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Before

The U.S. Special Committee on Aging Hearing

Examining Medicare and Medicaid Coordination for Dual-Eligibles

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Senator Corker, Chairman Kohl, and members of the Committee:

I very much appreciate the opportunity to testify before the Aging Committee on the very important topic of the CMS initiative related to improved care for dual eligible beneficiaries. The hearing is very timely given the size, scope, and speed with which these programs are proceeding. It is especially timely to have an exchange of state and federal perspectives on these state-based demonstrations. I acknowledge up front that my orientation lies with the Medicare program, which I consider a highly successful, social insurance program. Frankly I don't understand the logic of having the states take the lead in care for dual-eligible Medicare and Medicaid beneficiaries, although I do appreciate the growing pressure on state budgets and states' desire for financial relief in their Medicaid spending. I also appreciate that some successes in state-based programs has provided impetus for this initiative. I hope to gain an improved understanding from my colleagues of the panel on what states bring to the shared desire to improve care for the duals.

I practiced general internal medicine for over twenty years, the last twelve in a small group practice a few blocks from here. For the last three years of the Clinton Administration I had operational responsibility for Medicare payment policy and contracting with what are now called Medicare Advantage plans. I recently completed a three year term as a Commissioner of the Medicare Payment Advisory Commission (MedPAC), the last two as Vice-Chair. I am an Institute Fellow at the Urban Institute, doing policy research and analysis primarily on delivery system change and Medicare policy.

There is broad agreement on the need to do a better job on care for the duals. I have long supported a decisive change in payment from fee-for-service, which is proving increasingly dysfunctional, to capitation -- to plans and providers – so endorse the general approach in the dominant integrated payment approach that twenty states have opted for under the CMS initiative. As I will detail later, in fact there are numerous initiatives in Medicare to test new payment and organization of care models, improvements that will directly affect the care for duals and offer promise of program savings.

It is also true that some of the problem lies with inconsistency of Medicaid and Medicare rules and incentives, particularly in the areas of beneficiary eligibility for skilled nursing care and home health services. As summarized by MedPAC in its June, 2010 report, "Conflicting program incentives encourage providers to avoid costs rather than coordinate care, and poor coordination can raise spending and lower quality." The Affordable Care Act (ACA) reasonably called for state-based integrated care programs, which are proceeding now as part of the Financial Alignment Initiative.

There have been some notable successes of state-supported programs for disabled and for duals that gives encouragement to proceed aggressively, just as there have been successes in primarily Medicare-supported programs for care for dual-eligible beneficiaries. However, as we have learned repeatedly in Medicare demonstrations the challenges of scaling and generalizing from successful local initiatives is daunting. Anecdotes of successful program initiatives, often resulting from unique leadership and culture, while pointing to a direction for additional progress, should be viewed skeptically, especially when marketers start promoting a "$300 billion dollar opportunity" for the managed care industry. Rather than assume success, as CMS guidance and many of the state proposals convey, we are still at the early stages of testing models of improved care for duals.

In short, the reports of successful state-based local programs and innovative Medicare Advantage -- Special Needs Plans (MA-SNPs) responsibly should lead to real demonstrations, accompanied by robust evaluations to produce the needed evidence on which to base policy. My primary concern is that CMS's Financial Alignment Initiative is proceeding not as a real demonstration but rather is implementing program modifications, regardless of studied performance, comparable to the practical effect of Section 1115 Medicaid waivers, which are supposed to be demonstrations but which are recognized by all stakeholders as permitting permanent program changes. Medicare demos don't work that way -- and should not -- especially for the care provided to the most vulnerable beneficiaries of both Medicaid and Medicare programs.

