles, has been described by some as politically invisible. They are poor and often quite ill. This population tends to be female and living alone. By definition they are low-income. Most dual eligibles are minorities. Many experience cognitive impairment or mental health disorders. In short, they are amongst our most vulnerable citizens.

About 6 million indigent Medicare beneficiaries have some level of supplemental coverage under the Medicaid program. It is estimated that another 3–4 million are eligible but not enrolled. Because they are sicker and a more vulnerable population, dual-eligibles consume a disproportionate amount of resources under both Medicare and Medicaid. In 1995, while dual-eligibles constituted only about 17 percent of Medicaid beneficiaries, they accounted for about 35 percent of total Medicaid expenditures, largely due to long-term care costs. This same group represents only 16 percent of total Medicare beneficiaries, but accounts for about 30 percent of total Medicare spending. In 1995, health care costs for dual-eligibles reached $106 billion.

In far too many cases, Mr. Chairman, as we will hear today, dual-eligibles are often denied effective treatment because the system that will pay the bills often becomes the more important issue to providers than the actual care required by the patient. While unintentional, appropriate care for the patient becomes secondary and maneuvering through the health care maze becomes primary.

Mr. Chairman, this is inexcusable. We can and must do better. Let any one of us walk a mile in the shoes of our first two witnesses and I think we would see all too clearly our current system is in need of reform. We must seek an integrated system that provides case management or disease management with the goals of quality service, patient/family satisfaction, and cost containment being pursued simultaneously. Care must be provided on an integrated continuum.

Health care for our most vulnerable citizens should not be left to chance but pursued vigorously to ensure that it is the best it can be. Unnecessarily shifting costs from system to system, or shifting the patient from facility to facility, is not the American way.

With the number of dual-eligible beneficiaries expected to grow over time, the time to pursue solutions to this complex challenge is now. In my own State of Nevada, we have nearly 11,000 individuals who are dually eligible for both Medicare and Medicaid. For their benefit, and the benefit of those whose taxes support these programs, I look forward to today's testimony and sincerely hope that we will gain ideas about how to pursue this necessary reform. In my view, reform presents us with a win-win situation; a win for beneficiaries who, through an integrated system, will receive the care they need, where they need it, and when they need it, as well

as a win for the taxpayer, who will be assured much-needed emphasis is placed on cost containment and the prevention of unnecessary duplication and cost shifting.

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I am reminded of a comment once made by Dr. Robert Butler, the eminent geriatrician who was founding director of the National Institute on Aging. He said, and I am paraphrasing here: the best way to have a good system of health care for older Americans is for each of us to think of ourselves as someday being a frail, old person and then work to make sure that the system we want is in place when it is our turn to be old. I think this is sound advice as we listen today about the plight of dual-eligibles. I encourage all my colleagues on the committee to ask themselves: "Is this the system we want in place when it's our turn to be old?" Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We have Senator Feingold from Wisconsin.

STATEMENT OF SENATOR RUSSELL FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman. Let me thank you and the ranking member for calling the hearing, and I want to join in Senator Breaux's words about what a tremendous crowd it is, and my compliments to the Alzheimer's Association and other groups who worked to make sure that this hearing would happen and be well attended.

I have had a special interest in chronic and long-term care issues for some time, and the problems facing those individuals who are eligible for both Medicare and Medicaid is obviously a timely one, as we move to reform these programs both as a part of the program to balance the Federal budget but also as a part of a longer term effort to modernize both programs and making them fiscally sound. The hearing you have put together does an excellent job of describing the problems of the dually eligible and of possible approaches that we might consider to address those problems as well as to restrain the growing cost of care for this special group.

But of particular interest to me, though, are ways in which we can reduce long-term care costs for people in this group and even reduce the number of people who become dually eligible. The potential for savings is obviously enormous for both State and Federal budgets, and for individuals needing long-term care services and for their family member caregivers, the human benefits are equally great. Mr. Chairman, in Wisconsin, we confronted this issue in the early 1980's, and the long-term care reforms we instituted have saved hundreds of millions of dollars and allowed thousands of people in Wisconsin to remain in their own homes and with their own families rather than having to go prematurely to a nursing home.

The centerpiece of these reforms was something called the Community Options Program, known as COP. COP provides flexible home and community-based services that are responsive to the individual needs of those needing long-term care and their family member caregivers. This approach, Mr. Chairman, offering a flexible response to the different circumstances of each consumer, stands in great contrast to the systems that will be discussed here today. Indeed, the fundamental problem with these programs is that they take a you-need-what-we-have approach to consumers. No matter what the true needs of the consumer might be, our current programs, as Senator Breaux indicated, try to cram the

consumer into predetermined categories, making the consumer fit the program. One of today's witnesses offers what I thought was very telling testimony on this very problem. In her words, her mother "bounced from doctor to doctor, facility to facility, all dependent on what Medicare would pay for, not on what she needed to get better."

For those individuals who are eligible for both Medicaid and Medicare, this need to fit consumers to the service is further aggravated by the conflicts between the two health care programs. Mr. Chairman, as we look for answers today, I really do hope the committee will look at our very good experience on this in Wisconsin. I will be introducing legislation in the next few days to institute some of our long-term care reforms on a national basis, and I look forward to talking to fellow committee members about what we did in Wisconsin and how we can implement reforms that not only make the current system more responsive to the real needs of people needing long-term care, but also, I am convinced, providing serious savings in terms of tax dollars to the taxpayers of this country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Feingold.

Senator Wyden and then Senator Warner.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you very much, Mr. Chairman, and I want to join in the beaucoups for you and for Senator Breaux for holding this important hearing. I think it is very clear that in much of the United States, the system for caring for older folks who are eligible for Medicare and Medicaid is in total chaos. The challenge, it seems to me, is clear: we have some of the most vulnerable people in our society; and they simply are not getting care in the most appropriate setting; and the care is not being made available in the most cost-effective way. So, the challenge is to coordinate care and to pool Federal and State financing. What is especially important about your work, Mr. Chairman, is that we ought to move—and move now. It is very clear that when the baby boomers retire, we are headed for a demographic tsunami. The time to move on these issues is today.

I would wrap up with just a couple of points, Mr. Chairman. First, I would hope that as we look at these issues, and I know the General Accounting Office will also look at programs, we would look at my home State. In Oregon, we have been able to get several waivers to allow older people to participate in two programs that have essentially allowed us to pool the funds and use coordinated care to better serve older people: one called the PACE program, the Program of All-Inclusive Care for Seniors, and the other known as the Social HMO program.

In the Medicare modernization legislation that I introduced several weeks ago, we would expand the opportunity for the Health Care Financing Administration to fund these kinds of programs. The PACE programs and the Social HMO programs are models for how to look to the 21st century in terms of serving the dual eligibles, and you can find this principle working well in my hometown of Portland.

The last point that I would want to mention, Mr. Chairman, is that as I look in the audience today, I see a lot of strong potential. I see folks with whom I had a chance to work from my days at home when I was co-director of the Gray Panthers, the senior citizens' group. I am convinced that with your energy, Mr. Breaux's and that of the folks in the audience, we are going to be able to get on top of this and get Medicare ready for the next century. I look forward to working with you.

[The prepared statement of Senator Wyden follows:]

Prepared Statement of Senator Ron Wyden

Mr. Chairman, I'd like to thank you and our Ranking Minority Member, Mr. Breaux, for holding this hearing on a very important issue.

Indeed, it is my opinion that the current method of caring for Medicare and Medicaid "dual eligibles" is driven by eligibility category instead of the beneficiaries' health care needs.

The question of paramount importance—"What is the best way to provide the care that this beneficiary needs?—gets lost in the shuffle and replaced by the amoral calculus of "Who will pay for this beneficiary?" That the people in question are elderly, disabled, or both, is a horrible irony: these are the same people often least equipped to navigate the complexities of the American health care system. Research by the Health Care Financing Administration (HCFA) has determined that dual eligibles have fewer resources at their disposal, are more likely to live alone, and have more serious health conditions when compared to other Medicare beneficiaries.

The relationship between Medicare and Medicaid always been complicated. But the essence of the dual eligibles crisis is this: Medicare is federally funded and covers mainly acute care or hospital services; Medicaid is jointly funded between Federal and State governments and picks up the tab for institutional arrangements.

As currently operated, the system encourages poor decisions about care management. What is indefensible—and what we must not forget—is that these poor decisions have dramatic human costs, as we will see from the testimony of the first panel.

Fragmented care and bifurcated financing is where we are now. Putting the beneficiary first will require coordinated care and pooled Federal and State financing. Putting the beneficiary first will also require finding the best way to blend Medicare and Medicaid dollars to provide health care for people with long-term, rather than acute-care, needs. The impending demographic tsunami—the retirement of the baby boomers—underscores that we need to make changes now rather than later. We need to ensure that the long-term care of the baby boomers and future generations is affordable and of the highest quality. Standing back and doing nothing will only magnify the problems we will hear about in today's testimony.

One place we can look for inspiration is my home State of Oregon, where a successful system of waivers has helped to keep beneficiaries in the most appropriate care setting, in their homes and communities, rather than in institutions. There, also the Oregon Health Plan (OHP) has demonstrated how managed care successfully coordinate the complicated health care needs of dual eligibles. Other demonstration projects like the Program of All-inclusive Care for the Elderly (PACE), and Social HMO's (SHMO's) have integrated primary, acute and long-term care for the elderly while pooling Medicare and Medicaid dollars. *In fact, Portland has been both a PACE and SHMO site, and I believe that GAO should evaluate its two long-running side-by-side programs in terms of their quality and cost-effectiveness. We need to be able to replicate what works best in low-reimbursement areas on a national scale.* Significantly, PACE's capitation in Portland one of the two lowest in the country ($1,447/month compared to $4,632/month in the Bronx, NY).

The Health Care Financing Administration (HCFA) acknowledged last summer that PACE should move beyond demonstration status and that the SHMO demonstration should be extended. My proposed Medicare Modernization and Patient Protection Act (S–386) goes further, and directs the Secretary of Health and Human Services to expand both PACE and SHMO's so that the coordinated benefits of these innovative programs are available to more seniors, and especially seniors who are dually eligible. The Medicare Modernization and Patient Protection Act (S–386) remodels Medicare with what we know to work in the private sector, and in the Federal Employee Health Benefits Plan (FEHBP): Medicare can offer coordinated care, plan options, and consumer protections. PACE and SHMO's will be part of the ex-

panded range of options the Medicare Modernization and Patient Protection Act (S-386) will create for our seniors.

Still, long-term care needs to be addressed beyond the scope of the dual eligibles "problem"—that's why I intend to introduce a bill that will make it easier for all Americans to purchase long-term care insurance. Why the SHMO expansion I mentioned before would also benefit seniors as a whole when they consider their long-term care options.

We must not shrink from tackling the difficulties posed to us by Medicare, Medicaid and long-term care, as today's testimony will show.

The CHAIRMAN. Thank you.

Senator WARNER.

STATEMENT OF SENATOR JOHN WARNER

Senator WARNER. Thank you, Mr. Chairman. I join others in commending you and the distinguished ranking member for this hearing.

If you can indulge me in just a little personal reminiscence, my father was a medical doctor, and when I was in the Navy in World War II, he was stricken with terminal cancer. Once the medical fraternity to which he had devoted his life determined that there was no hope for him, he was brought into our home, where he received very loving home care by my mother. To the extent that I and my brother could contribute in his care, we did. It is that memory that induces me to work very hard with our colleagues here to provide every opportunity for home care. But then, there are instances when home care is not an option. My mother lived to be 96 years old, and she was very strong, mentally and physically, until her last year. At this time, we had to resort to other than home care for her care. So, I draw on a family experience which enriched me greatly and left me with many strong memories of this situation. I will be an active participant in this hearing drawing on my own experiences, and hopefully, we can have those experiences help others in the future.

I thank the chair.

[The prepared statement of Senator Warner follows:]

PREPARED STATEMENT OF SENATOR JOHN WARNER

Mr. Chairman, thank you for holding this hearing today to evaluate the delivery system for elderly persons with chronic conditions who are dually eligible for both Medicare and Medicaid.

The Commonwealth of Virginia has a large and growing senior population. By the year 2000, we are projected to have more than a million citizens over the age of 65 equaling 15 percent of our total population. This committee provides an outstanding forum for addressing their issues and concerns, and I look forward to participating.

The topic of today's hearing focuses on financing health care for dual eligibles, those eligible for both Medicare and Medicaid. This dually eligible population, which accounts for a disproportionately large share of spending in both programs, is expected to grow, putting an even greater strain on these programs to contain cost growth. The challenges presented to the Medicaid and Medicare programs to coordinate the financing and delivery of care for the dually eligible population are great.

We have all heard a lot about "Managed Care" in the last few years as millions of American workers have been enrolled in various HMO's, PPO's, and the like. It is extremely important that we document the record of long term care services in the age of managed care. With ongoing discussions and proposals to extend managed care options to greater numbers of Medicare and Medicaid beneficiaries, we need to know beforehand—as much as we can—how Managed Care affects the quality of long term care services for the chronically ill. Dually eligible beneficiaries are more likely to have poorer health status and require long-term care.

Mr. Chairman, later today, I will welcome members of the Virginia Alzheimer's Association to my office, and I look forward to sharing with them the results of this hearing.

The CHAIRMAN. I ask unanimous consent to include in the record the statement of Senator Hagel.

[The prepared statement of Senator Hagel follows:]

PREPARED STATEMENT OF SENATOR CHUCK HAGEL

Thank you Mr. Chairman. I look forward to hearing from our panelists this morning as they discuss the current health care delivery system for older Americans with chronic conditions, such as Alzheimer's disease, who are dually eligible for Medicare and Medicaid, as well as ideas for improving today's system.

We need to find better ways of coordinating care and making our health care system as user-friendly as possibly for this particularly vulnerable population with specialized needs. We need to streamline the existing bureaucratic maze which regularly determines whether Medicare, Medicaid or both will finance a dual eligible's care on any given day. We need to explore common sense public policy options that may be able to avoid much of the duplication of services and conflicting financial incentives that exist in the current system. We need to create peace of mind for dually eligible beneficiaries and their loved ones by seeking to eliminate, to the greatest extent possible, the need for these individuals to be bounced back and forth between the nursing home and the hospital and the phone calls, often late at night, to notify family members of the latest shift in status.

It is important to note from a policy standpoint that dual eligibles account for a disproportionate share of spending in the Medicare and Medicaid programs. These individuals made up about 16 percent of the Medicare population but utilized an estimated 30 percent of total Medicare expenditures in 1995. They made up 17 percent of the Medicaid population, but accounted for approximately 35 percent of Medicaid program payments.

Dual eligibles use more post-acute and long term care services—which are high cost areas for both Medicare and Medicaid—and account for 36 percent of Medicare's fastest growing components, skilled nursing facility (SNF) and home health services. More than 40 percent of dual eligibles have a mental or cognitive impairment, compared with only 9 percent of non-dual beneficiaries. This population is nearly 3 times as likely to have a mental disorder such as schizophrenia, over 4 times as likely to have Alzheimer's disease, and 10 times as likely to have mental retardation.

Dual eligibles are typically transferred from a nursing facility to a hospital when an episode of acute illness occurs. This is due to the fact that Medicaid reimbursement is not adequate to cover simple acute care services and Medicare will not pay for the delivery of services provided in a nursing home setting without an initial hospital stay of at least 3 days. Of course, the patient may be shuttled right back to the nursing home after the hospital evaluates the situation and denies admission. In any event, patients and their families are often subjected to disorienting and expensive ambulance trips to the hospital, emergency room evaluations and hospital stays, when care might have been provided in the nursing home setting were the reimbursement rules more flexible.

So many of our health care system's resources are devoted to caring for these beneficiaries that it is clearly in our best interests as innovative and thoughtful policymakers to design a more flexible and efficient payment and delivery system for our dual eligible population.

In its 1997 Annual Report to Congress, the Physician's Payment Review Commission (PPRC) recommended that any proposals developed to restructure Medicare and Medicaid should explicitly take into account implications for dual eligibles and that proposals should be assessed in terms of their effect on the potential for coordinating the financing and delivery of care. The PPRC also recommended that the Health Care Financing Administration, in conjunction with state Medicaid agencies, should develop and test improved ways to coordinate care and that any promising approaches should be tested through demonstration projects, the results of which should be made readily available. Today, we will hear descriptions of some of these new approaches to addressing dual eligible issues.

If we are to successfully preserve and revitalize Medicare and Medicaid, we must carefully examine all common sense, cost-effective reform proposals. In doing so, it is imperative that we pay close attention to the dual eligible issue in order to better coordinate the delivery of care and improve the quality of life for this vulnerable

population and their families. This is sound public policy. Moreover, for the sake of the dual eligibles and their loved ones, it is simply the right thing to do.

Again, thank you Mr. Chairman.

The CHAIRMAN. Yes; I thank each of my colleagues for their opening statements, particularly staying within the time limits. I appreciate it very much.

We are now going to ask the first panel to come and sit with your respective names there. I am going to introduce you. Our first two witnesses will present the committee with illustrations of the problems of fragmented care for the elderly with chronic conditions, and, following their testimony, we are going to hear from health care experts. They will talk about their experiences in providing care to persons with chronic conditions who are dually eligible. They will identify challenges due to the design of the system and present best practices examples and descriptions of innovative health networks addressing the chronic care needs of elderly individuals, and we will hear how elderly persons with chronic conditions benefit from the full continuum of services.

I am going to introduce all five of you first, and then, we will call on you in the way that we have been introduced. First, we are going to hear from Karin von Behren. Karin is a volunteer with the Orange County chapter of the Alzheimer's Association and works as a nurse. She is testifying on behalf of her mother, and her testimony will illustrate the fragmentation of the health care system.

Next, as we have heard from Senator Collins about Ms. Paul's contribution to this hearing, Ms. Paul is going to be testifying on behalf of her father-in-law, who passed away a month ago, and we extend our sympathy to you, Ms. Paul, and I am thankful that you are able to be here with us today to share with us these family experiences.

Our third witness is Dr. Richard Bennett. He is Executive Medical Director for long-term care LTC at the Johns Hopkins Bayview Medical Center and is Director of Geriatric Medicine and Gerontology. Dr. Bennett will share his experiences from the clinic and will talk about what challenges and barriers he faces as a practitioner in providing services to persons who are dually eligible.

Next, we will hear from Lucy Nonnenkamp. She is project director for Medicare Plus II, and that is a Kaiser Social HMO, and she has extensive experience in in-home care. She will provide examples and descriptions of the current programs that better serve the needs of persons who require chronic care.

Finally, we will hear from Jeanne Lally. She is Vice President of Continuum Services and Chronic Care of Fairview Hospital and Healthcare Services, and she will discuss Fairview Partners, which is a unique program that provides services to the frail elderly in nursing homes.

Before we get started, both for this panel and for the next panel, if you have longer statements than the 5 minutes you have been allotted, the entire statement will be printed in the record. We will have the lights here: blue for starting out; orange for 1 minute to go; and then, red is the end of 5 minutes. But I do not want to cut you off if you have a thought to complete after the red light has come on, so, please feel free to finish your thought or summarize as best you can at that point. The only reason it is necessary to

stay on schedule is I want to make it possible for as many of my colleagues to follow up your statement with questions so that we can fill out the record in a very specific way.

Would you start, Ms. von Behren.

STATEMENT OF KARIN VON BEHREN, VOLUNTEER, ORANGE COUNTY ALZHEIMER'S ASSOCIATION, ORANGE, CA

Ms. VON BEHREN. Chairman Grassley, Senator Breaux, members of the committee, it is an honor to appear before you today. My name is Karin von Behren, and I am from Orange, CA. My mother, Vanja Davidson, is 82 years old, and she has Alzheimer's disease. I am here today not only to tell you my story but also as a voice for the 400 or so people you see behind me. These people, volunteers with the Alzheimer's Association, are in Washington to speak with their own Members of Congress on behalf of the over 4 million people with Alzheimer's disease and the countless millions of people who take care of them. These people are the ones whose stories need to be heard as well as my own.

After my mother's diagnosis in 1992, she lived with my father in their family home of over 35 years. My father cared for my mother as her primary caregiver. She was basically independent, even after her diagnosis of Alzheimer's disease. She was able to watch television, go grocery shopping with my father, attend meetings with her friends at the Sons of Norway and spend time with her children and grandchildren. My mother and I were very close, and I considered myself fortunate to have a mother whom I could call my friend. We talked on the phone every day.

That all changed this past October. On October 18, 1996, my mother fell at home and was taken by ambulance to the hospital. This seemingly minor fall turned my mother onto a path in the health care system that bounced her around like a ping pong ball. She bounced from doctor to doctor, facility to facility, all dependent on what Medicare would pay for, not on what she needed to get better. Services would be terminated because the facility would review my mother's treatment and deem the services she needed no longer met Medicare payment requirements. The following information is the rocky road that my mother and our family traveled.

After the initial 4 days in the hospital, Medicare rules dictated that she be transferred to an intermediate rehabilitation center. After 10 days, she was transferred from the intermediate rehab center to a transitional care center: same facility, just a lower level of care. After 12 days in the TCU, she was moved to a skilled nursing facility because she no longer met the requirements that Medicare would pay for. She was evicted from the skilled nursing facility after 5 days—they were concerned for her safety—and transferred her to a local board and care home.

Within 6 days, she fell and was transferred to the hospital for emergency outpatient treatment and returned to the board and care home. Once back at the board and care, she became very agitated and violent, symptoms of her dementia caused by the turmoil of so many moves. Because of this behavior, she was transferred by ambulance—her third trip in an ambulance that day—to a local neuropsych hospital at the recommendation of the board and care's psychiatrist. After 14 days, she was transferred to yet another

neuropsych unit, and after 19 days, she was transferred to another board and care facility.

Her first night in residence, she fell and was transported to another local acute facility for emergency outpatient treatment and then transported back to the board and care home. After 53 days, her longest stay at any one facility, she fell again and this time broke her hip. She was transported and admitted to an acute care hospital. This stay encompassed 10 acute hospital days, 14 days in a transitional care unit, a transfer to a skilled rehab facility for 15 days, and finally, now, she is in a long-term care nursing home, probably for the rest of her life.

So, within a period of almost 7 months, my mother was evaluated by more than 20 doctors, too many direct care nurses to count, at least 10 discharge planners and was treated and cared for in 14 facilities. The total cost to Medicare for this one episode was $147,232.76. What this financial cost and these bills do not show are the human costs. The costs that my mother and my family have suffered are even greater. With all of this movement and displacement, her dementia advanced at an alarming rate, and now, she has lost her independence. Most days, she does not recognize me and pays little attention to me when I visit with her. There are no longer any daily phone calls from my mother; only calls from the facilities informing me of other falls and agitation and then wondering how long she can stay at this next facility.

My father has suffered severe depression, and, for a period of 14 days, was an inpatient at a neuropsych hospital. He was discharged 2 days before Christmas. He is no longer able to live at the family home and is unable to emotionally handle being with the woman he shared his life with for over 51 years.

It is uncertain how long my parents' financial resources will last. My mother's nursing home costs are escalating. Before October, Alzheimer's disease had taken away some of my mother's mind and independence. Now, Medicare and the disjointed health care system will take away the financial independence that my parents thought they would be able to enjoy.

I sit here today before you not because I think I am the only one who has had this happen to them in America. I sit here because I trusted and believed that the doctors, the case workers, the discharge planners and social workers would do the right thing for my mother, and they did, but based on the rules and guidelines of the Medicare system. Every time that my mother was moved, the move was justified by the fact that it was the only place that she could go that would give her the proper care and therapy that Medicare would pay for. Never was my mother's condition or the toll that it took on her every time she was moved the first thought of the medical professionals. It was secondary in every single case.

I personally do not blame these people for my mother's condition; I, myself, work for a group of doctors, and I have a great respect for their knowledge and expertise, and I understand the intricacies of billing and coding. What I do question is a system that can have such disregard for what is truly important. My greatest wish, in retrospect, is that I had moved my mother home and gotten help for my father after that first fall in October. Maybe then, she would still be the mother, the friend and grandmother who liked nothing

better than to bake the best chocolate chip cookies for her grandchildren and sit and rock in the glider in our back yard. Maybe then, the last years of her life would not be spent in a nursing home, spending down her assets and money to reach Medicaid levels of poverty. I will always question and berate myself for not making this decision.

I hope that by sharing my story with you, the current Medicare system can be changed: changed so that people are not placed into boxes dependent on who pays the bills; changed so that people like my mother are not treated like sacks of flour that can be moved from shelf to shelf to accommodate not only their needs but those of the health care system; changed so that when I grow old, my children and your children will not have to experience the frustration and hopelessness that my family has had to experience for the past 7 months.

I thank you for your time and this opportunity to tell you our family story.

[The prepared statement of Ms. von Behren follows:]

TESTIMONY OF KARIN von BEHREN
presented to
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE April 29, 1997

Chairman Grassley, Senator Breaux, members of the committee. It is an honor to appear before you today. My name is Karin von Behren and I am from Orange, California. My mother, Vanja Davidsen, is 82 years-old and she has Alzheimer's disease. I am here today not only to tell you my story, but also as a voice for the 400 or so people you see behind me. These people, volunteers with the Alzheimer's Association, are in Washington to speak with their own members of Congress on behalf of the over 4 million people with Alzheimer's disease -- and the countless millions of people who take care of them. These people are the one's whose stories need to be heard as well as my own.

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On October 18, 1996, my mother fell at home and was taken by ambulance to the hospital. This seemingly minor fall turned my mother onto a path in the health care system that bounced her around like a Ping-Pong ball. She bounced from doctor to doctor, facility to facility. All dependent on what Medicare would pay for -- not on what she needed to get better. Services would be terminated because the facility would review my mother's treatment and deem the services she needed no long met Medicare payment requirements. The following information is the rocky road that my mother and our family traveled:

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by ambulance (her third trip in an ambulance that day) to a local neuro-psych hospital at the recommendation of the board and care's psychiatrist.

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Before October, Alzheimer's disease had taken some of my mother's mind and independence, now Medicare and the disjointed system, that moved her around like a piece of cargo, has taken the rest.

I sit here today before you not because I think that I am the only one who has had this happen to them in America. I sit here because I trusted and believed that the doctors, the case workers, the discharge planners and social workers would do the right thing for my mother -- and they did, but based on the "rules, the guidelines" of the Medicare system. Every time my mother was moved, the move was justified by the fact that it was the only place she could go that would give her the proper care and therapy that Medicare would pay for. Never was my mother's condition or the toll that it took on her every time she was moved the first thought of the medical professionals -- it was secondary in every single case. I personally do not blame these people for my mother's condition. I myself

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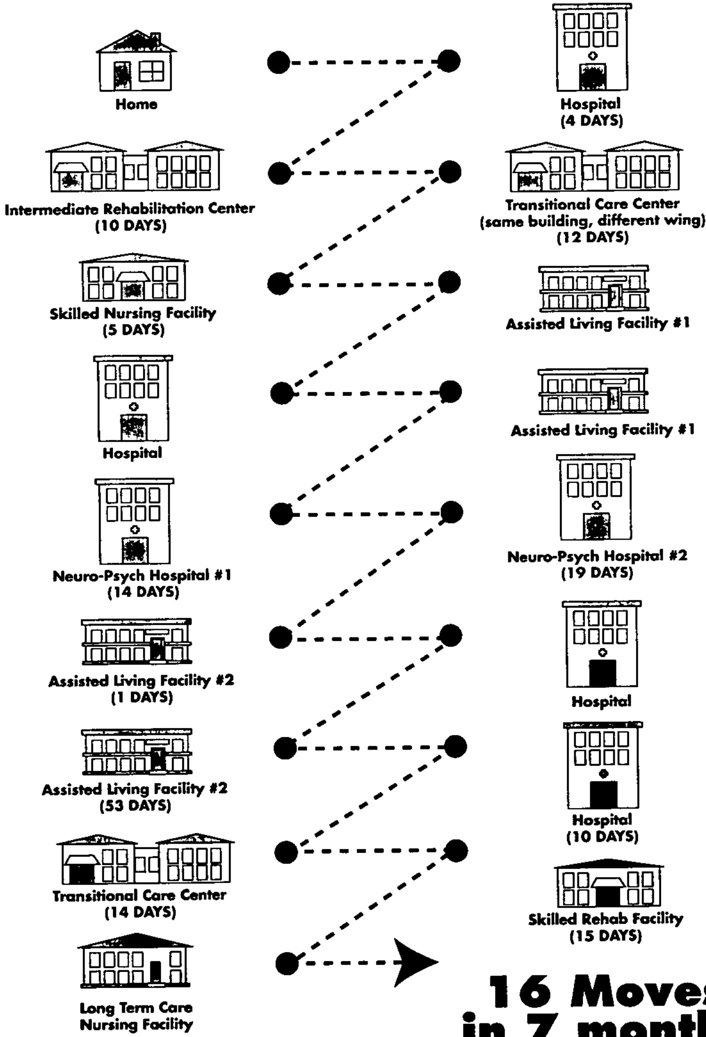
Thank you for your time and for this opportunity to tell you our family's story.

Ping Pong Medical Treatment



The CHAIRMAN. Thank you very much, and before we go on, I think I am going to ask my staff to turn that chart around so that the audience can see. Would you turn that chart around so that the audience can see the ping pong—that is how it is titled; good selection—but 16 moves in 7 months, and if there is anything that illustrates a disjointed delivery of medicine between two programs, this does it very well, and I hope the audience will take a look at that and study that.

Ms. Paul.

STATEMENT OF SUE PAUL, AUGUSTA, ME

Ms. PAUL. I am not a very good reader. The story of my father-in-law begins that he was a very well-liked man, and, like her story, he was placed in a boarding home because he had major heart problems and major breathing problems. He had emphysema, and then, he took a bad fall, and he was sent to the hospital. By May of last year, they decided that he needed nursing home care, Dr. Kane, who was his doctor.

Then, when they finally got him to agree to go to the nursing home, he was there for 30 days, and then, he was assessed, and Medicare and Medicaid and Senior Spectrum felt like he could go back to the boarding home. So, he was sent back to the boarding home. We went back and forth for the last year of his life with going from the nursing home to the boarding home, and the family never knew when they were going to get the call about Dad being transferred, and there was an incident where he was transferred to the hospital, and nobody was notified, and he took a cab back to the boarding home without us being notified, and my husband's boss found out and notified us.

I work 40 hours a week at a home, and I never knew when I was going to get the phone call that Dad had been transferred again from one place to another, and they gave him evaluations and different things, but they felt like if he could have stayed at Gray Birch, at the nursing home facility, he would have been better off; it would not have prolonged his life, but he would have been better off in getting the care, because boarding home facilities did not have the care that he needed. So, I feel like Medicaid and Medicare and the system—older people will need more care, and there will need to be more money appropriated for them to help get them, because what was not able to be taken care of with the system moving him around from place to place at this time was not—they felt like the system was not there.

The CHAIRMAN. Is that your testimony, then?

Ms. PAUL. Yes, more or less.

The CHAIRMAN. We thank you very much, and I know it is very difficult for you to give testimony, not only under the circumstances but because of the death as well, but we thank you for coming very much.

[The prepared statement of Ms. Paul follows:]

TESTIMONY OF SUE PAUL
AUGUSTA, MAINE
April 29, 1997

to SENATE SPECIAL COMMITTEE ON AGING

Thank you Senators for inviting me to tell you about my father in law, John Paul. Dad can't be here to tell his own story. He died four weeks ago yesterday. But I know he wants me to be here today. Maybe we can keep this from happening to someone else -- he would like that.

Dad was a truck driver. He was a smart, feisty man. But at 87, age finally caught up with him. He had emphysema, heart failure, diabetes, and short term memory loss. He needed a lot of care. Because all the money he had was his $600 Social Security check, he was one of those people you call the "dual eligibles". Medicare paid some of his bills and Medicaid paid the rest.

Dad lived in a large residential home -- Gilbert Manor. It is a nice place. The staff was always very good to Dad. He liked it there, especially because he could sneak the food he wasn't supposed to eat. But Gilbert Manor wasn't licensed for the care Dad needed. There were 125 elderly people living there. They had one nurse on duty during the day, but just a med tech at night. Dad lived upstairs by himself; the staff was downstairs. He didn't have any call button in his room. If he needed help, he would have to go down the hall to the bathroom and ring for somebody. He had a machine in his room to help him breathe, but he couldn't really manage it on his own. He was pretty confused at times, and he kept fooling with the medicine bottles.

In May he started having a lot of trouble breathing and they had to send him to the hospital. We agreed with Dad's doctor that it was time for him to go to a nursing home. He was discharged to Gray Birch. Medicare paid the bill at first and Medicaid agreed he could stay for 30 days. But at the end of that 30 days, they assessed him again and said he had to go back to Gilbert Manor. He wasn't really much better, but he could walk and feed and dress himself. So the state said he wasn't eligible for nursing home care.

His doctor and everyone at Gray Birch said he should stay there. But Medicaid wouldn't listen. It was like they put Dad on a merry-go-round.. Every time he had a medical problem, they would call the ambulance and send him back to the hospital. Sometimes they could take care of him in the emergency room, sometimes he had to be admitted. Sometimes he would be sent from the hospital to Gray Birch for a while. But every time, the state would do another assessment and send him back to Gilbert Manor. And every time, the doctor would object and so would we.

We tried to fight the system for Dad. But there was only so much we could do. We were all working full-time. My husband drives a cab. I work 40 hours at an adult care home, and I take care of my grandchildren on my days off, so my daughter can go to work.

I lost track of how many times they moved Dad. Because I was the contact person for the family, I would get calls at all hours of the day and night, at work and at home. They were moving him again. Usually they were pretty good at calling, but sometimes we didn't even know he had been moved. Once they took Dad to the hospital, and he called a cab to take him back to Gilbert Manor. We never would have known, but the driver who took him home was my husband's boss and he told us about it.

Sometimes Dad would have to go to the hospital for oxygen when his breathing got so bad. Three times, they had to take him in to stitch him up after a fall. The worst time was the night they found him unconscious in his room -- in insulin shock. Thank goodness, the med tech on duty that night thought Dad was pretty special and always went up to check on him.

Dad's last trip to the hospital was on Christmas day. Finally, the state agreed that he needed to be in a nursing home and said he could go to Gray Birch for 6 months. We all knew Dad would never leave again. When we went to see him, he would talk about when spring came, he was going to take his lunch and go to the river with his friends to fish all day. But that never happened. For the next 3 months, Gray Birch took care of him. They had everything he needed: the nurses (who loved him), the oxygen, the I-V's. He never had to go back to the hospital again. He died at Gray Birch on March 31.

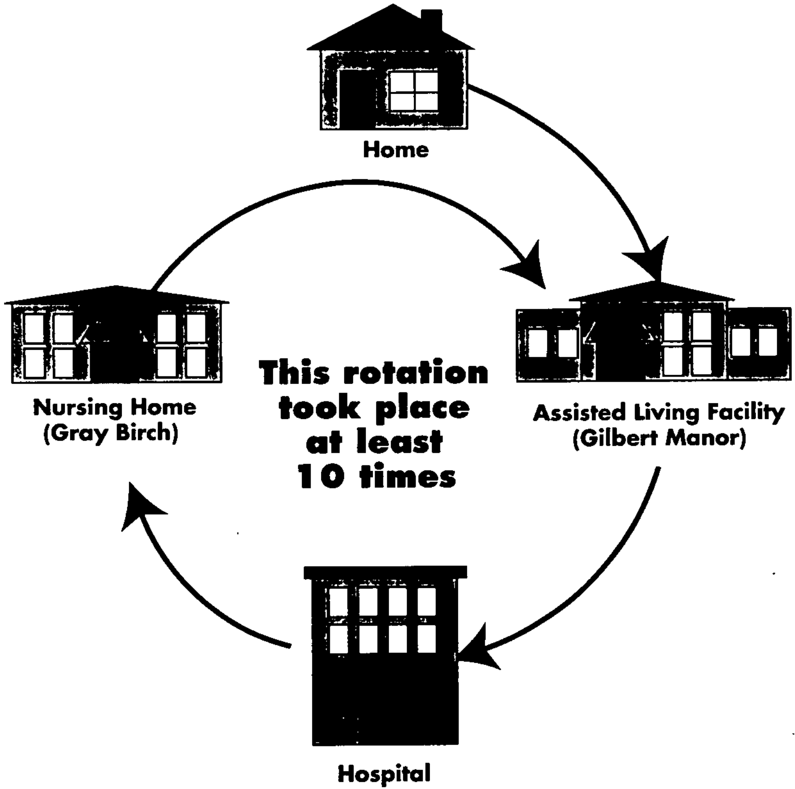
We were all so angry about what happened to Dad. But there just wasn't much we could do. Our hands were tied. The system never seemed to think about Dad first. Every time they moved him back to Gilbert Manor, they were thinking about saving money. But they ended up spending a lot more than they would have if they had just left him in the place that could take care of him.

I can't begin to add up all the bills. Every ambulance trip cost Medicare $500. Every emergency room visit cost at least $1500. Every new assessment cost $150 -- and they did that at least 10 times. And craziest of all, while Medicare was paying for his bed in the hospital or Gray Birch, Medicaid was paying to hold his empty bed at Gilbert Manor. It was all such a waste!

Dad was just one of the little people who got lost in the system. There are lots of others who can tell the same story. I do housekeeping at a home for adults with mental retardation. I see them being treated the same way. No one seems to think about them as human beings.

Thank you for listening to Dad's story. Our family did everything we could, but it wasn't enough. His doctor did everything he could, but it wasn't enough either. We need you to do something to make the system work better for all of these people who can't help themselves.

Merry-Go-Round Medical Treatment



The CHAIRMAN. Dr. Bennett, please.

STATEMENT OF RICHARD BENNETT, M.D., EXECUTIVE MEDICAL DIRECTOR FOR LONG TERM CARE, JOHNS HOPKINS GERIATRICS CENTER, BALTIMORE, MD

Dr. BENNETT. Chairman Grassley, Senator Breaux, members of the committee, my name is Richard Bennett. I have a longstanding interest in the care of the elderly and particularly in the care of the dually eligible. For the last several years, I have been involved in two demonstration projects that are targeted at the dually eligible: the PACE program at Johns Hopkins in Baltimore as well as the EverCare program, which is a capitated program for Medicare and Medicaid recipients in nursing homes.

Last year, I chaired the Maryland Long Term Managed Care Advisory Committee that was specifically targeted at looking at programs for the dually-eligible citizens of Maryland. Based upon my experience, I can assure you that the testimony we have already heard this morning from these family members describes events which are not unusual for elderly patients. Health care delivery is too often driven by rules and regulations rather than by what makes sense and what is best for an individual. The current system is complex and impossible for the average citizen or even a sophisticated consumer to easily navigate. At best, many times, patients and their families are frustrated, and, at worst, sometimes, patients are actually harmed.

Within the current system, needed services are regularly not provided, and illogical rules create perverse financial incentives. Let me give you three examples: the lack of care management at home; cost shifting from Medicaid to Medicare for nursing home patients; and patient transfers to subacute units.

Care management at home: for a patient with emphysema or lung disease who is dually eligible, Medicaid in that State may not pay for any nursing management at home. Medicaid may for nursing home care, which is more expensive; but typically no nursing management at home is paid for. Thus, we have seen the explosion in costs for Medicare home care services for many of these individuals which is now recognized as a long term care benefit by HCFA and many people who look at the Medicare system.

Cost shifting from Medicaid to Medicare for nursing home residents: Medicaid does not pay enough on a typical day to take care of a patient with acute care needs, like a febrile illness. However, I can send that patient to the hospital for a $500 ambulance trip, a $400 ER evaluation, and a $3,000 hospital stay, and at the end of 4 days, that patient comes back to the nursing home. Medicare has paid for that entire hospitalization as well as now will typically pick up some costs in the nursing home when all the patient really needed was to prevent the hospitalization an extra $100 or $200 per day in services over several days.

Next example: transfers to subacute units. Every place in the United States but in Maryland, we have a prospective payment system for hospital care. The hospital is reimbursed based on the patient's discharge diagnosis. How do you increase your profits? You shorten the hospital stay. The shorter the stay, the more money you make as a hospital. What is another way of increasing

the hospital reimbursement? Well, if the patient needs skilled nursing care, once the patient moves to the skilled nursing unit, a whole new income stream begins, now based on per diems. This explains the increase in skilled units and post-hospital Medicare costs that is seen around the country right now.

