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4 HEARING ON ``DUAL ELIGIBLES: UNDERSTANDING THIS VULNERABLE

5 POPULATION AND HOW TO IMPROVE THEIR CARE''

6 TUESDAY, JUNE 21, 2011

7 House of Representatives,

8 Subcommittee on Health

9 Committee on Energy and Commerce

10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 2:04 p.m., in

12 Room 2322 of the Rayburn House Office Building, Hon. Joe

13 Pitts [Chairman of the Subcommittee] presiding.

14 Members present: Representatives Pitts, Burgess,

15 Whitfield, Shimkus, Latta, Lance, Cassidy, Guthrie, Upton (ex

16 officio), Pallone, Christensen, Markey and Waxman (ex

17 officio).

18 Staff present: Howard Cohen, Chief Health Counsel; Andy

19 Duberstein, Special Assistant to Chairman Upton; Paul
20 Edattel, Professional Staff Member, Health; Julie Goon,
21 Health Policy Advisor; Kirby Howard, Legislative Clerk;
22 Debbie Keller, Press Secretary; Peter Kielty, Senior
23 Legislative Analyst; Ryan Long, Chief Counsel, Health; Carly
24 McWilliams, Legislative Clerk; Jeff Mortier, Professional
25 Staff Member; Katie Novaria, Legislative Clerk; John O'Shea,
26 Professional Staff Member, Health; Monica Popp, Professional
27 Staff Member, Health; Andrew Powaleny, Press Assistant; Heidi
28 Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator,
29 Admin/Human Resources; Tom Wilbur, Staff Assistant; Alli
30 Corr, Democratic Policy Analyst; Tim Gronniger, Democratic
31 Senior Professional Staff Member; Purvee Kempf, Democratic
32 Senior Counsel; and Karen Nelson, Democratic Deputy Committee
33 Staff Director for Health.

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34 Mr. {Pitts.} The subcommittee will come to order. The
35 chair recognizes himself for 5 minutes for an opening
36 statement.

37 Dual eligibles, those individuals who are eligible for
38 both the Medicare and Medicaid programs, are one of our
39 sickest, poorest, most costly and most vulnerable
40 populations. If we are to simultaneously improve and lower
41 the cost of their care, we must do a better job at
42 integrating Medicare and Medicaid benefits and services.

43 Dual eligibles are unique. While more than half of dual
44 eligibles live below the poverty line, only 8 percent of
45 Medicare-only beneficiaries have incomes below the poverty
46 line. Nineteen percent of dual eligibles live in an
47 institutional setting, while only 3 percent of Medicare-
48 eligible-only individuals live in such a setting. They are
49 also more likely to be hospitalized, to go to emergency
50 rooms, and to require long-term care than other Medicare
51 beneficiaries.

52 According to the Centers for Medicare and Medicaid
53 Services, more than 9 million people fall into the dual-
54 eligible category. Forty-three percent of them have at least
55 one mental or cognitive impairment, while 60 percent have
56 multiple chronic conditions.

57 According to the Kaiser Family Foundation, dual
58 eligibles, who make up only 15 percent of Medicaid
59 enrollment, consume 39 percent of total Medicaid spending.
60 Additionally, in 2005, the Medicare and Medicaid programs
61 spent an average of \$20,000 per dual eligible, almost five
62 times greater than the average amount spent on other Medicare
63 beneficiaries.

64 These individuals, who have fewer resources and more
65 complicated health care needs, face the added struggle of
66 trying to navigate both Medicare and Medicaid. Medicare
67 covers their basic acute health care services and
68 prescription drugs, and Medicaid fills in the gaps. Medicaid
69 generally pays the Medicare Part B premium and the cost
70 sharing for Medicare services. For some, Medicaid also
71 covers various benefits not covered by Medicare, including
72 long-term care supports and services, dental care,
73 eyeglasses, and other benefits.

74 Each State determines its own eligibility standards and
75 which benefits will be provided to Medicaid beneficiaries.
76 So, we are able to watch various States experiment with
77 different models and designs to better align the care of dual
78 eligibles. Currently, 15 states have been selected to
79 receive funding, data and technical assistance from CMS to
80 develop a more coordinated model of care for dual eligibles.

81 We can improve the quality of care that dual eligibles
82 receive. We can make their care more efficient and easier
83 for them to navigate. We can do all this while lowering
84 costs to both the federal government and the beneficiary.

85 I look forward to hearing from our witnesses today about
86 which models are being tried in the States and what we have
87 learned so far.

88 [The prepared statement of Mr. Pitts follows:]

89 ***** COMMITTEE INSERT *****

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90 Mr. {Pitts.} At this time I will yield the remaining
91 time to the vice chairman, Dr. Burgess.

92 Dr. {Burgess.} Thank you, Mr. Chairman.

93 In no other area is the lack of coordination at the
94 federal level more apparent than when we deal with people who
95 are dually eligible for Medicare and Medicaid. Studies of
96 the population make it clear that Medicaid is actually 56
97 separate programs administered by the States and territories
98 in the context of duals. It sometimes becomes a game of hot
99 potato.

100 Data suggest that duals are sicker when they are
101 hospitalized, that their costs are almost 10 percent greater,
102 and they have more episodes of avoidable hospitalization. It
103 is a symptom of no one being held accountable for their care.
104 Certainly, better alignment of Medicare and Medicaid is
105 needed.

106 Now, unfortunately, ACOs, accountable care
107 organizations, that may have provided a model and a good
108 place to start, it seems that once again the bureaucracy has
109 killed any such hope for that happening. The rule that was
110 produced on ACOs was virtually unintelligible and most large
111 groups that thought themselves to be ACOs have now moved away
112 from this.

113 You want to drive cost savings with better care. This
114 is a problem that really we could solve. Fifteen percent of
115 Medicaid enrollees are duals and they account for almost 40
116 percent of the program's spending. The old Willie Sutton
117 law, you rob banks because that is where the money is,
118 clearly it should apply here. And these patients are fully
119 covered by Medicare and the entire Medicare benefits package
120 and still they are five times costlier. These are patients
121 that are defined. We know where they are. We know who they
122 are. We know when they are accessing care and why they are
123 accessing it, and yet for some reason we lack the fundamental
124 amount of consistency for coordinating their benefits.

125 I rarely find myself agreeing with Ezra Klein and the
126 Washington Post, but I did last week when he talked about the
127 fact that this was an idea whose time has come. What I don't
128 understand is why it takes an entirely new federal agency
129 when CMS has had broad waiver authority and demonstration
130 authority for years to take care of this problem.

131 I will yield back the balance of my time.

132 [The prepared statement of Dr. Burgess follows:]

133 ***** COMMITTEE INSERT *****

|
134 Mr. {Pitts.} The chair thanks the gentleman and
135 recognizes the ranking member of the subcommittee, Mr.
136 Pallone, for 5 minutes.

137 Mr. {Pallone.} Thank you, Mr. Chairman.

138 I really welcome today's hearing on a critical issue:
139 the coordinating and improving of health care of those dually
140 eligible for Medicare and Medicaid programs, otherwise known
141 as dual eligibles, and I appreciate my colleagues for working
142 with us in preparing this hearing and look forward to our
143 discussion. This is an area of our health care system that I
144 think has potential for effective change.

145 The reality is that dual eligibles are a vulnerable
146 population. Their care is both costly and frequently
147 uncoordinated, which is resulting in poor outcomes in many
148 cases. In total, there are 9.2 million Americans who rely on
149 both Medicare and Medicaid. Meanwhile, they are
150 significantly poorer and tend to have extensive health care
151 needs. Overall, they are also more likely to suffer from
152 chronic conditions such as heart disease, pulmonary disease,
153 diabetes and Alzheimer's disease, and as such, their care is
154 complicated and too often they are not receiving the patient-
155 centered care they need and that they deserve.

156 In addition, dual eligibles represent less than 20

157 percent of the Medicare and Medicaid programs but bear the
158 responsibility for a significant amount of the programs'
159 expenses. In fact, in 2007, they comprised only 15 percent
160 of enrollees but represented 39 percent of Medicaid spending
161 and their medical costs were more than six times higher than
162 non-disabled adults in Medicaid. Meanwhile, in Medicare,
163 they represent 16 percent of enrollees and 27 percent of
164 expenditures. Compared to all other Medicare enrollees, the
165 health costs are nearly five times as great.

166 These are powerful numbers that demonstrate if we can
167 improve care coordination and make life better for these
168 individuals, there is also an opportunity for savings. That
169 is why, in passing the Affordable Care Act, we created the
170 Federal Coordinated Health Care Office at the Department of
171 Health and Human Services, otherwise known as the Medicare-
172 Medicaid Coordination Office. Its mission is to gain some
173 much-needed efficiency within the system for this group of
174 beneficiaries.

175 I must admit, the timing of the coordinated office, as
176 well as today's hearing, couldn't be better. Congress and
177 this committee are increasingly concerned about the rising
178 cost of Medicare health care coverage for the 45 million
179 elderly and disabled Americans and Medicaid's 55 million poor
180 patients. So what better place to explore, understand and

181 address than the sickest and most expensive populations to
182 cover. But we mustn't set a price tag on their care nor
183 should we shape policy with the goal of only saving money.

184 It is clear we have some real big challenges, yet some
185 real big opportunities in providing care for dual eligibles.
186 So I look forward to hearing from our expert panel today, and
187 I would specifically like to welcome Ms. Melanie Bella, the
188 head of the new coordinated office. I know that she has a
189 long history of aiming to restructure the services of dual
190 eligibles, so I look forward to hearing about her innovative
191 work.

192 I also look forward to hearing about the successful
193 efforts represented here today by the different panelists. I
194 hope we can hear some new ways Congress can be helpful in
195 addressing what has been a longstanding problem facing our
196 health care system.

197 And I yield back, Mr. Chairman. Thank you.

198 [The prepared statement of Mr. Pallone follows:]

199 ***** COMMITTEE INSERT *****

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200 Mr. {Pitts.} The chair thanks the gentleman and
201 recognizes the full committee chairman, Mr. Upton, for 5
202 minutes.

203 The {Chairman.} Well, thank you, Mr. Chairman.

204 According to CMS, more than 9 million Americans qualify
205 for both Medicare and Medicaid, including at least 257,000 in
206 Michigan.

207 I want to thank our two panels this afternoon for
208 agreeing to share their expertise in serving this vulnerable
209 population often referred to as dual eligibles. We look
210 forward to hearing your perspective on the health care needs
211 and the barriers that currently prevent them from properly
212 navigating the health care system.

213 This hearing is important for two key reasons. First,
214 we must better understand the distinctive behavioral and
215 physical health care complexities associated with the dual-
216 eligible population. And second, we need to better
217 understand what is currently being done to help these
218 individuals navigate the health care system. By the end of
219 the hearing, we should be able to identify what initiatives
220 exist to effectively integrate care for dual-eligible
221 populations, what coordination models are working, what
222 prevents these effective models from expanding, and building

223 on the positive efforts already underway, we must also look
224 for ways to modernize the current structure so these
225 individuals are ensured access to quality health care with
226 less red tape.

227 Most Americans have uniform coverage that guides them
228 through the complex health care system, but for the dual
229 eligible, that process is more complicated because have to
230 navigate the waters of two different entitlement programs
231 that offer different benefits and cover different services
232 and providers. Because of that segmented structure, we have
233 come to learn that dual eligibles have difficulty identifying
234 where to access good, quality care. Not surprisingly, they
235 frequently end up in the ER, which is harmful to both
236 patients and taxpayers who end up with the costly bill for
237 preventable hospitalizations.

238 Again, we welcome you, and I yield the balance of my
239 time to Dr. Cassidy.

240 [The prepared statement of Mr. Upton follows:]

241 ***** COMMITTEE INSERT *****

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242 Dr. {Cassidy.} Thank you, Chairman Pitts.

243 Medicare and Medicaid are important programs that are
244 unfortunately unsustainable in their current form. Medicare,
245 per the actuaries who run the program, is going bankrupt in
246 10 years hastened by \$500 billion extracted from it by
247 Obamacare. Medicaid is bankrupting States, and this was
248 before the Obamacare mandates that usurp States' rights.

249 Now, as a doctor who teaches, who still teaches and
250 treats the uninsured in a public hospital, though, my primary
251 concern is patient welfare, and fortunately, there is an
252 opportunity for improvement. As we know, dual eligibles
253 oftentimes have poor outcomes. Now, Republican have proposed
254 freeing States from the rigid Medicaid rules, which make it
255 difficult to coordinate benefits between Medicaid and
256 Medicare. We have also put forward a plan to save Medicare
257 from bankruptcy, to preserve Medicare as it has been known
258 for those who are on it, and to preserve it for those who
259 will be on it. Now, saving Medicare from bankruptcy is
260 important for all Americans, all senior citizens, but
261 particularly for dual eligibles.

262 Now, unfortunately, under the current situation,
263 Medicare provides incentives to treat patients in one way and
264 it provides Medicare incentives to treat patients in another

265 way, and these dueling incentives oftentimes lead to poor
266 patient outcomes. This is the problem of large bureaucracies
267 trying to dictate what happens to a patient in the patients'
268 exam room. We can do better.

269 So despite the fact that Medicare and Medicaid spend
270 disproportionate amounts upon dual-eligible patients, again,
271 their outcomes are poor, and this is actually the most
272 important issue. Now, we should note that we shouldn't take
273 the policy of do nothing for short-term political gain and
274 kick this issue of Medicare's fiscal solvency as an issue
275 down the road. We have got to address it now.

276 I am very interested in the perspectives presented here
277 today. I have had the pleasure to speak with Ms. Bella. She
278 is knowledgeable. I just look forward to it. Similarly, the
279 perspective of the PACE providers and the States. I will say
280 the Office of Dual Eligibles, I kind of like that. It is the
281 one provision of Obamacare I applaud. As we say in the
282 South, even a blind hog finds an acorn every now and then.

283 I yield back.

284 [The prepared statement of Dr. Cassidy follows:]

285 ***** COMMITTEE INSERT *****

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286 Mr. {Pitts.} The chair thanks the gentleman and
287 recognizes the ranking member of the full committee, Mr.
288 Waxman, for 5 minutes for an opening statement.

289 Mr. {Waxman.} Thank you very much, Mr. Chairman.

290 As observers of this hearing will note that by and large
291 whether you are a Democrat or a Republican, we care about
292 this issue and this is a hearing where we have collaborated
293 in providing panels that will give us the best information on
294 how we can address the problems that are unique to the people
295 who are dual eligibles, or both on Medicare and Medicaid.

296 This has been a major issue facing both programs. By
297 design, these individuals should have access to the best of
298 these programs, the best that each one has to offer, but too
299 often they struggle, fall between the cracks and cycle in and
300 out of nursing homes, hospitals, specialty care without
301 receiving the coordinated patient-focused care they deserve.

302 Dual eligibles are not a homogenous group but they can
303 be considered as several subgroups. Some, such as Medicare
304 beneficiaries who are eligible for Medicare by virtue of
305 their age and for Medicaid because they have low income, can
306 be in their mid 60s and may not differ significantly from
307 other Medicare beneficiaries in their need for care. Others,
308 however, such as adults under 65 with developmental

309 disabilities such as cerebral palsy or intellectual
310 disabilities, require significantly more care and resources
311 to live their lives. Older Medicare beneficiaries with
312 cognitive impairments such as Alzheimer's are another
313 significant and very frail subgroup, a group we are going to
314 hear about today.

315 Many of these individuals may require nursing home level
316 of care or home-based support services allowing them to live
317 outside of an institution. A disabled person under the age
318 of 65 costs Medicare and Medicaid between \$23,000 and \$84,000
319 in 2005 depending on whether he or she needed nursing home
320 stay. This is very expensive but not getting this care is
321 worse, resulting in eroding health, trips to the emergency
322 room, suffering for the patient and his or her family, and
323 astronomical costs for the patient and the taxpayer. These
324 costs present both a challenge and an opportunity to develop
325 and implement reforms that over time will simultaneously
326 improve care while reducing costs.

327 There is a Medicare Payment Advisory Commission and the
328 Medicaid and the child health program have their commissions
329 as well, and all these commissions have described how a lack
330 of coordination between Medicare and Medicaid can create
331 harmful and wasteful outcomes and misaligned incentives. For
332 example, a nursing facility may find it profitable to

333 transfer a complex patient to a hospital even if the facility
334 is capable of managing that patient because of different
335 payment rates and benefit rules in each program.

336 We have heard in this committee many times over the
337 years about problems generated by pure fee-for-service
338 medicine that provides no coordination of benefits. For
339 dually eligible beneficiaries, those problems are multiplied
340 because of their intensive care needs.

341 We face a lot of challenges in improving care for dual
342 eligibles and reducing costs to the taxpayer but it is
343 important to recognize that we shouldn't rush into new
344 programs for purely a budgetary focus. We should not assign
345 a price tag to this population and then design the policy
346 around it.