In recent weeks, a number of letters to HHS Secretary Sebelius and CMS Administrator Tavenner have raised important concerns about many aspects of how this initiative is proceeding. These include a July 11 letter from MedPAC, a July 10 letter from Senator Rockefeller, and a June 11 letter from seven Republican Senators on the Finance Committee, including ranking member Hatch. The titles of two recent Health Affairs articles by policy experts who have looked at the issues succinctly summarize what needs to be said about the CMS initiative. *There Is Little Experience And Limited Data to Support Policy Making On Integrated Care For Dual Eligibles*[1] and *Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans*[2]. These and other letters and commentaries have done a good job of explicating the many serious concerns about how the initiative is proceeding. I personally participated in MedPAC's deliberations that took place over many hours and can certify the non-partisan nature of the concerns. **Simply, while well-intentioned, the pace, size, and scope of the duals demo needs to be reviewed and substantially altered.**

[1] Gold M., Jacobson GA, and Garfield RL. There is little experience and limited data to support policy making on integrated care for dual eligible. Health Affairs, June 2012, 31:1176.

[2] Neuman P, Lyons B, Rentas J and Rowland D. Dx for a careful approach to moving dual eligible beneficiaries into managed care plans. Health Affairs, June 2012, 31:1186.

Approval of current state applications for large capitation programs and smaller fee-for-service initiatives in 26 state demonstrations would involve three of the seven million dual-eligible beneficiaries fully eligible for Medicaid services. CMS itself has indicated it wants to include 2 million or more in these programs, which itself is far too ambitious. Instead, CMS should scale down this demonstration to one that might involve as many as 500,000 dual eligibles in perhaps 8-10 states. Indeed, such a demonstration program would still constitute one of the largest real demonstrations Medicare has mounted.

Arguments for this shift include:

1. Medicaid managed care plans' **lack of experience** in providing both Medicare and Medicaid services for dual-eligible populations. About half of the states are building their proposals on a Medicaid managed care platform; the others use MA-SNPs. Medicaid plans typically care for relatively healthy adults and children, not for beneficiaries with severe mental illness, such as schizophrenia; developmental disabilities; severe physical disabilities, such as quadriplegia; end-stage renal disease, HIV and AIDs, dementia, and multiple chronic conditions. Many reside in nursing homes or receive intensive home and community based services. While as dually eligible for Medicaid and Medicare, at a clinical level, these heterogeneous subpopulations require unique provider expertise and a kind of coordination that varies across the particular clinical conditions. Experience with moms and kids does not qualify a managed care organization to provide and manage a provider network for duals. Further, it will take time that is not built in to the demonstration time-line for health plans to develop the requisite provider networks capable of responding to the various medical, behavioral, and long-term care needs of the various patient subpopulations. That expertise and experience must be developed, and qualification to serve as plan of choice worthy of receiving passive enrollment of beneficiaries, as is being proposed as a core element of the initiative, must be thoroughly demonstrated, not assumed.

Today, it is generally accepted that Medicaid managed care plans serve only about 120,000 duals. That experience is insufficient to support wholesale passive enrollment of dual-eligible beneficiaries into these demonstrations. MA-SNPs currently care for 1.2 million dual eligible Medicare enrollees, so at least have experience caring for duals. Yet, even with the MA-SNPs that target dual-eligible beneficiaries, there is little evidence supporting a level of performance that permits policy makers to presume that passive enrollment is in the beneficiary's best interest.

2. Medicaid managed care plan **lack of capacity** to accommodate large numbers of dual eligibles. Although some states have managed care infrastructures with additional capacity, some of the proposals in the CMS initiative are overly ambitious and realistically cannot be met within the time frames proposed. They seem to be based on "rosy scenarios," such as the

broad availability and success of patient-centered medical homes, which represent a promising approach but one that remains mostly untested in caring for a regular patient population, much less a population with the diverse and complex clinical problems posed by many of the duals. California wants within 3 years to enroll all 1.1 million duals in the state into Medicaid managed care plans, with exemptions only for enrollees of Medicare Advantage plans. According to a recent Health Affairs issue brief, the two Los Angeles County managed care plans which currently serve 7500 duals under the state's proposal might have to serve up to 375,000.