Today, I do not offer a single solution for the problems that exist within the current system. I do think it is worth stating that Medicare and Medicaid are good benefits for many individuals. Medicare offers a rich array of benefits, probably more than the vast majority of Americans enjoy through their own insurance programs. However, I truly believe that there are new approaches to financing which should be able to achieve cost savings, improve clinical outcomes, and increase patient and provider satisfaction. The PACE program, which combines Medicare and Medicaid funding, and the demonstration project in Minnesota, which is targeted at the dually eligible, are two examples. I would like to give you three more: individual care management, population-based care management, and increased capitation rates for nursing home-eligible patients.

Care management for specific individuals, particularly those who need frequent hospitalizations, could be paid for as an extra Medicare benefit. People could remain in fee-for-service and receive this new benefit. I am convinced that we could save money for targeted individuals by investing in this way. Similarly, we could have geographic programs that offered an extra Medicare benefit targeted in a geographic area, and the payment for the system would come from estimates of the actual cost savings.

Finally, increased capitation rates for nursing home eligible patients in the community. This is the group that managed care organizations are not enrolling because they are afraid of the costs. If we could increase the per capita payment, similar to the payment that is given now for nursing home patients, which is almost double the monthly payment for those not in nursing homes, this might be a way of bringing these very expensive patients into the managed care system.

I think our system can be made better. As we have heard, we really have to do it now, because by 2020 or 2025, the current system will be financially insupportable. What looks bad now is not so bad—it will be really worse in the future. I thank you for allowing me to testify today.

[The prepared statement of Dr. Bennett follows:]

United States Senate
Special Committee On Aging Testimony

Richard G. Bennett, M.D.
Associate Professor of Medicine
Johns Hopkins University School of Medicine

Good Morning Chairman Grassley, Senator Breaux, and Members of the Committee.

My name is Richard Bennett. I am a geriatrician who has a longstanding interest in providing care for older adults, and particularly in the provision of services to the dually-eligible in the community, in nursing homes, and in hospitals. For the last several years, I have been involved with two new demonstration projects which largely serve these dually-eligible individuals -- the PACE program (On-Lok replication model) and EverCare (a capitated Medicare program for nursing home residents). In addition, last year I chaired the Maryland Long-Term Managed Care Advisory Committee whose objective was to advise the Secretary of Health and Mental Hygiene concerning how best to provide services to the dually-eligible citizens of Maryland.

Based upon my experience, I can assure you that the testimony we have heard this morning from these family members describes events which are not unusual for many elderly patients. Health care delivery is too often driven by rules and regulations rather than by what makes sense and what is best for an individual. The current system is complex, and impossible for the average citizen -- or even a sophisticated consumer -- to easily navigate. At best, many times patients and their families are frustrated, and, at worst, sometimes patients are harmed. Within the current system, needed services are regularly not provided, and illogical rules create perverse financial incentives. Let me give you three examples:

1. *Lack of Care Management at Home.* Individuals with chronic diseases such as heart failure or emphysema who live at home often can benefit from nursing monitoring. Medicaid typically does not pay for regular nursing visits for patients at home (and usually only pays for such monitoring in a nursing home). This lack of care management leads, as in the testimony we have heard today, to exacerbation of illness, and recurrent hospitalizations, some of which are preventable. (N.B. The tremendous growth in Medicare's payment for in-home services, and the evolving recognition that home care services for many Medicare beneficiaries actually represent long-term care, can be explained in large part by the need for long-term care management for chronically ill Medicare beneficiaries.)

2. *Cost-Shifting (from Medicaid to Medicare) to Provide Acute Care for Nursing Home Patients.* More than seventy percent of patients in nursing homes are dually-eligible. When an acute illness strikes, hospitalization typically occurs. This is because Medicaid reimbursement is inadequate to cover even simple acute care

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services, and Medicare will not pay for the delivery of services in a nursing home without a 3-day stay in an acute hospital. Therefore, rather than receive care in their own environment, patients with simple febrile illnesses must endure $400 ambulance trips to the hospital; $500 emergency room evaluations; and $3,000 four-day hospital stays -- all paid for by Medicare. A more rational system would allow Medicare to pay the extra $100-$200 per day in services, e.g., for antibiotic therapy, which these patients could have used in the nursing home, and thus avoid much more expensive hospitalizations. (N.B. Some financially-challenged hospitals actually seek out nursing home partners to take advantage of such income streams.)

3. *Patient Transfers to "Subacute Units" to Maximize Medicare Payments.* Under the prospective payment system in effect in the United States (except in Maryland), hospitals are paid based on the patient's diagnosis at discharge. Under this system, the shorter the hospital stay, the greater the profit from the admission. Income can be further enhanced for those patients who require ongoing skilled nursing care following hospitalization, as new per diem income begins upon transfer to a "subacute" unit. The result is the rapid movement of patients out of the hospital onto a skilled nursing unit largely because of reimbursement considerations. (The rapid growth in expenditures for post-acute care has resulted from these financial incentives.)

Today, I do not offer any one solution to solve the many problems which exist within the current system. I do believe it is worth stating that the Medicare and Medicaid programs serve many seniors well. Medicare, in particular, is a rich benefit which offers more choice to American seniors than the vast majority of working Americans have within their own insurance products. However, particularly for the dually-eligible, new approaches to financing should be able to achieve significant cost savings, improve clinical outcomes,and increase <u>patient</u> and <u>provider</u> satisfaction.

Programs which blend financing streams for Medicaid and Medicare, such as the Program for All-inclusive Care for the Elderly (PACE) and the demonstration project for the dually-eligible in Minnesota, are two examples which deserve support and further study. Other innovative solutions should be considered, particularly for the majority of Medicare beneficiaries who will remain in a fee-for-service system in coming years. I will give three examples of programs which I believe also merit consideration:

1. *Individual Care Management.* Care management for specific individuals could be put in place by HCFA (directly or through a contracted agent or provider) in which a fee could be paid for care management. Selected individuals would typically be those with a high likelihood of needing recurrent hospitalization, e.g., a patient with congestive heart failure. These individuals might remain in the fee-for-service system, but receive an "extra Medicare benefit" which could save Medicare dollars.

2. *Population-Based Care Management.* Contracts could be given to manage a population of the dually-eligible within a given geographic area. Payment for the

care management system would be based upon the savings achieved in Medicare expenses as compared to historic and targeted utilization rates and costs.

3. *Increased Capitation Rates for Nursing Home-Eligible Patients in the Community.* Many dually-eligible beneficiaries are functionally impaired and candidates for nursing home placement. Managed care providers are reluctant to enroll such individuals into capitated programs because the capitated community rate for their care may be too low. Having an adjustment which would allow for a higher rate to be captured, similar to the rate for those in nursing homes, would accelerate the enrollment of the dually-eligible into these programs.

I truly believe that our current system can be made better. It is imperative that we improve the present system for the dually-eligible within the next 5-10 years, because, if we fail now, the demand for services for this group will be financially unsupportable by the first several decades of the next century.

Thank you for the opportunity to testify before you today. I hope my comments will be helpful as you consider this difficult matter.

The CHAIRMAN. Thank you, Dr. Bennett.
Ms. Nonnenkamp.

STATEMENT OF LUCY NONNENKAMP, PROJECT DIRECTOR, MEDICARE PLUS II, KAISER PERMANENTE, PORTLAND, OR

Ms. NONNENKAMP. Good morning. I appreciate the opportunity to testify today on behalf of the Social HMO sites and the PACE demonstration. While I do not officially represent PACE, I have been asked to address the benefits of PACE based on the many parallels between the two programs.

Both programs integrate primary, acute and long-term care financing and delivery systems to provide a coordinated, comprehensive care for the frail. The PACE model is designed exclusively for the frail and primarily enrolls a dually eligible population. The Social HMO is designed for a typically broad-based population of both the well and the frail, and they enroll primarily a Medicare-only population.

It is important to recognize that the frail in the Social HMO look very much like the frail in the PACE demonstrations in terms of age, and the number of functional impairments and chronic illnesses; for example, 40 percent of both populations, those in the PACE and those who are deemed nursing home certifiable in the Social HMO, have some form of dementia.

In summarizing the problems of the chronically ill and the dually eligible, we know that chronically ill people need to work with multiple providers to obtain optimum care. Their needs are complex, and they change over time. Providers need flexible benefits and services that go beyond the Medicare benefit package. Persons who are eligible for both Medicare and Medicaid are more at risk for chronic illness and need to access more systems to get those needs met. This population is three times as likely to be limited in their abilities to perform activities of daily living, one and a half times more likely to use inpatient care and eight times more likely to be living in an institution than their Medicare-only counterparts. Coordination of this care is critical for this population.

The Social HMO is a demonstration currently being conducted in three sites since 1985. Over 50,000 beneficiaries have participated over the past 12 years, and at Kaiser, we have enrolled 12,000 members, of which one-fourth have used the home and community-based services. These services, along with a short-term nursing home benefit, are added to the HMO's basic Medicare package, along with prescription drugs, hearing aids and eyeglasses. Through an annual population screening and internal referral systems, the resource coordinators identify Social HMO members who are at risk and need supportive services. They act to ensure that these needs are assessed and that the care is appropriate across the full continuum of care.

Our coordinators are part of the member's health care team, providing the home assessment and offering alternatives to the health care team, to the family and to the member themselves. At Kaiser, when a person becomes frail, they can receive up to $1,000 worth of in-home care per month with a 20 percent co-payment, an affordable and desirable benefit for most Americans. Studies demonstrate that the frail Social HMO beneficiaries are able to live at home

longer with these services and use less nursing home care. Members of the Social HMO are less likely to spend down and use Medicaid dollars.

The PACE model serves only the frail, primarily in an adult day health setting managed by a multidisciplinary team. Comprehensive benefits and services that cover both acute and long-term care can be utilized to develop the plan for the frail elderly person. This demonstration now has 12 sites across the country. We believe both programs offer valuable guidance to this committee on how to design consumer-oriented programs of care for the frail elderly and disabled. Consumers have access to an individualized, coordinated, flexible range of benefits. Access to traditionally non-reimbursable services and the flexibility in the benefit utilization make the difference between being institutionalized and remaining at home.

Reimbursement methods that reflect the additional risk incurred by the frail are vital to the functioning of this integrated model, so that the payers have an incentive to enroll high-cost beneficiaries. PACE offers a cost-effective model for the dually eligible population, and the Social HMO's offer a cost-effective model for individuals who cannot afford private long-term care insurance.

If further action is not taken by Congress or the administration, the current waiver authority for the three original Social HMO's will expire December 31, 1997, affecting over 22,000 beneficiaries. We are currently waiting for a 1-year administrative extension from HCFA. Since several members of this committee also serve on the Senate Finance Committee, we urgently request your serious consideration of the following recommendations: at a minimum, grant a 3-year extension for the Social HMO demonstration through the year 2000, as is included in the President's 1998 budget; enact an expansion of both the Social HMO and PACE programs as a standard benefit option for Medicare and Medicaid beneficiaries; and streamline administrative and oversight requirements of Medicare and Medicaid.

Americans should have access to a coordinated system of care with benefits that meet their needs. Let us know how we can assist Congress in making the reforms to better serve the needs of the chronically impaired and the dually eligible.

Thank you.

[The prepared statement of Ms. Nonnenkamp follows:]

TESTIMONY OF LUCY NONNENKAMP
PROJECT DIRECTOR, MEDICARE PLUS II,
KAISER PERMANENTE HEALTH PLAN

before the

SENATE SPECIAL COMMITTEE ON AGING

April 29, 1997

I. INTRODUCTION

Mr. Chairman and distinguished Members of this Committee, I am Lucy Nonnenkamp, Project Director of Medicare Plus II, one of the original Social Health Maintenance Organization (Social HMO) demonstration sites operated by the Kaiser Permanente Health Plan. I appreciate the opportunity to testify today on behalf of all Social HMO sites and to share with you our perspectives on the value of this important demonstration program. In addition, while I cannot officially represent the Program of All Inclusive Care for the Elderly (PACE) program since Kaiser Permanente does not operate a PACE demonstration, I also have been asked to address the benefits of the PACE demonstration based on the many parallels between the two programs.

The Social HMOs applaud your decision to hold this important hearing on the problems of the chronically-ill and dually eligible populations and to examine innovative solutions and best practices which can improve the health care and quality of life for these populations as well as reduce public health care expenditures. Further, we believe that the timing of this hearing is critical, since Congress is beginning to draft Medicare and Medicaid reform legislation which will include provisions to expand managed care options. Providers serving the chronically-ill and dually eligible through such innovative programs as the Social HMO and PACE demonstrations have valuable insights regarding the benefits of managed care programs. These benefits include enhanced coverage at lower costs for consumers, greater flexibility for providers and cost-savings for public payors. Both programs were designed with the following goals in mind:

- To test models for integrating primary, acute and long-term care benefits under a prepaid capitated financing arrangement pooling Medicare, Medicaid and private premiums;

- To offer Medicare beneficiaries access to a comprehensive range of acute, ancillary and community-based services;

- To increase access to home and community-based services, consistent with consumer preferences, and to delay or reduce institutionalization;

- To achieve Medicare and Medicaid savings by eliminating duplication and fragmentation, employing effective case management techniques, and substituting lower-cost services, where appropriate; and

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- To improve the quality of care and quality of life for the elderly, disabled and chronically-ill.

We believe that the information we share today provides important guidance to you and your colleagues in shaping the Medicare and Medicaid reform proposals about to be undertaken by the Senate Finance Committee. The Social HMO and PACE programs offer a viable model for expanded managed care options because:

- Today, these programs provide a cost-effective alternative for the highest-cost segments of the health care population -- chronically-ill and dually eligible persons.

- Social HMOs and PACE represent a more effective strategy for reducing Medicare and Medicaid expenditures than simply reducing provider payments and eliminating needed benefits. These programs fundamentally restructure financing and delivery approaches and align provider and payor incentives with respect to clinical and financial goals.

- Many states are considering the development of managed long-term care programs for the elderly and disabled. Careful analysis of Social HMO and PACE data can provide states a blueprint for developing acute and long-term care integration models for the Medicaid and the dually eligible populations. In addition, both programs can advise Congress about regulatory barriers which have created difficulties in integrating Medicaid benefits under capitated financing arrangements for the dually eligible population.

- Social HMOs and PACE programs provide the basis for developing risk-adjustments to payment rates based on the health status of beneficiaries. These data could provide the basis for Congressional exploration of a more rational Medicare savings strategy -- i.e., risk-based adjustments to TEFRA risk-contracts -- than simply imposing across the board rate reductions which will limit provider and payor interest and consumer access to Medicare managed care benefits.

We believe the Social HMO and PACE programs also offer valuable guidance to this Committee on how to design "consumer oriented" programs of care for the frail elderly and the disabled. Consider the following benefits to consumers:

- Consumers have access to an entire team of health professionals organized to assess their individual care needs and develop a special program of care to enable them to remain at home -- even as they become frail and vulnerable.

- Consumers have access to a flexible range of benefits across the preventive, ambulatory, acute and community-based continuum. Access to traditionally non-reimbursable services and flexibility in benefit utilization is the difference between being institutionalized and remaining at home.

- Reimbursement methods that reflect the additional risk incurred on behalf of frail enrollees provide incentives to enroll high-cost beneficiaries and assure the frail elderly's access to this innovative model.

- Social HMOs offer an affordable alternative to a long-term care benefit for those who cannot afford private long-term care insurance. While Social HMOs do not offer unlimited long-term care benefits, this program represents an important step in this direction for elderly persons who cannot afford private coverage but do not qualify for Medicaid.

- Medicaid contributions to the Social HMO not only provide for an integrated delivery system, but prevent consumers from being forced to leave providers they have used for many years. Since Medicare and Medicaid frequently use different program contractors and providers, many Medicaid beneficiaries entering managed care plans are forced to abandon their primary providers at the time they are most vulnerable and in need of assistance.

The current waiver authority for the three original Social HMOs will expire on December 31, 1997 if further action is not taken by Congress or the Administration. We currently are awaiting a one year administrative extension from HCFA and the President included a 3 year legislative extension in his FY 1998 budget proposal. While we remain hopeful that the administrative extension will be granted before the end of this year, such an extension would only serve as a short-term buffer until a longer legislative extension is granted or mainstream legislation is enacted. Further, we believe that there is sufficient evidence of the success of the Social HMO demonstration to allow this program to be mainstreamed. Since several members of this Committee also serve on the Senate Finance Committee, we urgently request your serious consideration of the following recommendations:

- at a minimum, grant a three year extension of the Social HMO demonstration through the year 2000;

- implement permanent waiver authority for existing Social HMO sites, assuming these sites demonstrate the ability to operate in a budget neutral fashion and to meet Social HMO rules regarding benefit structures, case management protocols and other key elements of the Social HMO program;

- enact an expansion of both the Social HMO and PACE programs as a standard benefit option for Medicare and Medicaid beneficiaries, where sites operate as mainstream providers, not demonstrations;

- streamline administrative and oversight requirements for Medicare and Medicaid and, where feasible, establish uniform policies in areas such as data collection and reporting, assessment policies and procedures, enrollment and grievance procedures, quality assurance measures, risk-contracting requirements, etc., to eliminate barriers to serving the dually eligible through managed care programs; and

- streamline the managed care waiver process such that states receive timely approval of authority to implement managed care programs for the elderly and disabled.

My testimony today will address the following areas:

- an overview of the problems of the chronically-ill and dually eligible;
- a description of two innovative models for integrating primary, acute and long-term care services for these two populations; and
- removing barriers to expanding and improving access to integrated systems of health care financing and delivery.

II. PROBLEMS OF THE CHRONICALLY-ILL AND DUALLY ELIGIBLE

A. Chronic Illness

The problems of the chronically-ill and dually eligible populations pose tremendous challenges to consumers, providers, payors and policy makers. A significant barrier to addressing the needs of the chronically-ill is lack of education among policy makers regarding the magnitude of the problem and the issues faced by those with chronic conditions and disabilities. Chronic conditions are the leading cause of morbidity and mortality in the U.S. today. Close to 100 million people in the U.S. have one or more chronic condition and about 40% of these individuals are limited in their daily activities. About 12 million of the chronically-ill and disabled are unable to attend work, school or live independently. Chronic conditions affect all ages, not just the elderly. For example, of the nearly 89 million persons with chronic conditions *living in the community* in 1993, only a quarter were 65 years or older. About 60% were between the ages of 18 and 64 and, the remainder, age 17 or younger.

In economic terms, chronic conditions resulted in $470 billion in medical expenditures and in excess of $230 billion in lost productivity in 1990 for a total of almost $660 billion. Almost 70% of national personal health care expenditures were for those with chronic disease and disabilities. About 65% of these expenses were for hospital and physician visits. Per capita expenditures for the chronically-ill are significantly higher than for those with only acute care conditions. In 1987 dollars (most recent data available), per capita costs for those with more than one chronic condition was $4,672 compared to only $817 for individuals with an acute care condition only. The costs associated with the care of the chronically-ill only will escalate in the future with the growth of this population which is expected to increase from the current size of almost 100 million to about 135 million in the next 20 years and to about 160 million in the next 40 years.

B. Dually Eligible

Individuals who are eligible for both Medicare and Medicaid benefits are referred to as "dual eligibles." In 1995, there were approximately 6 million such persons in the U.S. and this number is expected to double by 2030. Dual eligibles include the frail elderly, low-income non-

frail elderly, and non-elderly disabled persons. The nonelderly disabled and elderly persons aged 85 and older are the fastest growing segments of the dual eligible population.

The dual eligible population experience significant physical and cognitive health problems, and are much more likely to become chronically-ill than non-dual eligibles. Consider the following examples:

- over one-third of dual eligibles experience limitations in activities of daily living, compared to only 10% of the non-dual eligible;

- 62% of dual eligibles have one or more limitations in instrumental activities of daily living (IADLs), while 70% of the non-dual eligibles have no IADL limitations;

- twice as many dual-eligibles have had a stroke or suffer paralysis and two and a half times as many are likely to have a broken hip as non-dual eligibles;

- more than one quarter of dual eligibles use inpatient care each year compared to less than one-sixth of Medicare only beneficiaries; and

- dual eligibles are eight times as likely to be living in an institution.

While the dually eligible accounts for a small percentage of the total Medicare and Medicaid populations, they account for a sizable proportion of the expenditures. This population represents 16% of the total Medicare population, but about 30% of all program expenditures. They make up about 17% of the Medicaid population, but consume about 35% of total spending. In it estimated that about $110 billion was spent on the dually eligible in 1995, evenly divided between the Medicare and Medicaid expenditures. Furthermore, per capita expenditures for the dually eligible are significantly higher than for non-dual eligibles. For example, per capita spending for inpatient services is $2669 versus $1,533; for SNF services, $376 vs $105; for home health, $645 vs $266 and for physician and supplier services, $1,534 vs $920.

C. Implications

Since many dually eligible persons are afflicted with chronic conditions, both share mutual frustrations and difficulties in accessing appropriate health care services. The chronically-ill, which comprise a large share of the dually eligible population, require a wide range of primary, acute and long-term care services. This range of services is needed both during individual episodes of illness and across the lifespan of the chronic illness or condition. Because such persons require multiple services delivered by a wide array of health care professionals, ranging from social workers to physicians, there is a critical need for coordination of their care. Coordination of care is related both to quality and health care outcomes as well as cost-effectiveness.

We pose the following challenges to our current health care system and policymakers to evolve a model of care appropriate to the chronically-ill and dually eligible. The Social HMOs and

PACE programs have accepted these challenges and have taken them to heart in the development of their financing and delivery systems.

- A health care system cannot hope to produce optimal outcomes when literally dozens of health care professionals are treating the same person for a chronic condition over an extended period of time with no regard to care coordination. Absent care coordination, the chance for iatrogenic or provider-induced illness through such events as interactive drug reactions is great. Further, the ability to learn from or build upon the treatment plan of a prior provider is lost.

- The health care system must recognize that chronic conditions require different types of services than acute care conditions. Skilled nursing facility, home health care and supportive services become equally important as surgery and drugs for the chronic care population.

- The health care system must recognize that a different set of measurements are needed to evaluate health care outcomes for the chronically-ill (e.g., functional status measures) whose goals are often related to preventing further deterioration and promoting maximum functioning, as opposed to curing a disease.

- The health system must realign current financial incentives to improve access to care for the chronically-ill. Managed care plans have no incentive to accept chronically-ill persons -- whose costs can be up to five times higher than for persons with an acute condition -- without risk-adjusted payments which recognize higher cost realities.

- Health care financing across multiple payor sources must be integrated so that providers can access a single pool of funds and be permitted to use whatever combination of services are needed at a given time to meet the needs of a chronically-ill or dually eligible person.

- Health care systems integration is essential to building an effective system of care for the chronically-ill and dually eligible. Linkages at the administrative, clinical and financial levels are all critical to assuring quality, cost-effective service delivery.

- Oversight functions among multiple provider and payor sources must be streamlined to reduce duplication, fragmentation and conflicting incentives that detract from quality and increase costs.

III. OVERVIEW OF SOCIAL HMOS AND PACE DEMONSTRATIONS

The attached chart includes a side-by-side description of the similarities and differences between the Social HMO and PACE programs. Below are some highlights of each.

A. Similarities

- Integrate the full range of primary, acute and long-term care services (except that SHMOs do not cover *extended* nursing home stays).

- Offer an enhanced package of Medicare benefits such as pharmacy, dental, eyeglasses and hearing aids.

- Provide for the pooling of Medicare, Medicaid and private premiums, with varying amounts contributed by each pay source under each program.

- Use risk-adjusted payments to account for the health status of the populations served.

- Place strong emphasis on care management functions to assure timely, individualized interventions and appropriate, cost-effective resource utilization.

B. Differences

- SHMO members include a representative cross-section of the well and frail elderly; PACE residents must be nursing home certifiable to qualify for coverage.

- SHMO services are financed primarily by Medicare (between 73% and 99% of total revenues); the bulk of PACE funding comes from Medicaid (65%).

- SHMO beneficiaries are primarily Medicare eligibles; over 90% of PACE beneficiaries are dually eligible.

- SHMO provides a fixed home and community-based long-term care benefit (up to $1,000 per month); PACE provides unlimited coverage of long-term care services.

- SHMO sites offer members a choice with respect to providers, service plans and health settings; PACE members receive care from a core group of providers operating within a medical adult day care model.

- SHMO sites (N=3) currently serve between approximately 5,000 - 12,000 members; PACE sites (N=11) serve between 100 and 300 clients.

IV. SOCIAL HMOS

A. History

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984 (DEFRA). The purpose of this demonstration was to develop innovative financing and delivery models for integrating acute and long-term care services, and in the process, reduce health care costs and improve quality and appropriateness of care. The three original SHMO sites currently

operating include Elderplan, Inc. in Brooklyn, New York; Kaiser Permanente Health Plan in Portland, Oregon; and SCAN Health Plan of Long Beach, California. The program currently serves over 22,000 seniors through three of the original Social HMO sites. Since the program's inception, more than 50,000 seniors have been served.

DEFRA provided for a three and a half year demonstration which subsequently was extended three times by Congress (1987, 1990, and 1993). Current waiver authority is due will expire at the of this year absent a legislative or administrative extension. In addition, the Social HMO I sites were instrumental in gaining the approval of six additional "second generation" sites ("Social HMO II") under authority granted by OBRA 1990. The first such site became operational last year. These projects will test variations on the Social HMO I demonstration.

B. Goals

The architects of the Social HMO intended to eliminate many of the problems which continue to plague the traditional fee-for-service system such as fragmentation of service delivery and financing, duplication of administrative requirements across settings and programs, and conflicting policy directives. These problems are especially pernicious for providers serving the dually eligible population since duplication and fragmentation exists not only across health care settings but between the Medicare and Medicaid programs. Through the consolidation of acute and long-term care service structures, and the integration of public and private sector funding streams, the Social HMO designers have effectively implemented five of their key goals:

- producing Medicare and Medicaid cost-savings -- which could be used to increase service capacity in a budget neutral fashion -- through operational efficiencies, the provision of more appropriate levels of care and the downward substitution of lower-cost services;

- integrating the full range of acute and community-based long-term care services and providers to expand the continuum, more closely parallelling the needs of our aging Medicare population;

- consolidating services and professionals to enhance coordination of services and to generate norms of practice in caring for the frail elderly which would be applied uniformly across the spectrum of providers/settings;

- enrolling a cross-section of well and frail elderly to create an insurance risk pool for spreading the costs of care and reducing the burden on any one individual; and

- pooling funding sources for the dually eligible to eliminate barriers to effective clinical decision making -- such as the 3 day prior hospitalization requirement for Medicare SNF eligibility -- and allow providers to allocate resources based on individual enrollee needs.

C. Social HMO Benefit Package

Social HMOs, which operate under TEFRA risk contracts, offer Medicare beneficiaries a voluntary choice. Those selecting the Social HMO option receive an enhanced package of Medicare services. In addition to all Medicare Part A and B services, coverage includes pharmacy benefits, hearing aides, eyeglasses, and up to $1,000 per month in home and community-based long-term care services. This enhanced package of services received by enrollees are provided in a budget neutral fashion. The home and community-based services benefits are critical to helping subscribers avoid institutionalization and maximizing their independent functioning. Among the services offered are the following:

Case Management: Geriatric resource managers review each senior's medical needs and determine the long-term benefit package best suited to the individual. Progress is monitored on a regular, ongoing basis. Individuals who become "nursing home certifiable" (NHC) and, therefore, eligible for the community-based long-term care benefit, receive quarterly assessments to determine their ongoing need for long-term care services.

Personal Care Assistance: Personal care aides attend to many basic health needs related to activities of daily living (ADLs) such as bathing, toileting and dressing, to help seniors remain in the community and as independent as possible. These services are made available around-the-clock, if necessary.

Homemaker Services: These services include coverage of home chores such as laundry, cleaning, cooking and shopping, to further enhance an individual's ability to remain independent and in their own homes.

Respite care: This benefit is intended to help relieve the burden of caregivers -- generally spouses and family members --who provide an average of 92 hours a week of their time for their fragile loved ones. Respite care may involve adult day care, overnight or weekend stays at hospitals or nursing homes, or other relief.

Transportation for Medical Visits: Wheel chair, van and taxi services are provided to seniors to help assure access to health care services, such as physician office visits.

Adult Day Care: This service provides for a professionally staffed facility where seniors can remain safe and participate in social and medical activities during business hours, evenings or weekends.

Nursing Home Care: The Social HMO benefit provides for short-term nursing home stays of 14-30 days per spell of illness for additional rehabilitation or respite care which supports a home care plan.

Personal Emergency Response Systems: The Social HMO provides members a wireless electronic monitor which is worn around the neck and can be activated in the case of an emergency such as a fall. Members and their families gain a sense of security provided by this around-the-clock medical and emergency assistance benefit.

D. Consumer Benefits

Close to 60% of the 85 plus population are disabled and likely to need some type of support or assistance with activities of daily living. For those living in the community, nearly 90% receive assistance from relatives and friends. At least seven million Americans are involved in caring for a parent at any given time and between 20% and 40% of these caregivers have children under the age of 18 to care for at the same time. The majority of unpaid caregivers are women relatives, typically wives, daughters or daughters-in-law. Family support systems are often weak or non-existent, however, leaving those in need of assistance with daily living activities with no one to turn to for assistance. The frail elderly living alone, which account for almost 30% of the over 65 population, and higher for those 85 plus, are particularly vulnerable for institutionalization since often they don't have access to adequate informal support. Where family caregivers are available, they experience exhaustion from their enormous responsibilities and desperately need respite to be able to continue.

Elderplan recently conducted a study to assess the perceptions of baby boomers and their aging parents about the responsibilities being placed on boomers to meet their parents' health care needs. These demands are particularly taxing on the "sandwich generation" -- those adults caught between the demands of caring for their aging parents and their own children under age 18. Elderplans' survey revealed a wide chasm between the view points of seniors and their children. Below are highlights of this survey:

- Nearly 90% of boomers say taking care of their parents is one of their top three life priorities;
- While 94% of seniors believe their health conditions have little or no effect on their children's lives, nearly 80% of the adult children say their parents' health condition has affected their quality of life;
- Less than one third of seniors believe their health may have a great deal of impact on their adult children's time, but 60% of boomers believe their parents' health will have a great deal of impact;
- Less than one quarter of seniors expect to move in with their children, but over half of boomers anticipate having their parents move in at some point to help meet their health care needs; and
- About 81% of seniors do not believe their children will have to provide a great deal of financial support for their care compared to almost one third of children who believe they will.

The burden of providing continuous care for an elderly relative can take a tremendous physical, emotional and financial toll on informal caregivers. Some 12% of caregivers are forced to quit their jobs to provide full-time care to aging parents. Three significant problems faced by informal caregivers include:

- fragmentation of our current health and long-term care systems;

- the absence of financial support for long-term care services; and

- the paucity of assistance available to negotiate the complex web of services frequently needed by a person with multiple disabling conditions.

Further, despite older consumers' strongly stated preferences to remain in the community and receive care at home, and because our current reimbursement system is biased toward institutional services, older consumers frequently are forced to enter nursing homes in order to receive care. This payment bias needlessly increases overall health systems costs.

The Social HMO has helped thousands of older persons and their families resolve these dilemmas by providing the following benefits:

- Access to a coverage of a wider array of primary, acute and long-term care benefits which would not be reimbursed under the Medicare fee-for-service system, thus saving consumers considerable out-of-pocket expenses. Access to traditionally non-reimbursable services and flexibility in benefit utilization is the difference between being institutionalized and remaining at home.

- Access to an entire team of health professionals organized to assess their individual care needs and develop a special program of care to enable them to remain at home -- even as they become frail and vulnerable.

- Reimbursement methods that reflect the additional risk incurred by the frail is vital to the functioning of this integrated model. Without this risk-adjustor, payors have no incentive to enroll high-cost beneficiaries and the frail elderly and disabled will be denied access to this innovative model.

- Social HMOs offer an affordable alternative to a long-term care benefit for those who cannot afford private long-term care insurance. While Social HMOs do not offer unlimited long-term care benefits, this program represents an important step in this direction for elderly persons who cannot afford private coverage but do not qualify for Medicaid.

- Medicaid contributions to the Social HMO not only provides for an integrated delivery system, but prevents consumers from being forced to leave providers they have used for many years. Since Medicare and Medicaid frequently use different program contractors and providers, many Medicaid beneficiaries are forced to abandon their primary providers at the time they are most vulnerable and in need of assistance.

To personalize the benefits of the Social HMO, we have included three case studies below.

Case Study 1

Gladys lived an extremely active life until age 86 when she was diagnosed with cancer. Although she initially recovered from cancer treatment, she became increasingly frail and

forgetful and eventually was unable to continue living alone. Her granddaughter Lynn was considering leaving her job to care for Gladys when she discovered Kaiser Permanente's Social HMO. Kaiser initially provided adult day care services for Gladys twice weekly, provided homemaker services and installed an electronic response system, paying for 90% of related costs. Eventually, expanded care services were changed to adult day care five days per week at a foster home near Lynn's house and respite care to relieve Lynn of caretaking responsibilities periodically. Gladys was able to remain independent with Kaiser's support until she passed away, never being forced to leave Lynn's home and Lynn was able to maintain her employment.

Case Study 2

Romilda is an Elderplan member who experienced difficulties in getting to the doctors' office for follow-up treatment after undergoing total knee replacement surgery. To accommodate her needs, Romilda's physician volunteered to make house calls and Elderplan's home health nurse and physical therapist worked with her in her home until she regained use of the new knee. Following rehabilitation, Elderplan continued to coordinate Romilda's transportation to medical appointments and provide in-home personal care services 12 hours per week. This combination of services prevented her from entering a nursing home and helped her to maintain her independence.

Case Study 3

At age 73, Floyd became the primary caregiver for a wife who developed Alzheimer's Disease and a mother who was left half paralyzed by a stoke. Floyd was on the verge of emotional and physical burn out and severe financial distress in helping to pay for his wife and mother's care when he discovered the Social HMO and SCAN. The plan paid $625 per month towards a 24 hour per day, seven day per week live-in assistant for his mother, and also provided for medical equipment such as a wheel chair and railings for her bed. SCAN also paid for a large portion of adult day care services for his wife where she received care from 8 AM to 5 PM on weekdays by professional caregivers trained in the care of Alzheimer's patients. The support provided by SCAN prevented Floyd from having to institutionalize both his wife and mother over a two year period of overlapping care needs. Recently, Floyd's mother passed away and he had to place his wife in a custodial care facility. Nontheless, SCAN enabled Floyd to avoid paying for two years of nursing home care for his mother, an average annual cost of $36,000 and delay the time at which his wife was institutionalized, saving additional expenses.

E. Cost Savings Potential

Social HMO services are financed on a prepaid capitated basis. Benefits may be paid for in three ways: (1) Medicare only; (2) Medicare and private premiums; or (3) Medicare and Medicaid contributions. Differences in funding streams affect the relative size of the contribution to care. For example, SCAN contributes approximately $625 per month toward the cost of home and community-based services to the first two subscriber groups, but up to $1,000 per month for the dually eligible since SCAN also receives a capitation payment from Medicaid for this population in Los Angeles County. The enhanced package of services received by enrollees are provided in a budget neutral fashion. Social HMOs are paid, on average, 100% of the average adjusted per capita cost (AAPCC) of serving beneficiaries in their counties.

Actual payment amounts are adjusted to account for the functional status of individual beneficiaries.

Neither the Social HMO nor HCFA has conducted a comprehensive study of the cost-savings potential of this model. There are a number of built-in mechanisms to reduce or minimize health care expenditures, however, which we believe have substantially reduced system costs. Further, the Kaiser Permanente Center for Health Research conducted a study focusing on nursing home use between 1986 and 1988 which revealed substantial savings under this model. Data collected by the Social HMO Consortium reveal that the average spending for long-term care services plus the service coordination function averaged $38 per member per month across all four sites in 1990. This cost has not grown as fast as the Medicare skilled home health benefit. This amount was equivalent to about 11% of Medicare's per capita payment to plans that year. There are several ways in which the Social HMOs have been able to hold down costs.

Benefit Structure

Part of the cost-savings are achieved through the structure of the benefit. The Social HMO benefit package does not include unlimited long-term care services, but caps annual expenditures at between $7,500 and $12,000, depending on the site. In addition, the model includes a 14 to 30 day limit on non-Medicare nursing home care per spell of illness. This is consistent with the nature of the social HMO nursing home benefit which is used as a supplement to the community-based service benefit to pay for short-term respite stays, convalescence after Medicare nursing home coverage expires, or to cover the first portion of a permanent admission.

Data reveal that this per spell of illness limit has not placed a severe burden on enrollees. Of all Social HMO members using the long-term care benefit during a four year study period, less than 25% were authorized for care that exceeded 85% of the cap. Further, eligibility for care does not automatically translate into the use of services. We attribute the targeted use of the long-term care benefit to our highly effective care management system which continuously monitors the health status of those at risk for nursing home placement, coordinates informal support services with those of paid services and maximizes the use of the Medicare skilled benefit which is otherwise available to Social HMO members.

Care Management and Flexible Service Design

Data produced by the Kaiser Permanente study reveal the cost savings potential of the care management functions in this model. This study compared the experiences of members enrolled in Kaiser Permanente's standard Medicare HMO and the Social HMO. During the study period, the Social HMO offered 100 days of ICF or SNF coverage per benefit period as well as up to $1,000 per month in services delivered in home or community-based settings. Member copays were 10% for institutional and home care services. The benefits were managed by a service coordination unit that worked closely with hospital discharge planners, nursing home staff and home health care nurses to ensure appropriate and coordinated use of services. A major goal of members, their families and service coordinators was to avoid unnecessary institutionalization and to maximize independent functioning of members. Regular HMO members (i.e., those not enrolled in the Social HMO) received only Medicare-covered nursing home and home health care benefit.

The Kaiser Permanente study revealed many positive effects from the Social HMO benefit structure and service system. For example:

- short-term nursing home benefits reduced barriers to nursing home use for recuperative, respite and rehabilitative stays;
- home care benefits reduced nursing home lengths of stay by supporting more effective transitions back to the community;
- Medicaid expenditures resulting from "spend-down" were reduced by over 50% and these savings offset the higher AAPCC rate paid to Social HMOs by almost half; and
- members received access to a coordinated package of chronic care services and a supplemental long-term care benefit which significantly reduced the out-of-pocket costs they otherwise would have incurred without access to the long-term care benefit.

The Kaiser Permanente study showed that, compared to the regular HMO programs, Social HMO members were more likely to enter a nursing home but less likely to stay as many days. Social HMO members had 25% higher admission rates but they spent 29% fewer days in ICFs and 24% fewer days in nursing homes overall. These patterns suggest that the Social HMO long-term care management and benefit systems reduce barriers to nursing home entry for short-term and recuperative stays and helped members return home more often and sooner.

The study also revealed that Social HMO reduced Medicaid spending on nursing home care. Since less than 1% of these members were categorically eligible for Medicaid, almost all of the savings were due to delaying or avoiding Medicaid spend-down. Medicaid spending for ICF and SNF care for regular HMO members was about $212 per member per month compared to about $80 per month for Social HMO members. Over the 24 month study period, the Social HMO saved Medicaid an average of about $5.50 per member per month which is equal to about 2.2% of the average Medicare capitation rate during the study period. Accordingly, although Medicare pays Social HMOs an average of 5% more than standard HMOs (i.e., 100% of the AAPCC vs 95% of the AAPCC), almost half of this additional reimbursement is offset through Medicaid savings.

Service Innovations

Social HMOs also have developed a number of innovative approaches to further extend the formal services financed through Medicare, Medicaid and private insurance. I'd like to highlight an example of one such approach undertaken by Elderplan called the "Member-to-Member" program which operates as a Service Credit Bank. This program was established to help extend the formal chronic care benefit offered by the Social HMO. In this program, member-volunteers provide informal supportive services to member-recipients. These services fall into the general categories of escort, shopping, transportation, respite, friendly visiting, telephone reassurance, hospital/nursing home visiting, minor home repairs and peer counseling.

Service Credit Banking is an exciting new approach to mutual aid. It is based upon volunteers earning and spending Service Credits. Service Credits are a local, tax-exempt, computerized currency that utilizes time as the medium of exchange. Service Credits enable an individual to convert personal time into additional purchasing power by providing service to others. With this model, it is possible to generate large amounts of service without payment in money and, therefore, to operate a social service barter system on a scale much larger than ever before. Since the program's inception in June 1987, the Member-to-Member program has provided over 56,500 hours of service to almost 3,000 service recipients through the voluntary efforts of 238 volunteers. To provide some sense of the economic value of these services, in 1995 alone, this volunteer program delivered $161,701 worth of preventive and supportive services at a cost of about $74,000.

