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COORDINATED CARE OPTIONS FOR SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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COORDINATED CARE OPTIONS FOR SENIORS

TUESDAY, APRIL 29, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:37 a.m., in room B–138, Rayburn House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 22, 1997
No. HL–12

CONTACT: (202) 225–3943

Thomas Announces Hearing on Coordinated Care Options for Seniors

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on coordinated care for beneficiaries eligible for coverage under both the Medicare and Medicaid programs. The hearing will take place on Tuesday, April 29, 1997, in room B–318 Rayburn House Office Building, beginning at 9:30 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

As many as six million Americans, known as "dual eligibles," are enrolled in both the Medicare and Medicaid programs, and an additional three to four million Americans are eligible for both programs. For these dual eligibles, Medicaid may help pay Medicare premiums and deductibles, or cover services Medicare does not provide, such as hearing aids, prescription drugs, and long-term nursing home stays.

Most dual eligibles are poor and many have chronic illnesses or complex acute illnesses and are in need of long-term care services. Dual eligibles comprised about 16 percent of the Medicare population but accounted for about 30 percent of total Medicare expenditures in 1995. Similarly, dual eligibles made up 17 percent of the Medicaid population and accounted for approximately 35 percent of Medicaid payments in the same year. Because the fragmentation in today's health system is exacerbated when people are covered by both the Medicare and Medicaid programs, many believe that better coordination of care for dual eligible individuals can save tax dollars while improving the quality of care for this population.

Currently, there is not a generally available comprehensive integrated care benefit available to people eligible for both Medicare and Medicaid. However, there have been two major demonstration projects that have attempted to better coordinate care for some dual eligibles: Programs of All Inclusive Care for the Elderly (PACE) and Social Health Maintenance Organizations (SHMO). The PACE and SHMO programs, which currently cover about 23,000 elderly people, combine Medicare, Medicaid and private funds to provide integrated acute and chronic care services to target populations. In addition, several States, including California, Florida, Massachusetts, Ohio, Wisconsin, Minnesota, and Arizona have begun to explore ways to improve quality and reduce costs by managing and coordinating health care for dual eligibles.

In announcing the hearing, Chairman Thomas stated: "I strongly support expansion of innovative coordinated care programs, such as PACE and SHMOs. At the same time, I believe we need to look for ways to move beyond existing models to make coordinated care networks a permanent competitive option for all beneficiaries."

FOCUS OF THE HEARING:

The purpose of the hearing is to examine the PACE and SHMO programs, and other efforts to coordinate care for beneficiaries who may be eligible for coverage under both the Medicare and Medicaid programs.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Tuesday, May 13, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The Subcommittee will come to order.

I want to welcome you to today's hearing on coordinated care systems under the Medicare Program. The health care system generally and the Medicare and Medicaid Programs in particular are characterized by conflicting Federal and State rules and payment policies which reinforce, unfortunately, isolated administrative, clinical, and financial incentives for individual providers instead of focusing on what we are all supposed to be doing, and that is the needs of chronically ill patients.

These problems can lead to fragmented care, repeated and lengthy hospital stays, family stress, premature nursing home placement, and impoverishment for the 6 million so-called dual eligibles enrolled in both the Medicare and the Medicaid Programs who have chronic illnesses or complex acute illnesses.

It is pretty obvious, based upon the evidence presented by witnesses and other sources, that this fragmentation also leads, unfortunately, to excessive costs. While dual eligibles comprise about 16 percent of the Medicare population and 17 percent of the Medicaid enrollees, they account for about one-third of both Medicare and Medicaid spending. Moreover, as the baby boom population ages, the number of chronically ill Americans is projected, unfortunately, to grow by as much as 25 percent.

We need to remove administrative and financial barriers to coordinated care and provide incentives for providers to work together to care for chronically ill patients. Notwithstanding the testimony and the arguments which, I believe, are very good of a number of our witnesses for various approaches, yesterday, I introduced, along with Representatives Pete Stark, Ben Cardin, and the Chairman of the Commerce Health Subcommittee, Mike Bilirakis of Florida, the PACE Coverage Act of 1997, which would grant permanent provider status to the program for all-inclusive care for the elderly.

I do not mean to send a signal that other approaches are not worthy or appropriate or, in fact, would not be renewed before their termination date. It is just that there are items that need to be cleared up and/or vehicles other than stand-alone bills which might be appropriate to deal with some of the other concerns that we have, because although PACE is not the only solution to problems facing frail older Americans, it has been shown to provide high-quality services at a reduced price to both Medicare and Medicaid. We will also hear testimony, as I said, about other creative coordinated care options for dual eligibles, such as the social health maintenance organizations, SHMOs, and others.

At the same time, I do look forward to ideas that are going to be presented, especially in creating coordinated care networks that provide a continuum of care that is focused on the patient and their needs rather than on the bureaucratic structure, which I believe to be the current system.

Does the gentleman from Wisconsin wish to make any opening remarks?

Mr. KLECZKA. Very briefly, Mr. Chairman. I look forward to the testimony by the various panels today. One of the programs we will be talking about will be the municipal health services program, which, I should add, in my district, Milwaukee, is part of the pilot, along with Baltimore, San Jose, and Cincinnati, and hopefully, as

we develop legislation or review the legislation introduced by the Chairman, we can not only provide for continuance but also make sure that it is serving the population that it is intended to do.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman.

I would ask Dr. Meiners and Dr. Wallack to come forward at this time. I want to thank both of you for coming. I know you both have written statements and they will be made a part of the record, without objection. You can address us in any way you see fit in the time that you have available to inform us.

Dr. Meiners, if you will begin, and then we will go to Dr. Wallack.

STATEMENT OF MARK R. MEINERS, PH.D., ASSOCIATE DIRECTOR, UNIVERSITY OF MARYLAND CENTER ON AGING

Mr. MEINERS. Thank you. Mr. Chairman and Members of the Subcommittee, my name is Mark Meiners. I am based at the University of Maryland Center on Aging. I am an Associate Professor there. As part of my duties, I have worked quite a bit with the Robert Wood Johnson Foundation and I wanted to take my time today to chat with you about a couple of programs we are working on.

One is the Partnership for Long-Term Care, which is a long-term care insurance program, which may not seem obviously relevant to the immediate topic, but I think it is. The other is the Medicare-Medicaid Integration Program. Both of these are State-based programs and a lot of my work with the Johnson Foundation has been involved in program development related to health and aging issues.

States, as you know, are hungry for workable models to deal with their long-term care responsibilities. There is a general recognition of the need to improve health care delivery systems, particularly for those with chronic care needs. A commonly accepted premise is that to make progress, we must improve the integration and coordination of acute and long-term care, and to do this, we must experiment with new systems of care and financing.

While Medicaid's early involvement with managed care has focused on families and children, State policymakers are increasingly interested in enrolling all Medicaid beneficiaries into some form of managed care. The expansion of managed care for aged and disabled populations inevitably raises the question of how Medicare's acute care services can be coordinated with Medicaid's long-term care services.

The integration of acute and long-term care is important to the development of a coordinated managed care system that provides the flexibility and incentives to manage the full array of care for aged and disabled.

Now, as you know, the problem of fragmentation between Medicare and Medicaid is not new. Since the mideighties, policymakers have been looking for ways to end the fragmentation that seems to be inherent in the fee-for-service system. Beginning with the Channeling Project and On Lok in the eighties and continuing with the PACE Program and the Social HMOs, a variety of efforts have been made to create the necessary incentives for managed care providers to integrate acute and long-term care.

More recently, the Robert Wood Johnson Foundation has made a grant to the State of Minnesota to plan a managed care program that integrates acute and long-term care services. The Minnesota Senior Health Options Program received Federal approval last year to proceed with a demonstration program to enroll and capitate health maintenance organizations and other health plans.

One thing to note is that the Minnesota Senior Health Options Program is much more broadly based than either the SHMO or the HMO option. It includes a wider range of people at risk as well as those who are healthy.

Further development is likely to build on the efforts of the Social HMO and the PACE projects. Though these are few in number, they really have provided many good lessons for us in terms of how we work out the integration of acute and long-term care.

Unfortunately, I think that demonstrations like those of the PACE and SHMO have received complaints from both extremes in the policy debate and part of it is that people have grown tired of demonstrations, they want action, and the other part of it is that people really are afraid that the demonstrations are simply a foot in the door to greater benefit packages.

I think realistically, though, we need more efforts like those that we have had. They provide us with great learning experiences and, I think, have served to a great extent to help the Health Care Financing Administration sort out some of its own confusion about how Medicare and Medicaid ought to integrate.

I wanted to touch on the Partnership for Long-Term Care, a long-term care insurance program, partly because this Subcommittee had a hand in grandfathering the four States who are doing that program, but also at the time of that OBRA 1993 language, there were some restrictions placed that have really inhibited the development of the long-term care insurance partnership program.

Why I think that is important is because I think links between that partnership program and managed care are quite possible and need to be explored and States are interested in doing that. So, I would encourage you to take a look at some of my written testimony in that regard because I do not think we will be as successful as we want to be with the notions of Medicare-Medicaid integration on the public side unless we have equally strong programs on the private side. Medicaid, of course, is not available for everyone, so we need to encourage that gap to be filled with private long-term care insurance. There are some creative efforts going on to link PACE with long-term care insurance products and I will be happy to explore those with you further.

[The prepared statement follows:]

Statement of Mark R. Meiners, Ph.D., Associate Director, University of Maryland Center on Aging

Mr. Chairman and members of the Subcommittee, my name is Mark Meiners. I am an associate professor at the University of Maryland where I specialize in the economics of aging and health as it relates to public policy. As part of my duties I have helped the Robert Wood Johnson Foundation develop and direct several state programs designed to improv our Nations long-term care financing and delivery systems. This is fascinating yet frustrating work and we need your help to succeed. To highlight this I want to focus on two of the programs I am working on - the Partnership for Long-Term Care and the Medicare-Medicaid Integration Program. Each of these programs provide excellent case studies of the creativity and perseverance states have demonstrated in carrying out their long-term care responsibilities in the face of great barriers. It is the barriers with which we need your help.