3. **Uncertainty about what will work** in advance of actual experimentation and evaluation. As with ACOs, medical homes, and other major delivery initiatives, the Financial Alignment Initiative should require **proof of concept** before broad application. A real demonstration can provide that proof and can allow federal and state policymakers, and the managed care plans to work through a myriad of operational issues. For example, it may turn out that passive enrollment into definitively excellent managed care plans, with a well-functioning opt out provision, is a desirable approach to providing care for dual-eligible beneficiaries. However, working out exactly how to implement a real, workable opt out approach for beneficiaries with mental illness, developmental disabilities, and cognitive impairments, or for nursing home residents is likely to be very challenging and need revision as a demonstration proceeds. Similarly, currently there are no established quality measures to assess performance for some of the subgroups of duals, and as noted earlier, we have little information on which to base a conclusion that any particular manage care plan provides excellent care. A major demonstration would speed up development and implementation of serviceable quality metrics to permit elaboration of practical state-based programs to caring for duals.

4. **Effective evaluation as proof** is essential to fulfilling the ACA requirement that the CMA Chief Actuary certify that the demonstration has reduced spending with no diminution in quality, improved quality with no greater spending, or both. The current size and scope of the demos would not permit adequate evaluations. Yet, there would be political pressure to declare success regardless.

Although state-based policy makers express confidence that capitated managed care has to be better than uncoordinated fee-for-service, repeated experience with other "sure things" suggests caution. For example, for more than a decade health plan representatives touted the cost containing success of telephonic disease management administered by nurses in call centers, despite an absence of evidence from well done studies of positive effect. When finally subjected to a real test by CMS as the Medicare Health Support Program, albeit with demonstration design problems, it turned out that the approach did not actually reduce costs; many health plans have moved away from the call center approach to one of embedding nurses

in physician practices as a better strategy. What those with a stake in touting success knew to be the case proved to be wrong.

The ability of Medicaid managed care or MA-SNPs to do better than traditional Medicare on quality, access and costs remains a hypothesis in need of testing, not an assumption which, not incidentally, generates savings for state budgets. Although MA-SNPs have been in place since 2005, policy makers have little information on which to judge their performance. The available quality metrics are inadequate to assess relative quality of care; most are not relevant to the particular subpopulations of duals with very unique clinical circumstances. Further, on a national basis and in many of the states which have proposed interest in participating in the duals initiative, MA-SNPs actually spend more than traditional Medicare for providing Part A and B services. Although there may be some efficiency gained by aligning the Medicaid and Medicare funding through an integrated payment, there is no *a priori* basis for assuming that these programs will be more efficient than the current arrangements, even if on a theoretical basis capitation should provide a substantial advantage over fragmented fee-for-service in caring for patients with serious chronic conditions. A real demonstration with an adequate evaluation, rather than a waiver program, would help fill the current evidence gap.

5. **Too big to fail.** As noted earlier, under CMS's expressed strategy, about 30% of full dual-eligible beneficiaries would be asked to participate in these demonstrations; some would surely opt out. Some states propose that all of their duals or entire subpopulations of duals, e.g., all disabled dual beneficiaries, would be included in their state's demonstration. Setting these up would require prodigious effort on the part of participating managed care organizations -- to develop and contract with adequate provider networks, inform beneficiaries of being included and their rights to opt out, develop needed long-term services and supports, among other major obligations. The states and CMS would invest resources to develop and administer appropriate administrative oversight and monitoring procedures. Other parties that would have to spend substantial time and effort to support new activities include community support agencies, patient advocacy groups, and quality measure developers, among others.

Consider the following thought experiment. Assume that after 2 or 3 years, CMS's outside academic evaluators find quality or access problems in state programs, perhaps from inadequate provider networks. Based on this finding, according to the ACA, the CMS Chief Actuary next determines the demo as a whole has failed, despite some successes, and must be shut down. Would a future CMS Administrator actually then get on the phone to the involved Governors and tell them to shut down their programs and return to the *status quo ante*, once again dislocating beneficiaries, while disturbing state budgets. It won't happen, at least not in my thinking. In short, despite the lack of statutory authority, in effect, this demonstration

represents a permanent change to policy, as happens with Medicaid waivers. They will continue regardless of actual performance.