F. Health System Benefits

Chronic care represents the fastest-growing and highest cost segment of the health care sector. To effectively meet the needs of this population, and reign in health systems costs, our health care system must recognize the critical importance of the linkage between acute and long-term care services. National studies as well as data collected by the Social HMOs reveal that almost all long-term care needs originate from acute care illness. Accordingly, efforts to reduce the explosion of costs to the Federal and state governments and consumers for long-term care services must begin with the establishment of strong linkages between the acute and long-term care service sectors.

The Social HMO demonstrations have revealed a number of important linkages between these two systems and opportunities for cost-savings potential. One of the most important linkages relates to the identification of potentially disabling conditions and the development of treatment regimens to prevent or delay disabilities. Data from the Social HMO reveal that 60 to 70 percent of referrals to community-based LTC services come from the acute care system, including hospital discharge planners, utilization review staff, physician offices, etc. In many cases, individuals being referred only need short-term or mid-term rehabilitation service, not long-term custodial care. It is critical that acute and long-term care providers work together to identify patients' needs and develop appropriate treatment protocols and monitoring systems. Such monitor systems can provide for interventions before disabilities or conditions progress and require more costly medical treatment.

Social HMO data reveal that less than half of their enrolles assessed as nursing home certifiable (NHC) at any time remain consistently in this category for more than one year and many become fully independent following rehabilitation. Further, the Social HMOs have identified several factors which predict whether a patient is likely to remain nursing home certifiable and eligible for long-term care services over the long-run, or to regain functional ability and discontinue long-term care service utilization. For example, predictors of moving from the NHC category include recent hospitalization, female gender, heart conditions and recent fracture or injury. Predictors of remaining NHC include higher age, becoming NHC soon after enrollment, having higher numbers of ADL impairments and higher income. The Social HMOs continuously monitor the health status of those who are at risk of becoming NHC or who are assessed as NHC to assure appropriate interventions. For those who are at risk, preventive measures are implemented to reduce the likelihood of progressive disability. For those who are certified as

NHC, quarterly reassessments are performed to evaluate the effectiveness of the treatment regimens. Once an individual has regained functional independence, the long-term care benefit is discontinued and these resources can be directed to individuals in the system in need of these services.

Social HMOs include the type of effective geriatric assessment system which enables providers to (1) identify those at risk for disability and costly long-term care services; (2) develop appropriate interventions before the disabilities progress beyond the point of rehabilitation; and (3) establish a monitoring system for reassessing individuals' ongoing needs for services. A study published last year in *The New England Journal of Medicine* revealed that such assessments can delay the development of disability and reduce permanent nursing home stays among elderly persons living at home. This study examined the impact of an annual in-home comprehensive geriatric assessments and follow-up for individuals 75 and older. After three years of intervention, 22% of the survivors in the control group required assistance in performing the basic activities of daily living while only 12% of the survivors in the intervention group required such assistance. In addition, there were only one-sixth as many nursing home days for the intervention group. About 10% of those in the control group were permanently admitted to a nursing home compared to 4% of the intervention group. The study suggests that the prevention of decline in functional status was at least partially responsible for the reduction in nursing home admissions.

Although *The New England Journal* study did not include an analysis of the cost-savings potential of the geriatric assessment intervention program, certain assumptions can be made from the data provided. For example, during the second and third years of the study, there were significantly more physician visits among the intervention group than the control group. The cost of intervention for each year of disability-free life gained was about $6,000. This is approximately one sixth of the average cost of a year in a nursing home.

V. PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

The Program of All Inclusive Care for the Elderly (PACE) is a replication of On-Lok Senior Health Services, an integrated model of care operating in San Francisco for over 20 years. PACE programs provide a comprehensive package of primary, acute and long-term care services to individuals aged 55 certified by the state as eligible for nursing home level of care. Services include all Medicare and Medicaid covered benefits in addition to community-based long-term care services. Services are financed through pooled funding from Medicare, Medicaid and private premiums. In 1996, the monthly Medicare capitation ranged from $813 to $1,764 across PACE sites. The Medicaid capitation ranged from $1,486 to $4,006 during the same year.

PACE operates under a series of Medicare and Medicaid waivers which enable PACE providers: (1) to offer services that otherwise would not be reimbursable by these two programs; and (2) to waive restrictions on service provision such as the 3 day prior hospitalization requirement as a condition for skilled nursing facility payment. These waivers enable providers to offer an integrated package of benefits which are managed by an interdisciplinary team including primary care physicians, nurses, social workers, rehabilitation therapists, home health workers and others. PACE services are delivered primarily through an adult day care model which serves as the service "hub" where patients continuously are reassessed and where services such as

primary medical care, nursing, social work, rehabilitative and personal care services are available. Other services, such as hospital, nursing home and specialty medical care, are provided on a contract basis.

There currently are 11 (soon to be 12) fully operational PACE sites in place and an additional 14 PACE sites under development. Where the 12 fully operational sites receive capitated funding from the Medicare and Medicaid programs, the 14 sites under development receive Medicaid capitated payments while Medicare covered benefits continue to be paid on a fee-for-service basis. Medicare capitation, for sites beyond the current authorization of 15, is contingent upon Congressional action to approve additional PACE sites. The 12 fully operation sites are located in San Francisco, Sacramento, and Oakland, CA; Denver, Co; East Boston, MA; Detroit, MI; the Bronx and Rochester, NY; Portland, OR; Columbia, SC; El Paso, TX; and Milwaukee, WI. PACE census across sites was 3,192 at dually waivered sites and an additional 815 and Medicaid only sites as of December 31, 1996. The average annual growth rate was across sites was 18%.

PACE beneficiaries are, by definition, very frail since they must be nursing home certifiable to quality for coverage. PACE enrollees have, on average, 7.9 diagnosed medical conditions which affect their functional abilities and 2.7 disabilities in activities of daily living. More than half have bladder incontinence, arthritis or hypertension, over 40% have been diagnosed with dementia, and another 18% other cognitive impairments. Close to 40% of PACE enrollees live alone in the community. Other common diagnoses among PACE enrollees include diseases of the eyes and ears, stroke, coronary artery disease, depression/anxiety, diabetes and peripheral vascular disease.

Although HCFA has yet to release a formal evaluation of the PACE demonstration, data collected by the sites reveal cost savings to states of 5% to 15% relative to their costs outside of PACE. Much of these savings to states can be attributed to lower nursing home utilization. Although all PACE recipients are nursing home certifiable, only 6% of PACE capitation days were nursing home days in 1995. About 69% of service expenditures were for community services, including adult day health care, with primary care (31%); home care (24%); and other medical care (14%). Hospital and nursing home care accounted for 15% and program administration and plant operations accounted for 16%. Savings to the Medicare program can be seen in reduced hospital utilization. For example, in 1995, PACE wide hospitalization rates were 2,399 per thousand per annum, while among the general Medicare population in 1994, it was about 2,448 per thousand per annum. PACE participants' average lengths of stay were 4.9 compared to 7.6 days for the general Medicare population.

PACE offers consumers, providers and payors a variety of benefits such as:

- consumers receive access to a comprehensive package of primary, acute and long-term care services (with unlimited benefits) coordinated by an interdisciplinary team of providers, thereby eliminating the very considerable fragmentation of care which exists in the traditional system;

- consumers gain the ability to remain at home and independent for as long as possible;

- the Federal and state governments achieve cost savings through (1) the integration of services which reduces duplication of certain functions across the Medicare and Medicaid programs; and care management approaches which eliminate unnecessary service use and direct enrollees to the most cost-effective setting or service possible; and

- providers gain the flexibility of providing services based on clinical judgements regarding the individual needs of PACE enrollees, as opposed to decisions based on payment rules.

Like the Social HMO, the PACE program is restricted in its ability to both grow and serve more disabled residents and to modify the way it currently provides services. The size of the PACE program is limited by demonstration authority which currently is restricted to 15 sites. The way PACE programs deliver services is limited by the detailed protocols governing service delivery. For example, while the PACE protocol specifies an adult day health care center as the "hub" of the service delivery model, some providers would welcome the opportunity to test the PACE model in other locations such as assisted living facilities. In fact, housing is a key component of the PACE program in that many PACE residents do reside in senior housing settings as opposed to private family homes. Preliminary research indicates that some individuals may be more interested in receiving services from PACE programs if they could access care through venues other than adult day care.

Some of the PACE sites have begun to implement or consider variations on their programs within the framework of the current protocols. For example, the PACE site in Rochester New York has entered an arrangement with Blue Cross Blue Shield of Rochester to provide a private long-term care insurance "wrap around" product for PACE members who are Medicare only. That is, Blue Cross pays the PACE program a monthly premium equal to the Medicaid capitation amount for beneficiaries who are not eligible for Medicaid but who can afford to purchase this private coverage. This arrangement has enabled the Rochester PACE program to expand its market to middle-income persons and to protect these beneficiaries against spend-down to Medicaid. The Bronx, New York PACE program has engaged in discussions with Elderplan to establish an interface with this Social HMO to expand the scope of long-term care benefits available to Elderplan members.

PACE has been working with Members of Congress for the past few years to obtain legislation which would both expand the number of PACE sites available to senior citizens and to make permanent existing and future sites. PACE has identified sponsors and cosponsors of legislation designed to fulfill these goals. The PACE legislation would amend current law by:

- increasing the number of programs authorized to provide comprehensive, community-based services to frail, older adults;

- affording regular provider status to successful sites with "success" defined as provision of appropriate care of proper quality at a cost less than would otherwise have been incurred by Medicare and Medicaid; and

- specifically identifying quality of care safeguards previously incorporated by reference.

Case Study

To illustrate how PACE has helped individuals enable frail elderly to remain at home and maximize their independence even in the face of frail health, we offer a case study excerpted from *The American Journal of Managed Care* (Vol. II, NO.3, Mar. 1996).

"'Alice Brown,' age 95, has outlived her husband and three children and dwells alone in senior housing. As a result of a previous stroke, she has a walking problem and falls often.

As a result of a fall in 1993, Mrs. Brown entered a nursing home for two months. She insisted on returning to her apartment but experienced a significant decline in cognitive function and became paranoid. Although a case management program authorized as many as 70 hours of home care weekly for her, she had difficulty keeping workers. Pots and pans left on a burning stove set off her building's fire alarms several times. With Mrs. Brown's eviction near in September 1994, her case manager referred her to On Lok, which she joined.

The On Lok team agreed that home safety had to be improved immediately. To keep Mrs. Brown from using the stove, On Lok provides all her meals and home care three times daily. Mrs. Brown refuses to come to the [adult day health] center as frequently as the team prefers for best oversight but attends once per week.

Recently, late at night, Mrs. Brown fell, fracturing two ribs. Rather than entering a nursing home, however, she spent one night in the hospital; under On Lok's care and supervision, she then returned to her home.

On Lok has been able to maintain Mrs. Brown in the community by providing a range of services through an on-call physician. The physician initiates hospital care as soon as it becomes necessary, physical therapy and nursing care in the center the following day, personal care in her home, medication management and monitoring, and delivery of all meals."

VI. ISSUES RELATED TO THE DUALLY ELIGIBLE

The Social HMOs were designed to accommodate both the Medicare population and those dually eligible for both Medicare and Medicaid services. To date, however, all sites have had difficulty in fully integrating Medicaid benefits into the program and achieving significant enrollment of the dually eligible population. Barriers to integrating Medicaid coverage under capitated payment arrangements have included: (1) the Federal enrollment cap of 500 Medicaid beneficiaries per site as directed by administrative protocols; (2) the uncertain future of the Social HMO program which is dependent upon continuous extensions of current waiver authority; (3) general concerns about cost-shifting from the Federal to state governments. These barriers have made states reluctant to work through the complex task of establishing the administrative structure and payment methodologies necessary to integrate Medicaid coverage into the Social HMO benefit package.

Discrepancies between Medicare and Medicaid regulations, and the need to develop parallel administrative tracks for the same population, in areas such as quality assurance measures, grievance procedures (e.g. differences in definitions, timelines for appeals, etc.), and risk contracting requirements create additional disincentives. Some discrepancies arise from conflicts between services delivered under the concept of capitated risk-sharing versus services delivered within a fee-for-service frame of reference. Financial barriers have created an even greater road block. All three sites have experienced difficulties in identifying financial incentives for the dually eligible to participate in Social HMO programs and/or persuading state Medicaid programs to make capitated payments to plans for individuals who are not institutionalized and for whom states may be providing little or no services. Examples of site-by-site problems with Medicaid integration follow.

Kaiser Permanente attempted to establish a Medicaid contract for several years with both Oregon's Adult and Family Services, now Oregon Medical Assistance Program (OMAP) (responsible for medical services) and Senior and Disabled Services Division (SDSD) (responsible for home and community-based services, including nursing home, foster home, and assisted living). The SDSD program did not want to pay a capitated rate for low income seniors for community-based care unless the person was already on the SDSD caseload, thereby undermining the insurance structure of the Social HMO model. It was just too cumbersome for all parties to work it out for so few people who would be apart of the demonstration.

Medicaid members in Oregon are allowed to keep the premium paid to Kaiser Permanente, and enroll in the Social HMO as a private pay member. Individual OMAP case workers can see the advantage of the program and have supported participation of their clients. If a Social HMO Medicaid member becomes frail and is eligible for home- and community-based services, Kaiser Permanente becomes the first organizer and payor of services. The county's Aging Services Division agreed to pay the 20% copayment for the home- and community-based services received by the Medicaid client. Aging Services recognizes that the Social HMO is providing services that they would be responsible for if the person was not covered by the comprehensive benefits of the Social HMO.

Kaiser Permanente also held discussion with Washington's Department of Social and Health Services, and Aging and Adult Services Department in 1994, when Kaiser Permanente expanded to Clark County, WA. The departments felt the rules were too complex and cumbersome for them to work out an arrangement to participate in the Social HMO demonstration for so few members who might become eligible for Medicaid, and the State didn't want to participate in a demonstration that had an ending date. Accordingly, once a Social HMO member qualifies for Medicaid in Washington, the caseworker usually recommends that the client drop the Social HMO coverage.

Elderplan has experienced difficulties in both establishing enrollee incentives and obtaining the waiver necessary for Medicaid to pay Elderplan a Medicaid capitated payment. The state has been waiting for HCFA to approve a Medicaid managed care waiver for the elderly for over one year. Accordingly, there is no mechanism for the state to make capitated payments to Elderplan for the Medicaid portion of the plan's premium. There also is an absence of financial incentives for dually eligible elderly New Yorkers to enroll in Elderplan due to the structure of the state's Medicaid benefit. A dually eligible recipient in New York State receives 100% coverage of

primary, acute and long-term care services between Medicare and Medicaid benefits without any deductibles, copayments or premium payments. Since New York State's Medicaid program includes a rich package of home and community-based services, even this incentive under the Social HMO is absent since seniors are eligible for all of Elderplan's chronic care benefits under the standard Medicaid program.

The SCAN program also has encountered difficulties in integrating Medicaid and Medicare financing based on state regulatory restrictions. California has established a managed care strategy under which the state has been split into various county programs to enroll and service various Medi-Cal beneficiary groups. Some counties operate under a HCFA waivered "County Organized Health System (COHS) model while others have implemented "joint ventures" between counties and single large contractors to serve the Medi-Cal population. SCAN currently has approval to provide Social HMO services in Los Angeles County and Orange County. The former is a "two-plan" county and the later operates under the COHS system.

While SCAN receives Medicaid capitation for dually eligible enrollees in Los Angeles County, they receive no reimbursement from the COHS program in Orange County. In fact, SCAN has been precluded from enrolling the dually eligible population in Orange County because the county has elected not to allow Medicare risk contractors, including SCAN, to enroll the Medicaid portion of a dually eligible's entitlement benefits. In addition, the COHS in Orange County does not reimburse Medicare risk contracts for copayments and deductibles and, while they will pay for community-based Medicaid services on a fee-for-service basis, coverage of such services is extremely limited. Further, the California Department of Health Services recently has instituted a policy which precludes the enrollment of dually eligible persons in more than one managed care plan concurrently; i.e., Medicare and Medicaid risk contracts.

What seems clear to the Social HMO sites is that consumers and public payors lose under the scenarios described above. New York State clearly is an anomaly from a consumer perspective since few state Medicaid programs offer as generous a long-term care benefit package as New York. Dually eligible seniors in other states where Social HMOs operate or could be developed in future years lose access to a community-based long-term care benefit otherwise unavailable under Medicare as well as the continuity and coordination of care available through the case management aspect of the Social HMO program. Further, both the Federal and the State governments lose the ability to achieve significant cost savings by delaying spend-down and premature or unnecessary institutionalization and by eliminating the high cost of fragmentation and duplication of services and functions between the Medicare and Medicaid programs.

Finally, the Social HMOs strongly encourage the Federal government to address conflicts and duplication regarding administration and oversight requirements under the Medicare and Medicaid programs for the dually eligible population. We believe that significant savings could be achieved through the streamlining of these requirements and the establishment of uniform oversight and data collection requirements, enrollment and grievance procedures and other administrative functions. We suggest the Committee consider the establishment of an advisory committee within the Department of Health and Human Services to carefully examine the requirements of both programs and make recommendations to Congress regarding the establishment of uniform policies and procedures. As more and more states apply to HCFA for managed care waivers for the Medicaid program, pressure to streamline these requirements for

the dually eligible population can only increase. We know HCFA has taken a first step toward uniform procedures for this population in granting waivers for the Minnesota Senior Health Options program and suggest that the variances made for Minnesota be made available to other states as well.

VII. CONCLUSION

Mr. Chairman, while the Special Committee on Aging does not have legislative authority, we know that you and several other members of the Committee also serve on the Senate Finance Committee which has legislative jurisdiction over the Medicare and Medicaid programs. Accordingly, we request your assistance in helping preserve and expand access to innovative programs such as the Social HMO and PACE demonstrations to our nation's elderly, chronically-ill and disabled citizens. As I indicated at the outset of my testimony, the waiver authority under which the Social HMOs operate will expire at the end of this year if no further action is taken. On behalf of the existing sites and plan members, we urgently request your intervention to include in the budget bill provisions to include:

- at a minimum, a three year extension of the Social HMO demonstration through the year 2000;

- permanent waiver authority to existing Social HMO sites, assuming these sites demonstrate the ability to operate in a budget neutral fashion and to meet Social HMO rules regarding benefit structures, case management protocols and other key elements of the Social HMO program;

- an expansion of both the Social HMO and PACE programs as a standard benefit option for Medicare and Medicaid beneficiaries, where sites operate as mainstream providers, not demonstrations;

- streamline administrative and oversight requirements for Medicare and Medicaid and, where feasible, establish uniform policies in areas such as data collection and reporting, assessment policies and procedures, enrollment and grievance procedures, quality assurance measures, risk-contracting requirements, etc., to eliminate barriers to serving the dually eligible through managed care programs; and

- streamline the managed care waiver process such that states receive timely approval of authority to implement managed care programs for the elderly and disabled.

Mr. Chairman, the Social HMO program is one that warrants your attention and support. We sincerely hope that you will consider the Social HMO Consortium recommendations and help to make this cost effective care program available to thousands more seniors in the years to come.

COMPARISON OF SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMO I) AND PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) DEMONSTRATIONS

FEATURE	SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO)	PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
Sponsoring Organizations	HMOs and LTC providers: • Elderplan is sponsored by Metropolitan Health Systems, Brooklyn, NY • Medicare Plus II is sponsored by Kaiser Permanente Northwest Division • SCAN Health Plan (Senior Care Action Network) Long Beach, CA	Community service, long-term care and hospital providers (see attached list).
Current Enrollment	• Elderplan: 5,200 • Kaiser: 4,500 • SCAN: 12,000	• Across 11 dual waiver sites: 3,192 (Dec. 1996) • Across 8 Medicaid only sites: 815 (Dec. 1996)
Population Served	• Medicare-only • Dually eligible	• Dually eligible • Medicare Only
Population Risk Profile	• Well and frail elderly 65+; nursing home residents cannot enroll • Limited number of NHC frail (NHC) enrollees living at home	• Frail seniors 55+ • Must be NHC[1] to qualify for enrollment
Primary & Acute Benefits	• Medicare Part A & B • Medicare copays & deductibles • Prescription drugs, eyeglasses, hearing aides, dentures	• Medicare Part A & B • Medicare copays & deductibles • Prescription drugs, eyeglasses, hearing aides, dentures

[1]Nursing Home Certifiable

FEATURE	SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO)	PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
Chronic Care Benefits	• HCBS[2] and nursing facility services that do not meet Medicare skilled criteria are provided under monthly & annual cap (up to $1,000 per member per month).	Community-based services are authorized by a multi-disciplinary team under a program, not member-specific cap. No benefit limitations imposed in individual members.
Institutional Care	Short-term nursing home care which would not otherwise qualify for Medicare provided under an annual and/or lifetime cap.	unlimited lifetime benefits
Living Situations	Most members live in their own homes.	Most members live in their own homes or supportive living arrangements such as congregate housing facilities or adult foster homes; a small proportion live in nursing homes.
Provider Type(s)	HMOs and long-term care providers. Medical services provided by HMO providers and contracted providers. Members select their primary care physician.	Services centered around adult day care model. Medicare and LTC services provided by core program staff physicians, nurses, social workers, rehab and recreational therapists, and contracted providers for institutional care.
Funding Model	• Sites permitted to use queuing to obtain representative population of well and frail elderly; (only 1 of 3 sites continues to que) • Medicare is capitated at 100% of AAPCC • Risk-adjusted AAPCC for NHCs • Medicaid costs may be capitated by state arrangement • One SHMO I site charges private premiums (due to extremely low AAPCC), two have no premium charges	• Medicare capitated at 95% of AAPCC with risk adjustment equal to 2.39 (e.g. 2.39 x Medicare capitation) • Medicaid payments capitated per state arrangements. Rates are typically set at 85%-95% of states' costs for a comparably frail population receiving community-based and institutional long-term care services • No deductivles or copayments • Individuals ineligible for Medicaid pay for long-term care benefits with insurance or personal resources in amount equal to Medicaid contribution.

[2]Home and community-based services

FEATURE	SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO)	PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
Funding Sources	• Medicare (between 73% and 99% percent of total revenues) • Medicaid (between 1% and 5% of total revenues) • Private pay (between .4% and 23% of total revenues)	• Medicaid approximately 65% • Medicare 30% • Private Premiums < 5%
Copayments	• small copayments on certain items such as office visits, prescriptions, eyeglasses	No copayments
Service Delivery System	Integrated acute & LTC system using case management model with strong community-based service focus.	Intensive use of adult day care centers and multi-disciplinary teams.

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The CHAIRMAN. Thank you very much.
Ms. Lally.

STATEMENT OF JEANNE LALLY, VICE PRESIDENT, CONTINUUM SERVICES AND CHRONIC CARE, FAIRVIEW HOSPITAL AND HEALTHCARE SERVICES, MINNEAPOLIS, MN

Ms. LALLY. Good morning. Mr. Chairman and distinguished members of the committee, I really appreciate the opportunity to come and testify on behalf of the National Chronic Care Consortium and Fairview Hospital and Healthcare Services in Minneapolis to give you our perspectives and to tell you about an innovative program that we have developed.

Our program is aimed at the nursing home resident population, and I will tell you that the stories that we heard earlier are very much common and very much true. Virtually all nursing home residents are affected by a chronic condition. The majority are affected by Alzheimer's disease or dementia of some sort—say 70 percent of them—and they are also often medically complex, dealing with chronic and disabling conditions like diabetes, Parkinson's and the like. They represent one of the highest cost segments of the health care continuum. Unfortunately, the Medicare and Medicaid financing systems collide in the nursing home, and they produce a fragmented system that incents the use of the hospital, which is our most expensive care delivery element, for the care of nursing home residents when they are ill. The residents often fall between the cracks of the system, as you heard.

Moving a confused and frail older person away from their familiar, homelike environment into the more staccato environment of the hospital often increases their confusion, complicates their care and slows their recovery. We must get through the financial disincentives, as you have heard, that fragment the system. We must create the operational partnerships in the care delivery system that will optimize care delivery around the patient need.

The transformation is beginning in Minnesota. We are really trying. The payer community is taking steps to blend the financing streams of Medicare and Medicaid. In one example, a private HMO combined their risk contracts to bring their senior care dual product to the market in 1996. That was Medica Health Plans. In another example, the State of Minnesota's Senior Health Options Program that combines Medicare and Medicaid began enrollment just the first of the year.

This financing change is not enough, however. It must be accompanied by an actual change in operations and medical practice. With significant sponsorship from Fairview and financial support from the Robert Wood Johnson Foundation, Fairview Partners is an attempt to incorporate some of the key clinical learnings from prior demonstrations, such as PACE and SHMO, into more mainstream practice. Fairview Partners is a provider-based managed care initiative. Fourteen long-term care facilities, Fairview Physician Associates and Fairview Hospitals created Fairview Partners, an integrated system to care for nursing home residents. We have been serving residents only about 9 months, and current enrollment stands at about 220.

Medica is our initial payor, although now that the Senior Health Options demo has just begun, we are entering into additional payer contracts as well. Through the use of a capitation approach or full risk approach, Fairview Partners bears the risk for care delivery for nursing home residents. We have created appropriate financial incentives throughout the care delivery continuum, and efforts were made to "free up" primary care providers in planning for individual care plans for individual residents. Doctors and nurse practitioners in this program treat residents at home, in the nursing home, and they see them on a regular basis. They see them more frequently than Medicare would traditionally allow in an effort to proactively manage chronic conditions and treat illnesses earlier rather than later.

Higher-tech services that have traditionally been provided only in the hospital, we have made available in the nursing home. Clinical pathways help to assure consistent and appropriate clinical care. Care planning by primary providers is done in collaboration with the nursing home staff as opposed to in isolation from them, and families are involved as well.

If residents are hospitalized, their care plan follows them into the hospital, and they are directly followed by their FP physician. Their nurse practitioner visits them in the hospital and facilitates their transition back to the nursing home. The end result is earlier and more appropriate interventions and fewer and better-managed clinical crises. An actual example might tell the story more clearly: Mrs. K, an 82-year-old woman, became a member of Fairview Partners on August 1. The nurse practitioner arrived later that week to do her initial exam and found from the facility staff that she was not doing well. She was just finishing a 2-week course of a general antibiotic ordered by her previous physician after a fever was reported to him over the telephone.

The nurse practitioner completed her exam and suspected that the patient had pneumonia. She ordered appropriate x-ray, lab, that kind of thing, all of which was done in the nursing home, and confirmed her diagnosis. After consultation with the family, she began antibiotic treatment with a more specific IM antibiotic. The patient, who had Alzheimer's, was quite restless and agitated and repeatedly tried to get out of bed, even though she was much too weak to do so safely.

Because of the financial model that we created, the nursing home was able to provide a nursing assistant to provide one-to-one care. The patient was kept adequately calm. She did not need to be restrained. She had no falls or other complications, and after 3 days, she was successfully changed to an oral antibiotic and recovered fully. This story combines several facets of Fairview Partners' approach. It describes the good use of health care dollars to buy services—that is, the one-to-one nursing assistant care—that would not otherwise have been reimbursable, and it also serves as a good example of on-site clinical assessment versus over-the-phone assessment and treatment.

In the old model of medical management, she would very likely have been hospitalized, creating costs for ambulance, emergency room hospital care and specialty physician care, perhaps by several physicians. She would likely have been restrained, her confusion

significantly increased. So, you can see in this example, quality of care was enhanced, and costs were saved through the approach taken by Fairview Partners.

In focus groups, members reported very high satisfaction and were particularly happy with the return of the old-fashioned house call, as they called it. We continue to have our developmental issues and operational and regulatory challenges; enrollment is slow; collaboration is difficult; payer-provider relationships continue to be a struggle, and we continue to struggle with the adequacy of the very basis of the system: the Medicare AAPCC. I know I am over my 5 minutes, but I do want to thank you, Senator Grassley, for your help and your leadership and the work of yourself and your colleagues in trying to address the AAPCC issue. It is a real issue for us in Minnesota.

As you will see in my written testimony, the National Chronic Care Consortium has developed legislative recommendations to restructure Medicare and Medicaid, which I will not go over now, but I will refer you to my written testimony.

Thank you very much.

[The prepared statement of Ms. Lally follows:]

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TESTIMONY OF JEANNE LALLY
VICE PRESIDENT, CHRONIC CARE & THE CONTINUUM
FAIRVIEW HOSPITAL & HEALTHCARE SERVICES
on behalf of
THE NATIONAL CHRONIC CARE CONSORTIUM

before the
SENATE SPECIAL COMMITTEE ON AGING

April 29, 1997

INTRODUCTION

Mr. Chairman and distinguished Members of the Committee, I am Jeanne Lally, Vice-President of Continuum Services and Chronic Care at Fairview Hospital & Healthcare Services ("Fairview") in Minneapolis, Minnesota. I appreciate the opportunity to testify today on behalf of the National Chronic Care Consortium (NCCC) and to share with you an innovative model of care for persons with chronic diseases and disabilities, many of whom are dually eligible for benefits under the Medicare and Medicaid programs. The NCCC is a national nonprofit organization representing 30 of the leading-edge health care organizations operating integrated delivery systems in the U.S. and Canada.

All NCCC members provide the full array of primary, acute and long-term care services to commercial, Medicare and Medicaid populations. Because our membership represents the full continuum, we are not invested in promoting the interests of any single provider or professional designation. Rather, we are committed to testing and implementing innovative models of health care financing and delivery which are targeted to fully integrating providers, professionals and payors at every level of the health care system -- from governance structures to clinical programs to administrative and financing mechanisms.

I have been invited to share with the Committee information about an innovative program we have developed at Fairview called "Fairview Partners." This program was established in 1995. Fairview Partners' first payor contract was signed in 1996 with Medica Health Plans and included contracts under Medica's TEFRA Risk and SeniorCare Dual programs. Medica's "SeniorCare Dual Program" is the first of its kind to receive Federal approval. The goals of Medica's initiative are to:

- enable health care systems to better coordinate care and services for frail, elderly seniors;

- increase seniors' access to primary care and other appropriate services to delay the progression of disability and enhance patient outcomes;

- integrate Medicare and Medicaid funding into a single capitation rate to reduce cost-shifting between the programs and offer providers greater flexibility in the allocation of health care resources; and

- reduce costs to the Federal and state governments by reducing fragmentation, duplication and cost-shifting between Medicare and Medicaid through improved coordination of care and realignment of financial systems and incentives.

My testimony today will focus on four key areas:

- defining the problems of the chronically-ill and dually eligible population, across which there is significant overlap;

- identifying regulatory barriers and disincentives to integrating the full spectrum of services required by the chronically-ill and dually-eligible nursing home populations;

- describing one innovative health care model which integrates care for the dually-eligible with multiple chronic conditions who reside in nursing homes; and

- outlining model legislation developed by the National Chronic Care Consortium which would eliminate barriers to integrating primary, acute and long-term care services, resulting in better care for consumers and cost savings for public and private payors.

II. PROBLEMS OF THE CHRONICALLY-ILL AND DUALLY ELIGIBLE

A. Chronic Care

Since our health care system was formed several decades ago, the nature of illness in our country has shifted from a preponderance of acute care illnesses to a preponderance of chronic conditions. Chronic illness represents the highest-cost, fastest growing segment of our health care sector. The NCCC defines the seriously chronically-ill as:

> "people who possess one or more biological or physical condition(s) where the natural evolution of the condition(s) can significantly impact a person's overall quality of life, including an irreversible inability to perform basic physical and social functions. Serious and persistent chronic conditions are multidimensional, interdependent, complex and ongoing."

Examples of chronic conditions include Alzheimer's Disease, arthritis, heart disease, strokes, hip and other fractures, hypertension, and renal diseases. In 1995, approximately 100

million Americans were afflicted with chronic conditions. In the next 25 years, the size of the chronically-ill population will increase by about 35 million. While we often think of chronic illness primarily as a problem of the elderly, persons of every age are afflicted with chronic disease. Of those living in the community, about 64% are actually under age 65, while only 26% are aged 65 and above.

The elderly are more likely, however, to experience multiple chronic conditions. About 69% of those 65 and above have multiple conditions, while only 17% of those under age 17 and 29% of those aged 18-44 have more than one condition. These statistics become the more powerful when examined in the context of demographic trends. The elderly -- particularly those 85 and above with the greatest health care needs -- are the fastest growing segment of the population and also those most likely to have multiple chronic conditions. The magnitude of public and private health care expenditures for this population can only grow expotentially in the future. To minimize this growth, we must modify our current delivery and financing systems to more cost-effectively address the needs of this population.

As discussed further below, it also is critical to consider the direct interrelationship between acute and long-term care expenditures for the chronically-ill. While the chronically-ill consume a disproportionate share of acute care expenses in the early stages of disease, they also consume many more long-term care services in the later stages of illness. For example, we know that hypertension, diabetes and osteoporosis all are precursors to chronic conditions. We also know that there is a direct relationship between strokes and hip fractures and long-term care service use. From a healthcare services perspective, this information reveals that greater attention to preventive and primary care services can reduce future long-term care costs. From a public policy perspective, it suggests the need to develop administrative and financial policies that both recognize the interdependence between Medicare and Medicaid and that focus on long-run aggregate savings, not short-term savings directed toward individual providers and programs.

The economic consequences of chronic disease are significant. In 1995, nearly 70% of national expenditures for personal health care was for direct medical costs for persons with chronic conditions. Chronic illness cost our country approximately $660 billion -- $425 in direct medical expenses and the remainder in lost productivity. Further, chronic conditions are much more costly than acute care. For example, in 1987 dollars (most recent data available), annual per capita costs for those with only acute care conditions were $817 while per capita costs for those with a single chronic condition were $1,829. Those with more than one chronic condition incurred average costs of $4,672 annually. This differential can be attributed to the proportion of health care services consumed by this population. For example, approximately 69% of all hospital admissions and 80% of hospital days were attributed to the chronically-ill who had average lengths of stay of 7.8 days compared to 4.3 days for those with only acute conditions.

B. Dual Eligible

The population of individuals who are eligible for both Medicare and Medicaid benefits are referred to as the "dually eligible." In 1995, there were approximately 6 million dual eligibles in the U.S. and this number is expected to double by 2030 based on current trends. The large majority of this population are the elderly, virtually all of whom are eligible for Medicare benefits and many of whom become eligible for Medicaid benefits by depleting their resources on costly medical care. About 71% of the dually eligible are 65 and over and 17% are 85 or older. By contrast, only about 14% of dual eligibles are aged 44 or younger. The dually eligible are a subset of the chronically-ill and not only have the problems attendant to chronic illness mentioned above, but also scant financial resources, by definition. The implications relative to health status, service usage patterns and expenditures are highlighted below.

Poor Health Status: The dually eligible experience significantly more health problems than those who are eligible for Medicare only. Over one third of dual eligibles have limitations in ADLs compared to only 10% of the non-dually eligible and 62% have one or more IADL limitations compared to only 30% of the non-dual eligibles. The dually eligible also are more likely to experience one or more chronic condition. For example, twice as many dual eligibles have suffered a stroke and have some type of paralysis and two and a half times as many have broken a hip. About half of beneficiaries identified as having dementia are dually eligible and 46% of beneficiaries with other types of mental impairment fall into this category.

Service Utilization: Poor health status among dual eligibles translates into more intensive use of medical and related services, including post-acute and long-term care. On the acute care side, more than a quarter of dual eligibles use inpatient care compared to less than one-sixth of Medicare only beneficiaries. This population also is twice as likely to use skilled nursing facility and home health care services than Medicare only beneficiaries. About 36% of expenditures for Medicare skilled nursing facility and home health services were expended on the dually eligible. States have demonstrated similar spending patterns for this group.

Expenditures: In 1995, the U.S. spent approximately $110 billion on health care and related services for the dually eligible. These expenditures were evenly divided between the Medicare and Medicaid programs. While this population represents a relatively small share of each population, it consumes a substantial proportion of total expenditures. The dually eligible represent about 16% of all Medicare beneficiaries, but consume about 30% of total program expenditures. They represent about 17% of Medicaid beneficiaries, consuming approximately 35% of total Medicaid costs.

C. The Need for Health Systems Reform

As the above overview of the chronically-ill and dually eligible populations aptly illustrates, these populations share a number of common characteristics. Both populations consume a

disproportionate share of total health care services and expenditures due to the need for assistance with multiple health care services spanning the continuum of providers and health care settings. To date, our health care system has failed to recognize the need for integration of primary, acute and long-term care services in a fashion that: (1) simplifies access for consumers; (2) offers providers the flexibility to provide whatever combination of services are most appropriate and cost-effective at a given time for a specified population; (3) recognizes the potential to improve quality and reduce costs through an integrated delivery systems approach; and (4) takes a long-run view of systems reform and cost-containment.

Managed care approaches hold promise for helping to rein in the costs of care for the dually eligible population. While about 30% of the Medicaid population and almost 13% of the Medicare population are enrolled in managed care programs, however, only 3% of the dually eligible receive services from HMOs and like entities. Federal demonstrations like the Social Health Maintenance Organization (SHMO) and Program of All Inclusive Care for the Elderly (PACE) programs and state demonstrations like the Minnesota Senior Health Options (MSHO) and Wisconsin Partnership programs represent important steps toward better meeting the multidimensional, longitudinal needs of the chronically-ill and dually eligible more effectively. Each of these programs integrate, to varying degrees, the financing and delivery of health and related services for these populations. But none provide comprehensive coverage of the full range of primary, acute and long-term care services under a fully-integrated capitated financing approach for enrollees from onset to resolution of chronic disease.

The development of such a "utopian" system is dependent upon the modification of a plethora of Federal and state laws and regulations which continue to impede integration. Although 26 states enroll the elderly and disabled in risk-based managed care programs, only 16 states enroll the dually-eligible in such programs. Further, few integrate coverage of long-term care services under capitated payment systems and rarely is there any functional linkage between Medicare and Medicaid. States that are actively seeking linkages, such as Minnesota, are faced with a plethora of conflicting Federal and state rules and regulations ranging from discrepancies between Medicare and Medicaid payment incentives to conflicts between Federal risk-contracting requirements under the two programs. While some changes could be implemented through modifications to administrative rules, others require amendments to Federal and state laws.

It is critical that the Federal and state governments begin to better understand the interdependence between these two programs. No where is the need for such a linkage more visible and relevant to the Medicare and Medicaid programs than in the dually eligible population -- a subset of the chronically-ill population -- since this represents the most expensive intersection on the medical highway. Recognizing the interdependence between these two programs is essential to eliminate cost-shifting between programs, improve continuity of care for the chronically-ill and dually eligible and contain the growth of the two largest health care entitlement programs. Below is a more detailed discussion of the

regulatory barriers we face in serving the chronically-ill and dually eligible and the need for legislative and regulatory reform.

III. HEALTH SYSTEMS INTEGRATION THROUGH REGULATORY REFORM

A. Systems-Based Approach to Care

Chronic disease represents the highest-cost, fastest-growing segment of the health care system. To contain health care costs, we must recognize the need to shift our fundamental orientation to health care delivery from an acute care model to a chronic care model. The acute care model is designed to respond to crisis events and episodes of illness rather than the prevention of disability progression. An acute care approach focuses on isolated care planning and referral rather than management of patient care across the multiple disciplines providing primary, acute and long-term care services. Administrative, financing and delivery rules are based on the phase of illness being treated (acute vs rehabilitation vs long-term care), the treatment setting (hospital vs nursing home vs home care), and the health care professional delivering services (doctor vs nurse vs rehabilitation therapist).

Effective integration of chronic care services requires a "trilocular" view of health care delivery where the perspectives of acute, long-term care and managed care providers are taken into account. Acute care professions view chronic care in terms of illness and cure. They are very "high-tech" in service orientation and organize care in short-term, episodic approaches. Long-term care professionals view chronic care problems in terms of function and are "high-touch" in service orientation. They organize care over an extended period of time. Managed care professionals think of chronic care problems in terms of optimizing health outcomes and reducing costs. They approach health care solutions in terms of primary, secondary and tertiary prevention. Effective cost-containment will require the incorporation of all three perspectives into an integrated system of care.

The current system must be restructured to allow providers the flexibility and financial incentives to more effectively respond to the needs of the chronically-ill; manage care across time, place and profession; and to use whatever combination of care is most cost-effective. Providers must have the ability to make patient care decisions based on clinical judgements about the most effective treatments and settings, not based on which programs and services are reimbursed by a particular payor.