347 As we will hear today, the best and most successful
348 efforts to integrate care for the duals has been local and it
349 has been focused on a small group of beneficiaries. These
350 programs have been built around intensive interventions by
351 nurses, physicians, social workers, therapists and others.
352 But these interventions can be difficult to scale up to a
353 large population, and I think we need to be wary about grand
354 promises regarding this decades-old problem.

355 I want to mention that one of the results of the
356 Affordable Care Act, which some people call Obamacare, was to

357 extend the Medicare trust fund, and in fact, it was extended
358 over 12 years. Another thing to recognize is that whatever
359 cuts some of our colleagues objected to in the Affordable
360 Care Act, they took all of those cuts and went way beyond it
361 in their Medicare proposal, which they would transform into a
362 whole different system.

363 We have opportunities to save money we are spending on
364 dual eligibles by examining the drug rebates in Part D where
365 we pay a higher price for the dual eligibles than we used to
366 pay in the past. Providing better coordinated care and saving
367 money are not mutually exclusive goals and for the dual
368 eligibles, this may be the key to improved quality of care.

369 Thank you, Mr. Chairman, for calling this hearing.

370 [The prepared statement of Mr. Waxman follows:]

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372 Mr. {Pitts.} The chair thanks the gentleman.

373 We have two panels today, and I would like to ask panel

374 one to take her seat at the witness table. I want to thank

375 all the witnesses for agreeing to appear before the

376 committee. On panel one, we welcome Melanie Bella, who is

377 the Director of the Medicare and Medicaid Coordination Office

378 at the Centers for Medicare and Medicaid Services. Your

379 written testimony will be made part of the record. We would

380 ask that you please summarize your opening statement to 5

381 minutes and then we will go to questions and answers.

382 Welcome.

|
383 ^STATEMENT OF MELANIE BELLA, DIRECTOR OF THE FEDERAL
384 COORDINATED HEALTH CARE OFFICE, CENTERS FOR MEDICARE AND
385 MEDICAID SERVICES (CMS)

386 } Ms. {Bella.} Good afternoon, Chairman Pitts, Ranking
387 Member Pallone, Chairman Upton, Ranking Member Waxman and
388 members of the subcommittee. Thank you for the invitation to
389 participate in this discussion today. My name is Melanie
390 Bella, and I am the Director of the Federal Coordinated
391 Health Care Office at the Centers for Medicare and Medicaid
392 Services.

393 This office, which we are referring to as the Medicare
394 and Medicaid Coordination Office, to better explain our
395 mission, was created by the Affordable Care Act and our
396 single focus is the topic of the hearing today.

397 Medicare and Medicaid enrollees, also referred to as
398 dual eligibles, are a heterogeneous group. They include low-
399 income seniors, individuals with disabilities as well as
400 those with serious and persistent mental illness. Some
401 individuals start on Medicaid and age into Medicare. Other
402 individuals start on Medicare and have a functional or a
403 financial decline that makes them Medicaid eligible. Either
404 way, these individuals have very complex care needs. Three

405 out of five have multiple chronic conditions and two out of
406 five have at least one mental or cognitive impairment. Not
407 surprisingly, given their higher-than-average health care
408 needs, the cost of providing care for these individuals is
409 significant. Together, Medicare and Medicaid spend roughly
410 \$300 billion a year to provide care to this population.

411 Our office is working across Medicare and Medicaid with
412 States, providers and other stakeholders on a number of key
413 initiatives to ensure better health, better care and lower
414 costs through improvement for Medicare and Medicaid
415 enrollees. Specifically, our efforts are focused in three
416 main areas. The first is program alignment, the second is
417 data and analytics, and the third is models and
418 demonstrations. I will highlight a few of those efforts
419 today starting with program alignment.

420 Better coordination begins with program alignment.
421 Currently, Medicare and Medicaid enrollees must navigate two
422 completely separate systems, Medicare for coverage of basic
423 acute-care services and drugs, and Medicaid for coverage of
424 supplemental benefits such as long-care care supports and
425 services. Medicaid also provides help with Medicare premiums
426 and cost sharing. Although both programs provide important
427 benefits, they operate as separate systems with different
428 administrative procedures, statutory provisions and payment

429 policies. One of the first objectives of our office was to
430 catalog all of the places where Medicaid and Medicare
431 literally bump up against each other. This creates barriers
432 to effective care, and through internal and external
433 consultation and outreach, we use that opportunity to
434 identify places where we can improve alignment between the
435 two programs. We have published a list of these alignment
436 opportunities in the Federal Register, specifically to invite
437 public comment. This alignment initiative will allow us both
438 to identify barriers to high-quality cost-effective care as
439 well as prioritize areas for improvement.

440 Another key objective of this new office is to engage
441 our State partners. Improving quality and cost of care for
442 Medicare and Medicaid enrollees relies on effective
443 partnership with States because we share the responsibility
444 to provide care and to finance that care for this population.
445 Our office has recently announced two key initiatives that
446 support our State partners in improving care coordination for
447 Medicare and Medicaid enrollees. One of these initiatives
448 was the establishment of a new process for States to access
449 Medicare data for care coordination purposes. Lack of timely
450 Medicare data, particularly Part D data, has been a key
451 barrier for States in expanding care management efforts for
452 their dual population. These data provide States with a

453 powerful new tool to support their efforts to improve care
454 for some of their most complex and costly beneficiaries.

455 The second initiative done in partnership with the
456 Center for Medicaid and Medicare Innovation is the State
457 demonstrations to integrate for dual-eligible individuals
458 under which 15 States were competitively selected to design
459 new approaches to better coordinate care for Medicare and
460 Medicaid enrollees. Through these design contracts, CMS is
461 providing funding to selected States to support their efforts
462 to design person-centered approaches to coordinate care
463 across primary, acute, behavioral health and long-term
464 supports and services. The goal of this initiative is to
465 identify and validate new care delivery and payment models
466 that can be tested and then replicated in other States.
467 Importantly, though, our office serves as a resource to all
468 States and is available to provide technical assistance to
469 any State interested in working to improve quality and reduce
470 costs for its Medicare and Medicaid enrollees.

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

477 that improved care coordination and quality outcomes for this
478 complex population will result in better care at reduced cost
479 for both the Federal Government and States. Thank you very
480 much.

481 [The prepared statement of Ms. Bella follows:]

482 ***** INSERT 1 *****

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483 Mr. {Pitts.} Thank you. I want to thank you for your
484 opening statement. I will now begin the questioning and
485 recognize myself for 5 minutes for that purpose.

486 Director Bella, in a 2010 paper entitled ``Options for
487 Integrating Care for Dual-Eligible Beneficiaries,'' you
488 wrote: ``The goals should be clear: to provide
489 beneficiaries with the right care at the right time in the
490 right places and to give States and other stakeholders the
491 flexibility they need to design and test accountable models
492 of integrated care.'' Is it fair to say that you still
493 believe the current system does not provide States the
494 sufficient flexibility or incentives necessary to integrate
495 care for duals?

496 Ms. {Bella.} As I mentioned in my testimony, States are
497 critical partners for us and so we have to recognize the
498 variation in the States and understand where the States are
499 in being able to develop models to improve care for this
500 population. When I think of flexibility for this population,
501 I don't think of it in the context of being able to cut
502 benefits or services. I think about it in terms of we have a
503 population with very complex needs and we have to be able to
504 adapt to those needs, and by adapting to those needs, it
505 allows us to provide more cost-effective care than might

506 otherwise be available in the traditional Medicare and
507 Medicaid systems when they are fragmented and not integrated.
508 And so we see potential for integrated and coordinated
509 systems to be able to take a holistic look at an individual,
510 understand what that individual needs and make sure that we
511 are getting those needs met in the most cost-effective way.

512 Mr. {Pitts.} What feedback have you received from
513 States in your current capacity about their interest and
514 willingness to further integrate care for duals?

515 Ms. {Bella.} It is a great question. Everyone knows
516 States are financially strapped right now, now more than ever
517 before, and they recognize a tremendous opportunity to
518 improve quality, and by improving quality, help control costs
519 with this population. I have seen more motivation in States
520 than ever before to really understand the needs of this
521 population and to develop integrated and seamless systems of
522 care. Again, that improved quality, and by improving quality
523 will lead to reduced cost over time.

524 Mr. {Pitts.} As you know, there are various opinions on
525 how dual eligibles should be enrolled in integrated care
526 models or in coordinated care programs. Do you believe that
527 mandatory enrollment with an opt-out policy would increase
528 enrollment?

529 Ms. {Bella.} Certainly, enrollment is a significant

530 issue, and first and foremost I should say that the
531 commitment of our office is really to establish beneficiary
532 protections so that the programs we are creating are ones
533 that are better than what are available to beneficiaries
534 today.

535 In thinking about enrollment, enrollment is one of many
536 issues where we have to be open to exploring options to
537 understanding what is keeping people out of integrated
538 systems today, and again, this is one of the issues on the
539 list that we are committed to exploring with our State
540 partners.

541 Mr. {Pitts.} Your office recently announced the
542 availability of Medicare data on duals for States to access
543 on a project basis. Why do believe the availability of this
544 data was so important for States and what else can CMS do to
545 improve the availability of real-time Medicare data for
546 States and providers?

547 Ms. {Bella.} Well, I have a personal interest in this.
548 I am a former Medicaid director, and when Part D happened and
549 Medicaid agencies lost access to pharmacy data, it was like
550 tying their hand behind their back because a critical tool
551 was taken away to understand how to provide better care to
552 these beneficiaries. So by giving States these data, we
553 support their efforts to identify high-risk individuals to

554 provide the data to primary care providers and care managers
555 who are developing care plans to understand opportunities to
556 prevent hospitalizations, for example, or to reduce
557 medication errors or medications that are going to have
558 adverse effects with each other. We believe that putting the
559 data out there for States that we have will get them exactly
560 where they need to be. It is timely. It covers Medicare A,
561 B and D, and it is done in a way that allows us to protect
562 the important privacy and confidentiality safeguards yet
563 still give this critical tool to States who are trying to
564 design programs to improve quality.

565 Mr. {Pitts.} I think I have time for one more question.
566 Realizing the Medicaid expansions in PPACA do not directly
567 apply to dual eligibles, do you believe implementation of the
568 expansions could have a woodworking effect on the overall
569 system that could increase the number of woodworking dual
570 eligibles?

571 Ms. {Bella.} We have not done--the Office of the
572 Actuary has not done as detailed estimates on this as in
573 other populations but our early examination of the issue does
574 not lead us to believe that there will be a woodwork effect
575 for dual eligibles under the expansion.

576 Mr. {Pitts.} Thank you.

577 The chair recognizes the ranking member, Mr. Pallone,

578 for 5 minutes for questions.

579 Mr. {Pallone.} Thank you, Mr. Chairman. I was going to
580 ask unanimous consent for Ms. Christensen to sit in on
581 today's hearing, Mr. Chairman.

582 Mr. {Pitts.} Without objection, so ordered.

583 Mr. {Pallone.} Thank you, Mr. Chairman.

584 I wanted to try to ask you three questions and get to
585 get in three questions here, Ms. Bella. My first relates to
586 budgetary concerns. As you heard in my opening statement, I
587 am always concerned that decisions about dual eligibles are
588 based on budget concerns. I am not suggesting that that is
589 true for you but I always worry that that is a big factor or
590 maybe disproportionate to what it actually should be. And as
591 we said, you know, it is a very complicated group. There are
592 patients like people with developmental disabilities who may
593 be well under 65 but you also have duals who are people with
594 cognitive impairments like Alzheimer's diseases at advanced
595 stages, so because they are not the type of patients that
596 insurance companies are rushing to sign up for, you know,
597 that is another concern I have. It is a very expensive
598 population. So I think we have to be creative and assertive
599 in our attempts to improve care for duals but we also need to
600 be realistic in our goals and understand that it may be
601 costly and budgetary expedience should not drive our

602 treatment of the sickest and the frailest of our citizens.

603 So my question is, first question, can you tell us about
604 how you and your office are thinking about the dual eligibles
605 as groups? Are you looking at them by what kinds of diseases
606 that they might have or by the basis for eligibility for the
607 programs, and of course, you know, my concern is that it is
608 not budgetary driven.

609 Ms. {Bella.} You are exactly right. It is a very
610 diverse group. There are a few different ways that you can
611 think about slicing and dicing the population, and I think
612 that is one of the advantages to having this office is we are
613 really going to drill down and look at subset analysis of the
614 population. One of the ways we are looking is at the highest
615 level over and under 65 to understand the different care
616 needs of those groups and, for example, when the under-65
617 population with disabilities, the presence or absence of
618 mental illness, I like to call it a game changer. It
619 significantly changes the utilization, the picture. On the
620 corollary, the over 65s, the same thing can be said for
621 Alzheimer's and dementia, and you will hear more about that
622 today. So we are looking at those levels and we are teasing
623 out the subsets.

624 In addition, there is also ways of looking at the
625 population, understanding if their needs are more acute-care

626 driven so folks who have five, six, seven or eight physical
627 comorbidities or if they are long-term care driven, so these
628 are folks who have needs that are more supportive services
629 and those types of needs and the long-term care, some of
630 those individuals are in nursing homes and some of them are
631 in the community, so that further distinguishes how we have
632 to think about subsetting the population. Now, we tend not
633 to think about it by conditions or by eligibility groups. We
634 tend to look for care opportunities. So regardless of what
635 the profile is in many ways what needs to happen for these
636 patients is an assessment of their needs is the availability
637 of a care team, supports to get them the most cost-effective
638 services they need in whichever setting they need them.

639 So coming back to your question, those are examples of
640 ways we are looking at subsetting the population, and then
641 using that information to drive our decisions about what
642 types of care models, what types of care needs, what types of
643 payment and measurement systems we would have in place.

644 Mr. {Pallone.} Now I am going to try to get two more
645 things in. You mentioned the nursing home population. More
646 than half of all nursing facility residents are dual
647 eligibles. In 2007, more than 70 percent of Medicaid
648 expenditures for dual eligibles were for long-term care.
649 What can be done to improve the care and quality for people

650 in nursing homes and what are States proposing that would
651 help these individuals? Obviously I would prefer that they
652 not be in nursing homes. Are there ways to improve care in
653 nursing homes or get them out of nursing homes altogether so
654 they don't have to stay in the nursing homes?

655 Ms. {Bella.} The answer to that is yes, there are ways
656 to improve the care, and there are several States, many
657 States that are looking at rebalancing efforts. I think you
658 will hear about some initiatives in North Carolina in
659 particular to target those folks in nursing homes, but a
660 couple of examples. We can really focus on avoidable
661 hospitalizations of nursing home residents, and I will give
662 you some examples. Urinary tract infection, pressure ulcers,
663 dehydration, fall prevention, those are all things that are
664 avoidable and they are preventable, and by targeting
665 interventions and clinical resources on site, we can improve
666 the quality of care, reduce hospital transfers and presumably
667 help toward the cost-effectiveness change as well.

668 Mr. {Pallone.} My third question is, I know that, you
669 know, they worry about passing the buck, in other words, is
670 the State--who is responsible for their care, the State, the
671 plan, you know, their insurance plan, and a lot of times
672 there is passing of the buck in terms of who takes care of
673 them, who follows up, how to enforce their rights and fulfill

674 their medical needs. Who is truly accountable at the end of
675 the day for ensuring that the needs of duals are met and that
676 quality care is provided? Is it the plan, the State, the
677 Federal Government, and do you see it as part of your
678 office's mission to clarify that to make the pathway easier?
679 In other words, can you play a role in all this so that the
680 buck doesn't get passed?

681 I know I am out of time, Mr. Chairman. Maybe she can be
682 quick in her answer.

683 Ms. {Bella.} I will be quick. States and feds are
684 accountable. We share responsibility. Our office is
685 absolutely accountable, and I think the reason that was
686 created was to streamline care and to help make sure that we
687 do keep the systems together and improve accountability for
688 the program overall.

689 Mr. {Pallone.} So you try to coordinate between these?

690 Ms. {Bella.} Yes.

691 Mr. {Pallone.} Thank you.

692 Mr. {Pitts.} The chair thanks the gentleman and
693 recognizes the full committee chairman, Mr. Upton, for 5
694 minutes for questions.

695 The {Chairman.} Thank you, Mr. Chairman.

696 I appreciate your testimony. In your testimony of
697 course, you said the total annual spending for their care is

698 estimated at \$300 billion annually, and that the 9 million
699 Medicare/Medicaid enrollees accounted for approximately \$120
700 billion in combined Medicaid, federal and State spending in
701 2007, almost twice as much as Medicaid spent on all 29
702 million children that it covered in that year. Now, in
703 responding to Mr. Pallone, you talked about some savings you
704 may see in terms of targeting certain innovations. What
705 other ideas to eliminate barriers do you think we might be
706 able to achieve to actually see some real savings in the
707 program? What innovations should we think about here?