State Initiatives in Long-Term Care

It is not surprising that states have been the focal point in reform o long-term care. Much of long-term care is related to daily living needs rather than health care needs. This tends to make the approach to care more the concern of individuals and their communities. Perhaps even more important, financing and administration of long-term care under the Medicaid program has been an increasing burden for states. Their desire to find alternatives to nursing home care has provided most of the experience with program innovation.

States are hungry for workable models to help deal with their long-term care responsibilities. There is general recognition of the need to improve the health care delivery system for those with chronic care need A commonly accepted premise is that to make progress we must improve the integration and coordination of acute and long-term care. To do this, providers must experiment with new systems of care and financing. But Medicare and Medicaid policy have made this an extremely difficult task. Unnecessary hospitalizations of those in nursing homes are encouraged b low Medicaid reimbursements, bed hold day payments, and DRG related payment incentives for short stay hospital admissions. Medicare physicia payments are biased toward hospital care instead of care in the office, home, or nursing home. More emergency room visits, medical transportation, and readmissions result. Managed care is increasing being looked to as one way to handle these inefficiencies.

The recent growth of Medicare and Medicaid beneficiaries enrolled managed care has been unprecedented. Since 1993, Medicare enrollment has increased by over 60 percent and Medicaid enrollment by over 140 percent. Almost 4 million Medicare beneficiaries are now enrolled in managed care, representing more than 10 percent of the total Medicare population. While Medicaid's early involvement with managed care has focused on families and children, state policymakers are increasingly interested in enrolling all Medicaid beneficiaries into some form of

managed care. The expansion of managed care for aged and disabled populations inevitably raises the question of how Medicare's acute care services can be coordinated with Medicaid's long-term care services. The integration of acute and long-term care is important to the development c a coordinated managed health care system that provides the flexibility an incentives to manage the full array of care for aged and disabled consumers.

There are an estimated five to six million individuals in this country who are eligible for both Medicare and Medicaid. Many in this group hav complex medical and chronic care needs that require lengthy stays in a variety of long-term settings. Effective care management for such a population can best be accomplished when health plans have the ability t coordinate the service delivery and financing of the entire continuum of health and long-term care services. The current financing and delivery system contains many obstacles to the development of such an integrated system. Of major concern to the development of managed care programs the fragmentation of financing and responsibility for patient care. Medicare and Medicaid currently maintain wholly separate contracting, reimbursement and quality standards for managed care organizations, in spite of overlapping populations. If managed care providers are to be effective in accessing the most appropriate and cost effective care for thei patients they must be encouraged to use the entire continuum of care.

The problem of fragmentation between Medicare and Medicaid is n new. Since the mid 1980s, policymakers have been looking for ways to end the fragmentation that seems inherent in a fee-for-service system th funds different types of care through multiple funding sources for a singl group of clients. Beginning with The Channeling Project and On Lok in 1980s, and continuing with the Program For All-inclusive Care For The Elderly and the Social Health Maintenance Organizations, a variety of efforts have been made to create the necessary incentives for managed care providers to integrate acute and long-term care. These efforts form vision of integrated care that includes the full continuum of acute and lon term care services, and allows providers to purchase the most efficient service package for their clients, regardless specific payer regulations.

In 1992, The Robert Wood Johnson Foundation made a grant to the State of Minnesota to plan a managed care program that integrates acute care services under Medicare with long-term care services under Medicai The Minnesota Senior Health Options program received federal approval last year to proceed with a demonstration program to enroll and capitate health maintenance organizations and other health plans for the entire continuum of care for dual eligible persons over age 65. An important component of the program is the creation of a single contract between the state and the health plan. This contract makes the state responsible for monitoring the quality of services and the financial performance of the health plan. While the managed care infrastructure in many states is not

sufficient to simply replicate the Minnesota Senior Health Options prograr the program development and implementation stimulated by this effort has dramatically increased our understanding of the problems that must be solved to accomplish integrated care programs.

Models of Integration

Further development is likely to build on the efforts of the Social HMO's and the On Lok/PACE projects; two of the best known long-term care demonstration efforts that have survived and are now being replicated. Though few in number, these models provide evidence that will help further developments.

The Social HMO model emphasizes home and community care withir a limited managed long-term care benefit package and is designed to appeal as a supplement to Medicare HMO benefits that can help with chronic care needs. It is marketed to mostly healthy private pay individuals but is not limited to that segment of the population. As this model has evolved it has been criticized for being simply a benefit add-or without the system integration changes needed to improve chronic care delivery. In 1990 Congress authorized a second generation of the Social HMO model to refine its population targeting, financing methods, and benefits design.

In contrast to the Social HMO, the On Lok model and its ten site replication demonstration, PACE (Program for All-Inclusive Care for the Elderly), focuses on the other end of the continuum of need. It is targeted to the community-based frail elderly who are "nursing home certifiable" and likely near the end of their lives. The key service component is adult day care which serves much like a geriatric care clinic with daily activitie designed to allow for a stimulating environment along with close observation and supervision otherwise only available by institutionalizing the patient.

The PACE model is probably the best available example of successfu integration of acute and long-term care under managed care arrangement It has much more of the geriatric care orientation being sought in the second generation Social HMOs. But the model is primarily targeted to those eligible for both Medicare and Medicaid. Nonetheless, there is growing interest in making this model of care more appealing to private pay populations who need similar care. The trick will be to get people to accept the need for this care earlier (pay the premiums) while making a commitment to the prescribed delivery system. One approach that might work is to offer this care approach as a preferred provider arrangement under long-term care insurance contracts.

The Minnesota Senior Health Options (MSHO) program is more comprehensive approach to long-term care financing and organization is

that builds on the accomplishments of the SHMO and PACE demonstration The MSHO is seeking to demonstrate that integration of acute and long-term care financing can stimulate delivery system changes that will reduc cost shifting between Medicare and Medicaid and improve care outcomes. Its focus is those "dually eligible" for both Medicare and Medicaid. This population provides a good starting point to learn what it means to integrate acute and long-term care. Those who are Medicaid eligible tend to be relatively high cost users of care and there is interest in gaining insight about their patterns of care.

The MSHO program is in direct response to the desire to eliminate the financing barriers to more cost effective care for the elderly. Currentl states have little incentive to address chronic care needs because the savings are more likely to accrue on the Medicare side, for which the stat have no fiscal responsibility, while potentially increasing utilization of state financed Medicaid services. Incentives are strong for states to have as much care pushed to the acute care side as possible because there is nc state cost sharing with Medicare.

The MSHO program differs from the On Lok model in that its focus i broader than community residents who are nursing home certifiable. The intent is to include, in addition, those dually eligible in nursing homes and the well elderly in the community. It differs from the Social HMO becaus it will concentrate on serving the Medicaid eligible, and the benefit package is not limited to home and community care services.

The MSHO program has the advantage of building on the prepaid medical assistance program (PMAP) in several Minnesota counties that requires Medicaid eligible persons to enroll in one of several participating managed health care plans. While all Medicaid services except long-term care are covered under PMAP these services are limited and do not address the coordination of acute and long-term care. PMAP does, however, provide the administrative base allowing for integration of the benefits offered by Medicare, PMAP, and the new long-term care progran The idea is to give enrollees a choice between a LTCOP plan or the PMAP plan. To reduce consumer resistance to the new and unknown, enrollees will be allowed to disenroll from it to the regular PMAP program on a monthly basis.

In the past few years we have gained a much more detailed understanding of these disconnects because of the real world experience demonstrations like the SHMO, PACE, and Minnesota Senior Health Option (MSHO) programs. These examples suggest the need for new incentives along with payment methods that encourage providers to work together t overcome those problems. Pooled capitation payments along with managed care and flexibility are the mechanisms often suggested to encourage providers to work together in creating cost-effective care packages.

Unfortunately, demonstrations as a way to foster new ideas have been subject to complaints from both extremes in the debate on long-tern care. Those who want much more had grown tired of demonstrations and viewed them as poor substitutes for action. Those who fear the increased cost of new benefits see demonstrations as a foot in the door to just such an outcome. As a result demonstration programs have faced difficult tim since the early 1980's. Achieving the necessary waivers to try new approaches has been at best difficult and consumes so much time and effort that financing and delivery system innovations have been severely limited.

More recently there has been a growing recognition of the great difficulty our health care system has had because of the significant disconnects between Medicare and Medicaid. Ten specific areas have bee identified by Pam Parker, the director of the MSHO. They included the following:

1. Lack of Data Sharing About Enrollment
There is no automatic system of communication between the plans and the States or HCFA and the states to identify dual eligibles who are enrolled in these plans. A few states have obtained permission to process data from HCFA to obtain this information but the approval for getting the data and the subsequent process of matching the data are extremely cumbersome.

2. Difficulties in Avoiding Duplicate Payment for Overlapping Benefits
Where there are many Medicare risk plans, they may all have slightly different benefit sets, and plans may be constantly changing their benefit sets in response to a competitive market. This makes it very difficult to track and avoid duplicate Medicaid payments for overlapping benefits. In addition, financial documents submitted to HCFA (Adjusted Community Ratings) which outline details of how costs and benefits were calculated are private and states may not have access to them.

3. Unstable Markets and Medicare Managed Care Plans May Not Want to Contract with Medicaid
Medicare managed care plans may not want to contract with Medicaid and there is nothing requiring them to do so. So it is up to the State to attempt to negotiate with each separate plan. In some areas, the Medicare plan market is highly volatile and plans go in and out of the market leaving Medicaid trying to piggy back its Medicaid contracts on a very unstable base.

4. Enrollment in Two Different Plans
Medicare and Medicaid may not contract with the same plans since Medicare and Medicaid plan requirements are different. Many Medicare managed care plans do not have contracts with Medicaid and Medicaid managed care plans may not meet requirements for Medicare risk contracts with HCFA (e.g. the requirement for 50% commercial enrollment). In areas where

dual eligibles may also be enrolled in Medicaid managed care, they may end up in two different plans which causes huge difficulties in coordination of benefits. Because of the lack of systematic information, states and plans may not even know of this conflicting enrollment until providers try to bill and services or payments are denied.