This new vision must be grounded in the following integrated health network concepts:

- full continuum of care, integrated across discipline and setting;
- multidimensional care planning and implementation;
- emphasis on preventing, delaying or minimizing the progression of disability;
- capitated, shared-risk financing across providers;
- longitudinal focus, not episodic focus, with emphasis on cumulative cost and results.

B. Uniform Administration and Oversight

Health care administrative policies and procedures are based on the acute care model with its episodic orientation. Separate policy authorities exist for major segments of chronic care financing and separate administrative authorities exist for each Federal program. Regulations governing eligibility criteria, coverage rules, payment policies and evaluation methods differ across program categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined by clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation. Separate program administration locks in a major duplication of effort at the local level and makes it virtually impossible to measure, let alone manage, the unintended cost escalation.

For example, Medicare provides primary and acute care-related services to the elderly and disabled regardless of income. It is federally directed, administered through fiscal intermediaries, and reimburses acute care on a prospective basis and skilled care on a cost basis. Medicaid provides acute and long-term care coverage to the low-income, is federally defined, and administered by the state. Benefits vary from state to state as do income and asset eligibility criteria and reimbursement formulas. Differences in program authority and administrative requirements for the dually eligible who require acute and long-term care services create tremendous fragmentation in service delivery and needlessly increases system costs.

To date, policymakers have focused almost exclusively on financing reform as the solution to containing health care costs. Further, the types of reform measures most often put forth focus on short-term savings for specific budget categories as opposed to long-run aggregate savings across providers and programs. For example, current budget discussions are focused on achieving savings from reductions in hospital, nursing home, physician, and home health, budgets instead of broader solutions such as systems integration and regulatory simplification. Even if we move to a health care system which operates within a global budget and fully capitates all primary, acute and long-term care services, however, we won't be able to maximize cost-savings opportunities. Health care cost containment also is dependent on a restructuring of health care administrative and delivery systems. Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the chronically-ill.

The administration of health care financing must be standardized across providers and payors. Administration should be shifted from cost accounting systems focused on different payors and providers to a system which integrates financing administration for the network of providers delivering services to common patients. All network providers should be required to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes. While different providers and payors require information that is unique to their own setting, it is critical that integrated delivery systems define information

the same between providers where information is common to all. For example, assessment protocols for measuring functional and cognitive status should be compatible whether collected by a nurse or social worker in a nursing home or home care setting.

Administrative policies also should be modified to enable provider networks to use a single budget cycle; compatible bookkeeping, accounting and reporting structures; and compatible claims processing and other fiscal management methods across settings. In addition, financial management systems must begin linking cost data with outcomes data across providers and payors for purposes of assessing the cost-effectiveness of various treatment protocols and establishing outcome measures for evaluating performance.

C. Payment Reform

Our current health care financing system is replete with disincentives to cost-effective service delivery. Whether a public or private agency, payors are writing increasingly stringent contract or grant specifications for service delivery and monitoring care for specific services on a case-by-case basis. Control is organized around issues of service amount, frequency, and duration for specific care segments, rather than based on aggregate costs and cumulative effects. It is difficult for program integration to occur in the absence of a cumulative approach to cost containment, outcomes-based management, and global budget targets that allow for provider flexibility and innovation.

Most cost-containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk-arrangements. There is little or no incentive for providers to collaborate in cost-savings across the continuum of care. Even managed care organizations engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service basis -- one provider at a time. The result is risk management on an episodic basis by negotiating the lowest-priced contract for each provider or service. The result is a high cost administrative structure and ineffective delivery model for serving people with chronic conditions whose care needs cross time, place and profession. Cumulative costs increase and quality diminishes.

Policies governing provider practices must be less prescriptive of process and procedures used by individual providers and staff, and more focused on outcomes of care and the cumulative cost and care effects on the client and purchasers of care who act on the client's behalf. Structures for finance and administration must shift from containing costs within narrow health segments to giving providers incentives to collectively contain costs, prevent disability progression and emphasize customer satisfaction across time, place and profession. Provider-based systems should be established where provider networks are paid under shared-risk arrangements for achieving cumulative cost and outcome targets.

IV. BEST PRACTICES AND INNOVATIVE SOLUTIONS: FAIRVIEW PARTNERS

Fairview Partners is a collaborative partnership among 14 nursing homes, three hospitals and a large multi-specialty physician organization working together to enhance the quality of health care services provided to individuals residing in nursing homes. The vast majority of these individuals are dually eligible for Medicare and Medicaid. Fairview Partners was established to address many of the problems described above regarding regulatory barriers and disincentives to integrating primary, acute and long-term care services for the chronically-ill. Below is an overview of the problems that led Fairview to establish this innovative health care model and a comprehensive description of the program and how it works.

A. Background

Fairview Partners sits in a special situation. First, it operatés in Minnesota. Minnesota has a long and positive history in managed care - both in the commercial and publicly funded populations. The vast majority of the metropolitan Twin Cities population receives its health care through a managed care vehicle. The marketplace is experienced and competitive and is often looked to as the "wave of the future" in the health care arena. The Minnesota statistics are telling:

- We have the longest life expectancy of any state other than Hawaii;
- Our member satisfaction scores are continuously very high;
- Our per capita costs are among the lowest in the nation;
- We have no significant health care access problems.

And, yet, we still feel there is room for improvement:

- We have begun direct contracting between the purchaser and Care System;
- We are measuring outcomes and reporting them;
- We are more directly addressing community health and prevention;
- We are working diligently to address the fragmented systems for the dually eligible;
- We are designing managed care systems that will address the special needs of the disabled; and

- We continue the press to eliminate wasteful expense from the system.

The assets Minnesota brings to an initiative like Fairview Partners include a strong, high calibre long-term care delivery system, the willingness, skills and experience of an HMO like Medica Health Plan, a collaborative culture, and an interest in innovation.

Second, Fairview Partners enjoys significant sponsorship from Fairview Hospital and Healthcare Services (now known simply as "Fairview"). Under the sponsorship of the Lutheran church, Fairview began as a single hospital created to serve the needs of disadvantaged Norwegian immigrants in Minneapolis. From those beginnings 90 years ago, the Fairview organization has grown to be one of the largest and most comprehensive health care systems in Minnesota and successfully operates in one of the most advanced managed care marketplaces in the country. With the recent completion of the merger with the University of Minnesota Hospital and Clinics, Fairview's annual revenue totals $1 billion. And, its service array covers the entire range of health care services from home-based personal care and supportive services through the most high-tech quaternary services including bone marrow and solid organ transplants.

Fairview's core business is primary care, and its key goals relate to the advancement of community health. Fairview often works in partnership with other community organizations in initiatives such as Fairview Partners to benefit consumers and communities. Fairview remains a mission-driven, not-for-profit organization and has a long history of service and continued interest in the needs of the chronically-ill. Fairview and its long-term care affiliate, Ebenezer Society, are founding members of the National Chronic Care Consortium.

Third, Fairview Partners receives significant financial support and ongoing encouragement from the Robert Wood Johnson Foundation. The Foundation is highly dedicated to the fundamental systems change required of the health care system today and especially to the needs of the chronically-ill population.

B. The Problem

Nursing home residents often "fall between the cracks" of the health care system. Although the nursing home provides housing and basic health services, each resident has his/her own primary physician. Of course that results in varied approaches to primary care -- even within a given nursing home. When you add to the mix the confusing combination of health benefits and underlying financial incentives for the individuals, physicians, nursing homes and hospitals you get a fragmented system that promotes the use of the hospital for the care of nursing home residents during episodes of illness.

The Medicare and Medicaid financing systems collide in the nursing home. Since the average nursing home has two thirds of their residents covered by both Medicare and Medicaid, nowhere are the gaps, restrictions and barriers produced by these two systems more evident. Medicare doesn't pay for preventive care, but it does pay if you get sick. Doctors get paid

more when the patient is cared for in the hospital than if the patient is cared for in the nursing home. Often nursing home residents aren't eligible for coverage of needed therapies unless they've just returned from the hospital. Nursing homes often get paid more to take care of a resident if they've just returned from the hospital. Nursing homes don't get any additional reimbursement if they're taking care of a resident who is ill. But, if a resident is in the hospital, Medicaid pays the nursing home for the empty bed -- and on and on and on. Physicians and nursing homes work against these barriers every day. They struggle to make the puzzle pieces of benefits and financing fit together so they can provide good care.

This is not to say that the current system doesn't work - it does. But, it is cumbersome and expensive and it is organized around rafts of regulation and financing rules rather than the unique needs of this special vulnerable population. Hospitals have developed an enormous amount of technical and clinical expertise over the years. Those skills, however, have been oriented to technology and cure and have not, by and large, been focused on the health issues that are so prevalent in the nursing home population -- chronic conditions like Alzheimer's disease and congestive heart failure. Technology won't fix those -- and they don't need the full power of the high tech hospital of the 1990's.

What they do need is a system that's oriented to chronic care -- one that focuses on disability management and function rather than cure. Nursing homes carry the expertise here. And, they've developed an increased technological capability in the past decade. Certainly we'll still need the hospital -- we just need to work to assure that it's used only when truly needed. We must get past the financial disincentives that keep the provider systems separate and move to a system that rewards us for working together to provide better care. And, once we've done that we must create the operational partnerships within the health care delivery system that will truly utilize our combined capabilities.

This transformation is beginning in Minnesota. The payer community is taking steps to blend the purchasing power of Medicare and Medicaid. In 1995, Medica worked through the regulatory morass to combine their TEFRA Medicare Risk Contract and their Medical Assistance Risk Contract to bring a special capitated product for the dually eligible to the market in 1996. In 1997, after several years of development, the State of Minnesota's Senior Health Options demonstration project that combines Medicare and Medicaid funding began enrollment. These are difficult steps to take, because of the regulatory complexity created by these two separately designed systems. But, we've begun.

C. Fairview Partners

Pooling the financing is an absolutely necessary step, but by itself is not sufficient to produce real change. The financing change must be accompanied by a change in operations and medical practice. While many geriatrics demonstrations precede this one (SHMO, PACE, Evercare, Alzheimers), the learning from those demonstrations has not been easily transferred to the "mainstream" practices that comprise the bulk of the country's medical care delivery system. With the support of the Robert Wood Johnson Foundation (RWJ),

Fairview Partners is an attempt to incorporate some of the key clinical learnings from prior demonstrations into a more mainstream organization.

Fairview Partners is a provider-based managed care initiative. Building on long-standing collaborative relationships, 14 local long-term care facilities worked with Fairview Physician Associates, and Fairview hospitals to develop Fairview Partners, an integrated care system to care for nursing home residents. Leaders from all these organizations developed the organizational, clinical and financial systems that support enhanced care for this special population. Financing from the RWJ Foundation helped to offset some of the initial organizational costs, staff support and technical consulting to help Fairview Partners get off the ground. Initial planning was conducted in 1995, resulting in a formal joint venture agreement between the provider partners and a full risk contract with Medica in early 1996. Fairview Partners first enrollees were effective in July, 1996. Current enrollment stands at approximately 220.

D. The Organizational Partners

Fairview Partners is structured as a contractual joint venture among three central provider affiliations, including hospitals, long-term care facilities and physicians. Below is a brief description of the joint venture partners.

Fairview Hospital and Healthcare Services is a comprehensive integrated health care system comprised of a full array of health services including 30 primary care clinic sites, seven hospitals (three of which participate in Fairview Partners), four long-term care facilities (three of which participate in Fairview Partners), a comprehensive home care agency, 14 senior housing buildings, a network of retail pharmacies, a network of outpatient rehabilitation services, a comprehensive behavioral care network and many educational and social services - both facility- and community-based.

Fairview Physician Associates is a 700 member Physician-Hospital Organization organized to provide a full array of medical services in partnership with Fairview to support families and patients under a variety of contractual arrangements with payers. Comprised of primary care physicians and specialty care physicians, FPA members provide care at all stages of life.

The Long-Term Care Facilities are 14 community-based facilities. They represent some of the leading facilities in the area and are a mix of not-for-profit and proprietary facilities. Some are independent and others are part of larger, multi-facility organizations. They are:

Apple Valley Health Care Center, Augustana Home, Bloomington Good Samaritan Center, Ebenezer Hall, Ebenezer Luther Hall, Ebenezer Ridges Care Center, Edina Care Center, Friendship Village of Bloomington, Martin Luther Manor, Mount Olivet Careview Home, Richfield Health Center, University Good Samaritan Center, Walker Methodist Health Center and Walker Southview.

Medica Health Plan serves as the initial payer for Fairview Parters services. Medica is one of the area's largest health plans and brings a strong history with elderly services. Medica has both TEFRA and Prepaid Medical Assistance Risk Contracts which it combined to create a single, combined stream of funding for the elderly, dual eligible population.

E. The Structure

1. Organizational Arrangements

Fairview Partners is a contractual joint venture. A contractual arrangement between the provider organizations outlines each organization's responsibilities, the joint venture's decision-making processes, the financial model, etc. This organizational approach was chosen because the Fairview Partners initiative was undertaken as a demonstration project. More permanent organizational approaches are now being examined.

The Management Council serves as the operating board of directors. Each of the participating organizations has a voice on the Management Council. It approves the policies that guide operations, clinical care delivery and financial arrangements. It also establishes an ongoing committee structure, creates the arrangements with payers and contracting policies with vendors.

The Clinical Management Committee reports to the Management Council and is representative of the acute care, nursing home and primary care perspectives. The Clinical Management Committee has developed the clinical care guiding principles and care model, established the initial quality and service standards for vendors and developed clinical pathways and protocols.

The Financial Management Committee is another standing committee that is representative of the acute care, nursing home and primary care perspectives. That committee developed an initial financial model that includes overall guiding principles, internal pricing policies and risk sharing and incentive arrangements between Fairview Partners provider organizations.

2. Care Delivery

Proactive, primary care serves as the basis for the care delivery system. The primary care providers are gerontological nursing practitioners working collaboratively with physicians. Individualized care plans are developed for each enrollee and guide providers at all service settings to assure consistency and continuity. Clinical Pathways help to assure consistent, appropriate clinical care. Efforts are made to deliver services in the nursing home setting whenever clinically appropriate.

The clinical model that has been developed is focused on disability prevention and interdisciplinary practice. Care management is a shared accountability between the primary care team and the nursing home staff. Episodes of illness are managed with fewer hospital

admissions and less disruption to the resident. The overall results should be an improvement in clinical quality, resident satisfaction and a reduction in costs. Early outcomes are very encouraging.

3. Financial Model

At its foundation, this project has fundamental restructuring of the financial incentives through use of a capitation approach using Medica's standard TEFRA Medicare Risk and Prepaid Medical Assistance contracts. Fairview Partners bears total financial risk for the care delivery for enrollees. Within Fairview Partners, organizational providers share that financial risk through risk sharing arrangements. Appropriate financial incentives are created throughout the care delivery continuum. However, diligence was exercised to assure that individual physicians would not be exposed to inordinate financial risk. The financial model created a mechanism to pay providers for services based on existing Medicare and Medicaid systems (adjusted to reflect and incent clinical practice changes). These payments would be made out of a "common pot" of funds resulting from an overall Fairview Partners capitation amount. If there is an overall deficit or surplus in the "common pot" after provider payments have been made, that surplus or deficit will be shared among the providers in a prearranged manner. The model creates a reserve fund as a mechanism to fund deficits and a special reward pool to incent specific clinical practice changes.

4. Enrollee Input

Special approaches must be made to assure that the consumer perspective is imbedded in Fairview Partners' planning and delivery. In addition to the more standard approaches to measuring member satisfaction and appeals processes built into the health plan arrangements, Fairview Partners conducted two focus groups of family members of residents within the first six months of operation. One focus group was comprised of enrollees' family members and another of family members of residents who declined to enroll in Fairview Partners. Members reported very high satisfaction; those who declined did so primarily because of loyalty to their previous physician. As a result of these focus groups, several changes were made in the enrollment process and are now being implemented.

F. How Does Fairview Partners Look Different?

Doctors and gerontological nurse practitioners see residents "at home" -- in the nursing home. And, they see them more frequently in an effort to proactively manage chronic conditions and treat illnesses earlier rather than later. Higher tech services that traditionally have been provided only in the hospital are more available in the nursing home. Hospital nurses and nursing home nurses work together to develop and follow the same clinical pathways. Care planning by primary care providers is done in collaboration with nursing home clinical staff and families. Residents don't need to be "run through" the hospital to be eligible for medically needed therapies. Clinical information is more easily shared between nursing homes, physicians and hospitals, which reduces the number of duplicate tests and

diagnostic procedures and better enables caregivers to more fully understand a patient's clinical status. The end result is earlier and more appropriate interventions and fewer and better managed clinical crises for residents.

An actual example might tell the story more clearly. Mrs. L.K., an 82-year-old woman, became a member of Fairview Partners 8/1/96. The gerontological nurse practitioner arrived at the facility on 8/6/96 to do her initial physical exam, history and care plan. The facility's nursing staff related that they felt that Mrs. L.K. was not doing well. She was finishing a two-week course of empiric antibiotic ordered by her previous physician after a fever was reported to him over the phone.

The nurse practitioner completed her initial assessment and suspected that the patient had pneumonia. She ordered an X-ray, lab and EKG (all of which were done immediately, in the nursing home) and confirmed her diagnosis. After consultation with the family, she began antibiotic treatment with an IM antibiotic. The patient, who was demented, was quite restless/agitated and repeatedly tried to get out of bed, although she was too weak to do so safely. Because of the financial model within Fairview Partners, the long-term care facility was able to provide a nursing assistant to provide 1:1 care. The patient was kept adequately calm, did not have to be restrained, and did not have any falls or other complications. After three days of IM antibiotics she was successfully changed to an oral antibiotic and recovered fully.

This story combines several facets of Fairview Partners approach. It describes a good use of health care dollars to buy services (1:1 nursing assistant care) which is not otherwise reimbursable but allows hospitalization to be avoided. It also serves as a good example of on-site assessment vs. over-the-phone assessment and treatment.

In the "old model" of medical management, Mrs. LK would very likely have been hospitalized - creating costs for ambulance, emergency room, hospital care and specialty physician care by several physicians. She would likely have been restrained and her dementia significantly increased. As you can see in this example, quality of care was enhanced and costs were saved through the approach taken by Fairview Partners.

G. Ongoing Challenges

We offer the following observations about the ongoing challenges faced by Fairview Partners:

- **Historic differences in financial incentives and clinical perspective present potential barriers.** Regulatory barriers and restrictions abound.

- **Changing mainstream practices - both for physicians and nursing homes is difficult.** A critical success factor is the critical mass of enrollees for the nursing home. The 14 primary care physicians who serve these nursing homes

have committed to practice change and are being supported to varying degrees by the endorsement of the remaining FPA physicians who refer their patients to the program.

- **Bridging the historic gap between payer and provider brings real challenges and required learning for providers and payers alike.** A true care system/payer partnership is critical to real success. Each side must learn to appreciate, trust and respect the capabilities of the other. At this point in time we are likely duplicating some administrative costs - the education/enrollment costs and the "bird-dogging" of claims processing during the "shakedown" period of the product's implementation.

- **Collaborative initiatives are time intensive.** The fact that Fairview Partners has accomplished so much in less than two years is both remarkable and frustrating.

- **Enrollment has been slower than planned.** A revised enrollment and marketing process has now been implemented and will be assessed for its utility. The complexity of choosing first a health plan and then a care system is difficult for families. A critical mass of enrollment is vital in each facility to realize the clinical change desired. Financial viability is also dependent on adequate enrollment.

- **The Medicare capitation under the AAPCC continues to be a barrier to expansion in Minnesota.** The community-dwelling, dually eligible are especially problematic since their health care needs are significantly higher than others of their age and sex, and the AAPCC provides scant allowance for that fact.

- **While the Minnesota Senior Health Options Project is a laudable effort at coordinating the financing streams of Medicare and Medicaid, it makes intervention possible only very late in the game.** Since eligibility is limited to the time when one is actually Medicaid eligible, the MSHO providers don't have the necessary "tool kit" of a TEFRA financing stream prior to Medicaid eligibility. Medica's program actually meets the needs of the nursing home residents more completely since it offers both streams of funding. That way, whether the resident is private-pay or Medicaid eligible, the Fairview Partners program is available to them when they are planning for their medical care needs. Medica struggles with dual oversight, dual approvals of materials, etc., but they serve as the "integrator" of the Medicare and Medicaid financing streams.

- **The dually eligible elderly are thought about as a homogenous population.** Actually the nursing home population and the community-dwelling population

have different needs and issues and require quite distinct care delivery approaches. The limitations in public policy that historically "cut" populations by funding source rather than population health need result in systems that may meet the need of the majority while allowing the minority group to fall through the cracks. Medicare did make a positive step in trying to address special population's needs when the hospice benefit was created. Perhaps a special benefit for the nursing home population (whether dually eligible or not) is in order.

V. THE CHRONIC CARE ACT OF 1997

A. Overview

The NCCC has developed a legislative proposal for restructuring the Medicare and Medicaid programs which we believe can effectively address barriers to the integration of primary, acute and long-term care services for the chronically-ill and dually eligible populations. We are calling this model bill "The National Chronic Care Act of 1997." The purpose of the proposed measure is to establish national policies that:

- recognize chronic illness as the highest-cost, fastest-growing area of health care;
- promote integrated delivery systems and managed care payment methods as the most effective vehicles for improving healthcare outcomes and controlling health care cost inflation;
- provide a broader range of managed care options with special capabilities for serving the chronically-ill;
- streamline Medicare and Medicaid requirements to reduce duplication and fragmentation of care among primary, acute, and long-term care providers that deliver interrelated services for people with serious and disabling chronic conditions;
- create incentives for primary, acute and long-term care providers to restructure provider operations across time, place, and profession to prevent, delay, and/or minimize the progression of disability for people;
- establish policy/private sector partnerships to create new business technology to help enable purchasers, payors, and providers to restructure our current financing and delivery systems.

B. Benefits

The NCCC believes that numerous benefits would accrue to each of the Chronic Care Act's intended "stakeholders," including consumers, providers and payors and the Federal and State governments. Obviously, each of these stakeholders would benefit from the preservation of the Medicare and Medicaid programs which threaten to bankrupt national and state governments under current spending trends. Virtually every aspect of the Act has a long-term goal of cost-containment -- from the features embodied in regulatory simplification to the provisions directed toward promoting healthcare services integration. Additional benefits to specific stakeholders would include the following:

- **Consumers** would benefit through simplified access to and use of services; increased ability to control their own health care decisions; and improved quality measures and health outcomes.

- **Providers** would benefit through increased flexibility in the way they practice medicine and less burdensome regulatory requirements; opportunities for direct contracting with Medicare; and technical support in systems integration through a National Resource Center.

- **Public & Private Payors** would benefit from simplified oversight of the Medicare and Medicaid programs, operating under a compatible administrative structure; and a more rationale approach to long-run cost savings and control; i.e., healthcare services restructuring would replace rate setting and coverage limitations.

C. Key Elements of Chronic Care Act

The essential elements of the Chronic Care Act include:

- regulatory simplification and consolidation of public administration of healthcare services;

- the establishment of innovative integrated health care models defined by systems capacity criteria, not specific organizational structures;

- modified financing arrangements where capitated or fixed dollar payments are based on the financial risk incurred for defined populations, not average payments for the general population;

- the establishment of technical support for healthcare services transformation such as best practice methods and tools for specific disease categories, a national data base on chronic care, and chronic disease specific outcomes measures.

Each of these measures are enumerated further below.

1. **Regulatory Simplification**

The Secretary of HHS, working in conjunction with a National Resource Center Advisory Committee on Chronic Care, would be required to carefully examine Medicare, Medicaid and other Federal programs, to identify where such programs:

- duplicate the same functions across programs (e.g., Medicare and Medicaid);
- include policies across programs which create conflicting directives or incentives for providers and/or payors (e..g, policies that promote cost-shifting from Medicare to Medicaid); and
- include policies that are incompatible with an integrated approach to health care systems administration, financing and/or delivery (e.g., policies that restrict integration of Medicare and Medicaid oversight rules and payment streams).

The Advisory Committee would be required to examine program rules in a variety of areas such as payment methods and billing procedures; Medicare and Medicaid contracting requirements under risk-based financing arrangements; record keeping and reporting requirements; enrollment and coverage rules; health screening and risk identification and care planning functions; admissions and discharge rules and other case management functions; quality assurance and professional certification criteria; and consumer protection.

Based on its assessment of Federal and state regulations, the Advisory Committee would develop recommendations to Congress regarding statutory and regulatory changes needed to streamline the current regulatory process and promote the goals of the Chronic Care Act with respect to healthcare services integration. The recommendations would also provide the basis for establishing single provider certification for integrated delivery networks qualifying as a "Provider-Sponsored Organization" (PSO) or a "Chronic Care Network" (CCN). The qualifications for certification as a PSO or CCN are outlined below.

2. **Healthcare Services Innovations**

a. Chronic Care Networks

The Chronic Care Act outlines a process for establishing innovative healthcare services which better meet the needs of the chronically-ill. We call these integrated delivery systems "chronic care networks" (CCNs). Although we envision a specific type of provider designation for CCNs, as we currently have for HMOs, CMPs and other managed care entities, the Chronic Care Act would move Congress away from creating additional rigid structures governed by highly prescriptive protocols and towards a certification which

measures systems capacity instead of defining organizational structure. Similarly, instead of implementing CCNs under a demonstration model, the Chronic Care Act outlines a process for quickly mainstreaming innovative models and best practices under a transition model. Under this model, providers would be given a specified period of time to restructure the way they do business, technical assistance in implementing organizational changes and criteria for how they would be judged based on organizational capacity. Those meeting the certification criteria for chronic care capacity automatically would receive designation as a CCN at the end of the transition period.

There are several reasons the NCCC strongly encourages Congress to move beyond the demonstration approach:

- The rapid growth of the elderly population, the advancement of chronic conditions as the predominant and fastest growing health sector, and the acceleration of costs associated with these two trends strongly suggest the need for a new approach.

- Demonstrations are implemented in an artificial environment, freeze in place research designs, and prevent organizations from modifying their systems as more effective practices are developed. Currently, the rapid deployment of best practices in quality and cost-containment is sacrificed in the name of "validity and reliability" in research design and data collection methods.

- Demonstrations limit the number of healthcare services testing and refining particular frameworks at a given time and the number of consumers who can access benefits. For example, while there are 11 sites operating under PACE demonstrations, they collectively serve only about 3,000 persons. It is difficult to get individual providers much less entire systems to modify the way they practice medicine for a subset of patients representing a minuscule proportion of their entire caseload.

The private sector needs to have the burden of outmoded approaches to care alleviated, enabling it to re-engineer provider operations in keeping with the number one health care problem of our time. We need to lay the ground work for the entire industry, not just for greenhouse boutiques in addressing aggregate costs on a longitudinal basis. Smart business practice would dictate redefining systemwide practices in response to future conditions rather than short-term piece meal changes for a few while we keep everyone else locked into structures of the past.

b. Chronic Care Capacity

The NCCC does not believe that there is any one model that can meet the varying and multidimensional needs of the chronically-ill and disabled nationwide for a few reasons. First, the needs of an individual will be conditioned on the type and severity of their

condition(s), the degree of informal support available, and the type of financing available for formal services (e.g., Medicare, Medicaid, Medicare supplemental, long-term care insurance, etc.) Second, health care is very much a local phenomenon and systems need to be structured on the basis of the type and amount of services provided in a given community. For these reasons, in developing new managed care options, NCCC recommends that Congress focus on the development of capacity criteria which could be applied to any number of organizational structures instead of defining the structure itself. We believe that the following capacity criteria are critical to the establishment of a fully integrated delivery system:

- **Population-Based Planning** where chronic care population subgroups are profiled and targeted for establishing an integrated continuum of services for a defined population.

- **Integrated Continuum** of preventive, primary, acute care, transitional, and community and residential long-term care services;

- **Self-Care** information, assistance, and applied technology available for clients and their caregivers to optimize functional independence and well being;

- **Disability Prevention Guidelines** consisting of standardized methods for managing care across time and setting to prevent, delay and/or minimize effects of disability progression;

- **Integrated Care Management** coordinated by an interdisciplinary team of health professionals with authority to manage utilization, cost, and care across the spectrum of network services;

- **Integrated Information Systems** that allow provides to track aggregate cost, utilization, quality, and satisfaction data across settings and time for chronic conditions;

- **Integrated Continuous Quality Improvement Systems** for monitoring system performance and for changing practice patterns in response to network performance trends;

- **Pooled, Fixed-Dollar Shared Risk Financing** where fixed dollar payments limit aggregate costs, pooled financing reduces duplication of services and increased provider flexibility with resource allocation, and shared-risk methods create incentives for collaboration toward common clinical outcomes and cost targets;

- **Chronic Care Expertise** including common medical direction and leadership in other clinical areas and common in-service training in chronic care management;

- **Consumer Choice** including the right to participate in care decisions, establish advanced directives, and choose out-of-network providers by paying additional charges required for out-of-plan utilization.

3. Quality Assurance Guidelines

In moving from a health care approach that focuses on single settings to an approach oriented toward systems integration, new quality assurance measures are necessary. For example, rather than judging a provider's effectiveness in caring for a patient at every stop along the continuum, we should be developing tools that measure a person's health care status over the course of their condition. Further, since the goals of serving the chronically-ill typically are directed toward disability prevention, not disease cure, we need quality assurance measures that reflect a different expectation with regard to outcomes.

The Chronic Care Act aims to enhance the quality of care for the chronically-ill and disabled by establishing new guidelines and outcome measures which address the specific needs of this population. Certification guidelines would be designed to address the following issues:

- risk factors and interventions associated with progression of disability for chronic conditions;

- interrelationships among medical, functional, cognitive, social and environmental conditions;

- the clinical and financial efficacy of different treatment protocols for specific chronic conditions across care settings;

- indicators of client satisfaction;

- indicators of simplified methods for obtaining and receiving services and for moving from one setting to another;

- patient encounter data across care settings;

- a core data set (e.g., utilization, costs, quality, outcomes, etc.) and methods for managing care across time, place, and profession;

- other factors in moving toward monitoring cumulative clinical and cost outcomes.

4. Payment Methods

The Chronic Care Act would establish a capitated, risk-based payment system that establishes methods for adjusting payments to account for the service intensity and associated costs of the chronically-ill population being served based on such factors as prevalence of disease among enrollees, distribution of various conditions, severity of different conditions, etc. Payments to network providers would be capped at or below the aggregate costs to Medicare, Medicaid and other Federal programs of serving a comparable population in the fee-for-service system. The payment methods included in the Chronic Care Act are designed to achieve several goals:

- contain long-run aggregate costs through payment methods which offer greater flexibility in service delivery and, ultimately, produce better health outcomes;
- enhance consumer access to needed services and reduce costs by eliminating fragmentation across providers and payors;
- enhance provider flexibility in service delivery by pooling financial resources and allowing providers to use whatever combination of services are most appropriate and cost-effective for a given patient;
- create financial incentives to enroll high-risk, high-cost populations via a health-status risk-adjustor to capitated payments;
- streamline financial administration by establishing uniform administrative procedures and a single provider certification.

5. Technical Support for Systems Transformation

The Chronic Care Act would establish a National Resource Center on Chronic Care Integration to assist purchasers, providers and payors develop the infrastructure needed to support an integrated systems approach. The National Resource Center would undertake such initiatives as public education on chronic disease and disability prevention strategies; the establishment of a national data base to track and analyze clinical and financial data which would provide the basis for understanding chronic care costs and implementing more cost-effective care approaches; identifying and disseminating best practices for innovative models for delivering and financing chronic illness. Development priorities would include streamlining regulatory oversight across providers and programs; new payment methods; high-risk screening tools and clinical care pathways; technology for integrated information management; and new administrative, clinical and financial technologies (high-tech and low-tech) for systems integration and cost-containment.

The CHAIRMAN. You have said AAPCC, which is the reimbursement for Medicare, and particularly in Iowa and Minnesota and other States where we practice cost-effective medicine, it really does not give an equitable situation compared to some of the more high-cost areas of the country. We do have to deal with that.

I am going to start with you, Ms. Paul, if I could, please, to ask you a question, and it is asking you to kind of expand on what you said about your father-in-law being on this merry-go-round for 10 times, I guess, is what it is. You said that your father-in-law was frequently moved from Gilbert Manor after a hospital visit and a nursing home stay, and you also said that both you and your father-in-law's doctor objected to some of these moves. So, would you maybe expand a little bit more about why your father-in-law was moved in this merry-go-round fashion? This is a key question: do you know whether either Medicare or Medicaid rules were the reasons for the moves?

Ms. PAUL. Basically, that is what we understood, yes, that the Senior Spectrum and Medicaid and Medicare felt that Dad, because he could get up and dress and feed and take care of himself, was not considered nursing home care. He was considered boarding home care. But each time he was transferred back to the boarding home, something would happen, and he would end up back in the hospital, and then, we would end up going back to the nursing home again with Dr. Kane's orders. So, it was like Medicaid and Medicare and Senior Spectrum felt that where he was able to take care of himself part of the time, he was not considered nursing home care.

The CHAIRMAN. When the State required that he move, did you and his doctor have an opportunity to meet with them and explain what he needed, and do you know the reason that the State required the moves? Did they have their own doctors giving medical reasons for the move?

Ms. PAUL. No, we did not. Ann, from the Gray Birch Center, talked with them and explained that Dad needed—but no, we were never asked to speak to the State about anything, no.

The CHAIRMAN. Ms. von Behren, also, looking at your chart, you have got to be struck with the massive number of people who are involved in decisionmaking in regard to your mother's care, and, of course, I think we all know the answers, but I want to emphasize—it is really emphasizing the points that you made—did any of the people involved in these moves talk to each other? Did they sit down and develop a plan of care for your mother? Did your mother's medical information go with her from place to place?

Ms. VON BEHREN. There were never, to my knowledge, any team meetings between physicians or the new facility. Her primary care doctor, who treated her at home on an outpatient-type basis, did not follow her in the hospital. It was deemed that he would not come to the hospital, so, she was evaluated by a fresh team of physicians when she fell the very first time, and after that situation, when she was transferred to the rehab hospital, they did follow her one time, but then, the rehabilitative staff physicians took over her care. So, there was basically not a great deal of continuity of care and not a whole lot of communication between the facilities.

The CHAIRMAN. Well, as you have heard the last three witnesses on the panel testify about some ideas or about what is actually being done in some places, do you feel that their suggestions, if they had been instituted in the case of your relative or even Ms. Paul's relative, would that have made a much better situation in your instances, do you feel?

Ms. VON BEHREN. I feel in some instances, they would have been applicable for my mother. Certainly, the continuity of care and standard of care would have been much better for her than the situation that she received.

The CHAIRMAN. Ms. Paul, you have heard the same testimony. Do you have a feeling that your father-in-law would have been better treated medically, had less moves, as a result of programs that exist and have been described here?

Ms. PAUL. Yes, we do; we feel that if he could have stayed at the nursing home, it would not have prolonged his life, but it would have given him better care where he needed it.

The CHAIRMAN. Ms. Lally, we have heard today about a particular box that a beneficiary might fit in greatly determines the type of care that they receive. I expect that you have had a chance to think about the experiences that our two witnesses had with their relatives' care. Could you tell us if these experiences would be different if they had been patients under Fairview Partners' responsibility?

Ms. LALLY. Well, I certainly hope so, and it is those types of circumstances that we formed ourselves to address. I think you will find when you are out in the provider community that nobody is involved in senior services for the money. Most of the folks who are working in organized senior services and trying to develop new programs are in it to actually improve the delivery of care, because we see it so close up. Within the Fairview Partners model, they would have had a primary care physician and nurse practitioner team, so that there would have been much closer proactive care management, and for the time that they were in the nursing home, every effort would have been spent to avoid that hospital stay and to provide the services in a more comfortable and familiar environment. Particularly when you are dealing with the Alzheimer's situation, any move is very disruptive. You can take a very healthy Alzheimer's resident and move them to the hospital, and you have exacerbated their confusion right now.

So, yes, I believe our program is the kind of thing that they need.

The CHAIRMAN. My time is up. Before I go to Senator Breaux, for this panel as well as the succeeding panel, because a lot of members have conflicts and cannot be here—you have already seen some of our members go who have not had a chance to ask questions—sometimes, questions are submitted in writing, and if you get questions in writing from a particular member, I hope that you could have those returned to us in about a 2-week period of time to keep our record open. It gives us a chance to expand on it for members who cannot be here.

Senator BREAUX.

Senator BREAUX. Thank you, Mr. Chairman. I thank the panel very much for their testimony and presenting their personal stories. I think particularly, Ms. von Behren and Ms. Paul, you are

to be commended for being with us and telling your personal stories. There is probably not a great deal that we are going to be able to do to correct the experiences that both of you have gone through, but I think you can leave with the knowledge that telling the story to the U.S. Senate and to this Aging Committee in particular will help us formulate some answers to these problems so that never again does this have to happen.

I know, Ms. von Behren, that in your testimony, you talked about berating and blaming yourself for not finding the answer earlier for your mother, and I really do not think you should do that. You are dealing with a system that is incomprehensible for some of us who helped write it and even for those who deal with it professionally every day. It is really incomprehensible. How can we expect people out there to know where to go and to whom to go with the system as complicated as it is? We simply must structure something that makes the health care system in this country understandable to the average person trying to take care of their parents or their children or anybody, for that matter.

You have done something very, very worthwhile today in talking to us about your experiences. The example on the chart that Senator Grassley has, the ping pong medical treatment, that is really an embarrassment. We are not talking about a ping pong ball. We are talking about an actual person who has been bounced around from pillar to post. I think one of the reasons is because there was never any one person in charge of managing the care for that person, and that may be one of the answers that we need to be looking for: that people who are chronically ill have a case manager who determines where this person needs to be and what kind of treatment they need to receive and have it based on what that person needs and not what program they are under.

One of the potential solutions, Ms. Nonnenkamp, that we want to explore is the greater use of managed care. Now, I do not want to pick on Kaiser Permanente, but I want to talk about it generically as a managed care operation. Managed care has a great potential for saving money and providing quality health care. But because of the way managed care providers are reimbursed, there is a huge tendency, an actual incentive for managed care to go after the healthier people, because you are going to get reimbursed the same amount of money regardless of what type of people you have.

The argument is that HMO's have a real incentive to avoid enrolling high-cost and chronically ill patients. Managed care is doing very well, saving money. We have some great examples of that. But there is no question that they do seek out healthier senior citizens to enroll in their plans, because the healthier their patients are, the more money the operation is going to make.

Can you tell me if managed care is a potential solution to the problems of Ms. von Behren and Ms. Paul, how can we solve the problem of managed care operations only wanting to enroll the healthier type people?

Ms. NONNENKAMP. First of all, I work for a group model HMO, so, the physician's salary is not directly related to what services she/he orders or does not order. I think it is critical that we do provide some kind of risk adjustment for these high-cost people.

Senator BREAUX. There is none now.

Ms. NONNENKAMP. There is under the Social HMO and the PACE models, all of the demonstrations.

Senator BREAUX. Some of these new experimental-type programs.

Ms. NONNENKAMP. Right; we are paid a higher capitation for higher costs members. The frail at home cost us more than frail in institutions. So, I think it is critical that we recognize the higher costs and pay the managed care organization a higher rate of reimbursement, so they have some incentives to enroll the dually eligible or the chronic care.

Senator BREAUX. In order to do that, we are going to need Congressional action because of the way that we reimburse HMO's under Medicare.

Ms. NONNENKAMP. Yes. Currently our Social HMO site has 22 percent who are frail. Forty-four percent of them are over the age of 80, so, we do not fall into the stereotype of an HMO that avoids enrolling the chronically ill person.

Senator BREAUX. So, how do you get reimbursed under this social pact that you have?

Ms. NONNENKAMP. We are paid less for our well members in the Social HMO, and we are paid more for the frail. We get a higher rate of reimbursement, for the frail, between 2.5–2.8 times the average capitation rate for the well.

Senator BREAUX. OK; tell me: what would you have done with Ms. von Behren's—I am sorry; how do you pronounce your name?

Ms. VON BEHREN. Von Behren.

Senator BREAUX. As a person who has had my name mispronounced so many times, I want to be careful I do not do it again. [Laughter.]

How would your association handle Ms. von Behren's mother differently?