708 Ms. {Bella.} Sure. I appreciate the question.
709 Unfortunately, there is no silver bullet, and the savings
710 tend to happen over time. However, if you think about--I
711 think where we think holds the most promise is understanding
712 how do we create systems that are accountable and coordinated
713 for the 9 million dual eligibles. There are, by our count,
714 around 100,000 people that are in fully integrated programs,
715 and by fully integrated, I mean, there is an accountability
716 for both Medicaid and Medicare. So the opportunity is large
717 for the rest of the dual-eligible population, and absent that
718 coordination and integration, we are not as aligned and
719 efficient and effective as we could be. And so great
720 opportunity exists to look at delivery system and payment
721 reform models that understand how to create a way to take

722 care of the totality of a beneficiary's needs and how to
723 ensure that the incentives are aligned for doing so.

724 The {Chairman.} Well, can we actually come up with some
725 nuts and bolts to see not only the innovations but then lead
726 directly to some savings, and if so, what would the savings
727 be either as a percentage or real dollars?

728 Ms. {Bella.} So as was mentioned, one of the first
729 things we did is to engage States in a partnership to work
730 with us in an innovation center to design new fully
731 integrated models. So we have 15 States. That is exactly
732 what we are doing. We are working with them to design the
733 nuts and bolts of what this would take. We are in the design
734 phase so we don't have savings estimates for you at this
735 point. Certainly we can expect that there are opportunities,
736 as I mentioned, and some of the avoidable hospitalizations
737 but we also have seen in programs in the States that do have
738 them oftentimes there is an increase before you see a
739 decrease because there is a lot of pent-up demand, there is
740 care management that is occurring, there is new services that
741 are taking place in order to reduce other services now or
742 down the road. So it needs to balance out, but what we will
743 be working on getting some concrete estimates over time by
744 working with our States on the models that they would like to
745 do.

746 The {Chairman.} So as you are looking at those 15
747 States, how long will it take for them to complete the work
748 that they are doing and you can actually look at some
749 accountability in terms of what they have done?

750 Ms. {Bella.} The way we structured this demonstration
751 initiative right now is that it is a 12-month design period.
752 It doesn't mean that States that can't submit a proposal
753 earlier.

754 The {Chairman.} Which started when?

755 Ms. {Bella.} April.

756 The {Chairman.} April?

757 Ms. {Bella.} It started in April. Several States are
758 interested in putting something forward earlier, and as I
759 mentioned, all States are able to put proposals together, we
760 are just working with these 15 to receive funding, so States
761 aren't--like I said, they can come in sooner with ideas. We
762 designed this, because this isn't a typical CMS demonstration
763 where we are prescriptive about what we want to see because
764 that hasn't worked for us with the States so far, so we need
765 to work with the States to design what is going to be most
766 effective for each of them. However, this is a complex
767 population and we have to do this in a way that makes sure
768 that we are addressing significant issues around beneficiary
769 safeguards, provider participation, financial incentives

770 correctly, and that is why we have designed it in a design
771 phase.

772 The {Chairman.} Thank you. I yield back.

773 Mr. {Pitts.} The chair thanks the gentleman and
774 recognizes the ranking member of the full committee, Mr.
775 Waxman, for 5 minutes for questions.

776 Mr. {Waxman.} Thank you, Mr. Chairman.

777 There is an interaction between the issues we are
778 talking about today and the Medicare Advantage program is a
779 complicated one. Some Medicare Advantage special needs plans
780 have been around for a long time and built deep roots in
781 their communities. Others have less successful track records
782 and of course the program has for a long time been supported
783 by large subsidies provided by taxpayers and other
784 beneficiaries. The Affordable Care Act pared back many of
785 the extra payments to Medicare Advantage plans but not all of
786 them and not immediately. I was surprised to find that some
787 States are proposing to use Medicare Advantage benchmarks as
788 the basis for their proposed payments in the duals
789 integration demonstration. Ms. Bella, wouldn't the use of
790 Medicare Advantage benchmarks increase costs to the federal
791 taxpayer if they were adopted for duals integration
792 demonstration?

793 Ms. {Bella.} We certainly think that--as I mentioned,

794 our goal is to get more beneficiaries served in integrated
795 systems and so in integrated systems there is an opportunity
796 to achieve savings. You are obviously pointing out what we
797 all have seen in terms of the differential and the MA rates,
798 and I would just come back to that the purpose of the
799 innovation center is to develop and identify delivery system
800 and payment reforms that improve quality and reduce cost, and
801 so as we go forward with these demonstrations, that is going
802 to be our overriding principle, so we will work with States
803 to ensure that the proposals they are putting in place do
804 both of those things, which would mean understanding how we
805 would address the rate issue in a way that would support
806 improving quality but not add cost to the system.

807 Mr. {Waxman.} Well, we want to highlight that issue to
808 look at carefully in your design of these proposals. There
809 are numerous cost savings with regard to the Medicaid program
810 that shift costs from the Federal Government to the State
811 governments instead of lowering cost. The intent of this
812 hearing and the mission of the Medicare and Medicaid
813 Coordination Office is to improve care for dual-eligible
814 individuals, thereby lowering health care costs in Medicaid
815 and Medicare, a better way of saving money than shifting
816 responsibility.

817 I want to ask about some of these contracts you have

818 been talking about in response to other questions. You
819 recently awarded to 15 States to design coordination care
820 models. One requirement you included was integrating care
821 across primary, acute, behavioral health and long-term
822 support services. Can you discuss the importance of
823 integrating care across all these benefits, the barriers to
824 integrating care across all these benefits and how prevalent
825 such full integration is today?

826 Ms. {Bella.} Sure. The importance is to get at exactly
827 what you talked about, the opportunity to cost-shift, so we
828 need to mitigate or eliminate those opportunities, for
829 example, if we have acute care in one system and long-term
830 care in another system. But more importantly, if we are
831 going to put together systems of care that are better for
832 real people that need them, we have to provide a seamless way
833 of them interacting with the system rather than three
834 different cards, three different doctor networks, three
835 different grievances and appeals, and I say three because
836 most of the duals are in separate Part D plans so they are
837 navigating Medicaid, Medicare and pharmacy coverage. So that
838 is the importance of putting everything together in a way
839 that is seamless to them.

840 The challenges are many. There are certainly always--
841 whenever you change a system, there are concerns. We have

842 concerns with capacity, with provider capacity, particularly
843 in the long-term supports and services side. We have carve-
844 outs in some States, particularly around behavioral health,
845 so all those issues that we need to address, but the
846 opportunity is great, and one of the reasons these States
847 were selected was because they are committed to providing
848 full integration. As I mentioned earlier in response to
849 another question, we think only about 100,000, maybe 120,000
850 folks have fully integrated models. You will hear about one
851 of those today with the PACE program. But again, our goal is
852 to create those types of systems for significantly larger
853 numbers of Medicare and Medicaid enrollees.

854 Mr. {Waxman.} As you move forward in developing these
855 new systems for dual-eligible beneficiaries, I think it is
856 critical that you hear from the individuals and their family
857 caregivers and get their input into the process to ensure
858 that any new approaches are simple enough for these
859 individuals and their caregivers to navigate, protects the
860 rights currently guaranteed to beneficiaries in Medicare and
861 Medicaid while also meeting their health concerns. How will
862 your office ensure that we get these voices heard from the
863 patients and the caregivers?

864 Ms. {Bella.} Well, first of all, we share your
865 commitment and your interest in doing that. We are very

866 vigilant with the States on the expectations in terms of
867 stakeholder engagement. We have gotten wonderful input from
868 different consumer advocacy organizations about how to ensure
869 that is meaningful. We are doing focus groups of real dual-
870 eligible beneficiaries around the country so hearing from the
871 real people about what is working and what is not working,
872 why did some choose integrated systems, why did others not,
873 and so those types of conversations really will be informing
874 and driving our efforts.

875 Mr. {Waxman.} Thank you very much. Thank you, Mr.
876 Chairman.

877 Mr. {Pitts.} The chair thanks the gentleman and
878 recognizes the subcommittee vice chairman, Dr. Burgess, for 5
879 minutes for questions.

880 Dr. {Burgess.} Thank you, Mr. Chairman.

881 In the section of the Affordable Care Act that you
882 referenced that creates your office, there is paragraph E
883 says the Secretary shall as part of the budget submit to
884 Congress an annual reporting containing recommendations for
885 legislation that would improve care coordination and benefits
886 for dual-eligible individuals. When should we expect that
887 report?

888 Ms. {Bella.} So our office was officially created
889 December 30th through the Federal Register and so we missed

890 really the typical budget cycle. In February the Secretary
891 submitted a letter outlining the progress of the office to
892 date, committing to our priorities over the coming year, and
893 now that we are established we will get caught up on the
894 regular cycle and provide you that annual report as part of
895 the annual budget process as the mandate requires.

896 Dr. {Burgess.} So when should we expect to receive that
897 report?

898 Ms. {Bella.} Next year.

899 Dr. {Burgess.} Next year, January, next year--

900 Ms. {Bella.} Next year, February of 2012.

901 Dr. {Burgess.} It is just interesting, in the law that
902 was signed your office was created not later than March 1,
903 2010. It is always interesting how something can be created
904 3 weeks before the bill got signed into law.

905 Let me ask you a question. In January, Dr. Berwick was
906 at the Commonwealth Fund symposium that they put on every
907 year, and of course, he articulated this problem, and I think
908 he was a little more dramatic. He said 20 percent of the
909 beneficiaries are costing 80 percent of the money including
910 blind and disabled in that group as well. But that was a
911 pretty startling figure that he related. Now, another Member
912 of Congress who was there, and I can't take credit for this,
913 it was actually a Democrat who complained that American

914 health care was so complicated that he had to go out and hire
915 a concierge physician to manage his care between the two
916 coasts on which he lived, and so I asked Don Berwick, why
917 wouldn't you have a concierge doctor for a dual eligible. It
918 seems like it would make a lot more sense to pay a physician
919 to manage these conditions. I have got some figures from
920 2005 where it is \$26,000 a year that we spend on a
921 Medicare/Medicaid dual-eligible patient unless they have five
922 or more conditions in which case that cost doubles. It seems
923 like there is some significant efficiencies that could be
924 gained here through the integration of that care, whether you
925 call it a retainer physician, whether you call it integrated
926 primary care, but really putting the doctor and not the
927 agency and not a home health aide, putting the doctor in
928 charge of that patient and holding them accountable, of
929 course, to perform its metrics that you outlined, the
930 alignment, the data and the models and demonstrations. Why
931 not do that?

932 Ms. {Bella.} I don't think these things are mutually
933 exclusive. I think there are opportunities depending on what
934 is driving a beneficiary's needs. Some of them are less
935 medical. They are non-medical and so in those cases it does
936 make more sense to have a care manager, a behavioral health
937 specialist or a home health aide.

938 Dr. {Burgess.} But why not have a physician in charge
939 of all of those facets of care?

940 Ms. {Bella.} There are certainly models that do that,
941 and you may hear a little bit about those on the second
942 panel. There are a lot of medical-home initiatives underway
943 right now which the primary purpose is to support the
944 physician and provide infrastructure support so that the
945 physician is managing the totality of the care and is
946 accountable for the financing, so I think there is a lot of
947 promise for many of those models and several States are
948 exploring those very things.

949 Dr. {Burgess.} Well, forgive me for seeming impatient.
950 I think there is a lot more than a lot of promise. I think
951 there is a deliverable that could be obtained really in a
952 much shorter time frame than anything we have heard discussed
953 here this afternoon, and we are talking about enormous
954 amounts of money. We are talking about people's lives,
955 people who are medically fragile, whose care is of utmost
956 criticality to them and to their families, and I simply
957 cannot understand why we wouldn't move with greater dispatch.
958 We are going to have to wait another year for a report from
959 your office. I mean, these are things that should have been
960 in the works for some time.

961 Ms. {Bella.} Certainly, developing new delivery system

962 and payment models is first and foremost on what we are
963 doing. We are happy to come over and do briefings at any
964 time, and we have done that repeatedly with several staffs.
965 And the only other thing I would say is, again, it is not
966 that we are not advancing physician-directed medical-home-
967 type models but we are also looking at different types of
968 care models, some of which are less expensive and perhaps
969 better tied to a beneficiary's needs, which again would I
970 think advance what you are charging us to today, which is
971 control cost.

972 Dr. {Burgess.} Well, you do get what you pay for. You
973 know, the experience with the accountable care organization
974 rules and regs that came down is just so disappointing. So
975 many people had placed so much emphasis on this and so much
976 importance, and then to find the reg was absolutely
977 unworkable, that clinics who actually considered themselves
978 accountable care organizations said we can't do this, and I
979 worry about the same thing happening in this population where
980 it is so critical that we get it right.

981 Mr. {Pitts.} The chair thanks the gentleman and
982 recognizes the gentleman from Illinois, Mr. Shimkus, for 5
983 minutes for questions.

984 Mr. {Shimkus.} Thank you, Mr. Chairman.

985 Welcome. We are glad to have you here. Realizing that

986 the Medicaid expansions in the health care law do not in
987 totality affect dual eligibles, do you believe that the
988 expansion of Medicaid--and I know you mentioned this
989 woodworking aspect--do you fear the woodworking aspect with
990 the expansion of Medicaid under the health care law?

991 Ms. {Bella.} We don't, no.

992 Mr. {Shimkus.} The latest MedPAC report included a
993 chapter on dual eligibles. In its report, the commission
994 noted that a single program design is not likely to be
995 adopted in every State. They added, there is no clear
996 evidence about which programs are most effective for every
997 type of dual-eligible beneficiary. Do you agree that a one-
998 size-fits-all strategy for improving the coordination and
999 integration of care for duals is a bad strategy?

1000 Ms. {Bella.} We think it is very important that we
1001 recognize that there are different delivery system designs in
1002 the States, and if we are going to be effective, we have to
1003 work with States to understand what systems are going to work
1004 best for a given State, and honestly, for a population within
1005 that State.

1006 Mr. {Shimkus.} And following up on that, do you believe
1007 that mandatory enrollment with an opt-out policy would
1008 increase enrollment?

1009 Ms. {Bella.} As we discussed a little bit ago,

1010 enrollment is obviously a significant issue. We don't have
1011 as many people in these types of systems as we would like to
1012 today so it is one that we are exploring to understand. It
1013 is one that we are learning from in the focus groups as well
1014 to understand what it is that is holding back enrollment, and
1015 that is one of the things that is part of this design process
1016 in our work with both States and stakeholders.

1017 Mr. {Shimkus.} And part of the problem in obviously the
1018 Medicaid, the dual eligibles, the Medicaid and Medicare, is
1019 that the 50/50 share of Medicare and the ownership that the
1020 State has versus Medicare, which is the federal program, and,
1021 you know, the contention is or the fear that some States may
1022 not be motivated to help solve this based upon depriving them
1023 of the 50/50 share if Medicare is assuming more of a role, or
1024 a role. Can you talk me through that and your experience in
1025 talking with States and whether this might lend itself to a
1026 sharing of Medicare as part of this debate of how you have
1027 inclusive care?

1028 Ms. {Bella.} Sure. Our work with States highlights
1029 that an area that creates challenges is the misalignment of
1030 incentives between the Federal Government and the States.
1031 The governors have said that. NGA has said that. MedPAC has
1032 said that. This Administration recognizes that. So that is
1033 part of our work with States is to understand if we are going

1034 to get this right, we have to look at how we align the
1035 incentives to create systems of care that are better than we
1036 have today.

1037 Mr. {Shimkus.} And I will just end on this, and again,
1038 I appreciate your time and look forward to the second panel.
1039 Illinois in particular is a struggling State, as many States
1040 are, but we have a \$12 billion debt. A lot of it is due to
1041 the expansion of Medicaid without comparable increase in
1042 revenue by the State and so it just was borrowed money and
1043 the like. Under the health care law, which leads back to the
1044 first question, it actually increased enrollment for Medicaid
1045 versus over the very lucrative program the State has. That
1046 is why I would argue that there should be a concern about
1047 more people coming out into the arena based upon the expanded
1048 benefits, and I would hope that you all would take a closer
1049 look at that because I do think that is going to be
1050 additional liabilities for us that we are not calculating in
1051 costs today.

1052 Thank you, Mr. Chairman. I yield back.

1053 Dr. {Burgess.} Would the gentleman yield?

1054 Mr. {Shimkus.} I would yield to Dr. Burgess.

1055 Dr. {Burgess.} Can I go back to the integrated care
1056 question that I was talking about just a moment ago? So what
1057 is being done right now as far as making families aware of

1058 the availability of integrated type of care?

1059 Ms. {Bella.} It depends on a given State and a given
1060 health plan so there are opportunities to inform
1061 beneficiaries and their caregivers of integrated care options
1062 either through State efforts or through health plan efforts.

1063 Dr. {Burgess.} Is anything being done to enroll people
1064 in integrated care programs?

1065 Ms. {Bella.} Certainly, but there are two different
1066 enrollment processes, one for the Medicaid half of the person
1067 and one for the Medicare half of the person.

1068 Dr. {Burgess.} But the estimates I have are less than 2
1069 percent of all of the dual eligibles are in some type of
1070 integrated care program.

1071 Ms. {Bella.} Correct.

1072 Dr. {Burgess.} And yet the promise these types of
1073 programs hold is high. Maybe you can get back to me with
1074 some additional information on what is being done to foster
1075 that information.