5. Conflicting and Duplicative Administrative Requirements

States who try to piggy back Medicaid contracts on Medicare managed care contracts also face problems with conflicting and duplicative administrative requirements. HCFA contracts directly with Medicare HMOs while the States choose and manage Medicaid managed care plan contracts. Federal regulations and administrative requirements for enrollment and dis-enrollment, marketing, grievance procedures, payment schedules, oversight, data collection and virtually everything else involved in administration differs between Medicare and Medicaid. This makes it terribly difficult for the plan to operate in an efficient manner. It is subject to two different contracts with two different managing entities and two different sets of requirements for the same dually eligible enrollees.

6. Confusing Marketing Materials and Consumer Information

Furthermore, information approved under Medicare for distribution to enrollees may be misleading when applied to dual eligibles. Since HCFA reviews Medicare materials and the State reviews Medicaid materials under very different sets of rules, there is no easy way to coordinate this information to assure that it makes sense to the dually eligible beneficiary. A few states have worked out intricate arrangements with HCFA Regional Offices to try to coordinate but there remain many problems with those arrangements.

7. Medicare Managed Care Payments May Encourage Institutionalization

In addition, Medicare managed care payment policies may encourage cost shifting to Medicaid nursing home care for dual eligibles. Medicare payments are highest for persons in nursing homes. Since the Medicare risk plans are not liable for Medicaid long term care costs they have little incentive to avoid nursing home placements. Once persons are discharged to the community the AAPCC payment is considerably reduced and there are no risk adjusters targeted to the frail elderly to keep them out of nursing homes outside of special demonstrations. This is an example of where the acute care incentives work directly against Medicaid's desire to avoid premature institutional placement.

Some innovative Medicare managed care plans are interested enrolling stable chronically ill nursing home residents many of whom are dually eligible, because Medicare payments for them are high and they feel they can manage their acute care costs and avoid hospital stays more easily because they reside in a setting with 24 hour nursing coverage. Despite their many

benefits, these plans also have the potential to shift costs to Medicaid in the form of higher nursing home per diems and higher nursing home utilization. This arrangement falls short of an integrated acute and long term care delivery system because plans are not liable for long term care costs.

8. Lack of Medicare Managed Care Plan Coverage Due to AAPCC Variations

Even if states are able to contract with Medicare risk plans many of those plans operate only in certain regions of the State due to county by county variations in the AAPCC. For instance in Minnesota, where most counties are far below the national average AAPCC payments, Medicare risk contractors operate only in the seven county metro area. The other 80 counties including all of our rural areas are denied the choice of a Medicare managed care plan. In some states, because of the AAPCC disparities, there are no Medicare managed care plans in operation at all.

9. Medicare Plans May Not Want to Take Risk for Medicaid LTC Costs

States who want to move to integrated models such as those illustrated by PACE, would want to include costs for Medicaid nursing home per diems and home and community based services in Medicaid managed care contracts with Medicare managed care plans. Including these costs in the plan's responsibility can be helpful in avoiding premature nursing home placements and encouraging the use of home and community based services. However, there are only a few isolated cases outside of the PACE and SHMO demonstrations where states have been successful in including nursing home per diem and home and community based services in managed care capitations. Only Arizona has been successful in implementing this as a state wide strategy. One reason they have been able to do this is that they are the only state which has approval to require enrollment in plans which include all long term care costs. In Minnesota's MSHO demonstration, it has been difficult to get providers to accept risk for nursing home costs and for home and community services for frail seniors residing in the community, despite Medicare risk adjusters from HCFA to alleviate this problem.

10. Many Medicare Plans Lack Experience With Long Term Care Services

Traditional Medicare plans may lack the special expertise needed to deal appropriately and successfully with special needs of dual eligibles. In most markets Medicare plans have not had reason to develop relationships with long term care providers, particularly those offering home and community based services. While some care management models now exist for long term nursing home residents as described above, there are few models for the frail elderly in the community outside of those developed in PACE and SHMO.

To help states in their efforts to overcome the inefficiencies of care for those dually eligible for the full spectrum of Medicare and Medicaid benefits, the Robert Wood Johnson Foundation and the University of Maryland Center on Aging have recently launched the Medicare-Medicaid Integration Program (MMIP). The purpose of the Medicare/Medicaid Integration Program, (MMIP) is to end the fragmentation of financing, cas management, and service delivery that currently exists between Medicar and Medicaid. States will be provided with support in their efforts to restructure the way in which they finance and deliver acute and long-ter care.

The MMIP will assist state Medicaid programs to develop and implement integrated care programs that best meet the needs of the states' dual eligible population. States will be provided with grant fundin and access to a variety of technical assistance resources.

The Foundation will make $8 million available for this initiative. States can apply for grants of up to $300,000. Proposed projects are expected to last no more than two years. States successfully completing their initial grant may be eligible to apply for subsequent funding. States in all phases of planning and implementation are being encouraged to apply.

The Partnership for Long-Term Care

The Partnership for Long-Term Care is another state-based progran we have undertaken with the support of the Robert Wood Johnson Foundation It is another piece of the long-term care puzzle that could be important to the success of integrated care. The Partnership program is designed to stimulate the long-term care insurance market by helping to balance the difficult competing pressures between product value and pric Four states (California, Connecticut, Indiana, and New York) are currently operating this public-private partnership which provides consumers special protection against depletion of their assets in the financing of long term care.

The Partnership long term care insurance policies work in the following way. By buying a Partnership policy, a person qualifies for Medicaid benefits under special Medicaid rules. Once a non-Partnership policy runs out, an individual must spend virtually all of their savings before they qualify for Medicaid. In contrast, when a Partnership policy i exhausted, the policyholder is permitted to retain assets equal to the amount his or her insurance paid out (in NY they can keep all remaining assets). The person is then eligible for coverage under Medicaid without having to deplete previous savings.

Insurers participating in the Partnerships must meet the program certification standards. These standards ensure that participating long-term care policies are of high quality. Among the standards required in each state are inflation protection, minimum benefit amounts, and agent training. Participating insurers are also required to provide the state witl information on purchasers of certified products and on the utilization of benefits.

The Partnership states selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering numerous alternatives. The program is fiscally conservative, helps middl income people avoid impoverishment, serves as an alternative to Medicai estate planning, promotes better quality insurance products which promote consumer protection efforts, enhances public awareness regardin long term care needs and options, and helps maintain public support for the Medicaid program.

The following are highlights from Partnership policy sales in four states (CA, CT, IN, and NY) as of June 30, 1996. More than 26,000 applications have been received for the purchase of Partnership policies t mid-year 1996 across the four participating states. From these applications almost 20,000 partnership policies have been purchased (there is a lag between application and purchase). Of these purchases, there are currently more than 15,000 policies in force in the four states.

Three of the four states allow the sale of one and two year Partnership policies, (CA, CT, IN). The proportion of purchasers in these states buying one and two year polices remains high; California: 91%, Connecticut: 49%, and Indiana: 40%. The majority of Partnership policy purchasers are first time buyers. The proportion of first timers ranges from a high of 95% in California, to a low of 79% in Indiana. A significant proportion of Partnership policy purchasers is under age 65, ranging from a high of 56% in Connecticut to a low of 31% in California.

The Partnership Balancing Act

Partnership policy sales indicate steadily growing interest in public-private long-term care insurance policies. However, the numbers also reveal that the public is still wary about the need for such policies and needs positive reinforcement to consider such an investment in their future. There are good reasons for this that involve the differences in perspectives that have fueled the status quo.

In the early stages of program development, arguments against the Partnership were raised primarily by social insurance advocates who viewed the program as an incremental step which would erode support fc more ambitious reform. As the Partnership was implemented, insurers voiced their own dissatisfaction with certain aspects of the program desig because it deviated from some of the standard approaches used to marke this coverage and required extra attention beyond that for non-partnership products. Not satisfying everyone exactly to their liking is after all what we believe to be necessary for a workable public-private partnership.

Most of the arguments for and against the Partnership share commc issues viewed from different perspectives. Central to the strategy is the fact that Medicaid is the primary public payer for long-term care, that states are the key decision makers regarding Medicaid rules and insuranc regulation, and that the states need to be at least budget neutral in their efforts to provide a positive incentive to the insurance market.

OBRA '93 Language A Major Barrier to Replication

At least some of your committee members are quite familiar with the Partnership program having had a hand in grandfathering the curren states right to operate their programs as part of the 1993 Omnibus Reconciliation Act. That same legislation, however, put restrictions on the wider state replication of this idea which has proved to be a major barrie to broadening the success of this program.

At the time when the Partnership programs were initiated, two countervailing forces clashed. First, state interest in the Partnership grew well beyond the four states funded by the Robert Wood Johnson Foundation. In fact, 12 states passed enabling legislation to create programs modeled on the RWJF program. Second, the Omnibus Reconciliation Act of 1993 (OBRA '93), enacted the same year as the RWJF Partnership was implemented, contained language with both indirect and direct impact on the expansion of Partnership programs.

Indirectly, the Act closed several loopholes in the Medicaid eligibilit process, thereby providing further incentives for persons to purchase private insurance for long-term care. The Act also makes specific mentio of Partnership programs. The statute contains a "grandfather" clause which recognizes as approved the four initial states, plus a future progran in Iowa and a modified program in Massachusetts (protecting only the home from estate recovery). These states were allowed to operate their partnerships as planned since the Health Care Financing Administration had approved their state plan amendments before May 14, 1993.

While states obtaining a state plan amendment after that date are allowed to proceed with Partnership programs, they are also required to recover assets from the estates of all persons receiving services under

Medicaid. The result of this language is that the asset protection component of the Partnership is in effect only while the insured is alive. After the policyholder dies, states must recover what Medicaid spent fron the estate, including protected assets. At the very least this becomes a very complicated and convoluted message for consumers. It also removes one of the major incentives people have to plan for their long-term care needs. The effect has been to significantly stifle the growing interest in replicating the Partnership in other states. Promising efforts in Colorado, Illinois, Iowa, Maryland, Michigan, and Washington to name a few have been sidetracked by the impression that Congress did not support this program.