Ms. NONNENKAMP. We would have done an annual screening, so, we would have known she had some form of dementia ahead of time. We would have proactively gone out and done a home assessment, found out what the family caregiving situation was. Our goal is to help people stay at home when possible. If a person must go to a nursing home, we are very similar to Jeanne's program in that our nurse practitioners and primary care physicians are organized around our nursing home services. We bring many of the services there rather than bring people back into the hospital, psychiatrist would have gone to the nursing home. So, we are trying not to move a person from place to place.

Senator BREAUX. Well, what would have prevented her from going to, I do not know, 14 different institutions?

Ms. NONNENKAMP. I think having a care coordinator and a primary care team that are committed to working out a care plan for the person. New environments are especially difficult for patients with dementia. We would have kept this patient at home for as long as possible.

Senator BREAUX. What type of person would the care coordinator be?

Ms. NONNENKAMP. Typically, they either have a nursing or a social work background and are really specialists in the care of the aged.

Senator BREAUX. Ms. von Behren, I guess you probably went through people who said that that was what they did for your mom, did they not? But it was always a different person, I guess, not one single person following her case.

Ms. VON BEHREN. Well, there were various case workers, because every time she was admitted, there was a different person who was involved in her care.

Ms. NONNENKAMP. You know, each facility has a care coordinator, a discharge planner, and that is the difference, I think, with our program. There is one person who follows someone from the hospital to the nursing home to home health to their own residence or board and care home. Wherever they are, there is one person who is there to help coordinate those services. Again, these people need to see more than one provider. One provider cannot take care of someone with multiple chronic illnesses. There has to be a coordinator when they see specialists as well as their primary care physician.

Senator BREAUX. But do we have to move the patient to all of the providers?

Ms. NONNENKAMP. No.

Senator BREAUX. Or can the providers go to the patient? I mean, her being moved three times in one day in an ambulance has got to be just as disturbing as can possibly be for anybody.

Ms. NONNENKAMP. It is very painful to hear the stories, yes.

Senator BREAUX. It is an incomprehensible story.

Ms. NONNENKAMP. I agree.

Senator BREAUX. It is not the way the system is supposed to work.

So, I think that what we have to look at, Mr. Chairman, if managed care is the answer to these type of dually eligible patients, we have to do some risk adjustment, or HMO's are not going to take them.

Ms. NONNENKAMP. That is right.

Senator BREAUX. That is the bottom line. They are not going to take a chronically ill person when they can take a 70-year-old who plays tennis every other day.

The CHAIRMAN. Well, maybe it was Dr. Bennett: did you not suggest additional reimbursement in that sort of a situation?

Dr. BENNETT. Well, I think even for many people who remain in fee-for-service, one could have a care management strategy on top of the fee-for-service system, and since most people will remain in fee-for-service over the next half dozen years, at least——

Senator BREAUX. I hope not, but I accept your suggestion, but I hope that is not true.

Dr. BENNETT. It is hard to say.

Senator BREAUX. OK; thank you, Mr. Chairman.

The CHAIRMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

I want to follow up with a point that Senator Breaux was just making with my constituent from Maine, Ms. Paul, but first, I want to say to her how sorry I am that you not only have had to cope with losing your father-in-law but with a health care system that defied common sense and good medical practice, and you can feel good about contributing today, because we are really commit-

ted to trying to solve this problem and prevent the kind of problems that you had to endure.

During the past year, as your father-in-law was moved back and forth from Gilbert Manor to the hospital to the nursing home, did you ever get the sense that any single person was looking at the total picture and trying to coordinate or manage his overall care?

Ms. PAUL. At Gray Birch, there was Ann Butman, who was the head of Gray Birch, and she was trying to coordinate different things, but she could only do so much, because her hands were tied, too.

Senator COLLINS. Was your father-in-law's physician involved at each step?

Ms. PAUL. Yes, yes; Dr. Kane was. Dr. Kane felt that he needed the nursing home, and at the end of it, he felt that the boarding home did not have the qualifications that he needed at that point.

Senator COLLINS. One also wonders how much of the shifting around was driven by which program was paying. For example, Medicare likely paid for the first 20 days that your father-in-law spent at the nursing home after he was discharged from the hospital. After that, Medicaid would have to start picking up part of the tab and eventually all of the bill. Did you ever get the sense that the State was making decisions about how long your father-in-law could stay at Gray Birch, which was the nursing home, on the basis of which program was paying for the care?

Ms. PAUL. He was allowed to stay at Gray Birch only like 30 days, and then, he would have to go back to Gilbert, because he was quite capable of taking care of himself, but he was also starting in with dementia, which is the beginning of Alzheimer's. So, we were not sure which program was fully taking care of him, but we know it was only 30 days he was allowed to stay at Gray Birch.

Senator COLLINS. Thank you.

Dr. Bennett, we have heard this morning, and you have mentioned in your testimony, that the stories that we have heard from Ms. von Behren and Ms. Paul are not atypical, that they are problems that you have seen over and over again. Yet, in their case, at least the elderly patient had very effective family advocates. They had family close by who would fight for their care and who would help with the situation. But is that true of most frail elderly? Do they have family members close by? What about those frail elderly who may be all alone or whose relatives live far away? Do they have anyone to advocate for them or intervene in their behalf in such situations?

Dr. BENNETT. There is great variability from State to State in those types of programs, so, in many States, the State Office on Aging, which is another federally funded program different from Medicaid and Medicare, provides some of the services that you are talking about. But typically, those individuals have to be identified, often by someone from the health care community. So, someone comes to my office, and I recognize the problems that might be coming down the line, and I may refer them to an office on aging to get some oversight. But those programs are hard to find. The Alzheimer's Association sometimes provides those kinds of services in Maryland, for example. But you are right: if you do not have somebody who advocates for you, things can be truly bad, and even

in the cases where you have strong advocates, you sometimes cannot make the system work in the way that you would like it to.

Senator COLLINS. Thank you.

My final questions are for Ms. Lally and Ms. Nonnenkamp. I was very interested in hearing your testimony, because it offers hope to us. It offers an opportunity to do things in a better way. Are you sharing your experiences with other States? For example, the New England States have joined in a consortium to try to come up with a model plan and then apply for waivers in order to have a system that would provide better care in such situations of dual eligibility, and I am interested in whether you have been asked to contribute your ideas to the New England consortium or to other such groups.

Ms. LALLY. Fairview Partners is a provider-based initiative. The physician group, the hospitals and the nursing homes are working together, and also, in Minnesota, the payer collaboratives are working together to try to bring the payment streams together. It really requires both sides. You will hear from Pam Parker from Minnesota, so, she can talk about the learnings from payer side, as to what they have to do to try to bring the two streams together from a policy standpoint.

Fairview Partners enjoys some kickoff or early funding from the Robert Wood Johnson Foundation, and part of their real initiative is to try to replicate this kind of learning. When you have a group of providers who are trying something that really has not been tried before, they are very interested in documenting our learning, and, in fact, at the end of the week, I am going to be attending their national grantee conference. So, it is a number of providers that we are sharing our learnings with, and our reports are certainly available to anybody who wants to look at them.

Ms. NONNENKAMP. I am not aware of anybody from the Social HMO consulting with the New England group, but I do believe—we have presented at most of the major aging conferences for the last 12 years. I think we do pretty effective dissemination within the Kaiser system. We have an interregional committee on aging, and that is a forum for us to share best practices across the various divisions of Kaiser Permanente.

Senator COLLINS. Thank you very much.

The CHAIRMAN. I would like to add two followup questions, one to Ms. Lally and one to Dr. Bennett, if I could, please, and this is in regard—I will ask you first, in regard to Medicare payments to your program, I think you said that they are based on the AAPCC, and could you tell the committee how the AAPCC rates affect your program there in Minnesota, then?

Ms. LALLY. I might not be able to limit myself. It is kind of a hot button with us in Minnesota, and I know that you have got the same issue in Iowa, and there are other places to my right here that have some of the same issues.

Our AAPCC is about $350 per member per month in the metropolitan area of Minnesota. Now, outside the 7 counties, the remaining 60 counties in Minnesota, the AAPCC is demonstrably lower than that. If a program such as ours, where we are really trying to organize services to target the frail elderly, we will never be able to get programs like this off the dime with that level of AAPCC. The State of Minnesota has got the new dual eligible program that

they have brought forward, and they are making every effort to bring Medicare and Medicaid together. They still work off the base AAPCC, although they have rerated some things in Minnesota to give us some incentive to take care of the frail, but they are still limited by that basic piece, and that is going to continue to be a struggle when other parts of the country have AAPCC's that are two and almost three times that.

The CHAIRMAN. Dr. Bennett, on another point but returning to where we left off with Senator Breaux's questioning and my bringing up about fee-for-service versus—at that point, we were talking about giving more for additional risk, but you got into the subject that I was interested in: fee-for-service versus managed care. Are there other changes like care management that we can look at to improve situations for those who will stay on fee-for-service?

Dr. BENNETT. I think absolutely, and, in fact, I think that is where we—I have not heard enough debate about that topic, and I hope I can influence you in that way today. I think the vast majority of people will remain in fee-for-service over the next few years, and many of those individuals are high utilizers of Medicare resources, such as for hospitalizations. There are already small studies looking, for example, at patients who leave the hospital with a diagnosis of congestive heart failure. With a small investment of money, you can cut the hospitalization rates over the next year somewhere toward half for those individuals. So, if Medicare started acting like an insurer, most insurers actually do some care management, whether they are fee-for-service or not. Most employer-owned and managed insurance companies manage their enrollees. Medicare does not do that yet and by spending a little more money for care management, the savings would come, at least for targeted individuals, in decreased hospitalization. I think there is tremendous opportunity there that we are not looking at in the same way that we need to.

The CHAIRMAN. I thank each of you on this panel for your contribution to this public discussion, and hopefully, this meeting starts a process—whether it will be a short process or a longer process, I do not know—of change of public policy, so that we can make this system more comprehensible, more cost effective, with a better quality of care, basically just so that the left hand knows what the right hand is doing. We are starting a very important dialog here, and we thank you for this process. Keep in touch with us, please, because we will need your ongoing help in this process.

I will dismiss the first panel after thanking you and ask the second panel to come at this point.

The second panel, I am going to introduce to discuss the policy issues surrounding Medicare and Medicaid in the context of proposals to integrate acute and long-term care services. First, we are going to hear from Dr. William Scanlon. He comes before a lot of committees of Congress, particularly the Finance Committee and this committee, because he is director of Health Financing Systems Issues at the U.S. General Accounting Office. He is going to present to the committee background information on the dual eligible population and highlight the policy issues surrounding proposals to integrate Medicare and Medicaid.

Next, we will hear from Mr. Bruce Bullen. He serves as commissioner of the Massachusetts Division of Medical Assistance. He is going to give an overview of Massachusetts' initiative for dually eligible persons. His State is working to implement a program which will provide a full continuum of Medicare and Medicaid-covered services and home and community-based services.

The next witness is Pamela Parker, also from Minnesota. She is the director of the Minnesota Senior Health Options Program. This demonstration program combines Medicare and Medicaid financing and integrates acute and long-term care services for persons over age 65 who are dually eligible. She will present Minnesota's unique demonstration project, which provides a full range of integrated primary, acute and long-term care services to the elderly Medicare and Medicaid beneficiaries.

Last, we have Barbara Markham Smith. She is a senior research scientist for the Center for Health Policy Research. She is going to discuss her experiences in working with States to evaluate managed care initiatives. She will highlight the challenges facing States as they take on new roles as purchasers of systems of care.

So, we will start with you, Dr. Scanlon, and then go to Mr. Bullen, Ms. Parker, and Ms. Smith.

STATEMENT OF WILLIAM SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES, DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you, Mr. Chairman and members of the committee. I am very pleased to be here today as you discuss some of the issues that arise in financing care for dually eligible beneficiaries.

My comments today are going to focus on aspects of the dual eligibles, their characteristics, how Medicare and Medicaid each are affected by overlapping benefits and quality assurance issues that arise in using managed care to serve this population. Since the full text of my statement covers these areas in greater detail, I would like to highlight just a few key points for you now.

First, for some basic information about the dual eligible population, which numbers roughly 6 million individuals, about a third of whom are younger Medicare disabled beneficiaries and two-thirds of whom are elderly. By definition, as you have heard, they are poor. Three-quarters of them have incomes of below $10,000, and many have incomes below $5,000. Compared with Medicare-only beneficiaries, they are six times as likely to live in a nursing home, more likely to have a serious physical or cognitive impairment and report being in poor health. They are much more frequent users of emergency room care than are Medicare-only beneficiaries. Precise data are not available, but consistent with the data that you indicated, while they are only 6 million people, they account for roughly $106 billion in spending or a third of both programs' combined spending on their total beneficiary populations.

In concept, Medicare and Medicaid provide essential and complementary services to dually eligible beneficiaries. Medicare is the primary provider of hospital, post-hospital and physician care, while Medicare provides benefits beyond those covered by Medi-

care, such as prescription drugs and long-term care. In practice, however, Medicare and Medicaid's respective roles do not sort out this easily, and the health financing needs of the dually eligible populations surface numerous contradictions and policy conundrums when attempts are made to mesh the two programs.

With health care spending growing faster than general inflation, both programs are under pressures to cut costs. Thus, where benefits overlap and coverage guidelines allow for some discretion, program actions can result in shifting costs. Take Medicare's home health benefit, for example: because of Medicare's liberalized home health coverage guidelines, issued in 1989, States can get Medicare to cover much of the dual eligible's home care that previously would have only been covered under Medicaid. This could be one factor contributing to the sevenfold spike in Medicare home health care's payments between 1989 and 1996, from over $2 billion to over $17 billion in 1996.

Alternatively, States maintain that Medicare can shift costs to Medicaid for dual eligibles in nursing facilities. For example, when Medicare's skilled nursing facility coverage requiring daily skilled care are applied stringently, Medicare's coverage of dually eligible patients' skilled nursing facility stays may end early, and Medicaid takes over as the primary payer. Strict application of Medicare coverage criteria, while advantageous to Medicare, shifts some of the burden of financing skilled nursing facility care to Medicaid.

To better manage costs and care delivery, States are exploring ways to enroll their dual eligible population in managed care programs. In principle, States could mesh the financial and health care benefits of the two programs by enrolling these beneficiaries in a single system of coordinated care. However, Federal guarantees available to dually eligible beneficiaries by virtue of their Medicare status complicate state efforts to design such a system. One guarantee is freedom of choice, which allows Medicare beneficiaries to enroll in any Medicare HMO, disenroll virtually at will and go back to fee-for-service or join another plan. In contrast, with waivers from HCFA, States can require their Medicaid-only beneficiaries to enroll in managed care and can lock them in for up to a year.

A second barrier involves attempting to guarantee only acceptable quality plans participate in their programs. It involves provisions requiring commercial membership, so that plans are deemed qualified to serve Medicare beneficiaries. Both Medicare and Medicaid have these requirements, which are based on the hypothesis that a health plan's ability to attract private enrollees can serve as one assurance of quality. Medicare requires that plans serving program beneficiaries be composed of 50 percent commercial members, whereas Medicaid's commercial membership threshold is much lower at 25 percent, and HCFA has been willing to waive this requirement, as other quality assurance protections are substituted.

These conflicting requirements mean that beneficiaries may be forced to receive Medicaid benefits from one plan and Medicare benefits from another, foregoing any gain that would come from coordinating those benefits.

Despite these obstacles, several States have developed managed care programs that include their dual eligible beneficiaries. How-

ever, most of these programs are relatively recent. The newness of these programs, plus the limited experience of most managed care plans in serving persons with chronic and complex conditions, make it critical to adequately monitor the care received by this vulnerable population. We noted in a report last year that the oversight mechanisms designed to track a plan's performance in serving an average enrollee are not well-suited to monitoring service delivery for the relatively small numbers of enrollees with severe needs.

In conclusion, we believe that the concerns existing today in serving the dual eligibles will be accentuated in the future, when the demographic projections show this population increasing. States could experience a greater financial burden as the payer of beneficiaries' cost-sharing obligations under Medicare and, and at the same time, States will continue to pursue greater flexibility through HCFA-approved waivers to enroll their dually eligible beneficiaries in managed care.

In the interests of the beneficiaries, the Federal Government and the States, we continue to stress the need for well-developed quality assurance mechanisms and rigorous Federal and State oversight for these managed care programs.

Thank you, Mr. Chairman, and I would be happy to answer any questions you or other members of the committee have.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

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Testimony

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MEDICARE AND MEDICAID

Meeting Needs of Dual Eligibles Raises Difficult Cost and Care Issues

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-119

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss several issues that arise in financing health care for people known as dual eligibles–Medicare beneficiaries who are also eligible for some form of Medicaid support. In 1995, Medicare and Medicaid spending for the roughly 6 million dual eligibles totaled an estimated $106 billion, or almost a third of these programs' expenditures combined. This dually eligible population is expected to grow, resulting in ever greater health financing expenditures and care challenges. In addition, dual eligibles are, by definition, poor, and many are in poor health, with over 20 percent residing in nursing homes. While the very poor and very sick could benefit from a coordinated system of care, at times they can encounter a fragmented and confusing array of services.

My comments today will focus on three major areas: (1) the health characteristics of those who are eligible for both Medicare and Medicaid and the key structural differences between the two programs that serve this population, (2) benefit overlaps between these two programs and the associated shifting of care and costs between federal and state levels, and (3) states' efforts to use managed care to serve this population. Our work is based on our recent products on efforts to reform Medicare posthospital benefit payments and Medicare and Medicaid managed care issues, an analysis of federal data on dually eligible beneficiaries, and other relevant research. (A list of related GAO products appears at the end of this statement.)

In summary, the dually eligible population consists of people with a range of health needs–from the young to the very old and from the healthy to the disabled or chronically ill in nursing homes. Compared with Medicare-only beneficiaries, however, dually eligible beneficiaries are more likely to have poorer health status and require costly care, including long-term care. Meeting their needs under two programs that are administered under different rules complicates matters in both fee-for-service and managed care environments. The potential to cover posthospital and long-term care benefits under either program has resulted in costs being shifted between programs. Because the federal government pays the full cost of Medicare and shares the cost of Medicaid with the states, the greater financial burden generally falls on the federal government.

To better coordinate acute and long-term care needs while holding down costs, some states are assessing the potential for enrolling their dually eligible populations in a single managed care plan. However, differences in Medicare and Medicaid requirements for commercial managed care participation can create barriers to this approach. Because these barriers are largely related to certain statutory beneficiary guarantees, including beneficiaries' freedom to choose their own provider, granting waivers from federal requirements to states that are designing comprehensive managed care programs remains a delicate issue.

The implications of managing the costs of care for this population are significant at both the federal and state levels. The issue is important to the federal government because it pays for Medicare as well as for over half of Medicaid's costs. It is also important to state governments, because they have little control over federal decisions–such as the imposition of new Medicare cost-sharing requirements–that make their budgets vulnerable to unplanned fiscal liabilities. As states pursue greater flexibility to design more efficient and effective service delivery programs for this population through waivers of certain beneficiary protections guaranteed by federal statute, federal and state governments' rigorous oversight of care delivery remains essential.

POOR HEALTH STATUS, PROGRAM DIFFERENCES POSE CHALLENGES IN SERVING DUALLY ELIGIBLE POPULATION

In concept, Medicare and Medicaid provide essential and complementary services to dually eligible beneficiaries. Medicare is the primary provider of hospital, posthospital, and physician care, while Medicaid provides benefits beyond those covered by Medicare, such as prescription drugs and long-term care. In practice, however, Medicare and Medicaid's respective roles do not sort this out neatly, and the health financing needs of the dually eligible population surface numerous contradictions and policy conundrums when attempts are made to mesh the two programs.

Poor Health Status Characterizes the Condition of Many of the Dually Eligible

Dual eligibles are among the most vulnerable Medicare beneficiaries. Within this population, however, individuals' health needs and associated medical costs can vary substantially. Although some individuals incur few or no costs beyond those of the general population, many have substantially greater health care needs and fewer personal resources to meet those needs than the average Medicare beneficiary. By definition, dual eligibles are poor: about 20 percent have annual income of less than $5,000 a year; 80 percent have annual income of less than $10,000. Compared with Medicare-only beneficiaries, dually eligible beneficiaries are more likely to

- live in a nursing home or live alone;

- have a serious and chronic condition, and physical or cognitive impairment; and

- have less access to a regular source of care and preventive services, and higher use of emergency room care.

Medicare and Medicaid Display
Key Structural Differences

Medicare is a federally financed health insurance program administered by the Department of Health and Human Services' Health Care Financing Administration (HCFA). It covers almost all Americans 65 years old and older and certain individuals under 65 who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts. Part A covers inpatient hospital services, posthospital care in skilled nursing facilities (SNF), and care in patients' homes. Part B covers primarily physician and other outpatient services. In fiscal year 1996, Medicare covered an estimated 38 million beneficiaries at a cost of $197 billion.

Medicaid is a health insurance program financed and administered by both the federal government and the states. Its beneficiaries include poor children and their parents as well as low-income elderly, blind, and disabled individuals. In addition to covering primary and acute care, Medicaid covers outpatient prescription drugs and long-term care both in the home and in nursing facilities.

Medicaid, however, is not 1, but over 50 separate programs.[1] Although federal law mandates coverage of certain medical services and population groups, it also permits states to choose whether to cover additional services or low-income population groups. Thus, under Medicaid, the populations served and benefits provided vary across states. The percentage of Medicaid expenditures covered by the federal government also varies by state, depending on the state's per capita income, with a range from 50 to 83 percent. In 1996, the federal government paid 57 percent of the aggregate Medicaid costs of about $160 billion, which provided health care coverage for about 37 million beneficiaries.

Both programs have traditionally reimbursed providers through fee-for-service arrangements, but both have been developing managed care components in which beneficiaries obtain care from prepaid health plans. Managed care plans in both programs cover beneficiaries under terms that are different from those under fee-for-service arrangements. For example, managed care organizations are paid a fixed monthly amount for each enrollee to provide or arrange for medical services, which are typically coordinated through a primary care physician. In addition, Medicaid managed care programs differ among states. To implement these programs, states typically seek approval from HCFA to waive certain federal requirements. Named after sections of the Social Security Act that authorize the waivers, 1915(b) program waivers and 1115 demonstration waivers permit states to conduct managed care programs and experiment with plan participation and eligibility rules that would otherwise be prohibited by law.

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[1]There are 56 programs, 1 in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. territories.

Dual Eligibles Qualify for Medicare and Various Levels of Medicaid Support

Dually eligible individuals are Medicare beneficiaries first. According to the level of support provided by Medicaid, the dually eligible population is divided into two major groups: (1) those receiving Medicare cost-sharing support and additional Medicaid health care benefits ("full-benefit" individuals) and (2) those receiving help from Medicaid only to cover out-of-pocket costs after payment by Medicare. Collectively, both groups of dually eligible beneficiaries represent about 16 percent of the Medicare population but 30 percent of Medicare expenditures. Similarly, they account for about 17 percent of the Medicaid population but 35 percent of Medicaid expenditures.

States vary dramatically in the proportion of Medicare beneficiaries also enrolled in their Medicaid programs. According to one source, in 1993, two states' Medicaid programs covered more than 20 percent of their Medicare beneficiary populations, whereas eight states' Medicaid programs covered fewer than 7 percent of their states' Medicare beneficiaries.[2] These differences may reflect variation across states in demographic composition, state eligibility criteria, outreach efforts, and data reporting practices.

Full-benefit individuals–an estimated 5.4 million in 1995–compose the largest group of Medicare beneficiaries covered by Medicaid.[3] They qualify for Medicaid primarily because they are "categorically eligible"–that is, they are eligible for such cash assistance programs as Supplemental Security Income (SSI)–or because they are "medically needy," which means they have incomes or assets above the levels that would make them eligible for cash assistance but their medical expenses relative to their incomes are so substantial that states qualify them for assistance.[4]

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[2]Katie Merrell and others, "Medicare Beneficiaries Covered by Medicaid Buy-In Agreements," Health Affairs (Jan./Feb. 1997).

[3]This testimony focuses primarily on the dual eligibles who qualify for full benefits.

[4]States may also choose to provide Medicaid benefits to people with incomes up to 300 percent of SSI levels in nursing homes or receiving home and community-based services under a waiver, or to people with income between SSI levels and 100 percent of the poverty level who may not be receiving cash assistance.

A much smaller group of Medicare beneficiaries–an estimated 562,000 in 1995[5]–receives Medicaid coverage for certain Medicare financial obligations and includes two subgroups. The first consists of Qualified Medicare Beneficiaries–called QMBs. These people have incomes or assets that exceed the thresholds set for full-benefit eligibility but have incomes that are nevertheless at or below the federal poverty level. Medicaid pays these beneficiaries' Medicare monthly part B premiums and all copayments and deductibles required under Medicare. The second subgroup consists of Specified Low-Income Medicare Beneficiaries–called SLMBs. These people have incomes slightly above the federal poverty level; Medicaid pays their Medicare premiums but not copayments or deductibles.

The Congress enacted the QMB and SLMB programs in 1988 and 1990, respectively, out of concern for the financial hardship that Medicare cost-sharing requirements could pose for low-income people not eligible for Medicaid. As we reported in 1994 and others have stated more recently, since the programs were implemented, many individuals eligible for Medicaid's cost-sharing support have not taken advantage of it.[6] In 1995, an estimated 37 percent of people eligible for the QMB program were not enrolled, and an estimated 90 percent of people eligible for the SLMB program were not enrolled.[7]

BENEFIT OVERLAPS FOSTER SHIFTING OF FEE-FOR-SERVICE COSTS BETWEEN PROGRAMS

Both Medicare and Medicaid devote substantial resources to providing care to the dually eligible population. At the same time, both programs are under pressure to contain cost growth in their respective programs. This makes the substitution of services provided–and the resulting shifting of costs between federal and state levels–one alternative for limiting a program's fiscal liability. The net burden is likely to fall more heavily on the federal government, as the payer for all Medicare and more than half of Medicaid expenditures.

Dual eligibles can obtain similar services from both Medicare and Medicaid, especially home health and nursing facility care. Since 1989, when coverage guidelines were liberalized in response to court decisions, the home health care benefit has been essentially transformed from one focused on patients needing short-term care after

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[5]Precise numbers for these individuals are not readily available. For a recent estimate, see Judith Feder, "Medicare/Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations" (Georgetown University: Mar. 25, 1997).

[6]Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (GAO/HEHS-94-52, Jan. 20, 1994).

[7]Marilyn Moon and others, Protecting Low-Income Medicare Beneficiaries (The Urban Institute: Nov. 1996).

hospitalization to one that serves chronic, long-term care patients as well. Between 1989 and 1996, Medicare's part A home health care payments rose sevenfold, from $2.4 billion to $17.7 billion. As we testified before congressional committees earlier this year,[8] not only has the number of Medicare beneficiaries receiving home health care increased dramatically, but so has the intensity of visits for each beneficiary.[9]

Medicaid, as a payer for long-term and home-based care, can take advantage of Medicare's liberalized guidelines to help cover the costs of long-term care for dual eligibles. This practice, often referred to as "Medicare maximization," involves Medicaid's billing of Medicare first–where feasible–on behalf of dual eligibles. This practice is consistent with the Social Security Act, which requires that, when a service is covered by both programs, Medicare is the primary payer. A recent example is the enactment in 1996 of Minnesota's Medicare Maximization Initiative, a program designed to teach providers how to use Medicare for home care services and supplies and equipment for recipients who are dually eligible. In this way, Medicaid has been able to reduce its costs by capitalizing on the movement of Medicare's home health benefit from a post-acute focus to include long-term care benefits.

Alternatively, when Medicare's SNF coverage criteria for daily skilled care are applied more stringently, Medicare's coverage of a dually eligible patient's SNF stay may end earlier and Medicaid becomes the primary payer. Such a strict application of Medicare coverage criteria, while advantageous to Medicare, shifts some of the burden of financing SNF care to Medicaid.

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[8]We have testified before the Subcommittee on Health and Environment, House Committee on Commerce: Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997) and before the Subcommittee on Health, House Committee on Ways and Means: Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

[9]The number of Medicare beneficiaries receiving home health care more than doubled, from 1.7 million in 1989 to about 3.9 million, in 1996. During the same period, the average number of visits to home health beneficiaries also more than doubled, from 27 to 72. In addition, we found that the proportion of home health users receiving more than 30 visits increased from 24 percent in 1989 to 43 percent in 1993, and, during the same period, the proportion of those receiving more than 90 visits tripled, from 6 percent to 18 percent.

STATES' DESIRE TO USE MANAGED CARE MAY CONFLICT WITH FEDERAL GUARANTEES TO MEDICARE BENEFICIARIES

States are beginning to explore the use of managed care to serve their dually eligible populations. However, using managed care prepaid health plans presents another set of dilemmas. On the one hand, managed care, in principle, offers the potential for a single system of coordinated care to serve a population particularly likely to benefit from such a system. On the other hand, managed care plans–both in Medicare and Medicaid–have little experience serving a population with expensive medical and extensive long-term care needs. In addition, each of the respective programs has different terms for beneficiary and plan participation. Thus, as states consider enrolling dual eligibles in their managed care programs, they face certain barriers that require federal and state cooperation to overcome. With federal waivers from some statutory requirements, several states have removed key administrative obstacles, permitting the enrollment of the dually eligible population.

Differences in Managed Care Participation Terms Complicate States' Efforts to Coordinate Care

Medicare and Medicaid managed care programs are characterized by two key differences:

- "Freedom-of-choice" guarantees. Under Medicare, beneficiaries can enroll in any managed care plan with a Medicare contract and are free to disenroll every 30 days and reenter the fee-for-service system or join another managed care plan. Under Medicaid, with HCFA-granted waivers a state can require beneficiaries to enroll in a limited number of state managed care plans and can also "lock in" their enrollment for as long as 12 months.

- Plan participation requirements. In both programs, managed care plans must enroll a certain number of commercial members because of the hypothesis that a health plan's ability to attract private enrollees can serve as one assurance of quality. Medicare's commercial membership threshold of 50 percent is higher than Medicaid's, which is 25 percent–or waived altogether in the case of states that obtained special approval from HCFA.[10]

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[10]The administration has proposed replacing Medicare and Medicaid's commercial enrollment requirements with enhanced quality monitoring and measurement systems, yet to be defined.

As states seek greater control of their health financing and care delivery obligations, these program differences may serve as barriers to enrolling dual eligibles in a single managed care plan. Medicare's liberal disenrollment policy, coupled with its requirement to enroll beneficiaries in plans meeting the 50-percent commercial membership level, complicates states' ability to use managed care for their Medicaid beneficiaries with Medicare status.

For example, a state's ability to lock beneficiaries into a prepaid plan providing both Medicare and Medicaid benefits for an extended period may have the benefit of stabilizing the state's fiscal liability for health care, while offering the potential to coordinate care within a single network of providers. But dually eligible beneficiaries who exercise their Medicare right to leave the plan during the Medicaid lock-in period may expose the state to the cost-sharing obligations incurred with a fee-for-service or Medicare managed care provider and preclude the Medicaid plan's potential to organize a system of coordinated services. In addition, states may have existing contractual relationships with Medicaid managed care organizations that could serve the states' dual eligibles, but their public program membership exceeds the 50-percent threshold needed to comply with Medicare's rules for plans eligible to serve Medicare beneficiaries.

Beneficiary Protection in Managed Care More Critical for Dually Eligible Population

With its focus on coordinated care, managed care provides states an option for moving their dually eligible population into a single plan providing all or most required services. However, a Medicaid program's policy may preclude incorporating certain Medicare provisions--such as the freedom to choose among all participating plans and to disenroll monthly--which have been considered important beneficiary protections in managed care. As our recent testimony before this Committee indicated, the ability of plans to satisfy and retain beneficiaries is highly variable.[11]

The more complex and extensive needs of the dually eligible population accentuate the importance of beneficiary protections. However, limited experience on the part of states and plans serving--in a managed care setting--people with the demographic and health status traits of dual eligibles makes it difficult to identify beneficiary protections that will be effective and will minimize problems in coordinating these two programs. For example, we recently reviewed states' prepaid Medicaid programs serving disabled beneficiaries[12] and found that, of 17 states making managed care available to disabled

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[11]Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information (GAO/T-HEHS-97-109, Apr. 10, 1997).

[12]Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

people, 12 had less than 20 percent of their disabled beneficiaries enrolled. Of the six state programs requiring some or all of their disabled population to enroll in prepaid managed care, only one was more than 3 years old.

We also found that oversight mechanisms designed to track a plan's performance in delivering services to the average enrollee are not well-suited to monitor service delivery to the severely disabled, who may represent a small number of enrollees in a plan. About half of the 17 states enrolling disabled beneficiaries in prepaid managed care continued to rely on mechanisms such as beneficiaries' freedom to disenroll from or switch plans or on their access to grievance systems in lieu of more carefully targeted formal quality assurance systems.

SEVERAL CONCERNS ABOUT DUAL ELIGIBLES REMAIN ISSUES FOR THE FUTURE

Several factors highlight the importance of dual eligibility in the coming years: a growing dually eligible population, the potential for new cost-sharing obligations, and states' continued requests for waivers to implement innovative managed care programs.

The demographics of the dually eligible beneficiaries will undoubtedly continue to focus attention on the respective federal and state roles in serving this population. The numbers of dual eligibles are expected to increase, and the two groups that are likely to be dually eligible–the oldest elderly and the nonelderly disabled–are growing segments of the Medicare population.[13]

Among the various approaches being considered to contain the unsustainable growth in Medicare costs is the option to increase beneficiary cost sharing. However, if Medicare premiums and cost sharing are increased, these costs will consequently rise for the states, as payers of the dually eligibles' financial obligations under Medicare.

Finally, states are likely to continue seeking flexibility under HCFA's waiver approval process to overcome existing barriers to dual eligibles' enrollment in managed care. How HCFA will treat freedom-of-choice issues, such as the beneficiaries' right to disenroll monthly, and the "50-50" public/private membership rule remains an open question. Regardless of the approaches taken, our recent work in both Medicare and Medicaid managed care stresses repeatedly that, to ensure program accountability for the interests

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[13]Nonelderly disabled beneficiaries made up about 10 percent of the Medicare population in 1991 but are expected to make up nearly 18 percent in 2010. Similarly, beneficiaries aged 85 or older made up 8 percent of the Medicare population in 1991 but are expected to compose 11 percent of the Medicare population in 2010.

of both beneficiaries and the federal government, rigorous federal and state oversight of care and effective quality monitoring systems are essential.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Committee Members may have.

For more information on this testimony, please call Kathryn G. Allen, Acting Associate Director, on (202) 512-7059. Other major contributors included Hannah F. Fein and Sally J. Kaplan.

RELATED GAO PRODUCTS

Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-86, forthcoming).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997).

Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

Medicare HMOs: Potential Effects of a Limited Enrollment Period Policy (GAO/HEHS-97-50, Feb. 28, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

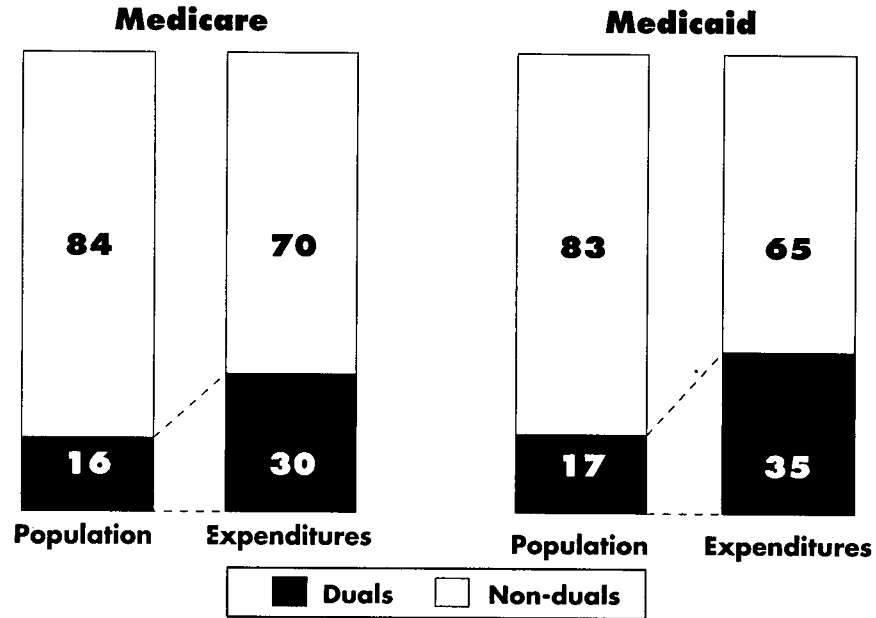
Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, Apr. 4, 1995).

Medicare and Medicaid: Many Eligible People Not Enrolled in Qualified Medicare Beneficiary Program (GAO/HEHS-94-52, Jan. 20, 1994).

(101559)

Medicare and Medicaid Expenditures for Dual Eligibles



Source: Health Care Financing Administration - Data from the Medicare Current Beneficiary Survey

The CHAIRMAN. Thank you.
Mr. Bullen.

STATEMENT OF BRUCE BULLEN, COMMISSIONER, MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE, BOSTON, MA

Mr. BULLEN. Thank you, Mr. Chairman, members of the committee.

My name is Bruce Bullen. I am the commissioner of medical assistance in Massachusetts, and I am responsible for the Medicaid program, and I am also the current chair of the National Association of State Medicaid Directors.

For several years now, Massachusetts and the other New England States, with the active assistance of the Health Care Financing Administration, have been collaborating on a regional approach to integrated care for Medicare and Medicaid dual eligibles. The consortium of States has recently submitted to HCFA a framework document outlining the structure of such a system in anticipation of the submission by each State of a waiver request to permit implementation.

States have been inspired to develop such proposals because of an increasing sense of frustration regarding their inability to improve the delivery system for dual eligibles. Many States have developed expertise in the administration of comprehensive service systems for other groups covered by Medicaid and believe that with Federal permission, the benefits of care coordination and management oversight could be brought to bear to serve this population better.

In Massachusetts, dual eligibles account for 25 percent of our caseload and 51 percent of Medicaid spending. The average dual eligible costs Medicaid 8½ times more to serve than the average AFDC family member. We have merged data files on Medicare and Medicaid spending for our dual eligibles in Massachusetts, and it turns out that Medicaid has two-thirds of the spending responsibility, despite the fact that Medicare is the primary payer. This is chiefly because long-term care, drugs, and Medicare cost-sharing are funded by Medicaid.

One of the central challenges to the New England Group's planning process is matching the data from the two funding streams, Medicare and Medicaid. This process is ongoing but has yielded very important planning information already. Attached to my testimony is a memorandum prepared by my colleague, Francis Finnegan, the Medicaid director in Maine, which furnishes some of the specific data for Maine, and I think you will find it of interest.

A major problem for both beneficiaries and policymakers is the sheer complexity of dual coverage. The benefit packages overlap; yet, they are different. The beneficiary is usually unaware that coverage is not continuous. Paperwork requirements and administrative rules are voluminous. To make matters worse, the two insurers have very strong incentives to shift financial responsibility to each other. A classic example is the elderly person who enters a hospital on Medicare, is transferred to a nursing home on Medicare, desires to remain in the nursing home and only then discovers that Medicare covers a limited amount of nursing home days.

As a result, the individual then discovers the Medicaid system and its rules, sometimes after having spent down assets and income.

Also, since the Medicare beneficiary goes to the nursing home before he or she is eligible for Medicaid, Medicaid cannot avert this admission by offering preventive or alternative care not included in the Medicare benefit package. This situation whipsaws low-income elders and disabled between the two systems in a manner which is unacceptable for the individual, for family members, and policymakers. Because neither program is ultimately responsible for the performance of the entire system, the potential for fragmented, ineffective, and reimbursement-driven decisionmaking is very high.

In Massachusetts, we are proposing to enroll dual-eligible seniors in a capitated senior care organization to be a voluntary plan capable of providing the full Medicare and Medicaid benefit package. We believe that if Medicare and Medicaid funds are blended and administered by us on behalf of both programs, quality of care, access to services, and customer satisfaction will improve. We also believe that cost savings can occur by reducing the incentive to overuse institutional services, by eliminating reimbursement-driven behavior, and by using the resources of both programs in concert rather than placing them in conflict.

The Massachusetts proposal will be submitted shortly, and it is described in some detail in the appendix to my testimony. Seniors who enroll will have the choice of a primary care clinician or a primary care team that includes a social services coordinator, depending on need, and will have the ability to access a full range of medical and nonmedical services without burdensome paperwork or bureaucratic obstacles. Senior care organizations will be held to very high standards of performance and rewarded for improving health status and consumer satisfaction.