1076 Ms. {Bella.} I would be happy to do so.

1077 Mr. {Pitts.} The chair thanks the gentleman and
1078 recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes
1079 for questions.

1080 Mr. {Latta.} Well, thanks very much, Director, for
1081 being with us this afternoon. I appreciate your time.

1082 Just a little background because I didn't see, where
1083 were you director at?

1084 Ms. {Bella.} Indiana.

1085 Mr. {Latta.} And how long were you the director in
1086 Indiana?

1087 Ms. {Bella.} From 2001 through 2005.

1088 Mr. {Latta.} I always like to find out a little bit
1089 about a person's background because sometimes it is good to
1090 see things from the other side of the fence. I was in the
1091 State legislature in Ohio for 11 years, and during that time
1092 we had our go-arounds, especially with the cost of Medicaid
1093 going up, what it is costing the State budget today, and so I
1094 am glad you have that experience.

1095 And not that I wasn't fascinated with all of your
1096 testimony but something struck me on page 4. In the second
1097 paragraph when you are talking about coordination of the
1098 offices, the one thing that really caught my attention was
1099 the seamless care, and I know that years ago when was in the
1100 legislature, I had been a county commissioner for 6 years
1101 prior to that, we had an individual in the county that we had
1102 a lot of problems trying to get to the right service, to the
1103 right place, and I was very proud of my home county in that
1104 we worked things out, and how we termed it was ``seamless.''
1105 And the reason I find that interesting is that how is it that

1106 it has taken this long for us to get to this point that after
1107 decades that we are finally starting to talk about seamless
1108 and then also in your testimony talking about the offices
1109 working to improve the collaboration and the communication
1110 out there. And again, I think that goes back that you have
1111 seen things from the other side of the fence that, you know,
1112 for decades States have been on the receiving end of things
1113 and the Federal Government is saying one thing and the State
1114 is saying, well, how are we going to get this done. So I
1115 will just ask you that.

1116 Ms. {Bella.} Well, a few thoughts. I mean, when these
1117 programs were created, I don't think it was ever envisioned
1118 there would be 9 million people eligible for both and so they
1119 work exactly as they were designed to work, which is
1120 completely separately, and we haven't had the resources to
1121 date committed and accountable for trying to put them
1122 together and create seamless systems, and you all fixed that
1123 by creating this office, and so I think it is a recognition.
1124 Oftentimes it seems to be the most difficult fiscal times
1125 that drive some good developments that could help real people
1126 and coordinate care, and that perhaps is what we are seeing
1127 today is one of the greatest advantages of having to realize
1128 where we need to focus is on this population and so we now
1129 have a group of people that is all we do, and so we are

1130 accountable for making that better and working with our State
1131 partners to do so.

1132 Mr. {Latta.} Let me ask this, if I may because, you
1133 know, I hate to say it this way, but we do have some
1134 established bureaucrats in this city that have been here for
1135 a while, and in listening to your testimony and answering the
1136 questions to other members with us today, you know, that you
1137 are talking about doing focus groups around the country, that
1138 you are going to be listening and that, you know, there is no
1139 one size that fits all because, again, like the State of Ohio
1140 is completely different than what is happening out in Idaho
1141 or you name it. But I think it is going to take the
1142 direction from you as someone that has seen it from the other
1143 side to really impose upon these individuals down here that
1144 there is something that occurs outside this beltway. I have
1145 folks back home ask me, I don't care what it is about, they
1146 say don't they understand what is going on back here, and it
1147 is very difficult to always have to tell them no. And so we
1148 are going to be looking for your guidance to make sure that
1149 these folks down here that have been here for a while
1150 understand that they do have to take that direction from you,
1151 that you are going to be listening, that you are going to
1152 have these focus groups to find out what works best.

1153 So with that, Mr. Chairman, I appreciate the time and I

1154 yield back.

1155 Mr. {Pitts.} The chair thanks the gentleman and
1156 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5
1157 minutes for questions.

1158 Dr. {Cassidy.} Thank you, Ms. Bella. I appreciated our
1159 phone conversation a little while ago and I appreciate your
1160 testimony today.

1161 Now, I have been trying to figure out, you mentioned the
1162 buckets of dual eligibles, and the partial duals versus the
1163 full duals, the full duals with the wraparound, and I gather
1164 the full duals may have custodial care paid for by Medicaid
1165 but medical services paid for by Medicare, and the partials
1166 will the deductible copay paid for by Medicaid. What percent
1167 of patients who are duals are in each bucket, and what
1168 percent of the expense of duals are in each bucket? Because
1169 clearly wherever--and then what are the medical outcomes of
1170 each bucket? Because clearly, if we have poor outcomes and
1171 higher expense for that more expense and poor outcomes in a
1172 bucket, that is where we should focus our attention, yet it
1173 seems as if it should take two different approaches.

1174 Ms. {Bella.} So the biggest bucket would be the full
1175 duals who are receiving all Medicaid services and Medicare
1176 services--

1177 Dr. {Cassidy.} Not to be rude, but just so I

1178 understand, so really, in the full duals, there is not that
1179 much that Medicaid is paying for for acute medical services,
1180 I gather; rather, they are paying for the custodial care. Is
1181 that correct?

1182 Ms. {Bella.} They are paying for largely the custodial
1183 care. They wrap around and provide some things like
1184 behavioral health services or home health, in cases where
1185 Medicare--it is wraparound acute. It is the wraparound for
1186 the cost share for the duals and then it is primarily the
1187 long-term care service and support.

1188 Dr. {Cassidy.} Okay. So then if we can differentiate
1189 how much the Medicaid dollar is going for custodial versus
1190 those medical services which Medicare does not pay for, do
1191 you all have data on that? Because I am gathering that most
1192 of the expense is in custodial care which is relatively--

1193 Ms. {Bella.} I would broaden it to call it long-term
1194 care supports and services just because people tend to think
1195 of custodial as an institutional base. So 70 percent of
1196 costs are in the long-term care bucket, if you will, for
1197 those folks.

1198 Dr. {Cassidy.} For the full duals?

1199 Ms. {Bella.} Yes, but again, that is not just the
1200 custodial care.

1201 Dr. {Cassidy.} So then if you separate out--okay.

1202 Medicare and Medicaid together, the duals are a higher
1203 percent relative to a cohort, a non-disabled cohort?

1204 Ms. {Bella.} Yes.

1205 Dr. {Cassidy.} Okay. So if you just look at the non-
1206 long-term-care costs for those duals, how does that relate
1207 compared to a cohort? Do you follow what I am saying?

1208 Ms. {Bella.} So on primarily their Medicare
1209 expenditures?

1210 Dr. {Cassidy.} Yes.

1211 Ms. {Bella.} Yes, they are still higher across the
1212 board.

1213 Dr. {Cassidy.} And is it as dramatic?

1214 Ms. {Bella.} It is fairly dramatic. I mean, if you
1215 think about they are qualifying people for both Medicaid and
1216 Medicare so they have not just the medical needs but they
1217 have a lot of psychosocial complexity.

1218 Dr. {Cassidy.} Now, let me ask you, we are going to
1219 hear about a PACE program, and I am very impressed with the
1220 concept of PACE but it is clearly not going to scale. I
1221 would like your perspective on why a program such as that is
1222 unable to go to scale.

1223 Ms. {Bella.} Well, PACE is designed for a very frail
1224 population so a couple of things. One is, PACE is for people
1225 who are 55 or older and you need a nursing facility level of

1226 care, so again, that is a very, very frail population.

1227 Dr. {Cassidy.} But that must be your highest expense
1228 population?

1229 Ms. {Bella.} It is a high expense, although--yes, it is
1230 a high expense.

1231 Dr. {Cassidy.} And there must be a heck of a lot more
1232 than 20,000 people or 100,000 or whatever.

1233 Ms. {Bella.} There are opportunities that Shawn will
1234 discuss, and they have been thinking about to get something
1235 that is available to more people in more States. It tends to
1236 be resource-intensive to get some of the programs started but
1237 it has very fundamental concepts that we want to replicate.

1238 Dr. {Cassidy.} Well, I accept that, it has got great
1239 concepts, and say this not to diss but rather to say--that is
1240 disrespect--but rather just haven't gone to scale.

1241 Ms. {Bella.} Yes. He is going to get into a lot more,
1242 but I would be happy to have another conversation with you
1243 offline.

1244 Dr. {Cassidy.} The ACO rules which are just, I mean,
1245 place great faith in supercomputers to contact, to follow
1246 different patient interactions, physician interactions I
1247 almost see as counterproductive. Have you read the ACO rules
1248 and thought about how they are going to apply to dual
1249 eligibles?

1250 Ms. {Bella.} I have to be honest, I haven't read every
1251 single page. I have read a majority and have been thinking
1252 about how do you take that model for folks that have long-
1253 term care, not just acute-care needs, and that have different
1254 funding streams, both Medicare and Medicaid, and make sure
1255 that we are creating a system that again doesn't provide
1256 opportunities--

1257 Dr. {Cassidy.} I understand that is what your approach
1258 is but what I have just gathered from you, most of the
1259 Medicaid expense is actually on the long-term care aspect of
1260 it and the ACO is going to be principally on the acute
1261 medical services. In that way, the ACO still doesn't dictate
1262 or assign or anything else, it just follows. I think you
1263 answered the question. The following, it still seems like
1264 that is what we have now. You are just merely following and
1265 paying a lot of money for this coordinated care.

1266 Ms. {Bella.} We are excited about the opportunity to
1267 work with our States. Again, we are thinking about how do
1268 you adapt more of a managed fee-for-service approach that has
1269 an accountability like an ACO that brings in the long-term
1270 care side for this population.

1271 Dr. {Cassidy.} Thank you. I yield back.

1272 Mr. {Pitts.} The chair thanks the gentleman and
1273 recognizes the gentleman from Kentucky, Mr. Whitfield, 5

1274 minutes for questions.

1275 Mr. {Whitfield.} Thank you, Mr. Chairman, and Ms.
1276 Bella, thanks for being with us today.

1277 When the Affordable Care Act was passed, the method used
1278 in passing it created a lot of animosity, much of which is
1279 still out there, and I am assuming that you were not even
1280 working at CMS when it passed, but the method used, for
1281 example, when it was on the House Floor, this bill was 2,500
1282 pages, whatever it was, we were not allowed to even offer one
1283 amendment. So I contrast that sort of process to deal with a
1284 complicated health care delivery system that has a lot of
1285 problems with what you are doing in your coordination office
1286 in which you are giving \$1 million to 15 different States for
1287 the purpose of allowing them to explore, be innovative and
1288 see if they can come up with a system that works so it could
1289 be replicated in other States, which I think is commendable.
1290 But that same suggestion has been made for Medicaid regarding
1291 the grants to the States. A lot of controversy in the
1292 Republican budget was, we will have a capitated system for
1293 Medicaid.

1294 My question would be, don't you think that there would
1295 be some merit in working out a system so that individual
1296 States on Medicaid could explore, be innovative? I know we
1297 are not talking about dual eligibles per se but the Medicaid

1298 program. Do you see any benefit by setting up a system that
1299 would work like that?

1300 Ms. {Bella.} We are really kind of singularly focused
1301 on setting up coordinated and accountable system for dual
1302 eligibles and making sure that there are beneficiary
1303 protections, access to care and funds sufficient to provide
1304 care in such a way that eventually helps with the cost
1305 conundrum.

1306 Mr. {Whitfield.} But at least you all are doing that
1307 with 15 States, so I think that is a good idea.

1308 I would like to yield the balance of my time to Dr.
1309 Burgess.

1310 Dr. {Burgess.} Thank you, Mr. Whitfield.

1311 If I could, let us just go back the fact that the
1312 spending per dual eligible in 2005, \$26,000, unless they had
1313 five or more conditions in which case it doubled to \$50,000.
1314 Obviously more medical conditions are going to cost more but
1315 it seems like that amount is greater in the dual-eligible
1316 realm than it is for the comparable Medicare patient with
1317 five or more chronic conditions. Is that a fair statement?

1318 Ms. {Bella.} Across the board, dual eligibles rate
1319 higher than Medicare-only beneficiaries, yes.

1320 Dr. {Burgess.} So is that increasing cost only because
1321 of the cost of long-term care or is there something else that

1322 is entering into that? What accounts for that cost
1323 differential?

1324 Ms. {Bella.} Well, this is a much more complex
1325 population and so the needs that they have and the way those
1326 needs translate into utilization of services is what drives
1327 cost. I mean, across the board, again, this population is
1328 poorer, sicker, more impaired than any other population.

1329 Dr. {Burgess.} Correct, which is why my anxiety about
1330 not having a knowledgeable medical person in charge of
1331 orchestrating all aspects of that care, if you don't have
1332 that, then you are going to get what you have got, and the
1333 last thing we want is more of what you have got because we
1334 haven't got any more to give to pay for what you have got.
1335 Do you follow me? I mean, this is so critical that we have
1336 the knowledgeable medical person in charge and responsible
1337 for that patient's care. The elderly patient in the nursing
1338 home doesn't just get a urinary tract infection, they get
1339 urosepsis, and they come into the hospital and they die after
1340 five days of intensive therapy. The outcome is just
1341 absolutely dreadful and it costs a lot of money. Someone to
1342 be able to anticipate that and prevent that is literally
1343 worth their weight in gold in that situation. Is that not
1344 correct?

1345 Ms. {Bella.} We are trying to create systems where

1346 there is an accountable care team and an entity that is--

1347 Dr. {Burgess.} You don't need a team, you need a
1348 person. You need one person to be accountable. I am sorry,
1349 I am old school. I am a doctor. In the old days, there was
1350 one person in charge and accountable.

1351 Mr. Chairman, against my better judgment, I am going to
1352 ask that this Ezra Klein article from the Washington Post
1353 from June 16th be entered into the record. Only about half
1354 of it is accurate but the part that is, is so accurate that I
1355 think it is worth sharing with our colleagues and the general
1356 public.

1357 Mr. {Pitts.} Without objection, so ordered.

1358 Dr. {Burgess.} Thank you.

1359 [The information follows:]

1360 ***** COMMITTEE INSERT *****

|
1361 Mr. {Pitts.} The chair thanks the gentleman and
1362 recognizes the gentlelady from the Virgin Islands, Dr.
1363 Christensen, for 5 minutes for questions.

1364 Dr. {Christensen.} Thank you, Mr. Chairman, and I thank
1365 you and the ranking member for allowing me to sit in on this
1366 important hearing, and I am particularly interested in being
1367 here because in the dual-eligible population, somewhere
1368 around 40 percent of that population are minorities, and so I
1369 hope, Director, that you are also working with the new Office
1370 of Minority Health to look at that subpopulation as you plan
1371 this coordination.

1372 So the dual-eligible population disproportionately
1373 suffers from racial, ethnic as well as geographic
1374 disparities, and these are particularly pronounced in the
1375 end-stage renal disease population. There has been a
1376 successful, I think, completion of a 5-year coordinated care
1377 demonstration for end-stage renal disease patients, and what
1378 are your thoughts about expanding this demonstration to the
1379 dual-eligible population? Is this something that your office
1380 can work with others to implement?

1381 Ms. {Bella.} Well, we are certainly interested in
1382 looking at all demonstration opportunities that could be
1383 tailored to the dual-eligible population for different

1384 subsets of the population so it is certainly something that
1385 we can go back and discuss further with our colleagues.

1386 Dr. {Christensen.} I think it might prove helpful,
1387 especially since end-stage renal disease, I am sure, accounts
1388 for a lot of the cost that Medicare puts out.

1389 Also as a provider, like Dr. Burgess, and having worked
1390 with AmeriHealth Mercy family of companies, which is one of
1391 our country's largest Medicaid managed care plans to help
1392 understand some of the challenges, I understand that under
1393 current regulations, services provided to Medicaid health
1394 plan enrollees by institutions are not counted in determining
1395 payments to providers and this results in fragmented care
1396 because states often choose not to enroll these populations
1397 into Medicaid health plans or they carve out provider
1398 services from the plan's benefit coverage. Are you familiar
1399 with this problem and barrier to enrollment or expanding
1400 enrollment and are there any plans to address this?

1401 Ms. {Bella.} It is certainly something that we have
1402 heard from some States and some plans, and again, kind of
1403 taking that list of everything we have to begin to understand
1404 and figure out how we are going to address greater
1405 opportunities to promote alignment. That would be part of
1406 what we have on that list.

1407 Dr. {Christensen.} Just one more question. Ms. Hewson

1408 from Community Care of North Carolina in her testimony, one
1409 of the things she notes is that programs targeting at-risk
1410 pre-duals may, you know, be something to really start looking
1411 at, not only for the care of those patients, better care of
1412 those patients, but also for the larger budget impact. Is
1413 this something that the office is working on?

1414 Ms. {Bella.} Absolutely. There is a huge opportunity
1415 with the pre-duals, particularly preventing their decline or
1416 their spend-down of resources and being smart about how we
1417 can make an investment on the front end and prevent migration
1418 into dual status. So yes, it is something that we are
1419 looking at.