Case Studies in Partnership Frustration

Several states decided to proceed with Partnership programs in the aftermath of the OBRA '93 restrictions. Believing that access to Medicaid coverage without impoverishment was a major benefit for citizens, Maryland and Illinois secured state-plan amendments to offer Partnershi programs modified to meet the OBRA '93 requirements. Each state modified the programs developed and implemented by their predecessors

Maryland decided to make state certified long-term care insurance policies eligible for asset protection rather than have special rules associated with Partnership policies. This approach made the Partnership strategy more visible and eliminated marketing against the Partnership. Though targeting concerns might be exacerbated by this approach, it was also a way to develop widespread knowledge concerning the partnership incentive among the middle income people who need the protection the most.

One major change implicit in this model was that Maryland did not require inflation protection. In the development of the RWJF Partnership program, inflation protection was a major point of contention with the insurers and the agents, who preferred that inflation protection not be required since the significant price increase reduces demand. However, a the RWJF Partnership states require inflation protection because they feel it is important to the budget neutrality of the program. It also helps assu the State's promise of protection of assets. Without inflation protection, the growing cost of deductible and co-pays could impoverish a policy holder before much asset protection could be secured. Maryland planned to deal with the inflation issue through consumer education campaigns, leaving the choice to consumers.

As the Maryland approach has not been implemented, this partnership strategy has not received a market test. Maryland tabled its program because of concerns about the estate recovery language in OBRA '93. The definition of the estate is broader than currently in use in Maryland, whic

would have the potential of penalizing insurance purchasers relative to those who had not purchased insurance; quite the opposite of the intent o the program.

Illinois, another state approved after OBRA '93, did not share this concern with Maryland and has implemented their program. Although initially Illinois chose the dollar-for-dollar model, they recently revised the program, developing a hybrid approach that switches to total asset protection for those who buy $200,000 of protection. The required inflation protection is optional. These changes were made to stimulate sluggish insurer interest. At this writing, it is too soon to tell whether the changes will overcome the perceived problems but so far insurers have n been very enthusiastic about participating.

Insurer support for the Partnership program has been eroded because the OBRA '93 restrictions have stifled the interest of states in pursuing the planning necessary for further program development and improvement. Without the chance to work toward standardizing the program across more states the costs of participation are high and the ability to influence the long-term care insurance market are limited.

As an interesting side-bar, the Partnership insurance strategy has captured international attention. Great Britain, faced with long-term care gaps in their public funding systems similar to those in the United States, is in the early stages of debating the details of a National version of the RWJF Partnership program. It appears the favored scheme is the "pound-for-pound" approach modified to provide a greater incentive (pound and half or even two pounds of asset protection) and greater assurance that protection of the home would be accomplished for those at the low end of the resource spectrum.

Next Steps

Without the repeal of the OBRA '93 restrictions on Partnership style asset protection, it may difficult to stimulate the multi-state interest necessary to justify the commitment of resources by insurers and their agents to support these alternative marketing strategies. But there is growing recognition that States need flexibility in dealing with the pressures on the Medicaid system and that private long-term care insurance is a needed alternative to public financing. The National Governor's Association has recently called for elimination of federal barriers to public-private insurance partnerships like those in the RWJF states and the expansion of authority to all states to implement such programs.

Next steps also involve investigation of strategies that do not depen on direct links to Medicaid. As noted earlier, the growing interest in managed care for both Medicare and Medicaid eligible populations has promoted greater recognition of the potential value of integrating acute and long-term care. Minnesota, Colorado, Florida, New York, and Wisconsi to name a few are launching programs to develop managed care program for those eligible for both Medicare and Medicaid. These programs have a their goal better more cost-effective care through the integration of provider systems and the coordination of care. Though the initial focus is on public pay clients the delivery system development lessons are equall relevant to long-term care insurance links that might be made with Medicare managed care products as the private market alternative for those not eligible for Medicaid. The growth of SHMO type products in the private sector could well benefit from the type of incentives offered by th Partnership program as a way to encourage the purchase comprehensive shorter term coverage that is appealing and affordable to middle and modest income purchasers. This is the group most at risk for spend-dowr to impoverishment if they need long-term care.

Chairman THOMAS. Thank you. I will have a question or two on that.

Dr. Wallack.

STATEMENT OF STANLEY S. WALLACK, PH.D., EXECUTIVE DIRECTOR, INSTITUTE FOR HEALTH POLICY, BRANDEIS UNIVERSITY; AND CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, LIFEPLANS, INC., WALTHAM, MASSACHUSETTS

Mr. WALLACK. Thank you. Good morning, Mr. Chairman and Members of the Subcommittee on Health.

My testimony today reflects my experiences in the two domains in which I work. First, I am on the faculty of the Heller Graduate School at Brandeis University, where I direct the Institute of Health Policy.

And second, I am the founder, chairman, and chief executive officer of LifePlans, a for-profit long-term care risk and care management company. LifePlans was founded in 1987 with its mission to help develop a credible private sector long-term care financing alternative to Medicaid. I had the privilege of speaking before this Subcommittee as the chairman of the Coalition for Long-Term Care Financing.

I want to acknowledge and thank this Subcommittee for leading the way with Federal tax clarifications, and I think these will be very important in terms of individuals taking responsibility for themselves and reducing the financial demands on Medicare and Medicaid in the future. I am a little bit concerned about how the act will be implemented, perhaps making the benefits very restrictive, and so we may end up with the qualified plans being less consumer friendly than many of the current policies on the market.

At the Institute for Health Policy at Brandeis, I developed, along with my colleagues, the Social HMO when HCFA asked me in 1979

to propose an alternative to fee-for-service Medicare, particularly for the older and frail elderly. The demonstration of the Social HMO concept did not start until 1985, requiring the cooperation of over a dozen foundations and actually an act of Congress.

The Social HMO, which was demonstrated at four sites, offered expanded benefits, in particular, prescription drugs and a limited personal care benefit with a dollar maximum. As you know, the Social HMO benefits occurred at no additional cost to the Federal Government. The Social HMO model has proven viable and a number of TEFRA HMOs are evolving and moving toward it.

I really have three points I would like to make today to this Subcommittee. They are, first of all, that I think we have evidence about coordinated care and that it can work in terms of improving health status and reducing costs.

Second, I think the Social HMO is a model that can work for the vast majority of elderly.

And finally, that although I support the PACE Program and legislation that would allow it to become a permanent provider, there are many other programs worthy of being innovated in the United States and I think we need much more general legislation to do that.

First of all, with regards to coordinated care, I think it is clear that we see in the acute care sector that coordinated care works. The substitution of preventive services, primary care services for hospitalization is evident. On the long-term care side, we see the same thing, we can keep people out of the nursing home, as we did in the SHMO by expanding home care benefits.

When it comes to linking or coordinating the long-term care system and the acute care system, I think we have evidence that if we focus on those who are disabled and bring medical management to them, whether it is in their home, whether it is in an adult day care center, whether it is in an assisted living environment or a nursing home, we, in fact, can avoid expensive hospitalization and emergency room visits. And by keeping people out of the hospital, we avoid them becoming more debilitated, and, we avoid a variety of other losses, particularly around physical functioning.

The key to coordinated acute and long-term care is really having a physician, perhaps a geriatrician on one side, the long-term care or the care manager on the other side, and a case manager in between them. Now, we can integrate them or coordinate them. There are various ways of doing it. The Social HMO, used more of a coordinated approach.

The point I would like to make to this Subcommittee, to really underscore it today, is that when we start talking about alternatives to Medicare, we have so few to consider. We have the Social HMO, done by an act of Congress. We have PACE, which was done by waivers. Why do we have so few? That is because we have to go through a very cumbersome research waiver process, which today is very foolish and time consuming.

The Social HMO can serve the vast majority of older people, well over 85 percent, and I think we have learned a great deal about how to help people—help people recover from short-term disability and care for them during transitions.

Another key finding of the Social HMO, which I hope this Subcommittee would consider, is that what we have learned, that a limited Medicare extended care benefit, home care, can deal with what Medicare was intended to deal with, that is to keep people from becoming permanently disabled and to help them when they come out of institutions.

What I find fascinating is this expansion of TEFRA HMOs in the last few years really parallels the tremendous growth in postacute benefits under Medicare. It was really with the double payment for subacute and acute care and the explosion in home care that we started to see HMOs, in fact, really grow in this market. And, whereas in 1989 half of the TEFRA HMOs could have lost money and half won money under the AAPCC, today, you can hardly lose under the AAPCC and that is related to the expansion in postacute benefits.

I think we can deal with this issue through benefit design—and I think in a fee-for-service market that is uncontrolled, you have to look at benefit design. The SHMO experience tells us that a limited home care benefit, 150 visits, 200 visits, would, in fact, be adequate to take care of almost all Medicare beneficiaries. If you did that, you would not only have short-term savings under Medicare, you would also be reducing the payments you are making to HMOs.

I know this Subcommittee is considering reducing the AAPCC payment, but it seems to me a much better way is realigning and controlling the growth in the Medicare Program in an appropriate way. You actually can fix both things—Medicare costs and excess HMO payments—at the same time.

When it comes to the permanently disabled, I think we have a lot of alternatives. Clearly, PACE is one that merges Medicare and Medicaid. I think the Social HMOs is one. As Mark said, with HMOs and private long-term care insurance, we can take care of the vast majority of people. I think modifying the Medicare Program to allow programs targeted on the frail, elderly and disabled like EverCare. I assume, Mr. Chairman, you are familiar with EverCare, which is a program focused on those Medicare beneficiaries who are in the nursing home where medical management in the nursing homes saves acute care dollars by reducing hospitalizations. If we modify Medicare Programs like PACE, EverCare and social HMOs, we can get tremendous savings in cost.

Now, I know, as you said, you have already introduced PACE legislation, and I certainly hope that the SHMO legislation would soon follow. As you mentioned in your press release, there were 23,000 people under the PACE and Social HMO projects today. Twenty-thousand-plus of them are in the SHMOs, and it seems to me appropriate that if you are going to legislate for PACE, you should be doing the same for SHMOs.