The other New England States are considering variants of this model. Maine, for example, will probably request approval to pilot their project in two counties rather than statewide. None of the other States currently are contemplating offering an early enrollment option, as we are in our model.

We would ask the committee to support efforts to provide States with the necessary flexibility to integrate Medicare and Medicaid funding streams. Barring this or while the issue is debated in Congress, we would ask the committee to support current State attempts to gain Federal approval for waivers to provide similar integrated systems of care. We believe we have the managed care purchasing experience and the infrastructure to offer a solution that works for Medicare, Medicaid, and their joint beneficiaries.

I have included as part of my testimony some draft language that would enable the States to establish Medicare/Medicaid integration demonstration projects for this purpose.

I thank you again for the opportunity to testify, and I look forward to continuing to work with the committee on this issue.

[The prepared statement of Mr. Bullen follows:]

AMERICAN PUBLIC WELFARE ASSOCIATION

Cornelius D. Hogan, President
A. Sidney Johnson III, Executive Director

TESTIMONY OF

BRUCE BULLEN

COMMISSIONER
MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE

AND

CHAIR
NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS (NASMD)

BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

APRIL 29, 1997

My name is Bruce Bullen. I am the Commissioner of Medical Assistance in Massachusetts, responsible for the administration of the Medicaid program, and also the current Chair of the National Association of State Medicaid Directors (NASMD). NASMD is an affiliate of the American Public Welfare Association.

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States have been inspired to develop such proposals because of an increasing sense of frustration regarding their inability to improve the delivery system for dual eligibles. Many states have developed expertise in the administration of comprehensive service systems for other groups covered by Medicaid and believe that, with federal permission, the benefits of care coordination and management oversight could be brought to bear to serve this population better.

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One of the central challenges to the New England group's planning process is matching the data from the two funding streams: Medicare and Medicaid. This process is ongoing, but has yielded very important planning information already. Attached to my testimony is a memorandum prepared by my colleague Francis Finnegan, the Medicaid Director in Maine, which furnishes some of the specific data for Maine. I think you will find it of interest.

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We would ask the Committee to support efforts to provide states with the necessary flexibility to integrate Medicare and Medicaid funding streams, and thereby improve the coordination of care to beneficiaries who are dually eligible. Barring this, or while the issue is debated in Congress, we would ask the Committee to support current state attempts to gain federal approval for waivers to provide similar integrated systems of care. We believe we have the managed care purchasing experience and the infrastructure to offer a solution that works for Medicare, Medicaid, and their joint beneficiaries. I have included as part of my testimony some draft language that would enable the states to establish Medicare/Medicaid Integration Demonstration Projects for this purpose.

I thank you again for the opportunity to testify before you today and look forward to continuing to work with the Committee on this very important issue.

Appendix A

MASSACHUSETTS INITIATIVE FOR DUALLY FLIGIBLE PERSONS

Target Population. Dually eligible older persons (65 years of age and older) and seniors with Medicaid coverage only will be offered the option of joining a Senior Care Organization (SCO). Enrollment will be voluntary. Massachusetts also proposes to offer early SCO enrollment to frail, low-income seniors would are currently ineligible for Medicaid but are at risk of entering a nursing home.

Benefit package. The SCO benefit package will include the full continuum of Medicare Part A and B services, Massachusetts Medicaid covered services, and home and community based waiver services. Critical to the design of this program is providing the SCO with the flexibility to deliver social support services, such as homemaker and chore services, in lieu of more medically intense services. SCOs will be permitted to add supplemental benefits, at their discretion, provided there is no additional cost to beneficiaries or the program. The provision of such incentives will be closely monitored.

Delivery System Design. The full continuum of Medicare and Medicaid services will be delivered through the SCO networks. Each beneficiary will select a Primary Care Provider (PCP), who, working with the beneficiary and other providers as appropriate, will develop an individualized plan of care. For individuals with complex care needs, the Primary Care Provider will assemble a team of providers responsible for coordinating the full continuum of services. Such teams will include a counselor who will have expertise in the area of community based long-term care services.

Through this initiative, Massachusetts wishes to stimulate the entrance into the health care marketplace of new kinds of organizations. SCOs may be developed out of different configurations of provider networks. They will, of course, have to be able to demonstrate compliance with extensive access, quality, and financial solvency standards. Massachusetts hopes to be able to offer a choice of at least two SCOs to every potential enrollee statewide.

Quality Management. Quality will be assured through a performance-based contracting system emphasizing measurement, continuous quality improvement, and performance-based incentives. The SCOs will implement clinical program initiatives specifically designed to meet the needs of dually eligible seniors. For example, SCOs will report on clinical indicators such as influenza and pneumonia vaccination rates, and will develop programs to address the needs of beneficiaries with certain chronic conditions such as diabetes, congestive heart failure, chronic obstructive pulmonary disorder, and dementia.

Enrollment Process. Enrollment in a SCO will be voluntary. An enrollment broker, independent of any provider or SCO, will provide each potential enrollee with complete and unbiased information in order for him/her to make an informed decision. If she/he decides to join a SCO, the enrollment broker will assist with the selection of a SCO that best meets his/her needs.

Funding. SCOs will be reimbursed on a capitated basis. Funding will come from Medicare and Medicaid, in separate payments, with funds being integrated at the level of the SCO.

APPENDIX B

Draft dual eligibles demonstration language

Sec. _____Medicare/Medicaid Integration Demonstration Projects.

(a) *Description of projects*

(1) In general. The Secretary of Health and Human Services shall conduct demonstration projects under this section to demonstrate the manner in which States may use funds from the Medicare program under Title XVIII of the Social Security Act and the Medicaid program under Title XIX of such Act (in this section referred to as the "Medicare and Medicaid programs") for the purpose of providing a more cost-effective full continuum of care for delivering services to meet the needs of elderly and disabled beneficiaries who are eligible for items and services under such programs, through integrated systems of care, with an emphasis on case management, prevention, and interventions designed to avoid institutionalization whenever possible. The Secretary shall use funds from the amounts appropriated for the Medicare and Medicaid programs to make the payments required under subsection (d)(1).

(2) Option to Participate. A State, or a coalition of States, may not require any individual eligible to receive items and services under the Medicare and Medicaid programs to participate in a demonstration project under this section.

(b) *Establishment*. The Secretary shall make payments in accordance with subsection (d) to a State, or coalitions of States, for the conduct of demonstration projects that provide for integrated systems of care in accordance with subsection (a).

(c) *Applications*. Each State, or a coalition of States, desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project. The Secretary shall approve or deny an application not later than 90 days after the receipt of such application.

(d) *Payments*.

(1) In general. For each fiscal year quarter occurring during a demonstration project conducted under this section, the Secretary shall pay to each participating State, or coalition of States, an amount equal to the Federal capitated payment rate determined under paragraph (2).

(2) Federal Capitated Payment Rate. The Secretary shall determine the Federal capitated payment rate for purposes of this section, which shall be equal to the anticipated Federal quarterly cost of providing care to elderly and disabled beneficiaries who are eligible for items and services under the Medicare and Medicaid programs and who have opted to participate in a demonstration project under this section.

. (3) State Payments. Each State conducting, or in the case of a coalition of States, participating in a demonstration project under this section shall make payments to the entities designated under paragraph (3) in a manner approved by the Secretary, which may include capitation or other risk-based reimbursement, for the cost of the items and services provided to elderly and disabled beneficiaries who have opted to participate in a demonstration project under this section.

(4) Budget Neutrality. The aggregate amount of Federal payments made to a state, or coalition of States, under this subsection for a fiscal year shall not exceed the aggregate amount of the payments that would otherwise have been made under the Medicare and Medicare programs combined for such fiscal year for items and services provided to beneficiaries under such programs but for the election of such beneficiaries to participate in a demonstration project under this section.

(e) *Designation of Entity*

(1) In general. Each State, or coalition of States, shall designate entities to provide items and services that are part of the demonstration project.

(2) Requirement. A State, or a coalition of States, may not designate an entity under subparagraph (1) unless such entity meets the quality, solvency, and coverage standards applicable to providers of items and services under the Medicare and Medicaid programs

(f) *Duration.*

(1) In general. The demonstration projects conducted under this section shall be conducted for a 5-year period, subject to annual review and approval by the Secretary.

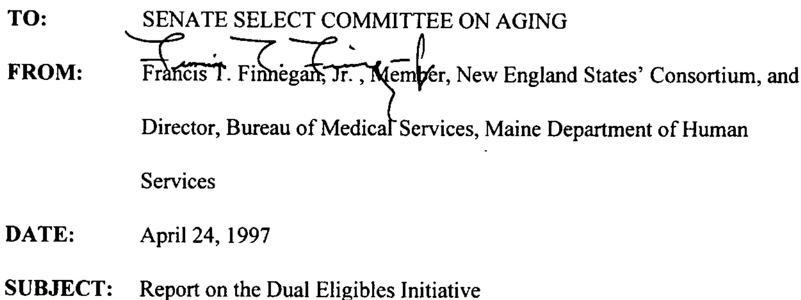
(2) Termination. The Secretary may, with 90 days' notice, terminate any demonstration project conducted under this section that is not in substantial compliance with the terms of the application approved by the Secretary under this section.

(g) *Oversight.* The Secretary shall establish quality standards for evaluating and monitoring the demonstration projects conducted under this section.

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

ANGUS S. KING, JR

MEMORANDUM



TO: SENATE SELECT COMMITTEE ON AGING

FROM: Francis T. Finnegan, Jr., Member, New England States' Consortium, and Director, Bureau of Medical Services, Maine Department of Human Services

DATE: April 24, 1997

SUBJECT: Report on the Dual Eligibles Initiative

This memorandum is divided into two sections. Part I is a brief update on the Dual Eligibles Initiative of the New England States' Consortium. Part II is a discussion of some of the issues surrounding the care of persons eligible for Medicaid and Medicare based on preliminary findings from claims data for 1994 linking the two programs at the client level. This report was prepared by staff of the Bureaus of Medical Services and Elder and Adult Services of the Maine Department of Human Services and of the Edmund S. Muskie School of Public Service of the University of Southern Maine.

PART I

Status of the New England Dual Eligible Initiative

In February of 1996, the key staff contacts from each of the six New England states and representatives from the central and Region I offices of the Health Care Financing Administration began a collaborative development process to create a managed care strategy which would integrate the delivery and financing of Medicaid and Medicare services for the dual eligible populations in their respective states. The initial vision for the product of this effort was a single, joint six state 1115 waiver application. Over the course of the past year and a half, the goal of a single waiver became unrealistic due to timing and scope issues among the six states. However, an extensive amount of staff time and resources had been devoted to developing consensus goals and objectives for all major design elements of an integrated managed care program for vulnerable populations. The New England states did not want this effort to be lost. The States remain committed to the value of collaboration in an area of great complexity and challenge. The result was the Framework for the New England States Demonstration Projects for Dually Eligible Persons.

The Consortium submitted the Framework to Bruce Vladeck, Administrator of the Health Care Financing Administration in March of this year. The Framework represents the States' collective vision for serving dual eligible people in the region. It was presented to HCFA as the blueprint for each of the New England states as each state proceeds to develop individual demonstration programs, tailor them to local conditions, and submit waiver requests as necessary. The next step in the process with HCFA is a joint meeting between key, senior HCFA officials and Commissioners from the New England states on May 12, 1997.

The Framework document is complete and will be discussed with HCFA and each of the states will continue to work toward a complete program design on their respective timelines. Maine and Massachusetts will submit their 1115 waiver applications in Spring 1997 (final drafts will be available in the near future). New Hampshire and Connecticut target submission of their 1115 waiver applications this summer. Vermont and Rhode Island do not have specific target submission dates at this time. However, as stated previously, the Consortium is committed to, and recognizes the value of, continued collaborative activity in select areas. A major conclusion of the first year and a half of the consortium is the realization that the integration of Medicare and Medicaid will be an extremely complex, evolutionary process that will require continuing collaboration.

In addition to the Framework, the New England Consortium has also:

- Developed and implemented a regional approach to linking Medicaid and Medicare data at the beneficiary level;

- Linked successfully Medicaid claims data with Medicare data provided through HCFA's Office of Research and Development (Massachusetts and Maine complete);

- Convened a Reimbursement Summit to discuss risk adjustment methods with nationally recognized experts;

- Convened a Medical Summit to discuss methods for achieving clinical integration of services, and to identify indicators for measuring success; and

- Established a Quality Workgroup that includes national experts, to develop quality program components that could be used throughout the region.

At this time a Memorandum of Understanding has been signed by the Commissioners in all six New England States. Part of that memorandum outlines a governance structure for the Consortium. Briefly, the governance structure defines executive committee membership, the nature of Consortium decisions and joint responsibilities of the Consortium. Commissioner Joyce Thomas of Connecticut is chair of the Consortium.

The future of the initiative: the proposal currently under consideration by each state includes a number of work groups in areas such as quality and reimbursement. Each of these workgroup, by May 1st, will develop a statement of purpose, a six month work plan, and products to be developed during that time frame. This information will be reviewed and discussed after May 1st and a final determination on the number of initial workgroups will be made by the Consortium. In addition to these formal groups, the states will continue ad hoc activity in several areas such as the technical discussions between the Consortium and HCFA on the linked data. One eventual goal is to compare the merged data bases among the six states, establishing a baseline for measuring the relative effectiveness of different initiatives to improve the care of the dually eligibles.

PART II

MANAGING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: A MEDICAID PERSPECTIVE

Managing programs to serve people who are dually eligible for Medicaid and Medicare is one of the most pressing and challenging issues facing state Medicaid programs. In Maine, the data base linking the two programs at the client level is just beginning to reveal the complex interrelationship between Medicaid and Medicare.

For every dollar the Medicare program spends on the dually eligible beneficiary, the Maine Medicaid program spends two dollars. At least 9 out of every 10 elderly Maine Medicaid beneficiaries are dually eligible and nearly half of the Medicaid adults with disabilities in Maine are dually eligible. Dually eligible beneficiaries are heavy consumers of health care

services and account for a disproportionate amount of spending by both Medicaid and Medicare programs. In Maine, elderly and disabled dually eligible beneficiaries represented 22.2 percent of the total Medicaid population in 1994 yet account for 41.5 percent of the total Medicaid budget. The elderly dually eligibles alone were 13 percent of enrollment and 28.6 percent of expenditures.

From the perspective of the Medicaid program, three issues emerge as most pressing:

- **The need to align the incentives of the two systems to promote preventive health practices and home and community based alternatives that meet the needs of the consumer;**
- **The need to rationalize the financing of the Medicare and Medicaid program to prevent cost shifting and promote long term savings; and**
- **The need to coordinate state and federal policy on all levels: clinical, financial, administrative and systems.**

Aligning the incentives of the two systems is critical in order to design programs that can meet the needs of consumers. Under the current system, the Medicaid program has limited ability to initiate care management programs or medical treatments that could prevent the onset of serious acute and chronic conditions which may lead to the need for institutional long term care services.

An example is pneumonia vaccines. Of 476 Medicaid clients who turned 65 during 1994, and thus became eligible for Pneumovax (immunization against pneumococcal disease) only 23 (4.8%) Medicaid claims for the vaccine were paid statewide. An ongoing analysis of Medicaid nursing home clients has identified that only 25 percent have been appropriately given Pneumovax. Statewide prevalence of properly immunized elderly for Pneumovax is 30 percent. Using this figure, the number of Medicaid elderly eligible for Pneumovax in 1994 was 70 percent of 22,740 or 15,918 clients. In fact, only 404 or 2.5 percent of the clients received the vaccination.

In 1994 the direct medical claims paid for pneumococcal pneumonia was $589,000—almost all avoidable by proper use of Pneumovax. There was also $69,000 of nursing home costs attributable to admissions resulting from pneumococcal infection, again avoidable. The cost of fully immunizing all elderly Medicaid eligibles in 1994 would have been under $160,000. The annual costs of keeping new eligibles immunized would run from $23,000 to $69,000. It is very clear that Pneumovax is extremely desirable and cost effective. However strongly Medicaid encourages this policy, it cannot track dually eligible clients who received the Pneumovax when Medicare was billed. Furthermore, the state Medicaid program can have almost no impact on the majority of the Medicare population who should have received Pneumovax at some point before also becoming Medicaid-eligible. This is a perfect example of how the lack of integration between Medicaid and Medicare impedes the use of a simple, yet highly effective preventive service

that in the long run will save many lives, avoid hospitalizations and prevent the use of long term care services.

A recent study in *Journal of the American Medical Association*[1] emphasized the importance of primary prevention and intensive treatment of acute medical conditions even with those who are severely disabled. According to this research, many effective interventions are underutilized in older patients even in the absence of contraindications. For Medicare clients, regardless of age, when medical conditions are not treated aggressively in the hospital, the total medical costs to the system rises substantially since the increased rate of catastrophic and progressive disabilities encourages increased consumption of home health and nursing home services.

A more coordinated and rationale approach to financing Medicaid and Medicare services can minimize the opportunities for cost shifting and maximize the long term savings. Early medical interventions and preventive services that are financed by the Medicare program will provide significant savings to the Medicaid program. Similarly, the Medicaid program covers a number of services where the long term cost savings accrue to the Medicare program.

The Medicaid drug benefit results in substantial long term savings for the Medicare program. High cost drugs such as metformin and troglitazone are proving extremely effective in the management of diabetes. As one of the leading medical conditions of younger adults with disabilities, proper medical management of this condition is a top priority. In Maine, 22 percent of the dually eligible disabled have diabetes and other metabolic diagnoses and per member per month cost are $659.86 for Medicaid and $566.98 for Medicare. Among the elderly, 21 percent have these conditions. For this population Medicaid spends $1140.28 per month and Medicare $729.92. Yet the physician, whose services are funded primarily by Medicare, manages and orders the drugs that control diabetes and are paid for by the Medicaid program. Early intensive treatment of diabetes, including drug therapy, provides substantial long term cost savings for both programs due to the reduced incidence of complications, disabilities, hospitalizations and nursing home placements.

State innovations can also translate into savings to Medicare. Maine's new point of sale pharmacy system saved $285,000 in a single quarter by discontinuing unnecessary prescriptions, reducing quantities of medications prescribed, or switching to safer drug therapies. Yet to be estimated is the implied savings to Medicare from reduced hospital costs for adverse drug interactions.

Also, Maine, like several other states, has an all state funded Drugs for the Elderly Program which provides medications for high cost chronic conditions for low income elderly not eligible for Medicaid. This is an example of how a state program reduces Medicare costs.

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[1] Ferrucci, L., et. al. Hospital Diagnoses, Medicare Charges, and Nursing Home Admissions in the Year When Older Persons Become Severely Disabled. *JAMA*. 1997; 277:728-734.

Aligning incentives and financing systems to provide the home and community based alternatives preferred by consumers is often met with fierce resistance. Medicaid and Medicare were designed over 30 years ago to meet unmet medical and institutional care needs of the poor and elderly. There remains an enormous institutional infrastructure much of it financed through the historical reimbursement strategies of the Medicaid and Medicare programs. The health care delivery system is shifting dramatically away from institutional care toward community-based care. Revolutionary improvements in diagnostic and surgical techniques, pharmacology and medical technology are providing the tools for this transition, but legislative and regulatory barriers must come down if a cost effective system is to be achieved.

In the early stage of analyzing the linked data for Maine, the anomalous interrelationships between the Medicaid and Medicare programs are becoming apparent. Incentives in the 'system' are aligned to cost shift whenever and wherever possible—between payers, between providers, and between programs. Any change in policy in the Medicare program directly affects the Medicaid program and vice versa.

It is imperative that state and federal policy toward dually eligible beneficiaries be coordinated, integrated, communicated at all levels: clinical, financial, administrative, and systems. Many of the barriers to successful integration of Medicaid and Medicare have been identified but others are only emerging.

The proposed rules to implement a new Medicare home health assessment system (OASIS) provides an extreme example of the disconnect between different sectors of our health care system. For the last ten years, significant and substantial resources and research have been devoted to the development of an assessment and care planning system for use in nursing facilities (the Resident Assessment Instrument and the Minimum Data Set). This system was extensively tested and validated in numerous settings prior to implementation in all nursing facilities in the country. Many states, Maine being one of them, have also invested in development of compatible assessment instruments for other sectors of the long term care system with the ultimate goal of developing a common set of definitions and language that can be used by all providers, payers and even consumers in the state. OASIS imposes a new set of definitions, assessment items, and protocols on the Medicare home health industry that are totally inconsistent with other federally developed and mandated long term care assessment systems. It is a step backward from a common language for long term care. Home health agencies who share information with nursing facilities, home care programs that provide extended long term care services, Medicaid programs and Medicare programs all need to be using common definitions, language and minimum data items to assure the appropriate care planning and coordination as people transition from one setting to another, one program to another, and one payer to another.

The successful integration of Medicaid and Medicare into a cost-effective health financing system for the dually eligible population faces three types of challenges, political, economic and bureaucratic. Limiting Medicaid and Medicare funding, without

concurrently creating the flexibility to manage Titles XVIII and XIX programs effectively will simply exacerbate current inefficiencies and cost shifting. From an economic perspective, if vested provider interests or "provider entitlements" are held sacred, there can be no true progress toward integration. Equally important, the current waiver process creates barriers to timely implementation of state specific reforms. The statutory and bureaucratic labyrinth that has been incrementally woven over the last three decades must be dismantled.

Selected characteristics of Medicaid and Medicare's role in covering the dually eligible population

For the elderly in Maine (1994):

- Medicare spends 10% of its total expenditures on physician services. Yet nearly 1/3 of all beneficiaries did not see a physician in a year. If states were allowed to better coordinate the Medicare and Medicaid programs, access to care could be improved for dually eligible seniors.

- Both the Medicare and the Medicaid programs cover the Pneumovax vaccine. There is no claims history common to both programs with which to track immunization rates for the elderly, so it is impossible to ensure that dually eligible beneficiaries receive the appropriate vaccinations.

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The CHAIRMAN. Thank you.
Ms. Parker.

STATEMENT OF PAMELA PARKER, DIRECTOR, MINNESOTA SENIORS HEALTH OPTIONS, ST. PAUL, MN

Ms. PARKER. Mr. Chairman and members of the committee, I am Pamela Parker. I am director of the Minnesota Senior Health Options Program at the Minnesota Department of Human Services, and we are the State Medicaid agency, providing coverage for about 550,000 individuals in the State of Minnesota, including 48,000 dually eligible seniors. We employ managed care principles and techniques largely in that effort, with 50 percent of our Medicaid population enrolled in managed care. Managed care is kind of the norm in Minnesota. Most employed persons are served through managed care, and we have a high degree of consumer satisfaction and a great deal of consumer protection regulation in place in Minnesota.

We were the first State to work with HCFA and, through the help of the Robert Wood Johnson Foundation, obtain waivers to merge financing for Medicare and Medicaid on a broader scale than, perhaps, the PACE and SHMO demonstrations that you have heard about today. In order to offer our own integrated Medicare and Medicaid managed care program for dual eligibles, called the Minnesota Senior Health Options Program, we have contracts with several HMO's. They subcontract with systems such as Jeanne Lally described, the Fairview Partners system, hopefully, and other types of care systems to provide integrated care, including home and community-based services and some of the nursing home care as well.

Our contract requirements for both Medicare and Medicaid have been merged into one contract under this new program, and we are attempting, as some have suggested here, to have one kind of care coordination or case manager across all systems whenever possible. We think that this program has great potential to realign the fiscal incentives that are working against each other in the current system. We think they can support sound clinical care and increase accountability for care as well as control costs. There has been a lot of interest in our program across the country. We are speaking to many States about it, and I have attached a program description for more detail about that program.

But I would really rather spend my time today talking about some of the issues that we have uncovered and struggled with as we developed that program. Managed care is seen as an opportunity, a tool, if you will, for States to assist in meeting the challenge of how we are going to serve the very high-cost population of dual eligibles as that population grows and ages and as we face the demographic challenges of the future.

Managed care has the potential to solve those problems for us; it gives us flexibility to move dollars and services around to meet needs, but if it is not integrated, managed care can actually further fragment an already unbearably fragmented system. Currently, there are two separate doors through which most dual eligibles enter managed care. One is through Medicare, and the other is through Medicaid, and entering one door at a time creates less integration and far more fragmentation for these dual eligibles.

Dual eligibles can voluntarily enroll in Medicare managed care, and they may be attracted by the low premiums and extra benefits available in some parts of the country—not in Minnesota, because we are one of the low AAPCC States, as you heard, but in other parts of the country, this is going on, and these extra benefits can save Medicaid dollars, because they often overlap with the things that Medicaid pays for, such as prescription drugs. But Medicaid has to figure out who has enrolled in these plans and how to track what extra benefits each plan has, in order to avoid double payment, and this is an administrative nightmare that we think could be addressed with proper resources at HCFA.

On the other hand, there are disadvantages to these enrollments in the Medicare managed care as well, because the Medicare plan is paid more for persons in institutional settings and less for people in the community, and they may, as we heard from Dr. Scanlon, have incentives to shift costs to the Medicaid system. So, enrollment in Medicare managed care plans alone is not the answer for us.

The second door through which dual eligibles can enter managed care is through the Medicaid-only door, and States can require seniors to enroll in Medicaid managed care plans, and more and more States are doing so. But the current policy that we have with HCFA regarding freedom of choice works against integrated care systems. HCFA requires that dually eligible Medicaid managed care enrollees be allowed to see any Medicare provider in or out of the plan, so the enrollee could choose a physician that is unknown to the plan who is responsible for the Medicaid services, and that physician could be ordering things that the Medicaid plan has to pay for, like prescription drugs, and there is no coordination between that physician and the Medicaid plan.

This ends up delaying services and causing denials of services, and while we understand that HCFA's policy is well-meaning, it has the effect of further crunching the dual eligible between two systems even more, and that is not a real freedom of choice.

There are too few doors through which a dual eligible can enter an integrated Medicare/Medicaid delivery system which coordinates primary, acute and long-term care services. The PACE and SHMO models are great models to start from, but they do not provide States with all of the necessary tools and the comprehensive coverage across a State which the States need. So, we have been looking at broader options, and there are two basic options that most States have been looking at. One, I would call piggybacking Medicaid managed care onto a Medicare managed care plan. Now, this is a very complex process. It still results in two different kinds of contracts with two different bosses for two pieces of the system, but you can start to merge some of this in that manner. But it does limit States to just working with Medicare managed care plans, and some States do not have any of those plans due to the AAPCC variations across the country. So, this alone is not an option for many States, while other States in the high AAPCC areas where there is a lot of Medicare managed care activity can pursue this; these other States cannot.

Another option is to pursue these special demonstration waivers, such as Minnesota has done, and that is possible, but there are

some great obstacles in that area. OMB has placed some budget neutrality agreement caps on these programs which do not work well. They do not recognize some of the case mix issues that you have with people at varying levels and the adverse selection that you can get when certain people want to enroll and other people do not. So, those issues have to be addressed before States can move forward with more of these kinds of demonstrations.

In order to make integrated care a reality for dual eligibles on a larger scope, I think we have to address these issues, but we also must invest much more in consumer education, advocacy and ombudsman services, and quality assurance measures for chronic care. I spent about 10 years of my career as an advocate for people in nursing homes. I also have a father who recently died of Alzheimer's, and I have also cared for an elderly, 95-year-old aunt in my own home with home and community-based services, so, I have lived this as a policymaker, and I have lived this as an individual within my own family.

I do not have any more patience for the current system that we have, and I would ask you to assist States and HCFA in working together to develop the partnerships that are needed to merge these two financing streams for dual eligibles and using managed care techniques.

Thank you.

[The prepared statement of Ms. Parker follows:]

States Face Major Obstacles
in Integrating Financing and Service Delivery for Persons Dually Eligible for Medicare and Medicaid

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Testimony before:
U.S. SENATE SPECIAL COMMITTEE ON AGING
April 29, 1997

I. INTRODUCTION AND BACKGROUND

Mr. Chairman and members of the Special Committee on Aging, my name is Pamela Parker. I am director of the Minnesota Senior Health Options Demonstration at the Minnesota Department of Human Services. The Minnesota Department of Human Services administers the Medicaid program in the State of Minnesota. We provide health care coverage for over 550,000 families, children, adults and disabled and elderly persons, making us the largest single health care purchaser in the state. Since 1985 Minnesota has operated the Prepaid Medical Assistance Program (PMAP) under a statewide 1115 waiver which requires Medicaid recipients to enroll in their choice of managed care plans. The PMAP program has 182,000 enrollees in HMOs which includes about 40% of the state's 48,000 dually eligible seniors. Another 100,000 Minnesota Care enrollees are also served through HMOs. Minnesota Care is a state subsidized program funded in part though Medicaid. Minnesota is in the process of expanding managed care choices for public health care programs throughout the state.

In fact, enrollment in HMOs or other forms of managed care is the norm for much of Minnesota's population. The majority of employed persons with health care coverage in the State of Minnesota are enrolled in HMOs or some other form of managed care plan. About one third of all seniors in Minnesota have also chosen to enroll in Medicare managed care plans. Minnesota requires that all HMOs be non-profit. We have extensive licensing requirements and consumer protections, and surveys show seniors have a very high degree of satisfaction with HMO management of health care services in Minnesota.

Minnesota has required enrollment of dually eligible seniors in its Prepaid Medical Assistance Program since it began in 1985. PMAP covers Medicare coinsurance and deductibles, prescription drugs and other Medicaid services for dual eligibles, but does not include long term care services which are paid fee for service. However, since 1990 the State has been working on a model to integrate Medicare and Medicaid and acute and long term care financing and services for dual eligibles in order to resolve the administrative conflicts and reduce cost shifting between the two programs. Conflicts between the programs result in poor clinical care incentives and a confusing, fragmented system for seniors. These problems must be resolved because Medicare reforms are certain to result in increased costs for dual eligibles that states will be unable to absorb, especially if proposed caps on Medicaid are enacted.

MINNESOTA SENIOR HEALTH OPTIONS DEMONSTRATION

In 1995 Minnesota was the first state to receive approval from HCFA to demonstrate a new program which integrates Medicare and Medicaid funding and acute and long term care service delivery in order to better serve seniors dually eligible for both Medicare and Medicaid in the seven county metro area in Minnesota. The demonstration operates under a combination of Medicaid 1115 and Medicare 222 waivers and is supported by grants from the Robert Wood Johnson Foundation.

This new Minnesota Senior Health Options (MSHO) demonstration was implemented in March 1997 and is now enrolling and serving a full range of dually eligible seniors including those in

nursing homes. While dually eligible seniors in Minnesota are required to enroll in managed care plans under the PMAP program, enrollment in MSHO is voluntary. MSHO is another product choice given to seniors in the metro area as they enroll in the PMAP program.

The demonstration operates through contracts with HMOs who in turn provide all Medicare and Medicaid services including home and community based services and nursing home care. A unique feature of the demonstration is that all services are covered under one contract with each plan and the contract is managed by the State. Under the demonstration the State is allowed to contract with smaller Medicaid plans who have not been able to participate in Medicare risk because they do not meet the requirement for 50% commercial enrollment. (These plans must meet most other requirements for Medicare risk contractors). However, Medicare risk plans may also participate. Other demonstration features include a single enrollment date and process for both Medicare and Medicaid and combined Medicare and Medicaid rate structures, grievance procedures and quality assurance and oversight processes and a risk adjustment payment from Medicare for frail elderly maintained in the community instead of nursing homes.

We think this program has great potential to:

- rearrange fiscal incentives to support sound clinical care,
- simplify a badly fragmented "non-system" of care for seniors and providers, and to
- increase accountability for costs, quality and outcomes of care.

Interest in this program has been high and we have received hundreds of calls from policy makers, providers, consumer advocates and researchers across the country.

Minnesota spent almost six years trying to develop the Minnesota Senior Health Options program. We faced fundamental obstacles which had to be worked through in extraordinary detail with HCFA's Office of Research and Demonstrations. I have attached a more complete description of Minnesota's MSHO program to this testimony for those who are interested. Rather than taking time today to describe the details of our program I have tried to outline and provide further discussion of the fundamental policy issues many states are facing as they try to develop integrated managed care systems for dual eligibles.

II. STATES LACK CONTROL OVER DUAL ELIGIBLE COSTS AND SERVICE DELIVERY BECAUSE MEDICARE POLICY DRIVES UTILIZATION OF MEDICAID SERVICES FOR DUAL ELIGIBLES

People who are dually eligible for Medicare and Medicaid comprise only about 18% of Minnesota's Medicaid enrollees but they account for as much as 50% of Minnesota's Medicaid costs. 60% of Minnesota's dually eligible seniors reside in nursing homes and Medicaid is the largest payor of their health care costs. States must be able to manage costs for dual eligibles

if they are to control overall growth in the Medicaid budget, especially if per capita caps on Medicaid are enacted by Congress. However, states lack the tools to manage costs for dual eligibles because Medicare policy has such a large effect on Medicaid utilization and spending.

Medicaid usually covers prescription drugs, transportation and long term care services while Medicare covers physician, hospital and related acute care costs for this population. In addition, Medicaid acts as a kind of Medigap policy for dual eligibles, paying for the Part B premium and coinsurance and deductibles not covered by Medicare. Physicians must authorize Medicaid services but they are paid mostly by Medicare and may be operating according to Medicare payment incentives.

Since states have no control over Medicare provider payment policies, states have limited ability to influence medical practice patterns which lead to increased utilization of Medicaid services for dual eligibles. For instance, Medicare pays physicians more to see beneficiaries in clinics and hospitals, less for nursing home visits and nothing for working with families to keep seniors out of nursing homes. This payment structure results in higher medical transportation costs and more permanent nursing home placements paid by Medicaid. Medicare pays hospitals under the DRG system with Medicaid picking up the Part A deductibles for dual eligibles. But hospitals may have incentives to discharge dual eligibles to nursing homes paid largely under Medicaid.

Changes in either program may shift costs to the other since many Medicare and Medicaid benefits overlap and substitute for each other. Millions are spent in administrative procedures designed to fight over which program should pay what under what circumstances. Providers must bill two or three different places for parts of the same service. These conflicts increase costs for both programs and produce fragmentation of care and poor clinical care incentives.

States are reluctant to participate in cost savings strategies for Medicare because they fear that Medicare policy changes will result in higher Medicaid costs. States have no way of accessing any of the Medicare savings to help cover their increased liabilities. Furthermore, if Medicare reforms such as co-payments for home health visits are enacted along with per capita caps on Medicaid, states won't be able to absorb these cost increases for dual eligibles.

III. ENROLLMENT IN MEDICAID MANAGED CARE PLANS FOR DUAL ELIGIBLES CAN START TO ADDRESS A FRAGMENTED SYSTEM BUT HCFA'S MEDICARE POLICY IS A BARRIER

States are increasingly relying on managed care purchasing strategies for all but their most costly populations, seniors and disabled persons. Enrollment of seniors in state Medicaid managed care plans has been minimal because of conflicts with Medicare policy. A few states have introduced voluntary managed care programs which include dual eligibles but enrollment has been relatively small. States fear they will not be able to control costs without broader enrollment. However, there are severe limitations on the ability of states to require enrollment of dual eligibles in managed care programs.

NEW HCFA POLICY SEVERELY LIMITS ENROLLMENT OF DUAL ELIGIBLES IN NEW MEDICAID MANAGED CARE PROGRAMS
HCFA has recently taken the position that enrollment of dual eligibles in mandatory Medicaid managed care programs is allowable only if this enrollment does not restrict Medicare services in any way. This means that the Medicaid plan cannot require the dual eligible enrollee to stay within their network of physicians, skilled nursing facilities, hospitals or home care providers because these services are usually covered by Medicare. Since physicians also control utilization of Medicaid services such as prescription drugs and long term care services for which the Medicaid plan is liable, this policy leaves the managed care plan without its primary means of managing utilization and makes managed care enrollment almost meaningless. It places the plan at financial risk for services over which they have no means of control.

THESE LIMITATIONS INCREASE FRAGMENTATION OF CARE FOR DUAL ELIGIBLES
Worse yet, this arrangement virtually guarantees fragmentation and lack of communication between care providers as the Medicaid health plan has no way of knowing what physician or health provider may be authorizing or providing services. It increases denials and delays in obtaining Medicaid services such as prescription drugs, transportation and medical supplies because physicians ordering them may not be aware of the plan's formularies and other payment and prior authorization policies.

At issue specifically is how payments of the Medicare coinsurance and deductibles for which Medicaid is responsible are handled in these arrangements. Some states, like Tennessee, which mandates enrollment of dual eligibles in Medicaid managed care plans, have been required to pay the Medicare coinsurance and deductibles outside of the Medicaid plan. For instance, dual eligibles may see a physician inside or outside the plan network, but either way the plan does not have the ability to pay the physician for any of their services. The physician bills Medicare directly and the coinsurance is paid directly by the State. In this approach, enrollees do not choose a primary care clinic so there is no primary physician case management and the system remains essentially fee for service except for a few services like prescription drugs. According to both state and health plan officials this arrangement creates huge problems.

Utah, which also requires enrollment of dual eligibles in Medicaid managed care in some parts of the State, has been allowed to include the coinsurances and deductibles in the health plan's capitation rate, making the plan responsible for paying any out of network providers. In this method the plan can educate the enrollee to make a primary care clinic choice, and the plan does pay the physician the coinsurance for their visits, but they also must bear the risk of payment for the coinsurance if the enrollee goes out of network. It is doubtful that this arrangement can be widely used by states. Many health plans say they would not be willing to go at risk for payment of coinsurances and other Medicaid services ordered by out of plan physicians.

ENROLLMENT OF DUAL ELIGIBLES IN STATES WITH EXCEPTIONS TO THE NEW POLICY WORKS WELL

Three states, Minnesota, Arizona and Oregon, have long standing approval from HCFA for mandatory enrollment of dual eligibles where the enrollee is required to stay within the Medicaid plan network in order to have the Medicare coinsurance paid to the provider. All of these states have fairly large networks of providers so there is a wide choice of participating physicians from which to choose. Similar to a Point of Service (POS) plan, dual eligibles can go to providers outside the Medicaid network if they pay some costs out of pocket. Enrollees can still go out of network for Medicare services but they will be billed for the Medicare coinsurance and deductibles. The arrangement has worked well in these states. Minnesota has been operating this way under the PMAP program since 1985 without problems. Arizona is the only state which has also included all long term care costs under these managed care arrangements. The requirement for enrollment and control of coinsurance and deductibles have been key elements of making that program work financially. Many other states are interested in Arizona's success because they see managed care as a tool to assist in managing long term care costs. However, HCFA has said that they will not approve any more of these arrangements because they may infringe on Medicare freedom of choice.

HCFA'S POLICY IGNORES TRADEOFFS MOST MEDICARE BENEFICIARIES MUST MAKE BETWEEN BROADER CHOICES AND LOWER COSTS FOR SUPPLEMENTAL COVERAGE

This new policy interpretation calls into question the very nature of the difference between the Medicare and Medicaid programs. Medicare covers a universal group of seniors without regard to income and assets. Yet, Medicare is not designed to cover all health care needs for seniors and in fact most seniors must purchase some kind of Medigap policy or Medicare plan coverage in order to cover the coinsurance and deductibles and other costs not covered through Medicare. While there are basic national standards for those Medigap and Medicare plan policies, they include certain rules and parameters for the extent of coverage and the beneficiary and providers must follow them in order to receive payment. Often this involves smaller network choices in return for lower out of pocket or premium payments.

Medicaid covers only those who do not have enough income or resources to cover their health care needs. For dual eligibles, Medicaid acts as their Medigap or Medicare plan policy, covering the coinsurances and deductibles and providing extended coverage when Medicare coverage runs out. The State as insurer and administrator of this coverage sets certain rules for coverage just as the Medigap or Medicare plans do. Low income seniors elect to enroll in Medicaid to receive this coverage. In return for complying with Medicaid's rules, the dual eligible receives complete coverage for a broad set of benefits and costs they cannot afford on their own. Because the coverage they receive includes long term care benefits, dual eligibles have even more comprehensive coverage than most seniors who pay for private insurance coverage. HCFA's new policy ignores the fact that most Medicare beneficiaries make certain trade offs between freedom of choice and costs of health care when they obtain Medigap type coverage and that by enrolling in Medicaid the dual eligible is making a similar trade off.