1420 Dr. {Christensen.} Thank you, Mr. Chairman.

1421 Mr. {Pitts.} The chair thanks the gentlelady.

1422 Mr. {Pallone.} Mr. Chairman, could I ask unanimous
1423 consent that Mr. Markey be allowed to participate in the
1424 subcommittee today?

1425 Mr. {Pitts.} Without objection, so ordered. Do you
1426 want to ask questions of this panel?

1427 Mr. {Markey.} If you don't mind, Mr. Chairman.

1428 Mr. {Pitts.} All right. The chair recognizes the
1429 gentleman for 5 minutes for questions.

1430 Mr. {Markey.} I thank you, Chairman Pitts and Ranking
1431 Member Pallone, for holding this hearing, and I would like to

1432 thank Melanie Bella for helping to lead the charge at CMS to
1433 improve care for 9 million patients who by definition are the
1434 sickest, poorest, costliest individuals covered by either
1435 Medicaid or Medicare. The landmark health care law included
1436 language that I authored to create a pilot program called
1437 Independence at Home to address the unique needs of Medicare
1438 patients who have multiple conditions including Alzheimer's,
1439 Parkinson's, et cetera. Caring for these patients is
1440 disproportionately expensive yet this population often
1441 receives substandard and uncoordinated care that produces
1442 conflicting diagnoses and confusing courses of treatment.
1443 Further, many of these individuals wish to remain at home
1444 rather than nursing homes or hospitals and they could do so
1445 if they were given some help. The Independence at Home
1446 program gets at the root of the problem by creating teams of
1447 health care providers who will work together to coordinate
1448 care for these patients and provide primary care services at
1449 the patient's own home. If they succeed in lowering costs
1450 beyond 5 percent, the providers will share in the additional
1451 savings, so there is a stake in lowering costs to the system.

1452 It seems to me that Independence at Home could also help
1453 us improve care for the patients who are eligible for both
1454 Medicare and Medicaid by integrating health care services
1455 provided by Medicare with long-term supports and services

1456 provided by Medicaid. For years we have seen the success of
1457 Independence at Home-style programs at more than 250 VA
1458 locations and elsewhere throughout the country. The VA
1459 programs have reduced nursing home care by 88 percent and
1460 reduced overall costs by 24 percent on the highest cost,
1461 chronically ill patients all while achieving record-high
1462 patient satisfaction rates. ElderPAC, which has been
1463 operating this style of program for the dual population,
1464 shows savings to the Medicaid program of 23 percent over the
1465 past decade.

1466 So let me ask you this, Ms. Bella. In light of the fact
1467 that the Independence at Home model has proven successful in
1468 lowering costs and improving outcomes among some of the most
1469 challenging Medicare patients. Don't you agree that your
1470 office should look at expanding this model of patients that
1471 are eligible for both Medicare and Medicaid?

1472 Ms. {Bella.} Well, first of all, we thank you for your
1473 leadership and support on this issue. We are very committed
1474 to models that allow dual-eligible beneficiaries to stay at
1475 home with supports. We are in discussion with our colleagues
1476 about the Independence at Home demonstration. As you know,
1477 it is still in development. It will be available the first
1478 of 2012 and we are looking for opportunities to make sure
1479 that it is in the mix of models that could be considered for

1480 dual eligibles.

1481 Mr. {Markey.} Is there in your experience a reason to
1482 believe that this is a good way of looking at how we keep
1483 these Alzheimer's and other patients at home longer and save
1484 the system money because they don't have to go to nursing
1485 homes?

1486 Ms. {Bella.} Certainly we are very interested in models
1487 that allow individuals to stay in care preferences of their
1488 choice and that are also cost-effective and so we do believe
1489 a model like this holds promise. Again, we look forward to
1490 understanding how we can adapt that in our work with States
1491 and others as we develop new delivery system models.

1492 Mr. {Markey.} And do you think that it makes some sense
1493 to incentivize the health care providers that they make money
1494 if they can figure out ways of saving money by keeping
1495 patients at home? Do you think that that will incentivize
1496 them to think anew about how to take care of these patients?

1497 Ms. {Bella.} Well, we always want to make sure that
1498 there is appropriate beneficiary safeguards in place and that
1499 people are getting the services that they need, but
1500 opportunities where we know that there are opportunities to
1501 align incentives, it certainly is a direction that the agency
1502 has been heading in terms of being able to do some
1503 performance-based outcomes payments.

1504 Mr. {Markey.} You know, I did that bill in conjunction
1505 with the Alzheimer's Association. As you know, there are 5
1506 million Americans right now with Alzheimer's and 15 million
1507 baby boomers are going to have Alzheimer's, so it is
1508 obviously important that there be a plan that coordinates
1509 with families, you know, who are the principal caregivers so
1510 that they can have the maximum amount of help at home,
1511 because once they go to a nursing home, it is \$60,000,
1512 \$70,000 a year on Medicaid, you know, for those families, so
1513 this is just a program that obviously meant to help keep them
1514 at home, save the system money, make the families happier and
1515 the patient as well in a setting where they would feel more
1516 comfortable, so we thank you, and I would like to continue to
1517 work with you on developing that program.

1518 Ms. {Bella.} I would be happy to do so.

1519 Mr. {Pitts.} The chair thanks the gentleman. That
1520 completes round one of questions. We have one follow-up.
1521 Dr. Cassidy.

1522 Dr. {Cassidy.} Ms. Bella, I should know this and I
1523 don't, and I apologize, but you mentioned a couple times that
1524 mental health issues are going to--you know, it is an
1525 independent variable, it sounds like. You do a retrogression
1526 analysis and it comes out mental health is a big issue. So a
1527 couple questions. Is this related to addictive disorders or

1528 is it related to, if you will, classical mental health
1529 issues, number one, you know, paranoid schizophrenia, for
1530 example. Is the issue that they are noncompliant with
1531 medical services and are going in and out with poorly
1532 controlled comorbidities or is the issue that they are going
1533 in and out with mental health admissions? And clearly, it
1534 seems as if that would be something that a wraparound managed
1535 care organization could theoretically improve outcomes and
1536 strengthen stability of the programs' finances. What is the
1537 track record of such programs?

1538 Ms. {Bella.} Let me try to take your questions in
1539 order. So the first, I mean, when we think about the folks
1540 that have behavioral health issues, it is mental illness, it
1541 is also substance use. There tends, as you know from
1542 treating patients, there is a higher prevalence of substance
1543 use in folks who--

1544 Dr. {Cassidy.} So that is a third category, if you
1545 will, combined?

1546 Ms. {Bella.} But you have the serious mental illness,
1547 schizophrenia, bipolar, and then you have folks that have
1548 depression and other symptoms. Clearly the utilization is
1549 different for those populations. What drives part of the
1550 trouble is there tends to be a disconnect in the physical and
1551 behavioral health systems, as you know, and a real lack of

1552 information sharing so that one half doesn't know what the
1553 other half is doing with regard to this patient, and again,
1554 as a practicing physician, you can understand why that would
1555 be so detrimental because the effects of--

1556 Dr. {Cassidy.} And again, that is why it just seems
1557 like managed care would be custom made, that this is where it
1558 would integrate and bring things together.

1559 Ms. {Bella.} Certainly. I mean, there's been
1560 different--States have tried different approaches. Some have
1561 given responsibility for everything to a health plan. Some
1562 have carved out behavioral health services to a health plan
1563 while physical health services have stayed in fee-for-service
1564 or sometimes physical health services have gone to yet
1565 another health plan. So there tends to be different
1566 mechanisms States have tried. There also have been a couple
1567 of really great pilots, one in Pennsylvania, that it was
1568 within a fee-for-service system but what they focused on was
1569 sharing information and aligning incentives between the
1570 physical health and the behavioral health world, and that
1571 made a huge difference.

1572 Dr. {Cassidy.} That was not managed care, that was
1573 just--there must have been some integration between the
1574 practice groups.

1575 Ms. {Bella.} There was management on the behavioral

1576 health side and it was fee-for-service with PMPM overlay on
1577 the physical health side but no structural or organizational
1578 integration, if you will, and it all got down to really
1579 understanding, making sure all people involved in that care
1580 had a clear picture of what the beneficiary was getting on
1581 both sides.

1582 Dr. {Cassidy.} Now, they couldn't have been doing that
1583 with Medicaid rates. They must have been paying Medicare
1584 rates to providers, correct? Because that would be time-
1585 intensive to transfer that.

1586 Ms. {Bella.} It was time-intensive. They had some
1587 outside support during the pilot phase but also they got
1588 smarter about how they delivered care. They used other types
1589 of practitioners. They did a lot with peer support
1590 specialists, and the cost dynamic is different when you--

1591 Dr. {Cassidy.} Do you have an analysis of that you
1592 could share with us? Because I think it is very intriguing.

1593 Ms. {Bella.} I am not sure that any final sort of
1594 journal-ready analysis has been published but I would be
1595 happy to share with you what has been done to date and
1596 certainly some descriptive analysis and the metrics that they
1597 are using.

1598 Dr. {Cassidy.} Sounds great. And my second question,
1599 which was, since we went to the third, is the increased

1600 expense due to multiple admissions for mental illnesses, for
1601 the paranoid schizophrenic, for example, or is it
1602 noncompliance with medical illnesses so it is bouncing in and
1603 out because their diabetes is poorly controlled, for example?

1604 Ms. {Bella.} It is hard to generalize. I mean, both,
1605 but clearly two things that both could be improved with
1606 integrated, coordinated and accountable systems.

1607 Dr. {Cassidy.} Do you have any idea of the--that will
1608 be a follow-up question at a later time, but I would be
1609 interested, again, I trying to understand which of this is
1610 compressible, long-term care is not as compressible, whereas
1611 perhaps this would be. What percent of the increased expense
1612 is related to this subgroup of populations, those with mental
1613 health and physical health issues simultaneously?

1614 Ms. {Bella.} We will call that our bucket analysis and
1615 we will work on getting you some analysis in those different
1616 categories across the board for the committee's
1617 consideration.

1618 Dr. {Cassidy.} Thank you.

1619 Mr. {Pitts.} The chair thanks the gentleman. We have a
1620 follow-up questions from Dr. Christensen.

1621 Dr. {Christensen.} Just a very brief question. As you
1622 know, the territories with Medicaid cap and not all of the
1623 help for Medicare either really have struggled to provide

1624 services for our dual eligibles so I just wanted to know if
1625 this process of coordination, if your office also looks at
1626 this issue in the U.S. territories.

1627 Ms. {Bella.} Our office is intended to be a resource
1628 for the States and the territories who are interested in
1629 improving care, so yes, we are available to work with the
1630 territories, absolutely.

1631 Mr. {Pitts.} The chair thanks the gentlelady. That
1632 concludes panel one. The chair thanks the Director for her
1633 excellent testimony and yields the ranking member for a
1634 unanimous consent request.

1635 Mr. {Pallone.} Thank you, Mr. Chairman. I would ask
1636 for unanimous consent to submit for the record the first
1637 report that Ms. Bella's office submitted to Congress as
1638 required by the ACA that one member, I think Dr. Burgess, was
1639 asking about.

1640 Mr. {Pitts.} Without objection, so ordered.

1641 [The information follows:]

1642 ***** COMMITTEE INSERT *****

|
1643 Mr. {Pallone.} And then I would ask unanimous consent
1644 to enter the statement of Mary Kay Henry, who is the
1645 president of SEIU, and I think you have both of these.

1646 Mr. {Pitts.} Without objection, so ordered.

1647 Mr. {Pallone.} Thank you.

1648 [The information follows:]

1649 ***** COMMITTEE INSERT *****

|
1650 Mr. {Pitts.} Thank you.

1651 At this time I will ask the second panel to come
1652 forward, and I will introduce them in the order of testimony.
1653 Robert Egge is the Alzheimer's Association's Vice President
1654 of Public Policy and Advocacy. Billy Millwee is the
1655 Associate Commissioner for Medicaid and Children's Health
1656 Insurance Program at the Texas Health and Human Services
1657 Commission. Denise Levis Hewson is the Director of Clinical
1658 Programs and Quality Improvement at Community Care of North
1659 Carolina. And Shawn Bloom is the President and CEO of the
1660 National PACE Association. Your written statements will be
1661 made part of the record and we ask you to summarize each of
1662 your opening statements in 5 minutes before the question-and-
1663 answer period.

1664 At this point the chair recognizes Robert Egge.

|
1665 ^STATEMENTS OF ROBERT EGGE, VICE PRESIDENT OF PUBLIC POLICY,
1666 ALZHEIMER'S ASSOCIATION; BILLY MILLWEE, ASSOCIATE
1667 COMMISSIONER FOR MEDICAID/CHIP, TEXAS HEALTH AND HUMAN
1668 SERVICES COMMISSION; DENISE LEVIS HEWSON, DIRECTOR OF
1669 CLINICAL PROGRAMS AND QUALITY IMPROVEMENT, COMMUNITY CARE OF
1670 NORTH CAROLINA; AND SHAWN BLOOM, PRESIDENT AND CHIEF
1671 EXECUTIVE OFFICER, NATIONAL PACE ASSOCIATION

|
1672 ^STATEMENT OF ROBERT EGGE

1673 } Mr. {Egge.} Good afternoon, Chairman Pitts, Ranking
1674 Member Pallone and distinguished members of the subcommittee.
1675 I am Robert Egge, Vice President of Public Policy of the
1676 Alzheimer's Association, and I thank you for the opportunity
1677 to appear here today.

1678 I want to begin by telling you about John and his wife
1679 Emma. John and Emma are an elderly, low-income couple who
1680 depend on both Medicare and Medicaid. John has Alzheimer's
1681 disease and diabetes. John's physician has been consistently
1682 attentive to his diabetes but not to his Alzheimer's. He has
1683 given John good diabetes treatment plan, but because of
1684 John's impairments due to his Alzheimer's, John has been
1685 increasingly unable to comprehend or follow those

1686 instructions. So despite his physician's efforts, John's
1687 diabetes and his overall health has steadily deteriorated.
1688 For her part, Emma has been ill-equipped to help John manage
1689 the demands of his dementia and his diabetes because of her
1690 own health and the lack of caregiver training and support
1691 that has been offered to her. Because of all of this, John
1692 and Emma began taking frequent trips to the hospital ER where
1693 John was regarded as a noncompliant, difficult diabetic.

1694 Most of the hospital staff did not seem to recognize
1695 John's dementia and that his noncompliance with diabetes
1696 treatments wasn't about John being obstinate or unmotivated
1697 but was due to his inability to self-manage his care. Those
1698 that did recognize the presence and the implications of his
1699 dementia were at a loss for what to do about it. So John
1700 continued to show up at the emergency room for diabetes-
1701 related conditions at ever more frequent intervals. Each
1702 time he was sent home with discharge orders often explained
1703 to him without Emma even present that he had no hope of
1704 following. These ER episodes were disconnected from his
1705 physician's care. John's hospitalizations increased, his
1706 health deteriorated, claims to Medicare and Medicaid mounted.
1707 Reluctantly, John and Emma decided he could no longer live in
1708 his home but had to enter a Medicaid-funded nursing home much
1709 sooner than either of them had hoped or expected.

1710 As reported in the Alzheimer's Association's 2011
1711 Alzheimer's disease facts and figures, there are an estimated
1712 5.4 million Americans like John with Alzheimer's, currently a
1713 terminal disease with no known means to prevent, stop or slow
1714 its progression, and there are almost 15 million unpaid
1715 caregivers, many like Emma, who help care for them. Those
1716 millions of Americans with Alzheimer's form a
1717 disproportionate share of the dual-eligible population.
1718 Sixty-one percent of dual-eligible individuals are
1719 cognitively or mentally impaired. Nearly one in every six
1720 dual eligibles has Alzheimer's disease or other dementia.
1721 Alzheimer's and other dementias are also extremely prevalent
1722 among dual eligibles in nursing homes where 59 percent of
1723 residents live with these conditions. Similarly, at any
1724 point in time, about one-quarter of all hospital patients age
1725 65 and older have Alzheimer's or other dementias.

1726 So this population of duals with Alzheimer's is large
1727 and scale and it is also very large in cost. Medicare
1728 payments for beneficiaries with Alzheimer's and other
1729 dementias are three times greater than for comparable
1730 beneficiaries without these conditions, and Medicaid payments
1731 are nine times higher. These facts lead to the first of two
1732 points I want to conclude with today.

1733 Individuals with Alzheimer's that depend on Medicare and

1734 Medicaid make up such a large, vulnerable and cost-intensive
1735 share of the dual-eligible population that policymakers
1736 should focus on these beneficiaries in pilots, demonstrations
1737 and broader system reform efforts. Recognizing this group is
1738 offering a leading opportunity to improve care while
1739 controlling cost.