But I believe you should go much beyond that, Mr. Chairman and Subcommittee. I think we should look for ways through legislative changes that would allow managed care programs that voluntarily enroll elderly and disabled, both in generalized and specialized care programs, to be instituted without having to go through this research waiver process. I think HCFA can contract with responsible plans and I have three specific recommendations to

change the statute that will allow the innovative programs that really are directed to the frail elderly and disabled to evolve.

One is we should delete from the statute the requirement for statewideness under HMOs. The uniformity of services would be number two. And, finally, the 50–50 rule. Right now, as you know, an HMO can only have 50 percent of its enrollment in Medicare and Medicaid. If we want to design programs for Medicare people and disabled people, we have to get rid of that 50–50 rule. I cannot overstate the importance of that.

I do not think we have should continue to rely on structural requirements for who can participate as an HMO. I think we know a lot today about the operations of HMOs and their outcomes. We should base our decisions on who is eligible by their performance.

By removing these restrictions I mentioned, you would allow long-term care or personal care providers, both not-for-profit and for-profit, who have a greater awareness of the personal and social needs, the continuum of needs of the frail and disabled population, to develop innovative and cost effective solutions.

Thank you, Mr. Chairman, for allowing me to testify.

[The prepared statement follows:]

Statement of Stanley S. Wallack, Ph.D., Executive Director, Institute for Health Policy, Brandeis University, and Chairman of the Board and Chief Executive Officer, LifePlans, Inc., Waltham, Massachusetts

Good morning, Mr. Chairman and members of the Sub-committee on Health. My testimony today reflects my experience in the two domains in which I work. First, I am on the faculty of the Heller Graduate School at Brandeis University and I am the Executive Director of the Institute for Health Policy. I am also the founder, Chairman and CEO of LifePlans, a for-profit long-term care risk and care management company. LifePlans was founded in 1987 with its mission being to help develop a credible private sector long-term care financing alternative to Medicaid. I had the privilege of speaking before this committee as the Chairman of the Coalition for Long-term Care Financing. I want to acknowledge and thank you and this Committee for passing federal tax clarifications and reasonable standards for long-term care. While I believe this legislation will be very important in terms of individuals accepting more financial responsibility for their personal care needs, rather than assuming Medicare and Medicaid will pay, I am concerned that the adoption of tight benefit triggers and the restrictions that allow benefits only after a person is permanently disabled will not allow appropriate prevention, home care and assistance services to be provided. These services can slow down the onset of permanent disability and discourage care from being provided in the appropriate place and at the appropriate time. Furthermore, the qualified may end up being less consumer friendly than many of the current policies or the market.

At the Institute for Health Policy at Brandeis University, I developed along with my colleagues, the Social/HMO model when HCFA asked me to propose an alternative to fee-for-service Medicare, particularly for older and frail elderly. The demonstration of the Social/HMO concept did not start until 1985, requiring the cooperation of over a dozen foundations and an Act of Congress.

The Social/HMO, which underwent demonstrations at four sites, offered expanded benefits, in particular prescription drugs and a limited personal care benefit with a dollar maximum. As you know, the Social/HMO benefits occurred at no additional cost to the Federal government. The Social/HMO model has proven viable and a number of TEFRA HMOs are evolving/moving towards it, if they aren't there already.

The Social/HMO with its limited custodial benefit was designed to serve those with short-term disability or the transition needs of the elderly. Providing skilled and supportive services for these individuals in a coordinated manner prevents individuals from becoming disabled as a consequence of an acute episode. For the vast majority of Medicare beneficiaries the dollar limit on benefits appears appropriate. The dollar limit, $6,000 to $12,000 per episode of illness translates into perhaps 100 to 200 home care visits. The success of the Social/HMO in providing the needed care with this benefit suggest that the quickest and perhaps best approach for bringing Medicare home health expenditures under control would be through a benefit redesign. A 100, 150 or 200 visit limit would provide substantial cost savings in the next fiscal year while maintaining Medicare's goals of preventing hospitalization and permanent disability.

My belief is that the Social/HMO, together with private long-term care insurance which now provides benefits that can be used in any location, can become a major financing and delivery alternative for coordinated health and long-term care. Accordingly, my comments and recommendation today support a legislative strategy that allows not only for the wide-spread adoption of PACE, the Program of All-Inclusive Care for the Elderly, but rather the development and widespread adoption of other programs designed specifically for the Medicare population. The PACE model is restricted to the combined funding of Medicare and Medicaid and a comprehensive delivery system built around adult day care. By differentiating this program in statute,

it sends a signal that this is the only appropriate way to deliver and finance care for the frail and disabled elderly.

If this committee wants to restrict itself to those programs that have gone through the HCFA waiver process, then the Social/HMO should receive the same treatment as PACE. The Social/HMO has been evaluated in much more detail than PACE and has been successful in enrolling many more elderly. Having made this somewhat self-serving statement, I would go further and say that we need legislative changes that will encourage the development and implementation of a wide range of programs that serve the acute and long-term care needs of Medicare's disabled, frail elderly and high risk individuals. This should not be done through the long and cumbersome waiver process. Markets (often the payers and consumers) decide through on-going evaluations whether programs work. With the appropriate changes in the statute, HCFA could still contract only with organizations that have the necessary knowledge, geriatric care, delivery capacity and financial wherewitheral to care for the concerned Medicare population.

Disabled and Frail Elderly

We know that the frail elderly and disabled often need and use a broader array and higher intensity of acute and long-term care service. The greater use of nursing homes, home care and personal care by the frail and disabled is obvious. However, these individuals are also much greater users of physicians and hospital services. Freiman and Murtaugh (1994) found that the 6.7% of the elderly who entered a nursing home in 1987 accounted for a quarter of all hospital days. Medicare nursing home residents have hospital admission rates two and half times (2.5) that of the entire Medicare population. Furthermore, some groups of Medicare disabled individuals living in the community have comparable high hospital use because they lack access to continuous care. We know from our experience with Social/HMOs, PACE and EverCare (a capitated program for nursing home residents) that the acute care costs of frail and elderly populations can be significantly reduced with appropriate and timely medical management. A coordinated or integrated delivery system is needed to assure that medical management can incorporate maintenance of health status, monitoring of an individual's condition and care during acute episodes. For the frail and disabled elderly, this means applying a geriatric model of care, which emphasizes the involvement of a multi-disciplinary team of professionals and low-tech solutions directed toward maximizing the function and stability of individuals.

By bringing managed medical care to individuals - whether in an adult day center as done in PACE, in a nursing home or other supportive housing, or to an individual's home, we can avoid expensive hospitalizations and emergency room visits. Moreover, we can reduce the onset of debilitating condition and adverse events (e.g., disorientation, infections, and loss of function) that occurs during hospitalization.

Geriatric care is most important for those who have chronic, multiple conditions that can interact with one another. By managing physical functioning and psychological conditions, geriatric care has the potential to avoid adverse reactions to poly-pharmaceutical treatment and acute flare-ups.

Managed Care and the Frail Elderly and Disabled

While the Federal government provided the seal of approval for HMOs in 1973 and allowed HMOs in 1982 to enroll Medicare beneficiaries, it has only been in the past few years that managed care enrollments for Medicare beneficiaries have grown

rapidly. This was a result of passed legislation in 1982 to allow HMOs to enroll in Medicare beneficiaries. The reason is not a shift in the treatment emphasis of HMOs, from a prevention or pediatric model to a geriatric model, but is related to the changing economics of TEFRA participation. The rapid growth in HMO Medicare enrollment parallels the explosion in Medicare's post-acute care expenditures. In 1990, HMOs had a fifty-fifty chance of earning a surplus under the AAPCC payment system if they enrolled a random population (i.e. neither favorable or unfavorable selection). Today, it is virtually impossible for an HMO to lose money serving the Medicare population. The double payments for acute and sub-acute care and the extraordinary growth in home health care points out the need to have either one entity fiscally responsible for medical management or fixed payment for post-acute care, or to redesign the post acute benefit structure.

The latter two policy changes would be appropriate for the vast majority of Medicare beneficiaries. However, a system of care that is capable of caring for frail and disabled elderly using a geriatric care model with appropriate financial incentives seems more desirable than a fee-for-service system.

The Design Choices

The Federal government needs to develop and encourage models of managed care for the geriatric population. Once in place, these systems are likely to develop special programs for the frail and disabled elderly. HMOs are developing disease management models or mini-HMOs within their system. They are not there yet with regard to geriatric care. So, we still have time to learn what is the preferred financing delivery system. The Social/HMO and PACE are two alternatives, and it is important to understand their similarities and differences as this committee develops legislation.

Similarities Between the Social/HMO and PACE

The Social/HMO and PACE are similar in an number of ways. First and foremost, the sponsors are dedicated to serving the geriatric population by providing either through contracts and protocols or under one auspice the appropriate array of acute and long-term care services. We have learned from the Social/HMO and PACE that the sponsor can be an HMO, a long-term care organization, a hospital or a medical group practice. Secondly, both programs had voluntary, as opposed to mandatory enrollment. The more we incorporate medical and long-term care (e.g., personal care services and merged financing), the greater the need for consumers to select the system of care.

Both systems also operate under a global capitation arrangement. When this occurs, management information systems -- which can be quite expensive -- must be established to coordinate acute and long-term care. While capitation has very strong incentives to provide care efficiently, some of us feel that it may have too strong an incentive to reduce care, particularly when the payers lack the knowledge to set appropriate prices.

Differences Between the Social/HMO and PACE

The two major differences between the Social/HMO and PACE are the populations they are designed to serve and the extent of delivery system integration. The Social/HMO cares for the elderly in a general managed care model, while PACE places the elderly in a specialized system of care. If an organization focuses only on the frail and disable elderly, it is likely to achieve better quality outcomes. However, its costs could be higher because of the lack of economies of scale. At this time, we

shouldn't prescribe what is the best delivery model, but rather encourage approaches which meet certain criteria. The answer as to whether a general or specialized system should prevail may be best left to the users once the necessary consumer protections are in place.

The second difference is the level of delivery system integration. The Social/HMO does not attempt to integrate the delivery system, rather it seeks to improve the transition of individuals and the communications and referrals between the acute and long-term care systems. This is done by having a case manager monitor client situations and coordinate the services between the two systems. This is the strategy of many HMOs today with regard to high cost cases or high risk care management.