And, then, continuing with my thought experiment, once the political decision is made that the "demonstrations" will continue, there would be no credible basis for turning down any other state that wanted in using comparable approaches**. In short, the size and scope of the current CMS initiative is a glide path for placing most dual eligible Medicaid and Medicare beneficiaries into state-sponsored and/or supervised managed care plans, surely not a result intended by the ACA provision setting up CMS Innovation Center demonstrations.**

6. An assumption of **upfront programmatic savings.** CMS has proposed a financing model that assumes upfront savings for Medicare and the states, rather than testing whether savings are actually achieved, which is the right way to proceed with a demonstration and was the approach adopted by CMS in the Shared Savings Program for ACOs. The approach advanced in this initiative will lead states to reflect those assumed savings in payment rates to capitated managed care plans, which in turn will likely have to take immediate short cuts to achieve savings. Although the purpose of the demonstrations is to test approaches to improving care for duals, helped by reduced care barriers posed by different Medicaid and Medicare program rules, I am concerned that the immediate response of financially pressured managed care organizations will be to limit rather than expand needed benefits for long-term services and supports and cut provider payment levels from Medicare levels, further threatening access to care.

Medicaid managed care plans generally are able to shadow price Medicaid fee-for-service payment levels for providers, which in some states are well below Medicare levels. Using low payment rates, the demonstration then would not be a test of whether state-based plans can achieve savings from improved coordination and quality improvement, thereby enhancing dual eligible beneficiaries' well-being and quality of life in the process. Rather, it would implement what doesn't need testing at all – we know Medicaid managed care plans can pay providers below their costs. The initiative is silent on the extent to which health plans can achieve savings through reduced payment rates.

One of the central obligations Medicare assumes as the country's largest payer is to pay the average costs of a reasonably efficient provider. But health plans negotiate rates with providers – commercial plans pay much more on average than Medicare, while Medicaid plans pay less in many states. The Medicaid plans are under no obligation to pay average costs but rather can and do pay on the margin, in some cases even less than providers' marginal costs. Hospitals generally have to accept these rates and then may attempt to cost-shift the shortfall to commercial health plans and self-funded employers. Physicians often do not accept what they consider substandard rates and do not participate in Medicaid managed care plan

networks, thereby producing limited Medicaid provider networks. Again, a limited network might be acceptable for care for relatively healthy adults and children, but could lead to serious quality and access problems for duals with complex behavioral and physical problems requiring specialized clinical expertise. The financing model of taking savings off the top and permitting managed care plans to impose below-Medicare payment rates on providers could actually shift costs to Medicare as well as to commercial insurers and self-funded employers as providers try to recoup their shortfalls. A true test of integration through capitated payments to managed care plans would require that provider payment rates would be actuarially equivalent to Medicare rates.

7. **Evaluation challenges posed by risk selection.** Recent Urban Institute research has found that while many duals have very high spending, nearly 40 percent of dual eligibles had lower average per capita spending than non-dual eligible Medicare beneficiaries.[3] They are dual eligible based on being poor, not because of substantial chronic health problems. This finding confirms that the problem of risk selection, which is a central issue in all programs involving capitation, will be especially relevant in making accurate payments in these demonstrations. The need for accurate risk adjustment for health status is clear but will be a challenge, especially for some of the high cost subpopulations, such as the severely mentally ill. Current risk adjustment methods used in Medicare Advantage seems to under-estimate the costs associated with patients with serious chronic health problems. In addition, the reality of risk selection has implications for the size of the demonstrations and the nature of the evaluations that need to be performed. The commitment to passive enrollment with an opt out and lack of a lengthy lock-in period means that there will be systematic risk selection beyond the control of the plans taking place as beneficiaries exercise their right to not participate.

Further, as we have learned in Medicare Advantage, plans themselves can also encourage and discourage patient participation. And they can code diagnoses that are used for risk adjustment in ways to enhance payment. In this initiative, we want to try to avoid the phenomenon seen in the Physician Group Practice Demonstration of attributed savings being more apparent than real because of coding changes that make patients seem relatively sicker than they actually are or more precisely, sicker than in a control group for whom there not comparable incentives to code more aggressively. All of this suggests restraint in the size of the initiatives and a commitment to evaluation designs that rely on concurrent control groups from the same state. In Medicaid waiver programs there is an attempt to include all similarly situated patients across the entire state. In contrast, in Medicare demonstrations, such an approach is not desirable because it undermines the ability to conduct valid and useful demonstrations. The reality of the very heterogeneous, dual-eligible populations makes

[3] Coughlin, TA, Waidmann, TA, and Phadera L. Among dual eligible, identifying the highest-cost individuals could help in crafting more targeted and effective responses. Health Affairs. May 2012, 31:1083.

meaningful risk adjustment to accurately assess performance on spending is another reason to scale back this initiative to a manageable size.