HCFA'S POLICY LIMITS STATE'S ABILITY TO MANAGE THEIR LONG TERM CARE RISK

As mentioned above, Medicaid covers services far beyond those covered in most Medigap policies or Medicare plans, such as long term care. The problem with HCFA's policy is keenly illustrated in the example of skilled nursing facility (SNF) coverage. Medicare beneficiaries may receive up to 100 days of SNF care if certain criteria are met. When stays for dual eligibles do not meet those criteria, Medicaid covers the costs as NF (Nursing Facility) custodial stay. Medicare pays the first 20 SNF days without a coinsurance, but days 21-100 require a coinsurance of $95 per day. For dual eligibles, Medicaid picks up this cost. In Minnesota, the Medicare coinsurance amount is about the same as the average Medicaid NF rate. Therefore after the first 20 SNF days the distinction between what day is a Medicare SNF day and what day is a Medicaid NF day is quite meaningless as the State is paying almost half of this cost out of state tax dollars either way. Minnesota's costs for this Medicare SNF coinsurance runs about $1,000,000 a month and we are a state that tends to have a low SNF utilization rate. This is a significant Medicaid expense. Yet, HCFA's policy would greatly restrict the State's ability to manage these costs because days 21-100 are considered Medicare coinsurance days.

Because of the overlap and substitution between Medicare and Medicaid benefits and the lack of distinctions between acute and long term care services, Medicaid is at great risk of cost shifting from Medicare providers. HCFA's policy essentially forces the State to take all the risk for long term care without means of protection. This policy must be revised to allow states to manage all of their costs including coinsurances and deductibles through enrollment in managed care plans.

IV. POOLING MEDICARE AND MEDICAID FINANCING CAN ADDRESS MANY PROBLEMS FOR DUAL ELIGIBLES

While current HCFA policy appears to preclude additional effective mandatory managed care models for dual eligibles, many states continue to explore voluntary managed care demonstrations which have the potential of integrating Medicaid and Medicare and acute and long term care services for dual eligibles.

Pooling Medicare and Medicaid funding through integrated managed care delivery systems can provide the flexibility needed to reduce conflicts between the two programs. Pooled financing allows managed care entities and long term care providers to develop collaborative clinical delivery structures and re-arrange payment strategies to improve quality and accountability for services to dual eligibles. Once these financing barriers are eliminated, managed care organizations have the opportunity to coordinate care management across the full range of acute and long term care services and address the clinical conflicts described above. Medicaid and Medicare are both protected from cost shifting since one entity is responsible for the full range of services.

These strategies are essential to successful operation under any future Medicaid spending caps. Even if Medicaid caps are not enacted, states must develop more effective systems for managing costs and services for dual eligibles as the population ages and the baby boomers near retirement. Demographic trends will place immense pressures on already strapped state resources and states cannot afford to wait to begin development of more efficient care delivery systems to meet the projected increases in need. States must be given the authority to pursue these strategies before it is too late to gain experience with models that are effective.

V. STATES FACE MAJOR POLICY ISSUES IN INTEGRATING MEDICARE AND MEDICAID SERVICE DELIVERY AND FINANCING FOR DUAL ELIGIBLES

MOST CURRENT DEMONSTRATIONS ARE TOO LIMITED TO MEET STATE NEEDS
Demonstrations like PACE and SHMO and those advocated by the National Chronic Care Consortium (NCCC) provide successful clinical models from which to build. However, current PACE and SHMO demonstrations are of limited assistance to states because sites are limited and enrollment capacity is small and may be targeted only to a subset of the dual eligible population. The role of states in design and management of these demonstrations has been quite minimal even though states remain a primary payor of services. Therefore many states are seeking broader statewide purchasing strategies which build on the NCCC principles and the experience in PACE and SHMO demonstrations but have the capacity to serve larger numbers of dual eligibles with varied needs.

BROADER OPTIONS FOR MERGING MEDICARE AND MEDICAID FINANCING INVOLVE COMPLEX ADMINISTRATIVE AND POLICY ISSUES
In addition to the PACE and SHMO models there appear to be two other approaches under current HCFA authority through which states can pursue these demonstrations. One is to "piggy back" Medicaid managed care contracts operated under Medicaid 1115 or 1915(b) waivers onto Medicare managed care plans and to encourage separate enrollment in both products under one plan. A newer approach is to couple Medicaid 1115 with Medicare 222 waivers to merge Medicare and Medicaid contracting and payment requirements. This is the approach taken by Minnesota, however, HCFA has expressed reluctance to approve more of these arrangements. Some of the complex policy and administrative issues involved in each of these approaches are described below.

OPTION ONE: ENROLLMENT OF DUAL ELIGIBLES IN MEDICARE MANAGED CARE PLANS
Like other Medicare beneficiaries, dual eligibles may choose to enroll in Medicare managed care plans. This enrollment poses both opportunities and great problems for states in trying to coordinate benefits for this population as discussed below.

Opportunities In Enrollment of Dual Eligibles in Medicare Managed Care Plans

1. Cost Savings and Clarification of Freedom of Choice
Where Medicare risk payments (AAPCCs or Average Adjusted Per Capita Costs) are high and therefore monthly premiums are low or have been reduced to 0, low income seniors, including dual eligibles may be enrolling in Medicare risk plans in larger numbers. Often these plans provide extra benefits such as prescription drugs which then overlap Medicaid benefits. State Medicaid agencies may benefit from cost savings created by these extra benefits if they can figure out how to avoid duplicative payments for these overlapping benefits.

Some states are "piggy backing" Medicaid managed care contracts onto Medicare risk plans so that enrollees can receive both Medicare and Medicaid services through a more coordinated system. These arrangements can solve many of the freedom of choice and network problems discussed above. However, there are also many problems with increased enrollment of dual eligibles in Medicare managed care plans as discussed below.

Problems With Enrollment of Dual Eligibles in Medicare Managed Care Plans

1. Lack of Data Sharing About Enrollment
There is no automatic system of communication between the plans and the States or HCFA and the states to identify dual eligibles who are enrolled in these plans. A few states have obtained permission to process data from HCFA to obtain this information but the approval for getting the data and the subsequent process of matching the data are extremely cumbersome.

2. Difficulties in Avoiding Duplicate Payment for Overlapping Benefits
Where there are many Medicare risk plans, they may all have sightly different benefit sets, and plans may be constantly changing their benefit sets in response to a competitive market. This makes it very difficult to track and avoid duplicate Medicaid payments for overlapping benefits. In addition, financial documents submitted to HCFA (Adjusted Community Ratings) which outline details of how costs and benefits were calculated are private and states may not have access to them.

3. Unstable Markets and Medicare Managed Care Plans May Not Want to Contract with Medicaid
Medicare managed care plans may not want to contract with Medicaid and there is nothing requiring them to do so. So it is up to the State to attempt to negotiate with each separate plan. In some areas, the Medicare plan market is highly volatile and plans go in and out of the market leaving Medicaid trying to piggy back its Medicaid contracts on a very unstable base.

4. Enrollment in Two Different Plans
Medicare and Medicaid may not contract with the same plans since Medicare and Medicaid plan requirements are different. Many Medicare managed care plans do not

have contracts with Medicaid and Medicaid managed care plans may not meet requirements for Medicare risk contracts with HCFA (eg. the requirement for 50% commercial enrollment). In areas where dual eligibles may also be enrolled in Medicaid managed care, they may end up in two different plans which causes huge difficulties in coordination of benefits. Because of the lack of systematic information, states and plans may not even know of this conflicting enrollment until providers try to bill and services or payments are denied.

5. Conflicting and Duplicative Administrative Requirements
States who try to piggy back Medicaid contracts on Medicare managed care contracts also face problems with conflicting and duplicative administrative requirements. HCFA contracts directly with Medicare HMOs while the States choose and manage Medicaid managed care plan contracts. Federal regulations and administrative requirements for enrollment and dis-enrollment, marketing, grievance procedures, payment schedules, oversight, data collection and virtually everything else involved in administration differs between Medicare and Medicaid. This makes it terribly difficult for the plan to operate in an efficient manner. It is subject to two different contracts with two different managing entities and two different sets of requirements for the same dually eligible enrollees.

6. Confusing Marketing Materials and Consumer Information
Furthermore, information approved under Medicare for distribution to enrollees may be misleading when applied to dual eligibles. Since HCFA reviews Medicare materials and the State reviews Medicaid materials under very different sets of rules, there is no easy way to coordinate this information to assure that it makes sense to the dually eligible beneficiary. A few states have worked out intricate arrangements with HCFA Regional Offices to try to coordinate but there remain many problems with those arrangements.

7. Medicare Managed Care Payments May Encourage Institutionalization
In addition, Medicare managed care payment policies may encourage cost shifting to Medicaid nursing home care for dual eligibles. Medicare payments are highest for persons in nursing homes. Since the Medicare risk plans are not liable for Medicaid long term care costs they have little incentive to avoid nursing home placements. Once persons are discharged to the community the AAPCC payment is considerably reduced and there are no risk adjustors targeted to the frail elderly to keep them out of nursing homes outside of special demonstrations. This is an example of where the acute care incentives work directly against Medicaid's desire to avoid premature institutional placement.

Some innovative Medicare managed care plans are interested enrolling stable chronically ill nursing home residents many of whom are dually eligible, because Medicare payments for them are high and they feel they can manage their acute care costs and avoid hospital stays more easily because they reside in a setting with 24 hour nursing coverage. Despite their many benefits, these plans also have the potential to shift costs to Medicaid

in the form of higher nursing home per diems and higher nursing home utilization. This arrangement falls short of an integrated acute and long term care delivery system because plans are not liable for long term care costs.

8. Lack of Medicare Managed Care Plan Coverage Due to AAPCC Variations
Even if states are able to contract with Medicare risk plans many of those plans operate only in certain regions of the State due to county by county variations in the AAPCC. For instance in Minnesota, where most counties are far below the national average AAPCC payments, Medicare risk contractors operate only in the seven county metro area. The other 80 counties including all of our rural areas are denied the choice of a Medicare managed care plan. In some states, because of the AAPCC disparities, there are no Medicare managed care plans in operation at all.

9. Medicare Plans May Not Want to Take Risk for Medicaid LTC Costs
States who want to move to integrated models such as those illustrated by PACE, would want to include costs for Medicaid nursing home per diems and home and community based services in Medicaid managed care contracts with Medicare managed care plans. Including these costs in the plan's responsibility can be helpful in avoiding premature nursing home placements and encouraging the use of home and community based services. However, there are only a few isolated cases outside of the PACE and SHMO demonstrations where states have been successful in including nursing home per diem and home and community based services in managed care capitations. Only Arizona has been successful in implementing this as a state wide strategy. One reason they have been able to do this is that they are the only state which has approval to require enrollment in plans which include all long term care costs. In Minnesota's MSHO demonstration, it has been difficult to get providers to accept risk for nursing home costs and for home and community services for frail seniors residing in the community, despite Medicare risk adjustors from HCFA to alleviate this problem.

10. Many Medicare Plans Lack Experience With Long Term Care Services
Traditional Medicare plans may lack the special expertise needed to deal appropriately and successfully with special needs of dual eligibles. In most markets Medicare plans have not had reason to develop relationships with long term care providers, particularly those offering home and community based services. While some care management models now exist for long term nursing home residents as described above, there are few models for the frail elderly in the community outside of those developed in PACE and SHMO.

OPTION TWO: STATE DUAL ELIGIBLE DEMONSTRATIONS UNDER MEDICAID 1115 AND MEDICARE 222 WAIVERS
Despite the great potential for piggy backing Medicaid contracts on Medicare risk plans there are still states where no such plans exist. Even where there is a Medicare risk market, those plans may not want to contract with the State for services to dual eligibles or the State may not want to contract with them for various reasons. The State may have

Medicaid plans that are far more experienced with dual eligibles or provider networks more capable of becoming geriatric care networks who cannot meet the 50/50 requirement but are able to operate similar to PSOs. States in these circumstances that want to develop of integrated managed care systems for dual eligibles must look for other approaches. Combining Medicaid 1115 managed care and Medicare 222 payment demonstration waivers may be an option for some of these states.

So far Minnesota appears to be the only state granted the combination of Medicaid 1115 waivers and Medicare 222 waivers. While HCFA has expressed reluctance to consider more "Minnesota Style" waiver requests it is unclear whether this is because of some specific features of Minnesota's design or whether this applies to the 1115/222 combination in general. Regardless, a number of other states are pursuing similar waiver requests with HCFA and the Robert Wood Johnson Foundation has announced a new funding initiative to encourage more states to seek integrated models.

Advantages to Demonstrations Combining Medicaid 1115 and Medicare 222 Waivers
This combination of waivers was important to Minnesota because it allowed us to consolidate all the Medicare and Medicaid managed care requirements into one contract managed by one entity at the state level, alleviating many of the duplications and conflicts listed above in the "piggy backing" approach. Enrollment and enrollee education materials are written specifically for dual eligibles and are much clearer than two separate packages of conflicting materials. Enrollment for Medicare and Medicaid is simultaneous, leaving no questions about who is to cover what when. It also allowed the State to contract with Medicaid only plans which was important given the lack of Medicare plans in Minnesota. And there is one coordinated rate scheme which attempts to encourage home and community based services and align acute and long term care clinical incentives.

Disadvantages: Budget Neutrality Cap Methodology is Inappropriate for Voluntary Enrollment Model
A major drawback to these demonstrations is OMB's particular application of budget neutrality caps on the covered population. OMB has required that a per capita spending cap be set on the demonstration enrollees. OMB's method for developing such caps is based on experience with state wide 1115 waivers which are expanding eligibility for Medicaid. In Minnesota, the new MSHO demonstration did not attempt to increase eligibility. Costs cannot exceed pre-set HCFA approved rates times the number of people enrolled. The only costs that can vary is related to the "mix" of needs of individuals who enroll. However, since HCFA requires that enrollment in the demonstration be voluntary, it was impossible to predict what mix of dual eligibles would choose to enroll. If such a cap is set on the average dual eligible costs and the demonstration attracts a disproportionate share of high cost enrollees (for instance nursing home residents), the budget cap may be exceeded. The problem then becomes how to agree to an appropriate mix of enrollees on which to establish the cap.

Because of this problem Minnesota was forced to accept a cap on the entire potential population of enrollees, putting the State at risk for expenditures into the future even for those not enrolled in the demonstration. If many of these dual eligibles enrolled in Medicare managed care plans where there may be incentives to shift costs to Medicaid, the State has no control over this choice and could be at risk for expenditures over the cap even though there is nothing they could have done about controlling those costs. This places any state who wants to proceed with such demonstrations in a "catch 22" position. A more reasonable budget neutrality method must be developed before states can move forward with dual eligible demonstrations under combined 1115/222 waivers.

VI. ADDITIONAL POLICY RECOMMENDATIONS

CONGRESS SHOULD ENCOURAGE HCFA TO REDUCE BARRIERS TO ENROLLMENT OF DUAL ELIGIBLES IN MEDICAID MANAGED CARE

Current HCFA policy should be changed to allow states to restrict payment of the Medicare coinsurance to Medicaid plan networks as long as those networks have adequate choices of physicians and other providers, similar to the arrangements in Minnesota's PMAP program, Arizona and Oregon. Without this change states cannot manage costs including those for long term care for dual eligibles and consumers will face an even more fragmented and uncoordinated system of care.

CONGRESS SHOULD ENCOURAGE HCFA TO ALLOW MORE 1115/222 DEMONSTRATIONS

While there may be some circumstances unique to Minnesota that led to certain waiver provisions that HCFA does not want to replicate, it is important that other states have the opportunity to pursue similar approaches. Congress should encourage HCFA to work with states who demonstrate the capacity to manage such coordinated programs for dual eligibles. In fact, very soon these approaches must move away from research and demonstration project status and become permanent features of the Medicaid and Medicare programs. States like Arizona prove that long term care can be effectively administered under a managed care system and models like PACE and SHMO and Minnesota's MSHO demonstration show that it is possible to merge Medicare and Medicaid financing. However, as discussed above, a fairer budget neutrality formula must be addressed before states can move forward.

Though it may seem premature to incorporate integrated financing models for dual eligibles into Medicare and Medicaid now, in a few years demographics are going to force this issue for us. We already know that the current fee for service system is fraught with problems. Use of managed care techniques can actually increase accountability in a system where accountability is fragmented and difficult to pinpoint. We should begin now to incorporate the tools we know will be needed for the future into the Medicare and Medicaid programs so that these approaches mature before the demographic crisis overwhelms our resources.

MORE ATTENTION MUST BE PAID TO QUALITY ASSURANCE (QA) MEASURES FOR CHRONIC CARE POPULATIONS

Minnesota's managed care licensing and consumer protection standards match or exceed all federal standards for Medicare risk contractors. However, many states lack strong oversight mechanisms. In general, current QA requirements and oversight procedures for both Medicare and Medicaid may be inadequate to protect dual eligibles when profit incentives have the potential to overshadow the benefits managed care can bring to this population. As states step up efforts to enroll dual eligibles in various managed care arrangements, far more resources must be invested in adapting oversight and monitoring systems for Medicare and Medicaid managed care to address the needs of a more vulnerable population.

While the application of HEDIS measures to Medicare and Medicaid plans and requirements for Medicaid encounter data are steps forward, they barely begin to address the complex issues in outcome measurement for frail elderly and disabled. HEDIS measures do not really address a population which largely resides in a nursing home. For example the Health of Seniors measure uses the SF 36 assessment instrument to assess changes in function over time but it is not relevant to nursing home residents. The planned methodology for administration of the CAHPS satisfaction survey (telephone interviews) is not appropriate for obtaining accurate information from nursing home residents either though we understand that HCFA may be working to resolve this issue.

HCFA is placing much effort on methods of assuring provider quality in specific settings (e.g. the OASIS assessment instrument for persons served by certified home care agencies and the MDS assessment in nursing homes) but these approaches may perpetuate fragmented "silo-based" care where each provider is regulated as if they were operating individually rather than as one of many who may be involved in the care of a frail individual throughout that individual's course of care or treatment. These site based approaches give us only snapshots of an individual's care in a given setting rather than an understanding of how care has been provided and managed overall. Providers will continue to operate in a fragmented system where no locus of accountability for integrated care can be identified unless more emphasis in placed on the links between providers. It is not clear how these efforts will relate to new measurement approaches for managed care such as HEDIS but this is an area that should be explored.

If we are truly concerned about fragmentation of care and duplicative or uncoordinated provider efforts, it may be more important to begin to assess how care for dual eligibles is coordinated between settings of care, and to develop instruments to monitor what happens to care outcomes and patient satisfaction over time as they are served by different parts of the system. The National Chronic Care Consortium (with which the State of Minnesota has a contract to assist with integration of clinical care for MSHO plans), has developed a tool for assessing how well different parts of the system are working together. This kind of tool can be the basis for development of new methods to monitor care outcomes of individuals over time and across settings.

INCREASED RESOURCES FOR OMBUDSMAN AND CONSUMER EDUCATION ARE NEEDED

Even if states are not allowed to step up efforts to enroll dual eligibles in Medicaid managed care plans, enrollment of dual eligibles is likely to increase rapidly in Medicare managed care plans. Many traditional consumer advocate groups such as those working with nursing home residents are unprepared to deal effectively with managed care plans and lack the resources to cope with the new rules of the game they are encountering. Many more resources need to be invested in strong consumer advocacy and consumer education programs targeted directly to the most frail dual eligible groups such as nursing home residents.

It appears inevitable that capitated payment approaches are to be important tools for managing care and services for dual eligibles in the future just as they are for other parts of the Medicare population. While I believe strongly that it is possible to maintain and even improve quality and accountability of care and services in capitated financing arrangements, responsible policy makers and state Medicaid managers never ignore the down side of capitation. Lack of strong consumer protections, poorly informed advocates and enrollees and inattentive oversight can doom state managed care programs for dual eligibles to failure. Funding to strengthen these functions is necessary to assure the credibility of the system in the long run.

HCFA SHOULD PURSUE SYSTEM WIDE SOLUTIONS TO CONFLICTS BETWEEN MEDICARE AND MEDICAID MANAGED CARE

Despite the problems outlined above, many states really have no choice but to seek better ways to coordinate Medicaid services with Medicare plans because this enrollment is growing and the problems with coordinating benefits for dual eligibles are immediate. HCFA too appears more open to creative solutions to the administrative and enrollment conflicts for dual eligibles and has even created new initiatives around dual eligible issues, but much more needs to be done and HCFA's resources in this area seem to be minimal. HCFA's Medicare policies for administration of Medicare risk plans still do not take into account the special issues around dual eligibles. Many of these problems could be solved by systematic solutions involving coordination of Medicare and Medicaid policy at the HCFA level and by building some policies to address issues for dual eligibles into Medicare's administration of managed care plans. This would be far more efficient than the plan by plan, state by state, region by region solutions being pursued now.

AAPCC REFORM IS NEEDED TO EXPAND CHOICES IN RURAL AREAS AND BRING MORE EQUITY TO BENEFIT PACKAGES AMONG STATES

AAPCC reforms such as those proposed by Senator Grassley and Representative Ramstad are essential to state efforts to increase coverage options for all seniors and are especially needed to increase the potential for integrated acute and long term care delivery systems for dual eligibles in rural areas. In Minnesota, Medicare plans are reluctant to operate outside of Minneapolis/St.Paul metropolitan area due to extremely low Medicare payments. This means the State is unable to expand its MHSO program beyond the metro area and dual eligibles in the rural areas are denied this option. AAPCC changes are needed before we can attract sufficient provider networks to maintain access in those areas.

Medicare plans in Minnesota offer few extra benefits and premiums are relatively high. Yet, in other states where AAPCCS are high plans are able to offer O premiums and many extra benefits. Many of these extra benefits (e.g.prescription drugs) are also part of the Medicaid benefit package. Some states may be able to realize considerable cost savings for the Medicaid budget by encouraging enrollment of dual eligibles in these plans. However, because of the disparities in the AAPCC formula, other states, like Minnesota, do not have the same advantages. This issue needs to be considered as part of any discussion of per capita caps on Medicaid and Medicare reform efforts must account for any disparate effects on state Medicaid budgets.

VII. CONCLUSION AND SUMMARY: CONGRESS SHOULD ASSURE STATES THAT THEY WILL HAVE THE TOOLS TO MANAGE THE CARE AND SERVICES FOR THE DUALLY ELIGIBLE POPULATION

States and HCFA can and must do a better job of managing care and services for the dually eligible than the current fragmented system which encourages cost shifting between providers and lacks accountability for care outcomes.

1. Current HCFA policy must be changed to allow states the ability to manage all of their costs including Medicare coinsurance and deductibles for dual eligibles through required enrollment in Medicaid managed care plans. Under current HCFA policy, care and services for dual eligibles will become even more fragmented and uncoordinated and states will be unable to function under proposed Medicaid funding caps because they lack the ability to control costs for the largest portion of their budgets.

2. Pooled Medicare and Medicaid financing, managed care and capitated payment arrangements are essential tools, and with the appropriate protections and incentives, they can be harnessed to address many of the problems in the current system while preserving the basic rights and benefits to seniors.

3. States must be supported in their efforts to seek creative ways to pool Medicare and Medicaid financing and work with providers to develop delivery systems to integrate acute and long term care. Congress should encourage HCFA to allow more 1115/222 waiver demonstrations. Such programs allow rearrangement of fiscal and utilization incentives to provide for more cost effective services, administrative efficiency and to increase accountability for care outcomes.

4. "Catch 22" budget neutrality methodologies for these programs must be adjusted.

5. Far more investment must be made in measurement of outcomes for frail dual eligibles and for expansion of ombudsman and client education programs to assure credibility of managed care programs for dual eligibles.

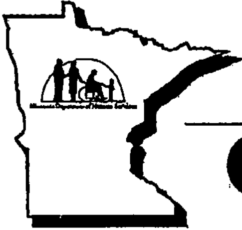
6. Medicare and Medicaid policy makers within HCFA should implement a system wide approach to mitigating conflicts caused by enrollment of dual eligibles in Medicare managed care plans.

7. Policies under both Medicare and Medicaid should encourage new partnerships and new organizational structures capable of taking risk for an integrated package of acute and long term care services. Elimination of the 50/50 rule is one policy change that could encourage integrated delivery systems.

8. Reform of the AAPCC is essential to expanding and bringing more equity to health care coverage choices for seniors in rural areas. Many states will be unable to move forward with integrated models without these changes. In Minnesota changes in the formula are critical to bringing equity to our rural areas and expanding our integrated model.

A PERSONAL NOTE

I have worked with Medicare and Medicaid for the past 25 years as a county case worker, consumer advocate, state long term care ombudsman, rate setter, regulator and program developer. I have also helped guide a father with Alzheimers and various other relatives through a confusing array of services, paper work and payment arrangements. I no longer have much patience for the current system. When I look toward my own retirement I fear that time is growing too short to assure that the kind of integrated delivery systems that could be possible will be there. I hope we are not forced to wait until the demographic crisis eclipses us to develop the programs that could be more effective in addressing our problems. Thank you for this opportunity to bring these concerns to your attention.



Minnesota

Senior Health *options*[SM]

complete care designed for seniors

Minnesota Senior Health Options
Program Summary

Minnesota Senior Health Options
Minnesota Department of Human Services
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MINNESOTA SENIOR HEALTH OPTIONS

INTRODUCTION **January 10, 1997**

The Minnesota Department of Human Services (DHS) has developed a new program called Minnesota Senior Health Options which combines Medicare and Medicaid financing and acute and long term care service delivery systems. This program was formerly known as the Long Term Care Options Project. (The name was changed after focus group research recommended a name which more accurately reflected the true nature of the program.) The program is authorized under Minnesota Statutes 256B.69 subd.23.

The demonstration facilitates the integration of primary, acute and long term care services for persons over age 65 who are dually eligible for both Medicare and Medicaid. Out of about 550,000 persons over age 65 in Minnesota, about 51,000 receive Medicaid. Minnesota's Medicaid program is called Medical Assistance (MA). About 49,000 seniors are dually eligible for both Medicaid and Medicare. About 18,000 of these dually eligible seniors reside in the seven county metro area. Minnesota has received federal Medicare 222 and Medicaid 1115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The waivers allow the State to combine the purchase of both Medicare and Medicaid services into one contract managed by the state. Minnesota is the first state ever to be granted such a combination of waivers. The waivers also allow contracting with smaller HMOs and CISNs which are currently not eligible to be Medicare risk contractors. In addition, the federal waivers granted Minnesota a Medicare risk adjustment payment for frail elderly dual eligibles in the community as an incentive to prevent unnecessary institutionalization. The demonstration is being implemented in the seven county metro area and will cover a five year period.

The Robert Wood Johnson Foundation (RWJF), which supported the planning stages for the demonstration, has provided a grant to cover the initial administration and implementation of the demonstration and this grant has been matched by Medicaid administrative funds from HCFA.

The MSHO demonstration has generated much national attention from health care publishers and educators, providers, health plans, policy makers, and other state officials due to its unique nature and precedents set in its development. Minnesota's progress in implementing MSHO is being carefully watched by a large number of organizations and individuals across the country. The Robert Wood Johnson Foundation has just announced a new initiative to provide $8,000,000 in grants to up to 10 states to build on Minnesota's MSHO model.

Problems with the Current System

County and state health workers, providers who work with the elderly, and consumers have long identified conflicts between Medicare and Medicaid policy and financing. There are many stories from frustrated physicians, health plans and patients about the fragmented health care system seniors experience today. It can be very difficult for seniors to access services from two or three different systems with different rules, case managers, telephone numbers, identification cards, etc. Seniors with chronic care needs may need a variety of services all at the same time. In reality, older persons' needs do not fit neatly into the separate acute and long term care financing and delivery boxes we have created. Specific problems with the current system include the following:

Fragmented clinical system - Each nursing home, hospital and home care agency conducts its own independent case management. Communication links between long term care providers and hospitals, clinics and physicians responsible for management of acute care services, are often lacking. There is often little coordination between the acute care and long term care systems and seniors' real needs may fall through the cracks.

Poor clinical incentives - Under its fee for service payment schedule, Medicare pays physicians more if they treat seniors in the hospital or clinic instead of the nursing home. Medicare pays physicians and other health care professionals nothing for working with families and community services to keep seniors in their own homes and out of institutions. In addition, Medicare risk plans are paid more for seniors in nursing homes and those payments are reduced substantially when the individual is discharged to the community. Since those who manage acute care services are not at risk for long term care costs, this payment arrangement sets up an incentive to institutionalize rather than work to prevent unnecessary nursing home placements.

Duplicative administration - Providers are required to duplicate paperwork and send one bill to Medicare and another bill to Medicaid for the same service. Dually eligible seniors receive a flurry of confusing paperwork from Medicare, even though Medicaid is paying for their Medicare coinsurance and deductibles.

Cost shifting between providers and programs - Hospitals have incentives to admit seniors frequently to obtain the Medicare payment, but not keep them very long. Nursing homes have incentives to send people to the hospital for short stays rather than treating the person when acute episodes occur because Medicaid does not directly reimburse for the extra care required. Health plans have no incentive to keep seniors in their own home rather than a nursing home.

Lack of accountability - Responsibility for care outcomes is passed from one provider to another which leads to further confusion among both providers and consumers. No one can track how much the services really cost because payments are fragmented between programs and payers.

What an Integrated System Accomplishes

Medicare policy and reimbursement drive clinical decisions that in turn affect Medicaid utilization and expenditures. For example, Medicare pays for hospital and physician care but decisions made by hospitals and physicians in response to Medicare payment incentives can affect Medicaid costs. Enrollment of dually eligible PMAP seniors in Medicare risk plans has recently become popular. However, this may provide incentives to institutionalize because these plans are paid higher payments from Medicare for persons in nursing homes and Medicare lacks payment adjustments for frail elders in the community. Yet, changes in either program may shift costs to the other, since many Medicare and Medicaid services substitute for each other. Cheaper services, primarily paid for by Medicaid such as nursing homes and home care, often substitute for more expensive Medicare services like hospitalization, shifting costs to the state. States have little incentive to help save Medicare dollars since they cannot share in any Medicare savings and because they fear this type of cost shifting.

Integrated Medicare and Medicaid funding can provide better clinical and cost incentives for services to elderly dual eligibles. Integrated Medicare and Medicaid capitations provide the flexibility needed to reduce conflicts between Medicare and Medicaid policy. Integrated financing allows health plans and long term care providers to develop collaborative clinical delivery structures and strategies to improve quality and accountability for services to seniors. Once these financing barriers are eliminated, health plans and providers are free to coordinate their care management across the full range of acute and

long term care services to seniors and address the clinical conflicts and problems outlined above. States are protected from cost shifting since one entity is responsible for the full range of services.

MSHO FEATURES
DHS has obtained federal waivers that allow the state to purchase both Medicare and Medicaid services in a combined package. Waivers include a combination of Medicare waivers under Section 222 of the Social Security Act and Medicaid waivers under Section 1115. Under the terms and conditions of the waivers granted by HCFA, the state is responsible for choosing contractors capable of providing a full range of integrated primary, acute and long term care services on a capitated risk basis. Administration of the Minnesota Senior Health Options builds on the current administration, rules and statutes of the Prepaid Medical Assistance Program (PMAP). However, most requirements applied to Medicare risk plans also apply.

Goals of the Demonstration
The success of Minnesota Senior Health Options will be based on meeting the following goals:
1. **Reorganizing service delivery systems** to support sound clinical incentives, reduce administrative complexity and create a seamless point of access for all services for clients and providers.
2. **Control overall cost growth** by providing incentives for lowest cost and most appropriate care, changing utilization patterns, and reduce cost shifting between Medicare and Medicaid.
3. **Create a single point of accountability** for tracking total costs and outcomes of care.

Current PMAP Program
Since 1985, Minnesota has been enrolling recipients of public medical assistance programs, including seniors in managed care health plans. Under PMAP, persons eligible for Medicaid (MA) in the seven county Metro area and nine other counties in Greater Minnesota are given a choice among several major health plans and/or a wide assortment of clinics and physicians with whom to enroll. Currently about 14,600 of Minnesota's 51,000 seniors who receive MA are enrolled in managed care plans through PMAP. About 7,500 of these PMAP enrollees live in nursing homes, and about 7,100 reside in the community. Most of them reside in the seven county metro area. Some of these seniors are also voluntarily enrolled in a Medicare risk plan operated by their PMAP plan.

Services provided through PMAP include: Medicare deductibles and co-insurance, physician visits, medical supplies and equipment, dental, hospitalization, therapies (PT, OT, ST, Psych), prescription drugs, medical transportation and some home care services. Although Medicare co-insurance and deductibles are paid through the health plans, Medicare pays providers directly for the remainder of the services.

The nursing home per diem and home and community based waivered services are not the responsibility of the managed care plans under PMAP. For seniors enrolled in PMAP, these services are paid directly by the department on a fee for service basis.

MSHO Services
Under Minnesota Senior Health Options, enrollees are entitled to receive all Medicaid services provided under PMAP as described above, plus all Medicare services under Parts A and B. In addition, health plans will provide services available under the current home and community based waiver (Elderly Waiver), which consists mainly of extended home care benefits to frail elderly eligible for nursing home care. A unique feature of Minnesota Senior Health Options also requires health plans

to be responsible for the first 180 days of care in a nursing facility for those who enroll in Minnesota Senior Health Options while living in the community. This feature maximizes the opportunity for innovation in non-institutional care and prevention of early institutional placement, especially for those who have chronic care needs.

MSHO Administration
The state negotiates contracts with Health Maintenance Organizations (HMOs) and/or Community Integrated Service Networks (CISNs) for capitated risk-based Medicare and Medicaid services. The state will manage these contracts for both Medicare and Medicaid services under an agreement with the Health Care Financing Administration (HCFA). Minnesota Senior Health Options allows Medicare risk contracting with smaller HMOs and CISNs who previously could not contract with Medicare on a risk basis. All MSHO plans must also have a PMAP contract in each county in which they offer MSHO. Contractors must meet most of the federal regulatory requirements of Medicare risk plans as well as most PMAP requirements.

Operational requirements for MSHO are contained in an Operational Protocol, developed by DHS and approved by HCFA. MSHO staff did extensive analysis of Medicare Risk Contract requirements, Medicaid managed care requirements, and Minnesota HMO and CISN licensing statutes and rules in order to develop one standard set of MSHO requirements which reduced conflicts and duplications between Medicare and Medicaid policies and state and federal oversight requirements. In addition, DHS and HCFA have entered into an agreement modeled after Medicare Risk plan contracts, which outlines the state's responsibilities for oversight for the MSHO demonstration. A model MSHO contract between the state and the MSHO contractors also was developed and approved by HCFA prior to the negotiation process.

RFP and Contract Negotiation Process
DHS issued an RFP outlining all Medicaid and Medicare requirements for MSHO in February of 1996. All 5 PMAP plans serving seniors in the seven county metro area did respond. Proposals were given an extensive review process including county staff and county board review and comment. In addition, MSHO staff met with managed care, public health and social services staff in each of the seven Metro counties. Based on the review process, invitations for contract negotiations were extended to three PMAP plans: Medica, MHP and UCare Minnesota. After additional information was submitted, invitations for contract negotiations were also extended to Health Partners and Blue Plus. Contract negotiations with UCare Minnesota for Ramsey County and for MHP for Hennepin County were finalized in December. Contracts were effective January 1, 1997. MHP began enrollment began in Hennepin county and UCare began in Ramsey county in February. UCare will be expanding its network to Hennepin County effective June 1, 1997. Contract negotiations with Medica are nearly complete with a scheduled start date of September 1997. Discussions continue with Health Partners and Blue Plus.

Health Plan Provider Networks
Health plans participating in MSHO have been encouraged to develop new partnerships with long term care providers and counties in order to better serve seniors. Allina, the health system affiliated with Medica, was the first to issue RFPs in 1995 requesting subcontractors to form integrated care systems of long term care providers and clinics in order to serve PMAP seniors who have also elected to enroll in its Medicare risk plan. Medica has proposed to subcontract with these same care systems to serve MSHO enrollees. In addition, UCare Minnesota, Wilder Senior Services and Health East have worked

together for several years to form a Geriatric Care Network in the east Metro area in preparation for MSHO and other future Medicare risk plan business.

As a result of a new awareness of the need for better coordination between acute and long term care and new methods of combining Medicare and Medicaid funding through MSHO and through enrollment of PMAP seniors in Medicare risk plans, several newly developed geriatric care networks or care systems have been formed. These new business ventures vary in structure and risk sharing arrangements. The new entities include a partnership between an HMO, hospitals, clinics and long term care facilities, a hospital entity partnered with a broad based long term care provider, a group of long term care providers who have created a joint venture for business arrangements with clinics and hospitals to manage a full spectrum of services on a subcapitated basis and a group of nursing homes which have formed a cooperative for more efficient contracting and purchasing arrangements. Entities include the UCare Minnesota/Wilder/Health East Geriatric Care Network, Fairview Partners, Care Partners and Care Choice.

In addition, Metropolitan Health Plan (MHP), which is Hennepin County's HMO, has entered into a unique agreement with Hennepin County Public Health and Hennepin County Social Services to make available and manage home and community based services as part of a move to integrate services. Several of the other potential MSHO contractors are also pursuing contracts with counties for preadmission screening, case management and some home and community based services. The difference will be that these county contracts will be part of coordinated care management systems which more closely link primary and acute care clinical care with long term care services.

Population Served
Persons over age 65, dually eligible for both Medicare and Medicaid (including both institutional and community based), residing in the seven-county Metro area are eligible to enroll. The project may expand to other PMAP counties later depending on interest among plans and counties and adequate Medicare payment levels in those counties.

Enrollment
Minnesota Senior Health Options is offered as a voluntary option to the standard PMAP plan. There is a single enrollment process conducted the county along with PMAP for both Medicare and Medicaid. Plans may market to their current PMAP enrollees and participate in the enrollment process for their current PMAP members. All marketing materials used by the state or contracted health plans must be reviewed by HCFA and must meet Medicare risk requirements for marketing materials except for those items for which waivers were granted. Enrollees may disenroll on a monthly basis but will stay in the same plan's PMAP program. Projected enrollment over the life of the project is estimated to be 4,000. Enrollment began in February 1997 in Hennepin and Ramsey counties. Other Metro counties will be added as health plans finalize networks in those areas.

Clinical Delivery System and Providers
Health systems participating in Minnesota Senior Health Options have been encouraged to create a network of providers that will accomplish the clinical integration that is at the heart of the demonstration. This may include the use of geriatricians, geriatric nurse practitioners and other professionals with geriatric experience. Contract requirements include assignment of a care manager who coordinates the overall continuing care of each enrollee. Care managers should have access to all of the plan's medical information and health resources. In addition to ensuring increased coordination

and communication across all types and sites of health care, contracting health plans are asked to find ways to coordinate with local agencies, family caregivers and volunteer organizations. Within the contract requirements, each plan has the flexibility to create a clinical design that fits within their own system.

Quality Assurance
Several levels of quality assurance (QA) have been built into the demonstration. The Minnesota Department of Health (MDH) is responsible for licensing, oversight and monitoring of all HMOs and CISNs. DHS maintains an interagency agreement with MDH for coordination of oversight functions of PMAP and MSHO contractors. Under the MSHO demonstration waivers, the State will incorporate quality assurance for Medicare services into its PMAP managed care quality assurance system and report to HCFA periodically on plan compliance. Relevant portions of the national standard set of HEDIS utilization measures will be collected. Additional outcome measures more specific to elderly with chronic care needs are being developed by the MSHO Quality Assurance Subcommittee. Encounter level data will be collected and analyzed. A special client satisfaction survey will also be implemented.

Complaints and Appeals
The current PMAP complaint and appeals system including access to the state PMAP ombudsman and county advocates and the fair hearings process is available to Minnesota Senior Health Options enrollees. Under the terms of the demonstration waivers, most Medicare complaints will also be handled through the PMAP process so that enrollees and health plans do not have to keep track of more than one grievance process. In addition, unlike Medicare's HMO grievance process which requires the enrollee to work though the HMO's internal process and sets certain dollar thresholds before the individual can access an independent review, Minnesota's current PMAP complaint and appeals process provides the enrollee the option of submitting an appeal directly to the state at any time without regard the dollar amount involved. If a Medicare related appeal is not resolved through the current PMAP appeals process, the enrollee still has access to review by the Medicare Reconsideration Project and an Administrative Law Judge at the federal level.

Technical and Educational Program
The department has subcontracted with the National Chronic Care Consortium (NCCC) for assistance in the development of a Technical and Educational Program (TEAP) which provides expert resources for enabling networks participating in MSHO to integrate acute and long term care services including concepts, clinical expertise and related tools. While a growing number of organizations and individuals are recognizing the need for integration, it is an evolving technology. The TEAP provides ongoing technical assistance to facilitate changes. The desired result is a process of ongoing collaboration regarding best practice models and a focal point for working on key issues in clinical care.