1740 The other major point I wanted to close with is that
1741 focusing on improving care for dual-eligible individuals with
1742 Alzheimer's won't only deliver benefits for these millions of
1743 Americans but will also have health benefits more generally.
1744 Over the years, our growing awareness of the significance of
1745 manageable chronic conditions like diabetes has led to an
1746 important emphasis on prevention, self-management and
1747 patient-centered care. Today, in a similar way, our growing
1748 awareness of the widespread impact of cognitive impairments
1749 due to Alzheimer's and other causes should draw much-needed
1750 attention to themes such as reducing program complexity, the
1751 detection, diagnosis and documentation of medical conditions
1752 like Alzheimer's, and to putting in place care plans that
1753 recognize not only an individual's cognitive abilities but
1754 fully recognize and support the critical role of the unpaid
1755 family caregiver.

1756 The foundation of effective care is in diagnosis, care
1757 planning and medical record documentation, principles

1758 contained in Mr. Markey's bill, the Hope for Alzheimer's Act,
1759 which the association strongly supports. Moreover, the
1760 insights underpinning this bill apply across the dual-
1761 eligible and Medicare populations.

1762 So again, thank you. The Alzheimer's Association
1763 greatly appreciates the opportunity to address these issues,
1764 and we look forward to our continuing work with the
1765 subcommittee.

1766 [The prepared statement of Mr. Egge follows:]

1767 ***** INSERT 2 *****

|
1768 Mr. {Pitts.} The chair thanks the gentleman and
1769 recognizes Mr. Millwee for 5 minutes.

|
1770 ^STATEMENT OF BILLY MILLWEE

1771 } Mr. {Millwee.} Thank you, Mr. Chairman, members of the
1772 committee. I would like to spend a few minutes speaking to
1773 you about the STAR PLUS program. The STAR PLUS program is a
1774 capitated managed care model that integrates acute and
1775 community-based care services for the aged, blind and
1776 disabled population in Texas. This includes the dual-
1777 eligible members.

1778 A little bit about the Texas Medicaid population. There
1779 are about 3.2 million people on Medicaid in Texas today. Of
1780 that number, about 700,000 are classified as aged, blind and
1781 disabled, and of that number, about 400,000 are duals. ABDs
1782 represent about 25 percent of the Medicaid population but
1783 approximately 58 percent of the total Medicaid cost.

1784 Where does STAR PLUS originate? STAR PLUS originated in
1785 1998 as a pilot in Harris County in Houston. It was created
1786 largely to address concerns about cost, quality and access to
1787 services for the aged, blind and disabled population, also
1788 the subset we refer to as duals, and to address how we could
1789 better integrate acute and long-term care for that
1790 population. The program was started with about 58,000 people
1791 in 1998. Today, STAR PLUS now serves 42 Texas counties and

1792 257,000 people. By March 2012, the program will be expanded
1793 to serve another 370,000 people in Texas in 80 counties.

1794 And here is how the program works at a very high level.
1795 It is an integrated care delivery model in a capitated
1796 managed care environment so we take acute care services and
1797 long-term care services and bundle those together, deliver
1798 them to the HMO. Central to that model is a primary care
1799 provider and a service coordinator who really work with that
1800 patient to get them the services that they need, whether
1801 those services are acute care or long-term care. The service
1802 coordinator is responsible for assessing that person's need
1803 and ensuring that the needs are met, and by doing that, it
1804 provides that early intervention so we keep people out of the
1805 hospital, out of the emergency room and out of the nursing
1806 institutions.

1807 Several studies to date by our external quality review
1808 organization have shown the model is effective. We have
1809 decreased inpatient services, hospitalizations about 22
1810 percent, reduced ED visits by 15 percent, and, more
1811 importantly, people who are involved in the program report a
1812 high degree of satisfaction with the program. We are excited
1813 about the opportunity now to work with CMS on how we can
1814 better coordinate care and I look forward to working with
1815 Melanie Bella in her program that she just started.

1816 [The prepared statement of Mr. Millwee follows:]

1817 ***** INSERT 3 *****

|
1818 Mr. {Pitts.} The chair thanks the gentleman and
1819 recognizes Ms. Hewson for 5 minutes.

|
1820 ^STATEMENT OF DENISE LEVIS HEWSON

1821 } Ms. {Hewson.} Good afternoon, Chairman Pitts and
1822 Ranking Member Pallone and the other distinguished members of
1823 the subcommittee. I am Denise Levis Hewson. I direct the
1824 clinical and quality programs for Community Care of North
1825 Carolina, and I appreciate the opportunity to tell you about
1826 our program. It is a collaborative organization of regional
1827 networks of health care providers, physicians, hospitals,
1828 health departments, social service agencies and other
1829 community organizations. Each network is a nonprofit
1830 organization and I work for the central office that helps
1831 coordinate and provides supports to all of the 14 networks.

1832 We create medical homes matching each patient with a
1833 primary care provider who leads an interdisciplinary team,
1834 professionals who coordinate seamless medical services aimed
1835 at producing better outcomes. Our challenge is not only to
1836 improve the quality of care but to cut costs without changing
1837 benefits and fees. As you start looking at changing the
1838 benefit package and fee structures, oftentimes you are
1839 pushing the patient into other delivery areas like the
1840 emergency room. You need engaged providers to do this
1841 program and engaged patients to be successful.

1842 Sustainable savings come only from learning to deliver
1843 care in a smarter and more coordinated way. We have been
1844 doing this for 10 years. We started as a pilot in 1998 and
1845 we have been adapting and refining this model, most recently
1846 really targeting the highest costs and highest risk.

1847 What is different about program is that it is led by
1848 physicians who are charged with changing the face of health
1849 care at the local community level. It is a bottom-up
1850 governance. It is key to getting buy-in at the practice
1851 level. We have begun to make some significant changes in
1852 local delivery systems. It is built on a model where each
1853 patient has a medical home. We have 1,400 medical homes
1854 across North Carolina in our 14 networks that provide the
1855 infrastructure to provide wraparound support to the medical
1856 homes. We have about 600 care managers. We have 30 medical
1857 directors, 14 network directors, 18 clinical pharmacists and
1858 10 local psychiatrists. These are local people managing
1859 local patients and driving improvements in their systems.
1860 The physicians are engaged because they are part of the
1861 solution. They lead the local teams. They decide how to
1862 collaborate best to get the best results.

1863 Efforts to improve care and save money are owned by
1864 those who directly provide that care. Our care managers know
1865 their patients. They know the community and the resources

1866 and that varies greatly in some of our rural communities.
1867 Care managers are the boots on the ground. They connect the
1868 dots between the patient, the physician, the specialist, the
1869 hospital, home health and other community resources. We
1870 believe that all health care is local and that community
1871 support for individuals with multiple chronic conditions can
1872 significantly improve health outcomes.

1873 One of the challenges in this program is defining the
1874 impactable population. You have to have the information and
1875 data to go after those patients and manage them and provide
1876 the right support so that they can have better outcomes.

1877 We serve over a million Medicaid recipients. We started
1878 as a Medicaid program. Now we have about 80,000 duals that
1879 are enrolled with our program. In addition, about 180,000 of
1880 those are aged, blind, disabled so those represent fairly
1881 large, significant high-cost patients. We get hospital data.
1882 Hospitals and community providers are partners in this
1883 organization. To manage these individuals, you have to
1884 follow them across different providers and delivery systems.

1885 We hope that this committee will look hard at better
1886 aligning Medicare and Medicaid services at the patient and
1887 community level, allow for shared savings in per-member, per-
1888 month management fees that provide patient management without
1889 capitation or risk models. We are a fee-for-service system.

1890 The delivery system must be patient centered. The important
1891 thing to remember is that patients need changes over time so
1892 a system must follow their needs across settings and
1893 providers. Our community-based medical home and network
1894 infrastructure focuses on population management strategies,
1895 and we aim to achieve the triple aims that we hear a lot in
1896 the literature, which is not only about improving quality,
1897 access and reliability but reducing the cost of that care.
1898 We have learned some key lessons in North Carolina with the
1899 dual population, and you have heard it by several of the
1900 other testimonies today that they have multiple
1901 comorbidities. They use the system more than a lot of other
1902 populations. They take a lot of medicines. And so they
1903 truly do benefit from a wraparound support at the community
1904 level. Our total annual budget for Community Care is about 1
1905 percent of the total Medicaid costs in North Carolina.

1906 Our commitment to quality doesn't just mean better care,
1907 it also leads to significant program savings. We asked the
1908 analytics company, Trio Solutions, to help us estimate
1909 savings, and they have done that and you have got more
1910 information of that in some of the handouts. Our trend data
1911 is fairly significant in terms of costs and savings.

1912 Mr. Chairman, I would like to thank you and the members
1913 of your subcommittee for the opportunity to be here today and

1914 discuss these issues, and we hope we can be a resource to you
1915 as you move ahead.

1916 [The prepared statement of Ms. Hewson follows:]

1917 ***** INSERT 4 *****

|
1918 Mr. {Pitts.} The chair thanks the gentlelady and
1919 recognizes Mr. Bloom for 5 minutes.

|
1920 ^STATEMENT OF SHAWN BLOOM

1921 } Mr. {Bloom.} Thank you very much, Chairman Pitts,
1922 Ranking Member Pallone and distinguished members of the
1923 subcommittee. I am Shawn Bloom, CEO of the National PACE
1924 Association. On behalf of NPA and its members, I am honored
1925 to testify today, and I appreciate the time that you have
1926 allotted us.

1927 I would like to kind of focus on three things, very
1928 briefly describe PACE to you and then offer some suggestions
1929 regarding ideas with respect to overcoming barriers that we
1930 have identified in expanding PACE, and three, identify some
1931 voluntary demonstration programs that we have generated in
1932 which we could expand the availability of PACE to additional
1933 eligible categories of dually eligible.

1934 First and foremost, PACE is a fully integrated model of
1935 care that exclusively serves the frailest, oldest and sickest
1936 subset of the duals, that is, the nursing home-eligible
1937 seniors. We do so in a manner that is really focused in the
1938 community in the sense that we are community based. Our goal
1939 in PACE is to allow individuals to remain living in their
1940 homes in the community. We do that through reducing nursing
1941 home use, reducing hospitalization, and we do that in a

1942 comprehensive fashion through integrated use of Medicare and
1943 Medicaid bundled payment, and the heartbeat within PACE is
1944 the interdisciplinary team, or the concierge team, if you
1945 want to call it that, in the sense that they are a fully
1946 employed staff that on a daily basis are involved in the
1947 care, delivery and management of the care of the individuals
1948 that we serve. And the third key feature of PACE is, we are
1949 accountable. We are accountable in the sense that we are
1950 accountable to government for the payment provided to PACE,
1951 90 percent of which comes from Medicare and Medicaid, and we
1952 are accountable to the families and the frail that we serve.
1953 And I think those three things taken together have very
1954 effectively aligned incentives for PACE. We are fully
1955 accountable for the cost and quality of care that we directly
1956 provide. So to the extent that we do a good job, those that
1957 we serve are able to stay out of the hospital, in their homes
1958 and achieve good health care.

1959 I think recognizing the effectiveness of PACE, a recent
1960 June 15th MedPAC report states: ``Fully integrated managed
1961 care plans and PACE providers offer the best opportunity to
1962 improve care coordination for dual-eligible beneficiaries
1963 across Medicare and Medicaid services.'' Authorized by the
1964 Balanced Budget Act of 1997, we have been around for 20
1965 years. We are a tested model of care, and we are very

1966 interested in finding ways to kind of growth.

1967 I think as has been mentioned earlier, and I think
1968 Melanie mentioned it, there have been significant obstacles
1969 to PACE growth, and we would like to kind of talk just a
1970 minute about those now. One, some of the regulatory
1971 requirements certainly focus on the required process of care
1972 rather than the outcomes of care, and those particular
1973 regulatory requirements have so far hindered growth,
1974 innovation and efficiency and how we deliver care. Two,
1975 fairly significant capital startup costs and long lead times
1976 for programs that accept full financial risk for a population
1977 that on average is about 300 people, that is a significant
1978 undertaking, and our eligibility for PACE is very narrow. We
1979 serve, as I mentioned earlier, a very small subset of the
1980 duals 55 years of age or older, and you have to be nursing
1981 home eligible. We believe there are opportunities to expand
1982 the availability of PACE.

1983 So to overcome these barriers, we recommend the
1984 following modifications to the PACE statute and regulation,
1985 and this is based on a decade of operational experience under
1986 the current regulation. One, allow us to more appropriately
1987 use contract community-based physicians rather than full
1988 employed physicians; two, take full advantage of the State
1989 license capability of nurse practitioners and physician

1990 assistants to practice up to their level of standards within
1991 the State practice acts; and then without compromising PACE
1992 participants' receipt of comprehensive care and assessment,
1993 allow more flexibility to personalize and individualize the
1994 use of interdisciplinary teams based on the individuals'
1995 needs, not using a one-size-fits-all approach. And lastly,
1996 allow States, and this is something of great interest to PACE
1997 providers right now, really begin to look at States and
1998 encourage them to see PACE as a means by which to pull people
1999 out of nursing homes. Some of our PACE programs throughout
2000 the States without great State support have had the ability
2001 to do that.

2002 With respect to voluntary demonstrations, we have five
2003 ideas with the goal of kind of expanding PACE and finding
2004 additional regulatory modifications. One, we would like to
2005 expand the availability of PACE to individuals under the age
2006 of 55 that are nursing home eligible. These are typically
2007 the physically disabled individuals that we believe would
2008 benefit from PACE. Two, allow at-risk or what we call high-
2009 need, high-risk, high-cost beneficiaries to have access to
2010 PACE, many of which are not currently nursing home eligible
2011 but we believe would benefit from PACE services. Three,
2012 reduce PACE organizations' reliance on the PACE center, which
2013 is really the focal point for the organization of services

2014 but not necessarily the need to kind of do it all there.
2015 Fourth, the ability to kind of implement alternative
2016 approaches to providing Part D drugs. Right now, we have to
2017 implement Part D in the context of a very small program whose
2018 benefit was designed for large health plans. And lastly, a
2019 demonstration with the objective of increasing Medicare-only
2020 beneficiaries' enrollment in PACE. Currently, about 90
2021 percent of all beneficiaries in PACE are duals but we believe
2022 it is a model of care that should be applicable to others.

2023 If I had more time, I could give you a great story about
2024 the actual benefits of PACE to a consumer but unfortunately I
2025 have run out of time, but we appreciate the opportunity to
2026 testify before the care, and as mentioned before, PACE is a
2027 tangible, proven model of care and we look forward to working
2028 with the committee to find ways to expand its reach. Thank
2029 you very much.

2030 [The prepared statement of Mr. Bloom follows:]

2031 ***** INSERT 5 *****

|
2032 Mr. {Pitts.} The chair thanks the gentleman and thanks
2033 the panel for your opening statements, and we will now do a
2034 round of questioning and the chair recognizes himself for 5
2035 minutes for that purpose.

2036 Mr. Millwee, as you know, States are generally not
2037 informed about hospitalizations or prescription drug
2038 information for dual eligibles. How important is Medicare
2039 data to States in coordinating care and reducing costs
2040 associated with dual eligibles?

2041 Mr. {Millwee.} Well, you are certainly correct.
2042 Without that data, we can't know the health condition of the
2043 dual-eligible member, and I think it is going to be critical
2044 as the Centers for Medicare and Medicaid coordination forms
2045 to provide States with that data so that we can implement the
2046 disease management programs that can be more cost effective
2047 if we were to have that data.

2048 Mr. {Pitts.} How does Texas share in the savings
2049 generated through the STAR PLUS program with the Federal
2050 Government? How important is it for States to be able to
2051 share in the savings generated by integrated care program for
2052 duals?

2053 Mr. {Millwee.} Well, today we don't share in that
2054 savings. The program was put in place to serve the

2055 population absent the need to share in that savings, and it
2056 has been recent that CMS was open again to discussions with
2057 the State about potential gain-sharing arrangements. So as
2058 we get that Medicare data, we believe that we can take to CMS
2059 a proposal that will demonstrate that STAR PLUS has created
2060 savings not only for the State on the Medicaid side but also
2061 for the Federal Government on the Medicare side, so we will
2062 be developing a proposal to take to CMS.

2063 Mr. {Pitts.} Thank you.

2064 Mr. Bloom, you wanted to talk about the benefits of PACE
2065 to consumers. Please explain in more detail your idea to
2066 modernize the PACE program to include alternative settings of
2067 care and why is the facility requirement a burden on the
2068 program today.

2069 Mr. {Bloom.} Yes, you know, I think historically the
2070 PACE program, if you drive by PACE program you will see what
2071 appears to be a very large day center within which there is
2072 space for a medical clinic, rehab, social services, personal
2073 care and possibly a kitchen. It has been a very convenient
2074 kind of focal point of care organization and deliver but what
2075 we have discovered over time is that the ability of PACE to
2076 grow is somewhat geographically constrained by the center.
2077 To the extent that we can begin contracting out, for example,
2078 for day center services using existing infrastructure down

2079 the street by an existing daycare provider would allow us to
2080 grow the program without undertaking significant capital
2081 costs and setting up a new center every time we want to
2082 expand our geographic market. That is but one example, and I
2083 could certainly offer you more.