Medicare's Role in Improving Care for Duals

Some of the rhetoric surrounding this important Initiative seems to assume that there has been a void of Medicare interest in improving care to the duals. In fact, in recent years, there has been a marked ramp up of Medicare programs for the duals. As noted earlier 1.2 million duals have affirmatively chosen to enroll in MA-SNPs. Almost twice as many have enrolled in regular MA plans. Testing accountable care organizations (ACOs), both in the Shared Savings Program and the Pioneer ACO program, is a major priority for CMS; Medicare beneficiaries with chronic health problems, including the duals, will be attributed to and cared for in ACOs. The Independence at Home Demonstration will test geriatric practice-based "house calls" for frail elderly who are often homebound – many are duals. Incentives on hospitals to reduce readmissions and bundled payment demonstrations are likely to spawn new approaches to care management for all Medicare beneficiaries, including duals.

As Senator Rockefeller suggested in his letter, instead of relying solely on a model that relies on multiple state efforts, CMS should also test models that bring care for dual eligible under the federal umbrella. Further, assignment to state-designated managed care organizations should not take precedence over these well-established Medicare programs and important demonstrations, essentially forcing beneficiaries to have to opt out of them in order to participate in Medicare-supported programs that they have affirmatively selected or, in the case of ACOs, been assigned to based on where they actually receive care.

Owing to the way services are covered in by Medicare and Medicaid, what makes dual eligibles high cost in one program does not necessarily make them high cost in the other. Urban Institute colleagues recently reported research finding a very small overlap in the highest spenders in the two programs.[4] Fewer than one percent of dual eligibles nationally were in the highest 10 percent of the spending distribution in both programs. Collectively high cost dual-eligible beneficiaries in both programs accounted for less than 5 percent of overall spending on duals in 2007. For top-spending Medicaid dual eligibles, the vast majority of their spending was for long-term care services, including the high costs of residence in nursing homes, most of which are paid by Medicaid. For top-spending Medicare dual eligibles, most spending was for acute care, often related to hospitalizations, which were overwhelmingly paid for by Medicare. The implication is that the financial pressure on Medicaid is related to financing long-term care, while for Medicare the pressure is related to potentially avoidable hospital and related

[4] Coughlin, TA, Waidmann, TA, and Phadera L. Among dual eligible, identifying the highest-cost individuals could help in crafting more targeted and effective responses. Health Affairs. May 2012, 31:1083.