The PACE model seeks to integrate the delivery of services as much as possible at the adult day center using a multi-disciplinary team to provide services. The team meets to conduct evaluations of individuals and to agree on their plan of care. Since the physician is just a member and not in charge of the "process" of care, physician acceptance of team decision-making is harder to achieve. Not surprisingly, PACE sites have had high physician turnover. Some consumers find the integrated adult day center team approach too rigid and unresponsive. Accordingly, some PACE programs are modifying the original PACE design by not requiring adult day care attendance.

The difficulty in achieving an adequate number of enrollees at the PACE sites suggests that other models of care and a broader target market need to be explored. An example is the development of Home-First, a Brooklyn, New York based organization for the over 65 that qualify for Medicare as well as adults with serious or disabling conditions. This comprehensive program will use one's home as the predominant site for care and allow individuals to retain their existing physician. It probably will be harder to control utilization and cost with this consumer driven model, but the enrollment potential seems greater.

Recommendations

It is clear that we are just beginning to learn how to best finance and deliver health care to the frail and disabled elderly. Managed care appears to have a great deal of promise. The disparate services required by these individuals needs to be coordinated and provided so as to be both cost-effective and appealing to consumers.

Managed care programs dedicated to the elderly, whether just the frail or all elderly, need to offer the appropriate set of benefits. Because of Medicare's limited benefits, these programs need to secure waivers from HCFA. To do this on a multi-site basis is very time consuming. However, once this has occurred and the programs prove viable, there is a desire to make them widely available. Interest in allowing the expansion of the PACE program without waivers is understandable. However, a similar argument can be made for the Social/HMO and other innovative programs. The Social/HMOs and PACE have passed a market test. Other models of care in operation, as well as those currently on the drawing board, should be allowed to compete with the Social/HMO and PACE.

For the permanently disabled, whether they are living in a nursing home, supportive housing or in their own home, a program that incorporates services for the medical, mental health and functioning needs of individuals may be necessary. A specialized organization with a service mission to care for these individuals will establish the needed operating strategies, provider behavior and delivery systems.

PACE is only one of the many possible specialized systems for the frail and disabled elderly. EverCare is another.

Rather than create a special status for the PACE program (and, I would hope Social/HMOs) in statute, I urge this committee to take the necessary steps that would allow these and other worthy programs to develop. Let them be evaluated in a competitive market by beneficiaries and HCFA. To set this in motion, legislation should be passed that allows managed care programs directed at the elderly and disabled, both general and specialized programs, to be initiated without having to go through the waiver process. Under the current system, HCFA research staff usually decide what models will be tested, how services are delivered and who can be a sponsor. This is far too restraining and paternalistic. Certainly, HCFA could certify and then contract with specialized delivery plans in a process similar to that now done for TEFRA HMOs. Legislative change would delete from the HMO statute the requirements for state wideness uniformity of services and that not more than half of the enrollment of Medicare and Medicaid beneficiaries. The importance of eliminating the 50/50 rule cannot be understated since Medicare-directed programs cannot be established with this constraint.

Given our gains in understanding the operations and performance of HMOs, we do not need to rely so heavily on restrictive structural criteria for limiting which HMOs can contract with HCFA. In particular, removing these restrictions would allow long-term care providers, both not-for-profit and for-profit, who have the greatest awareness of the personal and social needs of the frail and disabled population to develop innovative and cost-effective models.

Mr. Chairman, I appreciate the opportunity to present my thoughts. I would be happy to assist this sub-committee in any way as it develops these much needed legislative changes.

Endnote:
Freiman, M & Murtaugh. (1994, Oct) Interactions Between Hospital and Nursing Home Use. Rockville, MD, Agency for Health Care Policy and Research.

Chairman THOMAS. I thank both of you. Obviously, in the time you have, you could not go into the detail that you did in your written testimony. It is not only part of the record, we looked at it.

My problem is that I can give a really good half-an-hour speech about the needs for continuum of care and the way in which it should be focused, but when you take a look at what we have got and what it is going to take to get there, saying it and doing it are two different things.

Dr. Wallack, would you for just a minute expand on your argument about the number of home health visits, because, obviously, if we are dealing with integration of programs, we tend to look at the macro structure, but you mentioned briefly and focused on rethinking what we actually do, since there seemed to be an amazing parallel in terms of the benefits that were provided and the use structure that followed it.

Mr. WALLACK. Certainly. I know you know that what happened in 1988 as the result of a court action is that HCFA revised its administrative regulations. The court really required that HCFA could no longer talk about part time and intermittent. That meant you could not restrict people to home care who both needed less

than 8 hours a day and 7 days a week. It went from and to or. You could either get it part time or you could get it intermittently.

But that was not the big administrative change that occurred. That was not the change that really resulted in the explosion of home care services. What happened in the administrative changes is that they allowed a skilled nurse to, in fact, make a decision that somebody needed services and what could pursue from there was a whole variety of personal care services.

So if you look at the home health benefits today and their explosion, it is really for those who are getting over 100 visits or over 200 visits. We are starting to move home care, through administrative decisions and not legislative decisions, from an acute, postacute benefit to a custodial, long-term care benefit. If we are doing that, it seems to me Congress should say that is what we want to do. It was not the initial intention of Medicare.

Chairman THOMAS. I do not know that we want to do it and we got into it by a court action, but my question would be, as we are looking at new approaches to funding this rapidly growing area in home health care on a prospective payment basis, something as simple as a visit is not defined, and if we get into this whole structure without going after the definitional framework, I am afraid that we will have missed an opportunity.

If we can get into the procedures that are involved or the time increments, except then that runs counter to the desire I think you have expressed, and I expressed very briefly, about getting away from the micromanagement aspect. Now, how do you reconcile the two?

Mr. WALLACK. I agree with you. Getting into what a visit is is very difficult and that is going to micromanagement. We do not know what a visit is and we do not have a real definition of home care.

Chairman THOMAS. Well, we are going to before we put in a prospective payment system.

Mr. WALLACK. You are going to have to, are you not?

There are different ways of doing benefit redesign. I guess the point I was trying to make is that if you have an unrestricted fee-for-service system, the way you have to deal with this, is with benefit redesign. You have dropped benefit redesign from the debate, but I think that is what you have to use. You have restrictions on hospital days. You have restrictions on nursing home days. But somehow or other, you do not have it on home health care visits. It does not seem to me to make a lot of sense.

If you do not want to deal with the visits, maybe another benefit redesign is dealing with the dollar amounts. What we are going to see now is the average payments per episode is going to $8,000. My own view is you are going to have home health expenditures in a few years exceeding physician expenditures under Medicare.

Chairman THOMAS. That is what the growth lines look like.

Mr. WALLACK. So maybe it is a dollar benefit. Maybe you do not want to get into specific visits.

Chairman THOMAS. I am very interested in trying to promote private sector plan integration into the public dollars. We tried to offer some help in recent legislation with counting long-term care insurance and the actual costs of long-term care in the medical de-

duction structure. My problem is that if we had done that when the medical deduction was 2.5 percent of adjusted gross income, we might have had some impact, but when it is at 7.5 percent of adjusted gross income, even on lower incomes, that is a relatively high threshold.

Have you seen any evidence, or we even allow personal opinions here, that would suggest that maybe as we are spending dollars in this area, one of the ways that we could get some fairly decent stimulation of private sector insurance coordinated with Federal programs would be to focus on that 7.5 and maybe bring it down by one-third to 5 or even back to the original 2.5. Would that be useful at all, either Dr. Meiners or Dr. Wallack? And if you do not have an opinion, it is also acceptable not to have one.

Mr. MEINERS. I think it would certainly help with that specific problem. When it comes to subsidizing the market for long-term care insurance, I at this point am rather biased toward the partnership strategy because I think it is a way to target what moneys you might put toward supporting a market to those who are most at risk of spending down. It also is a subsidy that you do not give to everybody who buys a product, so it is more targeted in that way and, I think, more efficient.

It is only when somebody buys a partnership product, goes into benefit, uses those up, that then the subsidy occurs. That subsidy occurs around the time that the benefits of avoiding people going on Medicaid also occurs. So if you think in terms of a present value of subsidizing, it is much more efficient.

Chairman THOMAS. Yes.

Mr. MEINERS. If I was to work on the next steps, it would be to make sure that that partnership opportunity was more available to States. I do not think States are going to give away the store, and so I think that is an important thing to have happen.

Chairman THOMAS. It is partly counterintuitive, though. Witness what we did in 1993 in terms of requiring people to exhaust their resources before we are willing to offer alternatives. The idea that would be a real incentive for people to husband and for a State coordination runs a little counterintuitive to a number of people in terms of what either they would be willing to vote for or could vote for because, in fact, they did vote for it.

Mr. WALLACK. Could I make a comment, please?

Chairman THOMAS. Surely.

Mr. WALLACK. First of all, you are right about the 7.5 percent not being very powerful anymore with regard to the experience——

Chairman THOMAS. It is very powerful. Nothing happens.

Mr. WALLACK. Nothing happens. Right. You are absolutely right. Obviously, you can move to some kind of a credit, tax credit. But I think there are much more basic things.

When I talked before you on tax clarification, I sort of played my role as an economist and talked to you about tax deductibility as price reductions, and that they will do a little bit to affect the demand. Effectively, a tax benefit reduces the price and you will increase demand. But what is much more important, it seems to me, is the attitude of people about taking responsibility. Economists call that a shift in demand and I think that can happen. I think you started it now. But you have to tell the American public in

some way—it is the government they look toward—that this is how we are expecting to fund long-term care. The government cannot afford it. We could only fund Medicare and long-term care, but we have other things we want to do with Federal dollars.

The other thing that got lost in your bill, which I think could be very important, we want to encourage saving for long-term care earlier, people worrying about the costs of getting old when they are younger, when they are our age, I guess. The way to do that is through a savings account. I think you had an IRA approach that allowed people to put money in a dedicated program and, in fact, buildup their savings and then use it for long-term care. People are saving more. We have to come back to this perspective, start saving earlier for long-term care. I think this is an important thing to add.