2084 Mr. {Pitts.} Thank you.

2085 Ms. Hewson, you note in your testimony that the CCNC
2086 could have saved the State of North Carolina approximately
2087 \$1.5 billion between 2007 and 2009, and that 100 percent of
2088 all Medicaid savings remain in the State. How are those
2089 savings shared with your organization?

2090 Ms. {Hewson.} At this point they are not shared. It
2091 goes back into the Medicaid budget. But we have been able to
2092 maintain provider fees at 95 percent of Medicare. So in a
2093 way, that is a way to provide the infrastructure building and
2094 sustainability, but the money goes back into keeping the
2095 Medicaid program and dealing with the State budget issues.

2096 Mr. {Pitts.} Do you have more information on what
2097 portion of those savings are associated with the 80,000 dual
2098 eligibles you serve?

2099 Ms. {Hewson.} I don't have it on hand but we could
2100 certainly get that information for you. We are missing some
2101 of the Medicare data to be able to tell a complete story on
2102 the duals at this point.

2103 Mr. {Pitts.} How are the duals enrolled in your
2104 program? Is that mandatory enrollment?

2105 Ms. {Hewson.} It is voluntary. They typically choose--
2106 they are going to a provider that is participating with us,
2107 and oftentimes it is the provider that encourages them to
2108 enroll because they can then provide the wraparound support
2109 service of the care coordinators.

2110 Mr. {Pitts.} Are the other 220,000 duals in North
2111 Carolina mostly served through fee-for-service or are there
2112 other coordinated care programs in the State to serve those
2113 duals?

2114 Ms. {Hewson.} We have, I think, two PACE programs and
2115 several in application and then there is the Medicare
2116 Advantage program, a few of those, but primarily the rest are
2117 in fee-for-service.

2118 Mr. {Pitts.} Thank you.

2119 Mr. Egge, in your testimony you note several beneficiary
2120 examples where the complexity and fragmentation of the system
2121 prevent frail duals from gaining access to available
2122 services. You note that fully integrated system could
2123 alleviate administrative barriers. Do you believe such a
2124 system is a one-size-fits-all or do you believe there could
2125 be a variation of models that could be used to help improve
2126 beneficiary access to care?

2127 Mr. {Egge.} First of all, there is great variety in the
2128 experience of people with Alzheimer's and other dementias.
2129 Our suspicion is that there could be very some important
2130 common elements that we can use and design any kind of
2131 system, but at this point, innovation and looking at
2132 different kinds of approaches and how they work is very
2133 appropriate as we learn what is going to work best.

2134 Mr. {Pitts.} The chair thanks the gentleman and
2135 recognizes the ranking member, Mr. Pallone, for 5 minutes for
2136 questions.

2137 Mr. {Pallone.} Thank you, Mr. Chairman. I wanted to
2138 ask initial questions of Ms. Hewson and also Mr. Bloom. In
2139 Medicare, we have always maintained the principle that
2140 enrollment in managed care plans is voluntary for all
2141 Medicare beneficiaries. So let me start with Ms. Hewson.

2142 As I understand it, your program of coordinated care,
2143 although not a managed care plan, is voluntary for Medicare
2144 beneficiaries. Is that correct, and how does that impact the
2145 program, that it is voluntary?

2146 Ms. {Hewson.} Well, it is correct. I think by being
2147 voluntary, there is probably less enrollment than if it was
2148 an opt-out program, but typically they are enrolling because
2149 they want to have assured access to a primary care physician
2150 that they go to, and that physician is encouraging them so

2151 that they can use the resources of the network that supports
2152 the physician in leading their care.

2153 Mr. {Pallone.} And then similarly, Mr. Bloom, I know
2154 that the PACE association has long believed that it is
2155 important to have beneficiaries buy in through voluntary
2156 enrollment rather than requiring dual eligibles into PACE.
2157 Do you want to comment on that too?

2158 Mr. {Bloom.} Yes. Dually eligible beneficiaries have
2159 the opportunity to opt in and out of PACE, and that has been
2160 the longstanding track record within the PACE program since
2161 its inception. Having said that, we have very, very low
2162 levels of disenrollment which I think certainly aligns the
2163 incentives for us to keep our eye on the quality and the
2164 satisfaction to the beneficiary.

2165 Mr. {Pallone.} And I note that in MedPAC's chapter on
2166 dual eligibles released last week, they said that many of the
2167 groups they interviewed raised concerns about access to care
2168 for beneficiaries, particularly individuals with disabilities
2169 who have established relationships with doctors already, and
2170 I just want you to know, I support efforts to get duals into
2171 better care relationships but we need to be careful not to
2172 take away Medicare protections for the lowest income Medicare
2173 beneficiaries because they are trying to access help through
2174 Medicaid as well.

2175 Let me go back to Mr. Bloom. We recognize that PACE is
2176 a specialized program focused on the very medically needy and
2177 the fragile population so it not intended to nor would it be
2178 appropriate to serve all 9 million dual eligibles but
2179 currently PACE organizations have an enrollment of about
2180 22,000 people nationwide, and while we don't know exactly how
2181 many people could theoretically be eligible, we know it is
2182 not 9 million but it is obvious that there are a lot more
2183 people that you could serve. You described the desire of
2184 PACE organizations to expand enrollment, can you just tell me
2185 a little bit about what Congress could do to help PACE grow
2186 and the cautions you have about growing too fast. You know
2187 that PACE has long been supported by bipartisan members of
2188 the committee but we want to make expansions that would work
2189 and help improve care for people and not create problems.

2190 Mr. {Bloom.} Very good question, very good question.
2191 First off, I think as Melanie testified earlier, it is very
2192 important to note that the duals are a very diverse
2193 population. This ranges from the young disabled to the
2194 elderly that are simply low income to the elderly that are
2195 frail to older individuals with intellectual disabilities.
2196 It is a very diverse population. And I think based on our
2197 experience and experience working with other integrated-type
2198 providers, there are different approaches for different

2199 populations that we need to look at. In the context of PACE,
2200 PACE is very well designed for a very high-need, very frail,
2201 very functionally impaired population. The examples I gave
2202 earlier with respect to barriers to growth were really
2203 focused on the federal side.

2204 I would argue that there are an equal number, if not a
2205 greater number, of barriers that exist on the State side, one
2206 of which, and I will just throw it out, in this era that we
2207 live in today, you can get into a nursing home within a day
2208 typically. It often takes you 4 to 6 weeks to get into a
2209 community-based service program like PACE. That is because
2210 of the eligibility determination process in most States as
2211 well as some other administrative and other obstacles that
2212 exist. That is a significant barrier for growth in addition
2213 to some other kind of State-specific examples.

2214 Mr. {Pallone.} What is your sense of how many
2215 additional people could be helped, you know, could go into
2216 PACE if we made the improvements, you know, if we managed to
2217 do things that you are suggesting to make it more accessible?

2218 Mr. {Bloom.} Good question as well. You know, it is
2219 probably to note, we are not a health plan. At the heart of
2220 PACE is the provider. We fully employ all--I mean, I think
2221 90 percent of all care is provided directly by PACE
2222 employees, physicians, nurses and the like, so we are not

2223 going to be able scale each individual program on par with
2224 the United Health Plan or other large commercial health
2225 plans. Having said that, we do have programs that are as
2226 large as 2,600 people. We have programs in Appalachia as
2227 small as 40. So this is a program that can move large and
2228 small, so I do think each individual program is capable of
2229 serving several thousand people but I think you need multiple
2230 programs on the ground.

2231 Mr. {Pallone.} So theoretically, if you had a lot of
2232 them you could handle a lot more people?

2233 Mr. {Bloom.} Correct.

2234 Mr. {Pallone.} But they are going to have to be
2235 relatively small?

2236 Mr. {Bloom.} The solution to PACE growth is not to
2237 scale upon 76 that are on the ground today but to replicate
2238 the availability of the model throughout the country. The
2239 other witness testified, the State of North Carolina has two
2240 on the ground. They are filling the entire State with PACE.
2241 They will have 10 in development within 2 years. The State
2242 of Pennsylvania is another State where almost the entire
2243 State is full. The State of New Jersey within 2 years will
2244 probably have PACE available to every senior in the State.
2245 It takes a lot of leadership on the State. It takes a long-
2246 term vision, and I think it takes a strategic kind of

2247 approach to budgeting for Medicaid long-term care costs,
2248 which looks beyond the next 6 to 9 months, and that is
2249 difficult in this current era, admittedly. But I think it is
2250 possible and you are seeing examples of that across the
2251 States today.

2252 Mr. {Pallone.} All right. Thank you.

2253 Dr. {Burgess.} [Presiding] The gentleman's time is
2254 expired.

2255 Let me just ask each of you, what we have heard from
2256 this panel in various forms is the fact that an integrated-
2257 type model is possible and it does work seemingly every time
2258 it is tried. Is that something that I understand? Although
2259 the programs may be different that we have heard about, they
2260 all basically involved an integrated model of care with
2261 someone being responsible for the patient. I will start with
2262 Mr. Millwee from Texas.

2263 Mr. {Millwee.} Well, I think you are right. There are
2264 integrated care models out there, and what strikes me is none
2265 of these are mutually exclusive. There is no best answer.
2266 We have the STAR PLUS program because it works for us. We
2267 also have PACE. STAR PLUS and PACE can coexist, or they work
2268 well together. I am familiar with the North Carolina model
2269 and it could work very well for Texas in a rural area where
2270 we have STAR PLUS in urban areas. So I think the answers are

2271 out there. I think States have done a lot of work, a lot of
2272 innovative work on this very important issue for us because
2273 of the Medicaid expenditure and also Medicare is going to
2274 benefit from that too. So the models are out there.

2275 Dr. {Burgess.} Yes, Mr. Bloom.

2276 Mr. {Bloom.} Yes, I think that is exactly the answer.
2277 I couldn't agree more. The only thing I would add is that if
2278 you look at commercial health plans which typically are the
2279 approach to integrating care for the duals, they do receive
2280 integrating financing. They attempt through their contract
2281 network to integrate care but do they do a wonderful job I
2282 think at improving the coordination of care for the most part
2283 but they often will carve-out long-term care risk from their
2284 payment and that is the population we serve so I think as Mr.
2285 Millwee mentioned, these are programs that work very
2286 complementary, albeit for very distinct populations and
2287 segments of the duals. So if done right, I think Texas is a
2288 good example, they have a very good vision for how they want
2289 this to roll out. It provides great hope, great opportunity
2290 and also provides the rights to service product for the right
2291 population based on their unique needs at a particular point
2292 in time. But I do think this is the direction to go.

2293 Dr. {Burgess.} Mr. Egge, obviously the Independence at
2294 Home is a little bit difference but still it is care

2295 coordination. Is that not correct?

2296 Mr. {Egge.} That is right. With Independence at Home
2297 and other models, our aim is not to create a certain silo
2298 just for those with Alzheimer's and dementia but to make sure
2299 that every system like Independence at Home is fully dementia
2300 capable. Many people with Alzheimer's, for example, have
2301 greatly appreciated PACE programs and their enrollment there,
2302 so we just want to make sure that whatever systems are there,
2303 we fully recognize the importance of dealing with cognitive
2304 impairment and the caregiver.

2305 Dr. {Burgess.} I just have to say, your story about the
2306 gentleman with Alzheimer's who also had diabetes who accessed
2307 care the best that he could, that is a tough thing to listen
2308 to as a physician, that someone could be exposed to that many
2309 gaps in their care in seemingly a caring and competent
2310 environment of a major hospital emergency room. That is just
2311 tough to hear.

2312 Ms. Hewson?

2313 Ms. {Hewson.} I agree with the other panelists, other
2314 than I don't think just having integrated care assures that
2315 you are doing the right thing. I think you have to have a
2316 delivery system that does the right thing, and integrated
2317 care just is a way to align the incentives and the
2318 reimbursement strategies, and in North Carolina, we are not

2319 yet aligned in the reimbursement strategy although we are one
2320 of the 15 States that will be working with the coordinated
2321 office to develop a plan along that line, but we also have a
2322 very strong bias towards the medical home and keeping folks
2323 in the community, you know, delivered primarily through
2324 primary care providers is probably a model that has worked
2325 really well for us.

2326 Dr. {Burgess.} But primarily you do have to have--
2327 someone has to be responsible for that patient's care, and in
2328 my limited view of the world, that is obviously a physician,
2329 a single physician, but nevertheless, somebody has to be
2330 accountable for that patient's care on an ongoing basis.

2331 Well, what do you make of the fact that the MedPAC
2332 report from this year, the current one, says less than 2
2333 percent of all duals are enrolled in some type of integrated
2334 care program? Are they just not counting accurately because
2335 they are missing all of you out there or is that truly that
2336 we are only capturing a very, very small percentage of the
2337 dual eligibles?

2338 Ms. {Hewson.} I think MedPAC is counting when Medicaid
2339 and Medicare are putting funding together as an integrated
2340 approach which the PACE model is an example where both
2341 Medicare and Medicaid are funding the care of that
2342 individual. Our program, which serves over one million, is

2343 still a fee-for-service system so none of our individuals are
2344 counted in the MedPAC report. So the delivery system is
2345 integrated; the financing is not.

2346 Dr. {Burgess.} And what are the barriers to, or is
2347 there a problem with it being a fee-for-service system? Does
2348 that work well for you?

2349 Ms. {Hewson.} Well, I think you have to align the
2350 incentives. There are still silos and there is cost shifting
2351 that occurs so I think aligning the financial strategies and
2352 having, you know, Medicare and Medicaid sharing in those
2353 responsibilities, taking care of, in this instance, the duals
2354 is really important. So I think that is why we wanted to be
2355 one of those 15 States to develop that integrated model which
2356 aligns the integration with financing in addition to
2357 delivery.

2358 Dr. {Burgess.} Well, do you think more federal control
2359 is necessary? I mean, could you do your job better with a
2360 bigger and more powerful--

2361 Ms. {Hewson.} Well, I think you have heard ours is very
2362 local.

2363 Dr. {Burgess.} Yes, I think so too.

2364 Okay. My time is expired. I will recognize Dr. Cassidy
2365 for 5 minutes.

2366 Dr. {Cassidy.} The STAR PLUS program, now, I am just

2367 trying to understand it. Ms. Bella said that 70 percent of
2368 the costs of dual eligibles in Medicaid is related to the
2369 long-term care aspect of it and most of the Medicaid acute
2370 medical expense, is the wraparound for that which Medicare
2371 does not cover. It seems like your savings are quite
2372 substantial if the--and I am not challenging, I am just
2373 trying to learn--that the provider or the Medicare managed
2374 care organization with which you are contracting, the only
2375 place they can lower cost is in the Medicaid component of the
2376 acute care. Is that correct?

2377 Mr. {Millwee.} That is not the only place that have to
2378 manage cost and achieve effectively better utilization. I
2379 think it is through a number of mechanisms on the acute and
2380 long-term care support side. Remember, we are talking in
2381 STAR PLUS about the entire aged, blind and disabled
2382 population. It is not just a model for dual eligibles. So
2383 about 40, 50 percent are dual eligibles.

2384 Dr. {Cassidy.} I see.

2385 Mr. {Millwee.} So you have an acute care model of care
2386 that is integrated with the long-term care and what the HMO
2387 will likely do, particularly for the Medicaid that is aged,
2388 blind and disabled, is leverage those less expensive
2389 community-based services to keep them out of the more
2390 expensive acute care services, which is what we both want to

2391 do. We want to keep people out of nursing facilities and out
2392 of hospitals and sometimes a personal attendant will do that
2393 for you relatively inexpensively.

2394 Dr. {Cassidy.} So just for a specific example, if you
2395 can use your Medicare dollar to get a personal attendant for
2396 a patient who is pre-nursing home, if you will, then that can
2397 save money on the Medicaid side, which would be a much
2398 greater expense, by using the Medicare dollar to pay for a
2399 service that would not be available under Medicaid. Is that
2400 a good example?

2401 Mr. {Millwee.} That is correct. In fact, you might use
2402 a Medicaid cost to save Medicare money on the acute care
2403 side, and that is what we need to work through with CMS to
2404 talk about how we can leverage that to talk about some gain-
2405 sharing opportunities.

2406 Dr. {Cassidy.} Now, Mr. Bloom, although you said that
2407 you are not a health plan, you really do appear to be a staff
2408 model HMO. I mean, you are at risk, and you are using your
2409 own people. If you will, you are the Kaiser Permanente of
2410 the frail and fragile. Is that a fair statement?

2411 Mr. {Bloom.} That is an absolutely fair statement,
2412 absolutely, and I think we feel that burden every day in some
2413 of the requirements that we have to shoulder with respect--

2414 Dr. {Cassidy.} Let me ask you, I mean, because I only

2415 have a couple minutes, I don't mean to be rude. So when you
2416 speak of going beyond the duals into the Medicare only,
2417 again, effectively, you are becoming a staff model HMO for
2418 Medicare patients?

2419 Mr. {Bloom.} Correct. I would argue, however, that
2420 what we are suggesting is not all Medicare patients but those
2421 that we believe are high need, high risk and need kind of a
2422 medical home.