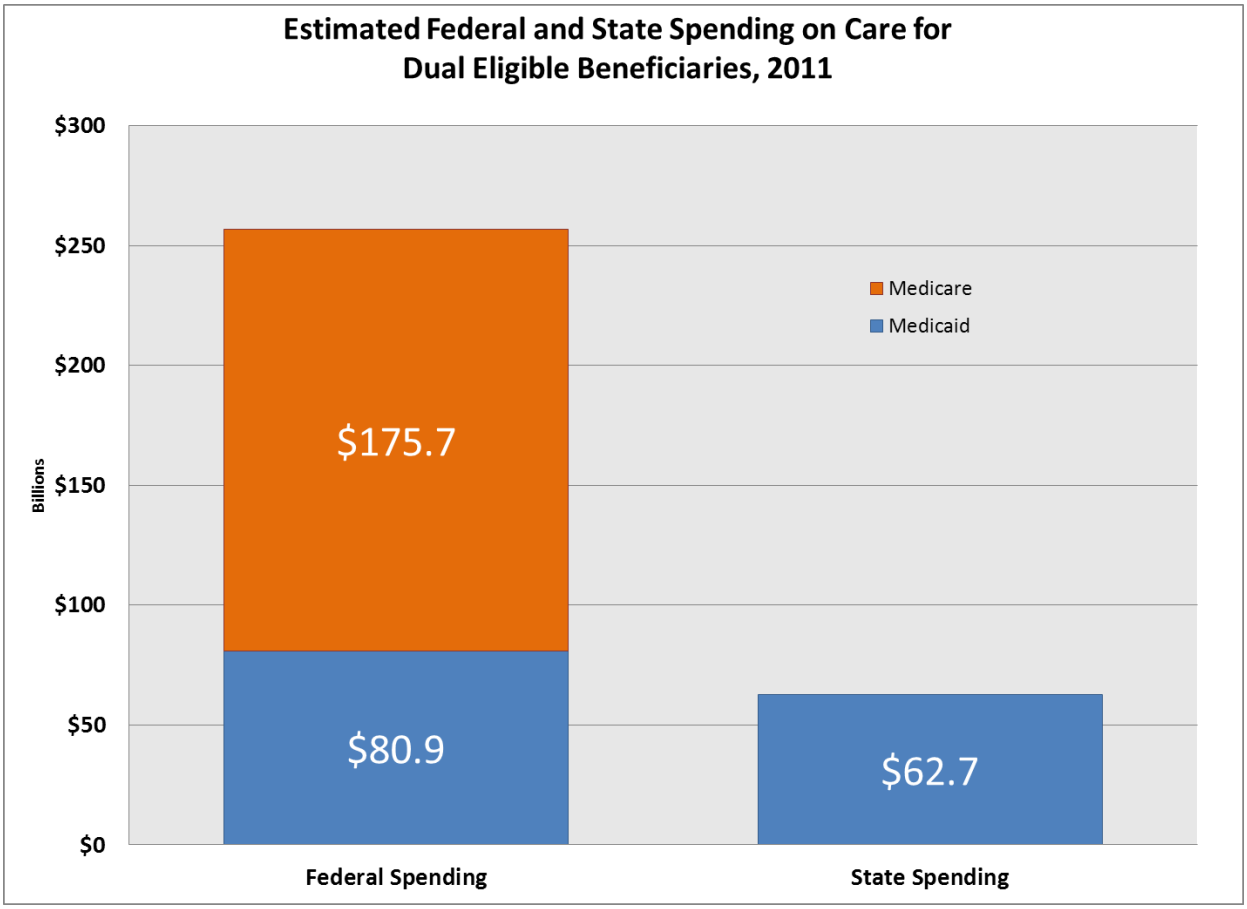
spending. As discussed above there are already extensive actions in place in Medicare to address avoidable acute care spending, some of which is by dual eligible beneficiaries.

Conclusion

Of the $320 billion Medicare and Medicaid dollars estimated as spent on duals in 2011, 80 percent represent federal dollars, more than two-thirds of which flowed through Medicare. (see attached table) Potential savings would come primarily from better management of Medicare-financed acute care services. As pointed out by Urban Institute colleagues, most of whom primarily study Medicaid, enhanced state, rather than federal, responsibility for overall spending increases the risk of cost-shifting to Medicare and undermining the quality of care for vulnerable beneficiaries.[5]

At the same time, while many dual eligibles do get their care from integrated Medicare Advantage plans and there are numerous Medicare initiatives, including ACOs, that will include duals, there has been little concerted effort on the Medicare side specifically to address the misalignment of financial interests between Medicare and Medicaid. That needs to change. In the meantime, it is reasonable to proceed with demonstrations of state-based initiatives given the great interest in the states and the extensive work that has already been extended in the Financial Alignment Initiative. However, the Initiative is far too large and needs to be substantially reduced with much more attention to the statutory requirement for high quality evaluations that permit a reasonably accurate assessment of the impact on spending and on quality of care for the affected beneficiaries.

[5] Feder J, Clemans-Cope L, Coughlin T, Holahan J, and Waidman T. Refocusing responsibility for dual eligible: why Medicare should take the lead. Urban Institute, October 2011.


Estimated Federal and State Spending on Care for Dual Eligible Beneficiaries, 2011
$300
$250
$200
$150
$100
$50
$0
Billions
$175.7
$80.9
$62.7
Medicare
Medicaid
Federal Spending
State Spending