Chairman THOMAS. I have had a super IRA bill in for some time with my colleague from Massachusetts. The problem is, when you go through the Congressional Budget Office, they write the expenses on the front 5 years of investing and they do not look at the long-term return of actually having people spend their own money rather than public money over a 20- or 25-year period.

Let us establish the fact that the 50–50 rule, if either of you are in agreement, which may have been a useful substitute at some time, although I wonder why, for a quality measurement, in fact, works exactly opposite when you are trying to build a coordinated structure that focuses on a particular group of folk, and that if you could not get fundamental agreement on the larger TEFRA risk HMOs, clearly, in the area that we are talking about, it makes no sense, we agreed, to——

Mr. WALLACK. Oh, I absolutely agree. I think I said that. But let me make a point, I think the Social HMO has a lot more potential. I mean, it is a much bigger potential program than PACE. If you target just on the disabled, a PACE-like program can meet the needs of those people who are disabled.

The Social HMO, it seems to me, is a more appropriate Medicare HMO program. I have not changed my view in the last 20 years. Having prescription drugs in the benefit makes a lot of sense to me, and some extended care package makes more sense for a Medicare Program.

If you had a lot of dedicated HMOs, like Social HMOs, they would eventually develop very integrated programs like PACE for those that have become disabled, because when people become disabled, they need a greater integration of services and those would evolve, it seems to me.

What we have really restrained, it seems to me, through these kinds of restrictions is the evolution of a lot of good plans. I think there are a lot of people out there who could help solve this problem if you would let them do it.

Chairman THOMAS. Part of the problem is that in looking at some of the changes that we are thinking about making, we will have Mr. Bringewatt later, but he has a Chronic Care Act of 1997 which is a complete vision, including ready-made bureaucracies to review the structure, and he will have a chance to comment back later, I am sure.

That is not going to be the solution, either, but when we sit here and get testimony from HCFA that they are only about 4 years away from a prospective payment system out there that they have had 15 years to talk about how they are going to get there, and you talk about the Social HMO as something that needs to go forward and we cannot get HCFA to tell us after all the years of experience we have had what is an appropriate model structure, it is very, very frustrating because you reach a point of trust in which you have to rely on folks in a larger structure doing what is right and we have not seen that in the recent past. That is one of the reasons you have a 50–50 rule.

So it is difficult to put a specific structure in place and it is probably impossible to get a trust structure in place, either.

Mr. WALLACK. When you think about where we are with those people that cost the most money and for whom we are responsible, it is discouraging that we have so few alternatives that have been tried. It is pretty remarkable. Particularly, when you compare it with the private sector and how they have evolved all sorts of alternatives in disease management. Just the kinds of things that are going on in the private sector now, are the kinds of things that would go on for Medicare beneficiaries if we loosened up these rules.

I guess that is really what I have been saying—that is what I think you should be thinking about is not just I PACE, I know it is important, but I think there is a much bigger issue out there.

Chairman THOMAS. I know, Doctor, but you cannot say loosen up the rules.

Mr. WALLACK. No, the statute.

Chairman THOMAS. Rethink.

Mr. WALLACK. Rethink.

Chairman THOMAS. Loosening makes a lot of folks nervous.

Mr. WALLACK. OK.

Chairman THOMAS. But rethinking is what we need to do, especially when you have dollars coming from the Federal Government under the rubric of Medicare and dollars coming from the Federal Government under the rubric of Medicaid and there are conflicts which cost more money.

One final question and I will turn it over to the gentleman from Wisconsin. There was also a discussion, especially in the Social HMOs, about the use of skilled nursing facilities, more nursing homes, and what I got out of it, and again, I will be corrected if I was wrong, was that there seems to be a general agreement that the nineties, 21st century high-tech hospital is way too expensive for doing a lot of things, but does it really make sense to recreate the fifties technology hospital in a skilled nursing facility to perform those functions. Maybe it makes sense to do so. But, you know, the lab work, the x rays, the stuff we used to get in what we used to call a hospital being done in a nursing facility rather than a hospital.

Mr. WALLACK. That is an interesting question. There are two parts to that subacute issue. One is the use of subacute after hospitalization. I believe the nursing home or the assisted living, places where people live are more appropriate than staying in a hospital. We should start bringing managed care to people rather

than bringing people to managed care. This results in shorter hospital stays.

I think, in nursing homes and other kinds of assisted living should, in fact, be a place where people get their acute care and thereby avoid going to the hospital. This results in fewer hospital admissions.

So I view the nursing homes as probably a place where we really should see expansion in the subacute side. It is less expensive. I think the hospitals have tremendous overhead. So I would say, yes, for both going into the hospital as well as coming out of the hospital, and I think you really get two hits there.

Chairman THOMAS. Dr. Meiners, do you have any comment on that?

Mr. MEINERS. One of the things I just wanted to comment on was the fact that I think we are learning an awful lot, along with HCFA, in the demonstrations we are doing. It has become very clear to me as we work with HCFA that they have had a Medicare focus for many, many years and their focus on Medicaid has only been emerging in the few past years. How Medicare and Medicaid have worked together is something that is a very new focus for HCFA.

You also have a disconnect between the States which are looking for what HCFA will let them do to integrate Medicare and Medicaid so that it will not be so difficult to get the waivers while HCFA is basically in the mode of receiving applications and going over them to see if they meet the law without really necessarily having a clear vision of what the States could or should do. So they are not talking to each other very clearly and comfortably.

It is not like there is one or several models that you can use easily to integrate Medicare and Medicaid. Part of HCFA that is focused on doing demonstrations and a demonstration means that you may actually do one such program and no more. However, when a waiver approach gets approved, the States want to use it as a model that they can replicate without a difficult approval process. For a variety of very technical reasons HCFA is not comfortable with this as yet.

We need to work through that. I know HCFA is working hard to do that, but it is still a very troubling process to the States who really are under duress to make integrated care work. I think directions from HCFA that supports states integration of Medicare and Medicaid systems is something we need to work on in a positive way to make it happen would be very helpful. Even then progress will be difficult because when you get down into the details, absolutely, there are laws and rules that get very tricky, like the 50–50 rule.

Some of those rules and restrictions we can do away with, but beyond those that Stan mentioned there are a whole host of others and we simply need the opportunity to work on with more of a mindset of can do, need to correct them. States are not out there asking for waivers to give away the store financially by any means. That is why I emphasized this Partnership for Long-Term Care in the OBRA language as part of my testimony. States need the chance to have those debates on their own home turf without Con-

gressional limits. That is a very helpful debate to have, and oftentimes leads to bright ideas, good ideas.

But if you stand in the way and say, no, you cannot do any more of those type programs, that is not very helpful. It takes away the one laboratory of experimentation, which is the States, that is really very active out there and has great potential.

Chairman THOMAS. We are hopeful that the mental side of HCFA has undergone a change, and I think evidence of that is their attempt to restructure and bring managed care into more of a core arrangement, which will allow for a closer in-house observation of the inconsistencies rather than two separate groups not talking to each other. Maybe that is the positive spin I can give it, but to the degree we can oversee that, as well, I think it will help.

The gentleman from Wisconsin?

Mr. KLECZKA. Thank you, Mr. Chairman.

Dr. Wallack, in your statement, you talk about individuals accepting more financial responsibility rather than assuming Medicare and Medicaid will pay. However, you have come before us wearing two hats and the flip side to that is, and, by the way, I am chief executive officer of LifePlans. I would like to sell you a policy. Is there any conflict here? I am having a little problem with this.

Mr. WALLACK. I should like to respond.

Mr. KLECZKA. The first goal is laudable. The second one is——

Mr. WALLACK. Well, no, in terms of addressing a social problem, I basically worked here in Congress for the Congressional Budget Office, where I headed up the health and welfare area, and I tried at one point——

Mr. KLECZKA. You are an insider. You know how we score these things.

Mr. WALLACK. Yes. I know how you score these things. I did a Part C of Medicare and looked at its costs and benefits. Once you are outside of Washington, you start to think about other financing alternatives. As a researcher at Brandeis, I realized that the private sector can respond to this and my own view is that we should let the private sector go as far as it possibly can and have Medicare dollars or Medicaid dollars focus on poor people and really be targeted, because we cannot afford everything.

So is there a conflict? I do not really think there is. I think you can do good social policy from the private sector as well as from the public sector.

Mr. KLECZKA. What type of experience have you had in selling long-term health policies?

Mr. WALLACK. We do not sell. What we have done——

Mr. KLECZKA. What is LifePlans, then?

Mr. WALLACK. What LifePlans does is help companies design products. I mean, we became involved back in 1987, when, basically, long-term care insurance was a postacute benefit. We have helped develop the product so it has moved to a very flexible product that you can use in any site. It has really improved, that is, the value of the product. It has moved from a medical criteria for benefits to a disability criteria for benefits. So I was involved in a lot of product development. We were involved a lot in the development, and now we help companies——

Mr. KLECZKA. Then for companies who are selling these policies, what type of activity have they seen?

Mr. WALLACK. Basically, what we do as a company is we help companies assess people for insurability. We help to assess people when they are eligible for benefits and then we help manage them if they go into benefits. So we are a risk and care management company in long-term care.

Mr. KLECZKA. There was an article or a story on the local news a day or two ago about long-term policies. Are these basically designed for individuals with a lot of assets, that should something occur, that they could possibly protect those assets for these purposes?

Mr. WALLACK. I think you can make that argument, but not for very wealthy people. They can pay themselves. I think long-term care is a problem for most of us who I would call the middle-income, upper-middle-income people, who have——

Mr. KLECZKA. Certainly not the poor. They——

Mr. WALLACK. Certainly not the poor. I mean, it would be foolish for a poor person.

Mr. KLECZKA. They depend on Medicaid.

Mr. WALLACK. That is right. We have Medicaid, and that is what Medicaid should do. It should deal with poor people.