The NCCC is a national organization based in the Twin Cities which includes sophisticated provider systems (hospitals, clinics, HMOs and long term care providers) throughout the country who are interested in better management of chronic care conditions. NCCC is known for its work in developing clinical integration tools such as assessment instruments and protocols, and for compiling information from all over the country on integration of acute and long term care.

In addition to providing regular newsletters and research information to MSHO contractors and provider networks, NCCC facilitates educational forums on clinical integration topics and develops

resources for use by MSHO clinicians based on input from an expert panel of clinicians and representatives from the integrated care systems participating in MSHO.

Advisory Committee/Consumer Input

During the five year development phase of the demonstration, several large public meetings and hundreds of smaller meetings were held to receive input from the public. A formal Advisory Committee comprised of 30 members meets quarterly for updates and input into Minnesota Senior Health Options. In addition, project staff maintain several on going committees with county managed care staff, and county elderly waiver and public health staff.

Research Design

The state is responsible for ongoing monitoring and research based on encounter and other project data. HCFA will contract with an independent entity to conduct the formal evaluation of Minnesota Senior Health Options.

Rates

DHS provides each Minnesota Senior Health Options contractor with a monthly per capita payment per enrollee which will include the PMAP capitation, a Medicaid Nursing Facility Add-on, and the Average Elderly Waiver payment as appropriate per Minnesota Senior Health Options policy. HCFA makes direct payment to each Minnesota Senior Health Options contractor for the monthly Adjusted Average Per Capita Costs (AAPCC) capitation. Minnesota Senior Health Options provides an increased Medicare capitation for frail elderly by applying an AAPCC risk adjustment factor. In exchange for these two Medicaid and Medicare capitation payments, Minnesota Senior Health Options contractors must provide all the medically necessary Medicaid, Medicare, Elderly Waiver and Nursing Facility services for the individuals enrolled in Minnesota Senior Health Options with the exception of long term nursing home per diems. (See attached chart for greater detail about rates.)

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Rate Structure for MMSHO

	Nursing Facility Residents	NH Certifiable Conversions - 1 year past d/c (1)	NH Certifiable (NHC) (waiver eligibles in the community)(2)	Other Community Based Recipients
Medicare	95% of Institutional AAPCC	PACE risk adjustor(3)	PACE risk adjustor	95% of non-institutional AAPCC
Medicaid Acute/Ancillary Services	Institutional PMAP rate	Institutional PMAP rate	Non-institutional PMAP rate + NF add-on	Non-institutional PMAP rate + NF add-on
Medicaid Long Term Care Costs	180 day NF liability(4) / Present system(5)	(2X average Elderly Waiver payment)	Average monthly Elderly Waiver payment	N/A

(1) Relevant to residents in nursing facility for more than 6 months.

(2) Enrollee status will change to the NHC category upon preadmission screening (PAS) using the state PAS tool.

(3) The PACE risk adjustor is 2.39 X 95% of the AAPCC

(4) MSHO contractors will be at risk for 180 of the Medicaid NF days in addition to Medicare Skilled Nursing Facility days for those who enroll in the MSHO from a community setting.

(5) NF per diems are paid through present fee-for-service system directly by the State (1) for those who enroll in MSHO while in a NF, and (2) after the contractor has paid for 180 days of NF liability for those who enrolled in MSHO while in the community.

Rate Structure for MMSHO

Medicare Payments

Once per month, HCFA will make payment for Medicare services directly to MSHO contractors. Specific rates will be determined using the appropriate adjusted average per capita costs (AAPCC) modifiers (e.g., age, sex, county, and institutional status). The PACE risk adjustor is the same as that used under the Program of All-Inclusive Care for the Elderly, a HCFA demonstration which enrolls community-based frail elderly. Medicare payments to MSHO contractors will not be reduced for administrative costs by HCFA or the State.

Medicaid Payments

The Medicaid component of the MSHO rates will consist of the same payments that are made to existing PMAP contractors with the following modifications: (1) for Conversions (column 2), contractors receive the institutional PMAP rate, even though these enrollees are non-institutionalized. They will also receive 2X the average monthly Elderly Waiver (EW) payment; (2) for community-based enrollees who are NHC (column 3), contractors will receive 1X the average monthly EW payment and the NF Add-on, which is pre-payment for up to 180 days of Medicaid nursing facility per diems: (3) for community-based enrollees who are Non-NHC (column 4), contractors will also receive the NF Add-on.

MSHO Risk Arrangements

All MSHO/PMAP contractors will participate in the MSHO on a risk basis.

MSHO Administrative Costs

Administration of the MSHO is funded by a $1.2 million grant from the Robert Wood Johnson Foundation to be used over six years. The grant is matched by state and federal Medicaid administrative funds.

Senator BREAUX [presiding]. Thank you, Ms. Parker.
Ms. Smith.

STATEMENT OF BARBARA MARKHAM SMITH, SENIOR RESEARCH STAFF, CENTER FOR HEALTH POLICY RESEARCH, WASHINGTON, DC

Ms. SMITH. Thank you, Senator; it is a pleasure to be here. I am just going to summarize my testimony briefly for you.

At the Center for Health Policy Research, we conducted a study of Medicare managed care contracts. We were impelled by the transformation of Medicaid from an insurance program to one of the country's largest purchasers of private insurance. We looked at what populations participate, how services are structured and identified key issues presented by the transformation.

Obviously, any time a State or a market engages in a transformation of this magnitude, there are going to be enormous challenges to the State. Of course, one of the key challenges is getting plans to participate in this market for relatively low capitation rates. What we found in the study was that there was tremendous variation among and between States in where they were in this evolutionary process. However, generally, the enrollment of Medicaid populations into managed care tracked the enrollment of populations into managed care in the private sector. This means that basically, younger, healthier families tended to be enrolled and that the chronically ill populations, the frail populations, either were not mandatorily involved or were explicitly excluded.

Now, the interesting thing is that in terms of the complexity of their health care needs and their long-term enrollment in the program unlike the AFDC population, which tends to churn in and out of Medicaid, the dually eligible population is really ideally suited for managed care. They are there for the long run. It is much easier in managed care to track outcomes, to monitor care when people are enrolled over longer periods of time. Their complex health care needs, obviously, indicate a need for care coordination and management.

But that is the difference between the theory and the reality. In reality, the managed care plans have very limited experience with the care of chronically ill people, and the States, with some exceptions, have limited experience in how to get these populations into managed care and assure the performance levels that they need. The limited experience is reflected in the contracts in terms of lack of specifications for transition requirements for people who are in ongoing treatment and an absence of specifications regarding special enrollment procedures for chronically ill people, access to specialists and other types of special service, needs that they have in addition to their direct medical care needs.

Now, I have to say that this—evolutionary point where we have not yet achieved integration of the chronically ill, into managed care applies to the non-dual eligible population as well. In other words, chronically disabled children have the same specialized health care needs as the dual eligible population, and the state of managed care right now is no more able to handle these problems than it is to handle the complex needs of dual eligibles.

There are some barriers to the continued evolution of managed care for this population. As I mentioned before, you have an unattractive risk pool for plans and a low capitation rate. The delinking of Medicaid and welfare will probably have the effect of worsening the Medicaid risk pool, because it will mean that people will not be automatically enrolled in Medicaid. You will not get as many of the healthy population enrolled. You will tend to get people enrolled in Medicaid at the point at which they need services. So, while the capitation does not change, the capitation becomes devalued, because you have a sicker risk pool.

Finally, if a per capita cap were imposed on Medicaid, I think that would probably bring any effort to evolve managed care for dual eligibles to a screeching halt. It would not become financially feasible for plans to come in and manage risk.

In terms of future recommendations, I think the point here is that we need to think in terms of slow and prudent expansion. This is not going to happen overnight. There are many market barriers. There are clinical barriers.

Some things that would facilitate the evolution of managed care for this population would be a joint and several capitation process, where you have coordination between Medicare and Medicaid to have a separate contribution to capitation for these processes. I would not recommend relinquishing Federal control of Medicare dollars into state-regulated plans or plans that are exclusively regulated by States.

I think that for this population, you need to consider, because you have the Medicare considerations as well as the Medicaid considerations, assuring that federally qualified plans participate in this joint capitation method.

Finally, because it is, unfortunately, going to be a slow process rather than a rapid process, I think we have to continue to work on efforts to improve coordination administratively and financially and clinically within the fee-for-service system, because it simply is not going to happen overnight. You are going to have to be sure that you maintain these systems in transition.

Thank you.

[The prepared statement of Ms. Smith follows:]

CENTER FOR HEALTH POLICY RESEARCH

Testimony Before the United States Senate Special Committee on Aging

Dirksen Building, Room G-31
Washington, DC 20510-6400

April 29, 1997

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TESTIMONY OF BARBARA MARKHAM SMITH
U.S. SENATE SPECIAL COMMITTEE ON AGING
APRIL 29, 1997

The transformation to managed care may be the most important development since the rise of modern medicine and the use of insurance to pay for health care. This transformation has not only changed the relationship between providers and patients but also has transformed Medicaid from a health care financing program to one of the nation's largest purchasers of private insurance. As a result of the move to Medicaid managed care, the Center for Health Policy Research undertook a nationwide study of the managed care contracts between states and managed care plans.

The study -- which is in its second phase -- has two purposes. The first is to present an overview of the structure and content of the detailed service agreements which describe Medicaid managed care arrangements, including what populations participate and how services are structured. The second purpose is to identify key issues presented by Medicaid's shift from payor to purchaser of managed care.

In a transformation of this magnitude, the states face enormous challenges in their effort to construct integrated delivery systems for poor people and people who have special health care needs, an effort which has no parallel in the private insurance sector. Among the primary challenges is convincing private companies to enter the Medicaid market which offers relatively low capitation rates.

While some states have longstanding experience with managed care and operate in mature markets, many states do not. The transformation to Medicaid managed care is thus in its infancy and is a highly evolutionary process. Accordingly, states generally -- with some notable

exceptions -- have largely based their managed care programs on the private employer model that offers primary and acute care to a population composed of relatively healthy young families -- the AFDC population. As with the private sector, states have less experience with managed care for the elderly and disabled.

Theoretically, the dually eligible population is ideally suited to managed care because the complexity of their medical needs lends itself to case management and coordinated care. In addition, dually eligible individuals are enrolled in the Medicare and Medicaid programs on a long-term basis making enrollment more stable and tracking and monitoring of care more feasible to assure clinical coordination and accountability by the plans. The long-term enrollment of dual eligibles also creates more incentives for plans to make investments in care that pay off only in the long term. This stands in stark contrast to the AFDC population which tends to be enrolled in Medicaid only episodically, churning in and out of the program and thereby creating plan disincentives to preventive investments in care.

While managed care should theoretically work well for chronically ill populations, the marketplace to date is only at the beginning stages of development. As seen in the attached table, many states exclude certain disabled populations from mandatory plan enrollment. Whether this exclusion is inititated by the states or by the plans entering the Medicaid market is unclear. Even where disabled populations are included, state efforts to develop the specifications for providing care to chronically ill, disabled people and the frail elderly are in very early stages of evolution.

Because managed care in the private employment sector has been used almost exclusively for healthy, often young, working families, there is simply very limited experience upon which to develop standards for care of the disabled/chronically ill population in a managed care context.

Therefore, states are faced with the challenge of first trying to define what services and structures are needed and then trying to translate these definitions into a contract. The limited experience of plans in caring for these types of populations – in contrast with the traditional medical system who has cared for them almost exclusively – would indicate that these standards should not simply be left to plan discretion.

The early stage of evolution for this process is clearly reflected in the contracts themselves. For example, even where diabled beneficiaries are technically eligible, we can see in the attached table that language on inclusion of specialists in the provider networks is provided in only a minority of state contracts. Indeed, network requirements tend to focus on primary care providers, pediatricians, and maternity care providers -- providers appropriate for the AFDC population. Similarly, provisions dealing with transition arrangements for people in on-going treatment, access to specialists, or special communication services for diabled people are relatively rare. Virtually all contracts specifically exclude long-term nursing home care from plan services.

It is important to note that these problems do not affect only dual eligibles but affect all people with complex health care needs. A disabled child enrolled in a Medicaid managed care plan who is not eligible for Medicare needs the same network sophistication as a dually eligible adult.

Our initial review of 1996 contracts indicates that some states are moving more aggressively to enroll disabled populations. Florida, for example, now specifically incorporates a frail elderly program in its managed care system. Massachusetts and Minnesota are also engaged in a targeted effort to include the chronically ill into their managed care programs. However, these states are the exception, not the rule.

Plans have not shown a willingness to enter this high-risk market for relatively low capitation rates. Setting an appropriate risk-adjusted premium remains a major challenge and it seems unlikely that the integration of the dual eligible population could be accomplished purely on the basis of capitation. Some blending of capitation with stop/ loss provisions and fee-for-service payment would likely have to occur.

Other financing problems are likely to have a chilling effect on the evolution of managed care for this population as well as for the AFDC population. Specifically, the de-linking of welfare and Medicaid will probably cause an actuarial worsening of the Medicaid risk pool. This will occur because instead of relatively healthy families automatically becoming enrolled in Medicaid, people will tend to be enrolled only as they become ill or seek services. As the risk pool worsens while the capitation payment remains stable, the ability to attract plans will decline.

A per capita cap on Medicaid payments would merely intensify this effect. This would occur for two reasons. First, the cap would not reflect the actuarial needs of the worsening risk pool since the cap is based on the existing composition of the risk pool. Secondly, the cap's baseline as proposed is drawn from a period of unusually low Medicaid spending, unlike the welfare cap which is based on a period of high welfare spending, giving states a much more comfortable margin with which to implement new programs during a period of strong economic growth. The combined effect of worsening risk pools and the implementation of a Medicaid per capita cap is the most effective way to bring any further evolution of the Medicaid managed care market to a screeching halt. Efforts to coordinate care for dual eligibles even in the traditional health care sector will become much more difficult under these financial constraints.

The market participation might improve if Medicare funding streams are added to the capitation since Medicare rates are higher than Medicaid rates. This would best be accomplished by having Medicaid and Medicare contribute separately and jointly to the premium rather than trying to merge the funding streams. Separate contributions to the premium would present less risk to the Medicare trust funds. Specifically, Medicare remains liable for Medicare services to the dually eligible population. If beneficiaries fail to get services from plans, Medicare may end up paying twice for the same services – once in the capitation to the plan and again to pay for those services in the fee-for-service sector if the plan fails to perform. This risk is minimized if Medicare is getting direct accountability from the plan and is paying for care only in federally qualified plans. In addition, this payment approach could be used as a mechanism to encourage federally qualified managed care plans to participate in the state Medicaid markets, improving the market for Medicaid-only programs.

In attempting to create better coordination of care and a continuum of care, it is important to recognize that the market may not yet be ready to absorb some of the policy changes considered desirable. Accordingly, substantial acceleration of the enrollment of the dually eligible population into managed care cannot realistically occur until a greater consensus is reached regarding the network and administrative capabilities required to provide and coordinate adequate clinical care. Further work on methodologies for measuring performance and tracking outcomes may also assure that patients benefit from the transition from fee-for -service care from traditional providers to the managed care system. While Medicare funding may be essential to attracting plans to this market, assuring administrative and financial coordination to maintain acccountability to the federal taxpayer remains problemmatical in most states. Given the tenative nature of this market, we believe that slow and careful expansion offers the best option for dually

eligible people and for the programs. Because integration into managed care of necessity will occur over an extended period of time, attention should not be diverted from how to improve coordination of care and services within the existing system.

Table 1.a Selected Provisions Related to Disability

Does the contract or RFP address whether: 1) certain categories of recipients are enrolled, 2) specialty providers are available in the network, and 3) special communication services are available for persons with disability?

	AZ	CA	CO	CT	DE	DC	FL		GA	HI		IL	IA		KS	KY	ME	MD	MA	MI	MN	MO	MT
							FULL	MH		FULL	BH		MH	SA									
Managed Care Enrolled Population (excerpted from Table 1.1 of study)																							
Persons with disability	●	●	●		●		●	●/E	●	E	●		●	●		●			●/E	●/E	E	●/E	●/E
Elderly		●	●/E		●		●/E	E	●	●/E	●		E	E				●		●	●		●/E
Residents of long-term care facilities		E	●/E			E	E	E	E				E	●/E				●/E		●/E	■/E	E	E
Persons needing long-term home and community care		E	●/E											●				●		●			●/E
Provider Network Standards (excerpted from Table 3.1 of study)																							
Specialty care providers	●	●		●	●		●		●	●	●						●					●	
Translation Services and Cultural Competence (excerpted from Table 3.6 of study)																							
Disability-communication capacity required in network																			●				
Materials in other language or in form useful to people with disabilities	●	●					●	●	●			●			●	●			●		●	●	
Services for persons with speech, language, hearing, or vision related disabilities														●					●		●	●	●

● means that an issue was addressed in the contract or RFP.

E means that the enrollment category has been explicitly excluded from the contract or RFP.

●/E means that certain groups within an enrollment category have been explicitly excluded from the contract or RFP.

■ reflects state revisions of contracts or RFP subsequent to study period and incorporated at state request.

Table 1.b Selected Provisions Related to Disability

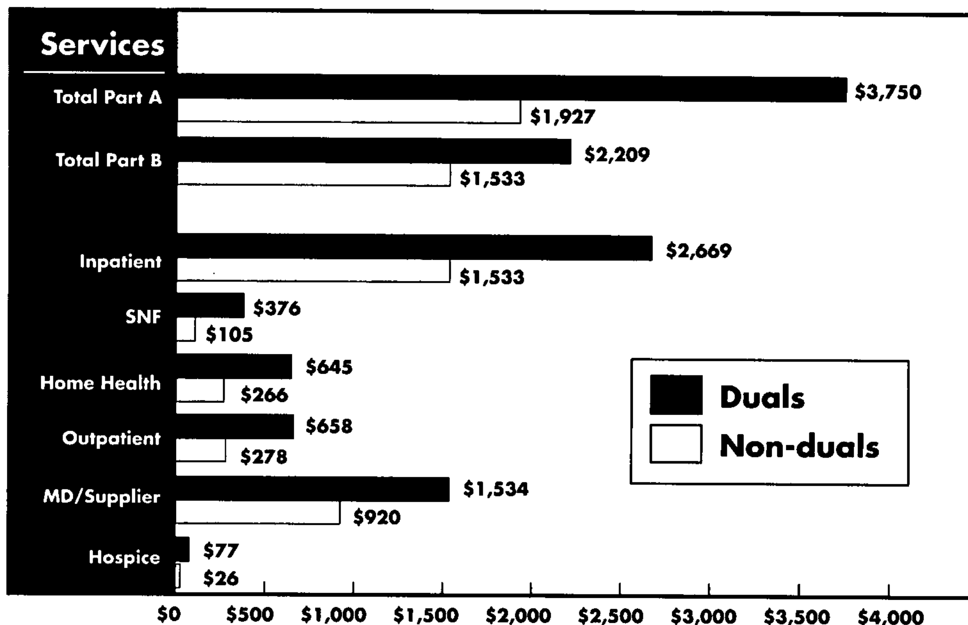
Does the contract or RFP address whether: certain categories of recipients enrolled, 2) specialty providers available n the network, an 3) speial communication ervics are available for persons with isability?

	NE FULL	NE MH	NH	NJ	NY FULL	NY MH	NC	OH	OR FULL	OR MH	PA	RI	TN	TX	UT FULL	UT MH	VT	VA	WA FULL	WA MH	WV	WI
Managed Care Enrolled Popoulation (from Table 1.1 of study)																						
Persons with disability	●	●		●	●	●	●			●	●		●		●	●	●	●		●	●	◘
Elderly	●	●				●				●	●		●		●	●	●	●		●		◘
Residents of long-term care facilities	E	●		E	●/E					●			●					●		●	E	
Persons needing long-term home and community care	●/E	●			●					●			●					●		●		◘
Provider Network Standards (from Table 3.1 of study)																						
Specialty care providers	●			●	●		●	●			●	●	●				●	●			●	◘
Translation Services and Cultural Competence (excerpted from Table 3.6 of study)																						
Disability-communication capacity required in network				●																		
Materials in other language or in form useful to people with disabilities	●	●		●	●		●	●		●		●					●				●	●
Services for persons with speech, language, hearing, or vision related disabilities	●	●	●	●	●						●			●		●	●		●		●	

● means that an issue was addressed in the contract or RFP.
E means that the enrollment category has been explicitly excluded from the contract or RFP.
●/E means that certain groups within an enrollment category have been explicitly excluded from the contract or RFP.
◘ reflects state revisions of contracts or RFP subsequent to study period and incorporated at state request.

Average Annual Medicare Expenditures per Eligible

On average, dual eligibles have much higher service expenditures, particularly with respect to post-acute care services (home health and SNF)



Average Annual Expenditures Per Eligible

Source: Health Care Financing Adminsitration - Data From the Medicare Current Beneficiary Survey

The CHAIRMAN [presiding]. Thank you.

I think I will go to Senator Breaux and Senator Hagel before I ask questions, and then, if you are finished questioning, I can go beyond the 5 minutes.

Senator BREAUX. Well, I will.

The CHAIRMAN. OK.

Senator BREAUX. We will make some adjustments.

The CHAIRMAN. OK.

Senator BREAUX. Thank you very much; I thank the panel very much.

Dr. Scanlon, you did a fine paper. It is really a good summary of the problem. I appreciate the amount of work that went into that. It really helps clarify the nature of the problem.

Senator Grassley and I both sit on the Finance Committee, which deals with this issue. If you all were members of the Finance Committee instead of Senator Grassley and myself, do you have any suggestions as to what you would offer as amendments to either the Medicare or Medicaid program to help resolve some of the problems with the dual eligibles? I am thinking in terms of the greater flexibility as needed by the States, and I do not know whether that is something that we need to legislate. Do any of you have any suggestions? I think we all know what the problem is. I am just not sure how to integrate the two programs, when they have different standards; different ins and outs, how long you have to stay, when you can get back out and different areas of coverage. We have two great programs, but we have a lot of people caught in the middle.

Any suggestions on what we should do to try to help resolve it?

Mr. SCANLON. Well, I think we are in a situation where we are dealing with essentially a set of outmoded rules with respect to managed care. As we have talked about before, the Medicare program and the Medicaid program began in 1965, when our world was almost exclusively fee-for-service. We are still working with many of the same kinds of rules, and while we have grafted in new provisions with respect to managed care, some of them were rather simplistic and have not proved to be very effective over time.

Senator BREAUX. Well, what do we have to do with managed care in order to have them become attracted to the chronically ill population that is out there? They do not want them right now.

Mr. SCANLON. Appropriate payment, as has been mentioned here, is one of the most critical aspects.

Senator BREAUX. It would require a legislative fix to do that.

Mr. SCANLON. Right. We have heard that it is more expensive to keep a person at home and serve them at home than it is for a managed care organization to serve an institutionalized beneficiary, yet, the managed care payment under Medicare currently, for institutionalized beneficiaries, is significantly higher. We do not have good risk adjusters in the Medicare program at present. We need better risk adjusters so that managed care organizations do not want to shun persons with chronic illness; that they are willing to accept them and work to retain them. It is very important that they remain members of the managed care organization as their needs become more complex.

Senator BREAUX. Well, do we have to set up a dual track kind of payment, for chronically ill Medicare patients and those for just acutely ill?

Mr. SCANLON. Well, I think that a risk adjustment system could be a single system. It would recognize that there are chronic illnesses that add to costs in one way and that everyone is at risk for some acute episodes that are going to add to costs and that they can be incorporated within the risk adjustment system as well.

So, it would essentially be one system. People would recognize that individuals who we knew would have higher expected costs, that an HMO would receive higher payment for them. Then, therefore, they would be willing to accept them.

Senator BREAUX. Mr. Bullen and Ms. Parker, have you been able to get the waivers in your programs that are necessary in order to try to incorporate Medicare and Medicaid, or are you lacking some things that you think you need to be able to do to make it work?

Mr. BULLEN. Well, I think we are working cooperatively with HCFA. They seem to be interested in this problem. The process is a laborious one. There are constraints on what HCFA can approve and cannot approve that should be addressed, we think. We are willing to go forward even in the current environment with a voluntary program, because, frankly, I think the single biggest improvement we could make here is integrating the funding streams in an accountable way. There is nobody at the wheel right now, and the growth rates in both programs—as you heard in my testimony, 51 percent of our spending in Massachusetts is attributable to dual eligibles. The growth rates in Medicare and Medicaid can be controlled by having the right incentives in place in an integrated system that is accountable to a single entity, and what is happening now is that there is shifting going on back and forth that is driving up the rates of both programs. You really need to do something about that, and it is going to be difficult to control either program for this particular group, who are beneficiaries of both programs, an extremely expensive, extremely needy group, and we really need to address it.

Senator BREAUX. Ms. Parker, do you have any suggestions?

Ms. PARKER. Mr. Chairman, Senator Breaux, HCFA appears to have the authorities that they need to provide demonstration waivers to States for this at their discretion, but this is not a permanent solution. These are going to be very isolated demonstrations. There are only going to be a few States that are going to be in a position like we were to get them. It took us 6 years to get those waivers, to work those details out with HCFA. It is going to take other States less time because, I think, of some of the work that we have done, but it is a very cumbersome process. It is not a complete solution.

What we need is a longer-range approach that starts to look at how these fundings can be integrated on a permanent basis, not just on a 5-year demonstration basis.

Senator BREAUX. May I ask Ms. Smith for a last comment, Chuck?

The CHAIRMAN. Yes.

Senator BREAUX. Do you have a comment on what I was asking about? I am trying to figure out what we need to do.

Ms. SMITH. Yes, sir; the point that I think it is important to make is that if you look at Massachusetts or Minnesota or Oregon, those are very mature managed care markets, and they are just at this point, after many years of evolution, getting to the point where they can start to develop programs to do this. Many other States around the country are not there yet. The more experienced States also are States which have highly regulated managed care environments within their own States, so that they have an ability to track outcomes and maintain financial accountability.

I think that what you really are going to need to look at is, if you were building a spacecraft, redundant systems, because you are going to have to have a system that enables people to get the care that they need as you evolve into other types of systems, so that as one system fails or runs into glitches or does not get to where you need to go that you have not got a disaster on your hands. You are going to have to move simultaneously on a number of fronts.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you. I wish to add my thanks to the panel for coming before us this morning to help us with this issue.

Ms. Parker, I would like to continue in this vein of questioning if I might. Do you think HCFA has expressed reluctance over the years to move forward with more waiver arrangements?

Ms. PARKER. Mr. Chairman, Senator Hagel, HCFA has made some statements about that they were not going to do any more Minnesota type of arrangements. I think that maybe has changed and has softened more recently. I think there may also be some confusion over the difference between our regular Medicaid managed care program in Minnesota, which is called the Prepaid Medical Assistance Program, which does require enrollment of dual eligibles and the difference between that program and our new Minnesota Senior Health Options Program, which is not a mandatory enrollment; it is a voluntary enrollment, and HCFA has taken some strong stands on the issue of mandatory versus voluntary enrollment.

But I think that there definitely are some—I will stop there for right now.

Senator HAGEL. Can you tell me what proportion of the costs for your State of dually eligible beneficiaries are paid by the State of Minnesota?

Ms. PARKER. Well, it depends, Senator, Mr. Chairman, it depends on the individual. If you look at the kinds of individuals you have, we have basically four major categories. We have the type of person who is in a nursing facility; they typically have a little bit less acute care costs and higher long-term care costs. You have frail elderly in the community who can have both high acute care costs and high long-term care costs. Then, you have a person who is in the community who is more well off. They are poor, but their health is better. They may be on Medicaid, and they may have lower acute care costs and lower Medicaid costs. So, it depends on those individuals.

Senator HAGEL. Thank you.

Mr. Bullen, I noted in your prepared testimony that you mentioned senior care organizations—I am quoting from your testimony—in Massachusetts will "be rewarded for improving health status and customer satisfaction." Would you explain that a little bit? How will these senior care organizations be rewarded?

Mr. BULLEN. Well, you have to remember that this is a contractual arrangement between us and a managed care organization, and we would set performance goals as conditions of the contract, as conditions of the capitation and payments; measure their ability to provide the services that are called for in the contract and to improve quality and require, for instance, that customer satisfaction and other measures be used to determine whether or not quality is being improved. We would also require that they initiate a continuous quality improvement system for managing care. So, there are many different, chiefly contractual, ways in which we would ensure that performance, in aggregate, is measured and that the performance of the senior care organization is connected to the payment that is made.

There are a number of ways that we would enforce that if performance were not forthcoming.

Senator HAGEL. Well, how do you reward those organizations?

Mr. BULLEN. Well, there are both rewards and punishments; for instance, and again, we have some experience with this in our basic managed care program—those HMO's in Massachusetts that do well by Medicaid recipients and we have specific ways that we hold them accountable are given preferential treatment when it comes time for enrollment of new recipients, and, on the other side of the coin, the ones that are not performing, have their enrollment frozen. If they are not performing well, they are not offered contracts the next time around when it comes time to bid the system.

Senator HAGEL. Do you think these are particularly important dynamics of the program?

Mr. BULLEN. Absolutely; that is what is missing right now. You see, the payers, the funding sources, do not have control over the performance of the system, so that there is a lot of reimbursement-driven behavior that the payers, Medicare and Medicaid, cannot really do anything about. What you need is an organization interested in the outcomes of the system itself, an organization that knows that its reward, its compensation, is tied to whether or not the health status of an enrollee improves.

Senator HAGEL. Thank you.

The CHAIRMAN. Well, thank you very much, Senator Hagel. I appreciate your coming. We had a good turnout at this hearing, and you add to that.

Dr. Scanlon, I would ask you, in regard to several different places in your testimony, you stressed the importance of Federal and State oversight. Obviously, we are getting a lot of innovative initiatives on the part of the States, exploring managed care, particularly managed care for vulnerable populations. What would you suggest in the way of increased oversight there?

Mr. SCANLON. I think we need to change the nature of some of the oversight functions that we are undertaking. At this point, we have put a great emphasis on the process of care that HMO's have rather than on the actual outcomes or the substance of care deliv-

ered. I think we need to move into, as Mr. Bullen indicated, a much greater focus on outcomes.—hold plans accountable for achieving positive outcomes for their beneficiaries.

I think we also need to be very concerned about moving away from focusing on the average alone. What we are talking about in terms of vulnerable populations is often the very extremely small segment of the overall population, and their experience is very, very important, and if we do not identify whether or not they are getting adequate care, the average may lead us astray. We are concluding that care is fine within an HMO, when actually, people who need it most are actually suffering.

The CHAIRMAN. Obviously, we could have 50 different States going 50 different ways with their own Medicaid packages of rules and regulations. Is there any need for standardization in order to have proper functioning?

Mr. SCANLON. I do not think we are at a point where standardization is really a feasible or a wise alternative. We are, in some respects, in the infancy of quality measurement within public program use of managed care. The fact that the States are trying various approaches is positive in the sense that we can learn from them, and as long as we maintain this, I think this is in some respects our continuous quality improvement process. If we maintain an avenue by which we can take the knowledge that individual States generate and disseminate it among other States as well as at the Federal level, we will benefit from these varied approaches that are being tried by different States.

The CHAIRMAN. Ms. Parker, Ms. Smith, would you like to put your nodding heads in words so we have got that on the record, the extent to which you agree with what he said? Because you are kind of where the rubber meets the road, you know.

Ms. PARKER. Thank you, Mr. Chairman.

Yes, I definitely support Dr. Scanlon's comments. Some of the measures that are being developed for managed care outcomes, such as the HEDIS measures, and there is a satisfaction survey that is part of that; there is also a health of seniors assessment that is part of that that is going to be applied to Medicare managed care plans. While we applaud HCFA's efforts to start moving forward more aggressively in the area of outcome measurement in Medicare managed care, these measures just do not go far enough in really looking at the chronic care populations. For instance, the health of seniors assessment measure that they are going to be looking at requires an enrollment of 12 months before the data is valid, and it does not adequately address the seniors in a nursing home setting. The scale does not work appropriately.

So, some of these measures that are being developed are, as he says, in their infancy stages and are going to have to be—there are going to have to be a lot more resources invested, I think, in HCFA. HCFA is going to have to be given the resources to invest much more in developing these across the country, and I think there are definitely strategies that can—I would not go so far as to say let us standardize them, but certainly, strategies that many, many States should be participating in and working with rather than each pursuing totally individual efforts. I think there is a lot of coordination that can go on, and that effort has to be led by

someone, and I think that entity has to be HCFA, but HCFA has to be given the resources to be able to do that.

The CHAIRMAN. Ms. Smith, did you have anything to add?

Ms. SMITH. Yes, Mr. Chairman, I also agree with Dr. Scanlon's remarks. I think that we are really looking at a market which is, in some way, almost too immature for standards, because if we try to develop specific managed care standards right now for this population, we do not really know what they would be. But I think that what is called for and what our study calls for is a forum of some sort, some kind of consensus building process that is organized and formal to bring HCFA and the States and the plans and consumers together to attempt to look at what kinds of performance standards ought to be developed, given differing policy choices and how those performance standards can be measured and evaluated.

I think that we have a lot of people around the country doing a lot of interesting work, but there needs to be some more organized sharing of information.

The CHAIRMAN. Mr. Bullen, in regard to oversight by Federal and State governments as States are pursuing greater flexibility in these innovative programs that they have to do to work through the waiver process, could you elaborate on the types of oversight measures that Massachusetts is planning to implement and, most importantly, whether they are going to interface with the Federal oversight measures?

Mr. BULLEN. Yes. We are planning to implement a very aggressive quality management approach, as I outlined, that is contractually based. The arrangement that we would like to strike with HCFA is that we would essentially be their purchasing agent for their services and would be accountable to them as a payer, as a responsible party, for meeting the kinds of goals they want to set for this population. We would, for instance, ask our senior care organizations to be accountable for meeting certain standards with respect to rates of immunization for influenza or pneumonia to stress preventive care. We would hope to have the relationship with HCFA conducted on that basis rather than on the kinds of bureaucratic State plan types of discussions of whether or not this or that fits within a particular category of authorization.

I would much rather talk with HCFA in terms of whether or not our approach here is actually improving health outcomes for enrollees. I think HCFA is moving in that direction. I think it would be good for them to hear from Congress that you would like to see it move in that direction, if that is possible.

The CHAIRMAN. I want to bring up to each of you the freedom of choice issue, the right to disenroll and also that 50/50 public/private membership rule for managed care plans. These are the delicate issues in the discussions about integrating Medicare services with Medicaid services. Would voluntary participation in such plans sidestep that issue? If participation were voluntary, would such plans work if we were to do that? In particular, could such plans work if beneficiaries are able to disenroll monthly?

Mr. SCANLON. I think it would go back to some of the information that we provided you at the last hearing, at which I was a witness, where we talked about the performance of HMO's and how it varied so much within a marketplace. We can see that the 50/50 rule

is not doing the job in terms of satisfying beneficiaries so that they want to stay within HMO's. We saw as many as 40 percent of enrollees leaving certain HMO's within the course of a year.

We need better quality assurance rules for plans to participate than the 50/50 rule. So, trying to retain it does not make sense. It makes much more sense to devote our energies unto quality assurance rules that truly can promote quality.

We also thought, as we discussed at that hearing, that information sharing among beneficiaries is a very important force in terms of encouraging quality of care. I think if we can promote better quality among HMO's that an individual with a chronic illness, an individual with significant needs, would want to be in a managed care organization. As we have heard today, when you have a significant number of needs, you would like a navigator to be able to take you through the system and find the services that you need and to bargain on your behalf with providers and get the providers to come to you instead of you always having to go to wherever the provider is. Those are the kinds of things that you want to have accomplished.

So, if we can hold HMO's accountable for providing those kinds of services and make beneficiaries aware that those services are present, then, I think we will find that beneficiaries join HMO's and stay in the HMO over longer periods of time.

The CHAIRMAN. Yes, Mr. Bullen.

Mr. BULLEN. I would add that I think choice is important, but I think we overvalue choice or weigh it wrongly. It is choice within a context. The choice, unfortunately, that is afforded now, for instance, for a Medicare recipient is to join an HMO and to disenroll immediately, and the problem with that is that it can be used by HMO's as well as the recipients. That is one of the major reasons that you do not have the kind of enrollment that you want in HMO's. Anyone who is chronically ill can disenroll immediately or can be advised to disenroll immediately. So, what you really want is choice within a managed care environment, as opposed to I will just take my chances in fee-for-service. I think that is never going to work properly. There has to be some structuring of the choice.

The CHAIRMAN. Do either one of you have anything to add to that?

Ms. PARKER. I do not think that, given, Mr. Chairman, the enrollment currently in the current PACE and SHMO demonstrations of dual eligibles has been very small on a voluntary basis, and I do not think that voluntary enrollment is going to end up being the strategy that is going to get States the control of the costs and services for this population to provide real choice of integrated care systems for individuals.

What geriatricians whom we have worked with to develop our system told us right at the beginning is that there are great tradeoffs between vastly large networks or having complete ultimate choice to go to any doctor that you want to and the good care management that can come from having a smaller panel of physicians who really know the population and are really working together with other care providers to provide integrated care.

So, I think we are going to have to make some of those tradeoffs between being able to run around and go to any provider inside or

outside the network, as is in the current system, and, perhaps, have more choices of different integrated care networks where you have a smaller provider panel, but you can choose among many of those smaller groups to provide your integrated care.

The CHAIRMAN. Ms. Smith.

Ms. SMITH. Yes, sir. I think that clearly, as has been pointed out, the churning in and out of enrollment can be used by the plans. It also creates tremendous disincentives to preventive investments in care, because those preventive investments pay off in the long term. If a patient is going to be out of the system when those investments pay off, the plans just do not have much incentive to make those investments.

The problem is that when you have mandatory or guaranteed enrollment over a period of a year in a system where your quality controls are still weak, or you have not developed sufficient network standards or access, then, the voluntary disenrollment, short-term disenrollment, has acted as a safety valve, a consumer protection for the patient when they are not getting services in the plan to get out and get the services. As you move to lengthen periods of enrollment, that has to be accompanied by or preceded by sufficient quality controls, network standards, specialist access standards, to assure that sufficient access to services is maintained during that mandatory period of enrollment.

The CHAIRMAN. I have one question. I will ask it of Mr. Bullen. Anyone else is welcome to respond, but it is more about Massachusetts. We have discussed here mostly managed care types of approaches. Does the Massachusetts plan or any plan that you might know of look at ways to apply innovative methods to the fee-for-service system as well?

Mr. BULLEN. Well, a lot of the features of the plan could be implemented in fee-for-service if there were an accountability built in. The problem with the current fee-for-service structure as it relates to the dual eligibles is not just the fee-for-service but the fact that you have the two different payers with the two different rules. So, the integration of that system, the accountability of the system, the payment methods are really secondary to that. The problem right now is that there is not a system. There is not an accountable structure.

Certainly, the use of preventive services and diversionary services to try to promote independence and keep people out of institutions who do not need to go there, there are ways and mechanisms for doing that in a fee-for-service environment. It is a little hard when the benefits accrue to another payer for doing that, but I assume it can be done. The problem is that the incentives are not there to do it right now.

The CHAIRMAN. Well, I thank each of you for participating and helping us bring attention to the problems of 6 million dually eligible Americans. If there is anything that people are cynical about, it is that government sometimes does not run programs very well, and, as we have seen by the charts that we had before us today, people being on kind of a merry-go-round for health care does not lead to a great deal of confidence in government. It also gives us a chance to learn from our laboratories of government in America, our States, because at least in some States, we are attempting to

improve on the system and make sure that people are not on the merry-go-round. Congress ought to learn what we can from this. As it stands today, it seems to me that people who require this sort of chronic care are the losers as well as, to some extent, taxpayers.

So, I hope that today's discussion and the additional research that will come from it will lay the groundwork for a solution to what has been described here as a very real problem, a very serious problem and not just one that is in theory, but as we have heard from two witnesses today, very detrimentally impacts certain families.

So, you have all contributed to this, and I assume that we are going to be in discussion with you as time goes on to see what we can do, either in a small way or in a big way. I am afraid that if we wait for a long period of time to do something in a big way, we might not get anything done, but maybe we ought to look at what interim steps we can take, particularly with the resources of HCFA, as somebody suggested here, as a way of helping out, because charts like this do not do the process of government a very good public relations job, and if we want to reduce people's cynicism of government, we have got to improve our delivery of services.

I thank you very much and adjourn the hearing.

[Whereupon, at 12:02 p.m., the committee was adjourned.]

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