2423 Dr. {Cassidy.} Now, next, I have been fascinated since
2424 Dr. Nelson came from Baton Rouge to speak to her, and of
2425 course, we know each other personally and I have read about
2426 your program, but I have spoken to folks who criticize it and
2427 saying that really the cost savings are not there. In your
2428 testimony, you gave an anecdote which spoke of an individual
2429 but that when you actually kind of run the numbers with a big
2430 spreadsheet, that PACE has not been shown to save money. Is
2431 that a fair or unfair criticism?

2432 Mr. {Bloom.} I think it is an unfair criticism. There
2433 have been definitive government studies, two of which
2434 actually that looked at the Medicare cost in PACE and found
2435 that at worst we were budget neutral. On the Medicaid side,
2436 there has never been a definitive longitudinal study of PACE
2437 cost. Having said that, we continue to see States added to
2438 the list of PACE states. I think that what we have told

2439 States from day one is to the extent you set your rates
2440 appropriately, all of which are significantly below nursing
2441 home costs, then you in the longitudinal measurement will
2442 save money.

2443 Dr. {Cassidy.} Now, but again, maybe the criticism was
2444 that by keeping people out of the nursing home but still
2445 getting nursing home per diems, that again there are Medicaid
2446 savings that are not realized. Now, again, I am channeling
2447 right now.

2448 Mr. {Bloom.} I think what you are suggesting yes, our
2449 PACE rate includes a component of costs that reflect the full
2450 risk that we are assuming for long-term placement, and there
2451 are, you know, roughly on any given day 7 to 8 percent of the
2452 people we serve are permanently placed in a nursing home at
2453 cost to us, not to the State. So again, the true benefits of
2454 the--

2455 Dr. {Cassidy.} So it is a cohort savings, if you will?

2456 Mr. {Bloom.} It is a cohort savings, so the State is
2457 literally in many ways similar to--

2458 Dr. {Cassidy.} I am about of time. Sorry. Can you
2459 send those two articles that you have?

2460 Mr. {Bloom.} Yes.

2461 Dr. {Cassidy.} Now, Ms. Hewson, the savings that you
2462 have, you actually have your pediatric population in your CCN

2463 and you have your duals in the CCN. You savings you describe
2464 are global. What percentage of those are attributable to the
2465 dual eligibles? And that is my last question.

2466 Ms. {Hewson.} Well, I would say a greater percentage
2467 are due to the aged, blind and disabled, which include the
2468 dual eligibles, so we have over 100,000 straight Medicaid
2469 aged, blind, disabled so when we look at savings we are
2470 looking primarily at the aged, blind and disabled that are
2471 straight Medicaid because we don't have all the data on the
2472 Medicare so we are missing some of the hospital data in Part
2473 D and Part B data.

2474 Dr. {Cassidy.} You have done a good job of analyzing
2475 your data. Could you forward the more complete report on
2476 that?

2477 Ms. {Hewson.} Yes.

2478 Dr. {Cassidy.} Thank you. I yield back.

2479 Dr. {Burgess.} The gentleman's time is expired. The
2480 chair recognizes the gentlelady from the Virgin Islands, Dr.
2481 Christensen, 5 minutes for the purposes of questions.

2482 Dr. {Christensen.} Thank you, Mr. Chairman.

2483 I guess I have a pretty broad question that anyone can
2484 answer. I probably would address is mainly to Mr. Millwee
2485 and Mr. Bloom and Ms. Hewson. I know that minorities figure
2486 very disproportionately in Alzheimer's cases as well, but

2487 some of the sickest individuals in Medicare and Medicaid of
2488 course are racial and ethnic minorities, so can each of you
2489 tell me what percentage of your population are people of
2490 color of those that you serve? Are the referrals
2491 proportional to the need? Is more outreach needed and are
2492 you experiencing the same positive outcomes and cost savings
2493 in the racial and ethnic minority population compared to the
2494 others?

2495 Mr. {Millwee.} I don't have those numbers with me
2496 today. I do know that there is an equal benefit but I just
2497 don't have those numbers with me today but we would be glad
2498 to get those for you.

2499 Mr. {Bloom.} Yes, I can't cite specific statistics but
2500 I am fairly confident that the majority of people served by
2501 PACE are minorities. I anecdotally note many programs where
2502 it is literally nearly 100 percent minority based on the
2503 neighborhood within which they exist and the like, but I
2504 would be happy to get you the specific figures. But yes, it
2505 is a program that is focused on that segment of the
2506 population.

2507 Ms. {Hewson.} We serve all the minority Medicaid
2508 population in the State. We have all the safety-net
2509 providers participating in our program, and in the medical
2510 home models when you actually look at some of the quality

2511 performance metrics have been able to really show improvement
2512 in disparities because if you are providing best care for
2513 diabetes, you are doing it across the board for all your
2514 patients and so that has been a very rewarding quality metric
2515 that we have been tracking. I will be glad to send you more
2516 information if you would like.

2517 Dr. {Christensen.} Thanks. I know that they are there.
2518 We just weren't hearing about them, and I would expect that
2519 the models that you are talking about would be improving the
2520 care across the board.

2521 Mr. Bloom, have you had occasion to look at or been
2522 asked to look at the PACE model in any of the territories,
2523 and if you know, do you foresee any barriers that would
2524 prevent you from setting up one of the PACE programs in one
2525 of the offshore areas?

2526 Mr. {Bloom.} We did have some initial and very
2527 preliminary discussions with Puerto Rico a number of years
2528 ago. They didn't progress on anything constructive after
2529 that, however. Having said that, we are always open, and I
2530 am not aware of any barriers to expanding PACE into any of
2531 the territories and actually would argue what little I know
2532 about the Medicaid program for the territories that I think
2533 it would be very mutually beneficial, so I would be happy to
2534 talk to you about that.

2535 Dr. {Christensen.} Everybody has talked about, you
2536 know, the need for your programs and the fact that your
2537 programs are really community based. One of the amendments
2538 that I was involved in in the Affordable Care Act had to do
2539 with grants for community health workers, and I was just
2540 curious as to whether you utilize them in your programs. Mr.
2541 Egge, do you think that the community health worker would be
2542 a program that would be of assistance in care giving, even as
2543 the alternate caregiver in the Alzheimer's situation?

2544 Mr. {Egge.} Yes, we certainly found that is the case,
2545 that services that are provided in the community by social
2546 workers and by others can be tremendously important,
2547 especially at the early stages of Alzheimer's and other
2548 dementias while people are still able to live quite
2549 successfully in the community if they have that kind of
2550 support. We have found that is extremely important to well
2551 being for both the individual, and if they are living with
2552 somebody else, for their caregivers as well.

2553 Dr. {Christensen.} Everybody uses community health
2554 workers?

2555 Ms. {Hewson.} In North Carolina--

2556 Dr. {Christensen.} Promotores?

2557 Ms. {Hewson.} Promotores, and with the self-management
2558 of chronic disease, we engage lay community health advisors

2559 that actually live in the community that they are doing the
2560 chronic self-management programs so they have been very, very
2561 beneficial.

2562 Dr. {Christensen.} Thank you. I am always concerned
2563 that the issue of quality of health care is often pitted
2564 against whether health care costs are you are bundling and
2565 trying to bring these programs together, do you see any
2566 problems in moving forward to ensure that the dual-eligible
2567 health care quality and access in the health outcomes and not
2568 pitted against or held hostage to the health care cost
2569 containment issues?

2570 Mr. {Millwee.} Well, in STAR PLUS, we believe that
2571 critical to that is the external quality review organization
2572 where we aren't dependent upon just the State's data, we
2573 aren't dependent upon the HMO data but have an independent
2574 source to verify and look at the data that can measure, sure,
2575 the program is cost-effective but is it providing high-
2576 quality service or access to services where they should be.
2577 So we believe that is critical, and as we learn more about
2578 quality and its importance on the program to change the
2579 program to respond to those concerns.

2580 Dr. {Christensen.} Anyone else?

2581 Mr. {Bloom.} I would simply say that in PACE, we are,
2582 as I mentioned, we operate at full financial risk for all

2583 Medicare, Medicaid and medically necessary services with no
2584 carve-out, no copay, no deductible, no benefit limitations.
2585 We are immensely motivated and incentivized to provide good
2586 health outcomes. As the provider of care and the bearer of
2587 risk at the end of the day we are accountable, and it is
2588 truly in our best interest to get out in front of
2589 individuals' care needs and so that is what perfectly aligns
2590 the incentives within PACE.

2591 Dr. {Burgess.} The gentlelady's time is expired. The
2592 chair now recognizes the gentleman from New Jersey, Mr.
2593 Lance, for 5 minutes for the purposes of questions, please.

2594 Mr. {Lance.} Thank you, Mr. Chairman, and I yield my
2595 time to you, Mr. Chairman.

2596 Dr. {Burgess.} That is very kind of you.

2597 Let me just ask you, Mr. Millwee, since we have a little
2598 additional time, you have talked in your testimony about the
2599 service coordinators, but some people look at that and say
2600 well, you are adding personnel so you are going to be adding
2601 cost. How does that work? How do you justify that?

2602 Mr. {Millwee.} Well, some might speculate that would
2603 increase cost but actually that service coordinator,
2604 remember, that service coordinator is a clinical person who
2605 is working with that client so that clinical service
2606 coordinator is actually a dollar saver in many ways because

2607 they are identifying what that patient needs and how to get
2608 that for them so that we can have those early interventions
2609 so we don't have the hospitalizations or the nursing facility
2610 admits or the emergency department visits. So they literally
2611 pay for themselves time and again by having that intervention
2612 to make sure that the people who need those services, whether
2613 they are Medicaid or Medicare, that they are getting those
2614 things.

2615 Dr. {Burgess.} So you have demonstrable savings that
2616 you can point to in your program in Texas?

2617 Mr. {Millwee.} Absolutely.

2618 Dr. {Burgess.} And do you think that works in Texas, do
2619 you think it would transition or translate to work on a
2620 national scale?

2621 Mr. {Millwee.} Well, I think it could work in other
2622 States. I think the model is transferable. I don't think
2623 that people who are sick in Texas are any different that much
2624 really than people in Washington or California but I think
2625 that they could--the model is completely transferable to
2626 other States.

2627 Dr. {Burgess.} Do you have, can you share data with the
2628 committee, not necessarily right now, but is there data that
2629 you can share with us as to the actual dollar figures that
2630 have been saved?

2631 Mr. {Millwee.} We certainly can. We can provide the
2632 committee with that information.

2633 Dr. {Burgess.} And how do you get around HIPAA?

2634 Mr. {Millwee.} Well, we wouldn't provide you with
2635 client-specific data. We would provide you with deidentified
2636 aggregate information that would--

2637 Dr. {Burgess.} But more generally, how do the service
2638 coordinators themselves, how do they navigate the system
2639 under the constraints of HIPAA?

2640 Mr. {Millwee.} Well, they are working with the client
2641 as an agent of the client, so they can--

2642 Dr. {Burgess.} So they are fully integrated into it?

2643 Mr. {Millwee.} They are fully integrated into it, so
2644 they are not really burdened by HIPAA.

2645 Dr. {Burgess.} Generally, how do they monitor the day-
2646 to-day health of a patient? Is it telephonic, or how do they
2647 do that?

2648 Mr. {Millwee.} It is not high tech, it is high touch.
2649 It is people talking to people, picking up the phone and
2650 talking to that person, finding out how they are doing. We
2651 do use electronic health records. A lot of the HMOs are
2652 moving to that. But it really comes down to relationships
2653 and somebody caring about another person, picking up the
2654 phone and calling them and seeing what they need.

2655 Dr. {Burgess.} That is what is so crucial, somebody
2656 caring about someone else. And Mr. Egge's story that still
2657 haunts me, you know, somebody caring about someone else, that
2658 wouldn't be happening.

2659 Mr. {Millwee.} Right.

2660 Dr. {Burgess.} I am going to yield back the balance of
2661 my time and recognize the gentleman from Massachusetts for 5
2662 minutes for the purpose of questions.

2663 Mr. {Markey.} Thank you, Chairman Burgess, very much.

2664 Mr. Egge, you did a good job in highlighting the
2665 important place for Alzheimer's patients in this discussion.
2666 More than 22 percent of seniors with Alzheimer's disease
2667 qualify for both Medicare and Medicaid coverage. Often these
2668 seniors rely on Medicaid to pay for expensive nursing home
2669 services. Since Alzheimer's patients can require constant
2670 attention, nursing home care for patients and Alzheimer's can
2671 ultimately wind up being three times as expensive as nursing
2672 home care for those without it. As a result of those costly
2673 nursing home stays, in 2004 the average Medicaid payment for
2674 a Medicare beneficiary over 65 with Alzheimer's was nine
2675 times larger than the average Medicaid payment for other
2676 beneficiaries in the same group. As such, seniors with
2677 Alzheimer's represent an extremely vulnerable portion of the
2678 dually eligible population.

2679 I also have a particular interest in Alzheimer's since
2680 my mother passed away from it, which is why I created the
2681 Alzheimer's Caucus with Congressman Smith from New Jersey 13
2682 years ago. I have seen it firsthand and I know the
2683 incredible commitment that our family had to make to keep my
2684 mother at home during that entire period of time.

2685 One ongoing problem is the disconnect between those in
2686 the medical office seeing patients and those in the home
2687 caring for them. In your testimony, Mr. Egge, you mentioned
2688 the bill that Dr. Burgess and I have introduced, the Hope for
2689 Alzheimer's Act, which would encourage doctors to diagnose
2690 Alzheimer's patients earlier. After an Alzheimer's diagnosis
2691 is made, the bill that allows caregivers to be included in a
2692 conversation between doctors and patients to help plan for
2693 the disease and treatments. That conversation would give
2694 caregivers and doctors a reason to be working together
2695 because it will be the caregiver who will help the patient
2696 remember their diabetes medication and avoid ending up in a
2697 hospital.

2698 In your testimony, you talked about John, who suffered
2699 from diabetes but because of his Alzheimer's disease found it
2700 difficult to follow his doctor's instructions. As a result,
2701 he ended up in the emergency room, and the doctors there were
2702 unaware of the Alzheimer's disease which created a struggle

2703 to provide further care. Can you, Mr. Egge, explain how a
2704 formal and documented diagnosis of Alzheimer's will help to
2705 improve care amongst different providers and settings?

2706 Mr. {Egge.} Yes, we found from our experience that the
2707 documentation of Alzheimer's or other forms of dementia is
2708 critical care and it is critical to coordinated care. So the
2709 reason it matters is because you cannot provide appropriate
2710 care if you don't know dementia exists, and we talked about
2711 how that pertains of course to how you handle instructions
2712 for compliance, for instance, whether that can be directed to
2713 the individual or provided to a caregiver if available or
2714 perhaps to a surrogate when not, so in that sense it is
2715 fundamental. It is also fundamental when we think about
2716 documentation of the condition, the medical record, follows
2717 that person with a well-functioning system from setting to
2718 setting. We know that care transitions are one of the most
2719 risky moments for those with Alzheimer's and other dementias
2720 because of all the problems that can happen, especially in a
2721 hospital setting and others as they transition in and out.
2722 So it is critical to this committee that there is that
2723 documentation, diagnosis and then documentation.

2724 Mr. {Markey.} So this is an amazing number, but just
2725 one disease, Alzheimer's, last year cost the Federal
2726 Government \$130 billion out of Medicare and Medicaid. It is

2727 just an astounding number. You know, it is about a quarter
2728 of the entire defense budget, and that is just one disease,
2729 Alzheimer's. How with the Hope Act support caregivers and
2730 help provide them access to the resources they need to care
2731 for their loved ones, to keep them at home and as a results
2732 keep down the costs to the program?

2733 Mr. {Egge.} That is a great question, and one element
2734 of the Hope Act in particular is groundbreaking in that it
2735 provides for the first time for the health care provider to
2736 have consultations with the caregiver, whether or not the
2737 individual with Alzheimer's or other dementia is present,
2738 which is extremely important because sometimes it is most
2739 appropriate for the conversation to happen in number of
2740 different ways, so we applaud that and it is built on the
2741 recognition of how important a caregiver is for these
2742 individuals.

2743 Mr. {Markey.} Thank you, Mr. Egge. You know, it is
2744 \$130 billion now. By the time all the baby boomers have it,
2745 15 billion, the bill for Alzheimer's will equal the defense
2746 budget. It will be about \$500 billion or \$600 billion a
2747 year. So I think it is also calling upon us to increase the
2748 NIH research budget so that we can find a cure because
2749 ultimately we can't balance the budget if we have a problem
2750 like this that is on the horizon.

2751 Thank you, Mr. Chairman, so much.

2752 Dr. {Burgess.} The gentleman's time is expired, and
2753 actually that concludes today's hearing. I remind members
2754 they have 10 business days to submit questions for the
2755 record, and I ask that the witnesses all agreed to respond
2756 promptly to these questions.

2757 The committee is now adjourned.

2758 [Whereupon, at 4:28 p.m., the subcommittee was
2759 adjourned.]