But a lot of us sort of have some savings, have some assets, and I think we do want to protect them, but that is not the primary reason people buy long-term care insurance. If you ask them why they buy long-term care insurance, they buy it to remain independent. They do not want their kids to be responsible for them. They want to have choice. And right now, the policies allow them to be at home or to be wherever. The policies are very flexible. It gives them the opportunity to get what they want in terms of——

Mr. KLECZKA. Let me turn real quickly to home health care. We have seen a real explosion in the cost of that program. Outside of a definition of visits and possibly some limitation, one of the administration budget proposals is to shift the cost of part B but not apply any premium to that or copay. What is your view of trying to restrain costs in home health care, which, as you know, is going out the window? I would like both gentlemen to comment.

Mr. WALLACK. Would you like to go first?

Mr. KLECZKA. Maybe you could cite some real abuses that we should be looking for, because they clearly are there.

Mr. MEINERS. I have tracked that a little bit, as much through the articles that we have seen about it, and, frankly, I am not sure whether it is—my understanding is that there has been movement between part A and part B over the years. It is very confusing. It would result in people contributing some premium to the cost of home care, which they would not be doing under part A.

Mr. KLECZKA. The proposal, as I recall it, and I may be corrected by my colleagues, is that it would be picked up by part B but not be applicable to the premium. Is that not correct?

Mr. WALLACK. And there is no copay. Can I——

Mrs. JOHNSON. The current proposal is no copay, but it is a reform of the way we pay for home health, eventually ending up in a payment per episode.

Mr. WALLACK. Eventually, as you said. Let me comment on that, on the question. The part A to part B is the way it once was—I guess that is fine, if you want to do it. I think there are a number of people who get home care as a result of coming out of the hospital. There are a number of people in the community that need some to avoid going into the hospital.

I think, however, given that this program has absolutely no restrictions on it, it is completely supply driven. It is the worst of the fee-for-service we could imagine, unlimited benefits, absolutely no copays. You have to approach this, again, from what I call a demand side or a benefits design approach. I think, personally, there should be benefit restrictions that are reasonable, and very generous in terms of really trying to do what Medicare was designed to do, but copays certainly makes sense. You have to deal with the demand side of the equation a little bit. Therefore, copays in that program like we have in other programs make a lot of sense to me.

Mr. MEINERS. From a State perspective on the Medicaid side, filling in the deductibles and copays, is an extra unfunded liability the way things work now. That would be a major concern to States.

Mr. KLECZKA. Thank you.

Mrs. JOHNSON [presiding]. Mr. McCrery.

Mr. MCCRERY. Dr. Wallack, in your recommendations at the conclusion of your written testimony, you say, "Rather than create a special status for the PACE Program in statute, I urge the Committee to take the necessary steps that would allow these and other worthy programs to develop," and then you say that these programs ought to be able to be initiated without having to go through the waiver process.

How would these programs be recognized by HCFA and how would the payment be made?

Mr. WALLACK. I think if we, again, deleted from the statute some of those restrictions, like the 50–50 rule, they could apply to HCFA much like TEFRA HMOs do now and HCFA would have all the ability, it seems to me, to decide that these programs have the appropriate knowledge base to do the care, they have the appropriate geriatric care, they have the right delivery system, they have the right financial wherewithal. HCFA would contract with them. It is a contracting mechanism, much like we do with the private sector in HMOs. So you would have HCFA being able to contract like it does right now. They would become, or fall under some kind of a TEFRA system. There is nothing different there.

I think we have to come to a point, with 5 million people in HMOs and given the system and where it is going, there will be a lot more, that we are going to have to deal with this thing through effective contracting and oversight. You know, just as in these demonstrations, we look at them, we evaluate them. By making a law, HCFA should not end doing oversight. Oversight should go on continually, to look at all the programs.

So we need to view this as a continual change in HCFA rather than a research project, which you hire academics like myself that can rip them all apart. This is the way we have to start things in motion and we have to have an ongoing process of evaluating what works and what does not work and make the necessary changes.

Mr. MCCRERY. Would it be a capitated payment to these——

Mr. WALLACK. We could get into a long discussion about capitation. I do not know if you want to do that.

Mr. MCCRERY. I do.

Mr. WALLACK. You do? What would you like to know, then?

Mr. MCCRERY. I only have 5 minutes, but I am just curious. Do you envision these other types of organizations being paid on a capitated basis?

Mr. WALLACK. Absolutely. I mean, absolutely. If the Congress decides that the option to fee-for-service is full capitation, absolutely, they should get paid full capitation, and, clearly, like the PACE model, they can deal with that. You can deal with it just from Medicare capitation, which I think is possible. I think you could take care of people in assisted living or in nursing homes or other places just with a Medicare capitation because you can avoid expensive hospitalizations.

I think the way you sort of pay people, the AAPCC now needs to be rethought so that people of certain health status or disability status, whether they are in an institution or not in an institution, need to be reimbursed at a higher level. I think we should change some of the rate cells. But I absolutely think, yes, the answer could be capitation.

Mr. MCCRERY. Dr. Meiners, do you have any comments on that subject of capitation and how we would pay for these types of organizations that are kind of providing an array of services, from acute care to subacute care to——

Mr. MEINERS. Well, I think that capitation probably is the way to jar loose the kind of system changes that we want to see. You talk about expanding the continuum of care. I think that is going to happen when you are better able to meld the dollars from Medicare and Medicaid both under capitation. You can certainly do subcapitationss on a lot of populations, which basically is what PACE and SHMO are. EverCare is a subcapitation. There is really nothing wrong with those, but they are pieces of the bigger puzzle.

I think whenever you have subcapitations and then some component, reimbursed on a fee-for-service basis, then there are cost-shifting incentives. More problematic is that if you have pieces of the care system under managed care, they had better be under the same managed care system or you may have two case managers doing different things and working against each other.

So that is one of the things that I think the innovations of the Minnesota Senior Health Options Program has really learned from SHMO and PACE and developed a capitation arrangement that includes Medicare and Medicaid dollars for all elderly and disabled populations, not just those in nursing homes, not just those at risk in the community, but healthy as well as at-risk and nursing home populations, and that reduces some of that cost shifting that can occur.

Mr. WALLACK. I would like to add one comment that as Mark was talking I thought about. Really, I think it is unfortunate that we have now made synonymous capitation and managed care. That is not what a lot of us—I was involved going way back in the HMO Act when I was here in Washington. We really meant care management. That is what we were really talking about. All of a sudden, it just becomes this fixed payment, and I really believe you can get

managed care, or what I believe is managed care, without going to full capitation, but still creating the proper incentives for the providers to be efficient.

I think it is an impossibility for government to set by regulation the right price. Either we have to get off that system, or we have to go to something other than capitation, but please do not link managed care with capitation. They are different things.

Mr. MCCRERY. So we could have capitation for seniors for either managed care or fee-for-service.

Mr. WALLACK. I think so. Well, I do, but I will take this opportunity——

Mr. MCCRERY. I do, too. I am surprised to hear somebody agree with me.

Mr. WALLACK. Brandeis is trying to start a HCFA demonstration right now. It is, I think, a very exciting demonstration with regards to fee-for-service payment. It is called the group volume performance standard demonstration, where we deal with large medical groups in this country that are very interested in doing this. They are incented using the current total payments per unique beneficiary they are now seeing. The groups are paid on a fee-for-service basis and we give them an overall target per person and we increase that by the rate of increase in the AAPCC. If the cost stays below the target, HCFA shares in the gains, the savings, with that site.

So it is a fee-for-service system. But the basic elements of managed care, which are very important, are there as well. You have to have care management of the person, utilization management, appropriate protocols. Second, you have to select preferred providers who you really think are good providers. And finally you have to provide incentives. The incentive does not have to be full capitation, but there does have to be some incentive on a population basis to, in fact, manage the people you care for in a better way.

Mr. MEINERS. I think you are absolutely right. I mean, at some level, once you have a new paradigm of care, you could buy it on a fee-for-service basis and have a case manager coordinate it.

I think one of the concerns I have, though, is that is like leaping ahead of where we are in terms of understanding how to do that. To some extent, we need, I think I would argue, we need some of these incentives that came with capitation to force the integrated care systems to come together. That is not to say they cannot happen through a negotiated, coordinated fashion. I think they can. But I also do not think it is one approach or the other. I think we still need to find those better systems of care.

Some of this discussion of home care and what we do about that and how much to provide really comes from, rather than thinking that we can define that up front, we need to provide an opportunity for the care givers to really define a level of care and hold them responsibly in sort of a satisfaction and quality approach.

I think that is why HCFA is emphasizing quality assurance. That is why the States are emphasizing a quality approach. It is the outcomes that are important. But you need to have the resources pulled together at this point, it seems to me, and right now, they are not. Medicare and Medicaid are huge disconnects in so many different ways that I think the capitation mindset is al-

most necessary because it brings those two pools of dollars together, at least for the dual eligibles.

Mr. MCCRERY. Thank you.

Mrs. JOHNSON. Thank you.

Actually, this has been a very interesting discussion, I think right on point. I think capitation in its most simplistic form has a lot of problems. We are not very good at solving the outlier problem under the DRG system and with smaller hospitals out there and shorter lengths of stay, we are seeing now a folly of DRGs with no accommodation for severity. So I am reluctant to, myself, see us move entirely in the direction of capitation.

Yet, I do hear what you are saying about you will not get the level of integration if you do not put it out there hard. We certainly are seeing that in social services as a result of welfare reform. For the first time, I see the social services in my town sitting down at the same table. I chaired the Child Guidance Clinic for 12 years. We could not get the three family service agencies in town to think seriously about cutting overhead.

So you do have to force the level of integration of services that we need, but ultimately, you have to do better than a flat capitation plan and I am not sure—this is a longer discussion, but I think we do need to have it. This is a big problem in the home health care area, and certainly if we do not come to some kind of rational decision about it this year, we will not generate the savings in that sector we need to.

The President just shifts payment into the general fund. Well, that is just more competition for education and environmental protection. All discretionary spending is a sixth of the budget, so it is sort of dumb to put $40 billion more in to compete with everything else that we are having trouble funding.

You each, though, did go through a useful list of legislative barriers to the integration of acute and long-term care services for dual eligibles. Would you lay out some of the solutions? What of the most important things to solve, and what is the way we could solve them?

Again, having been very much involved in the VNA system, this dual eligible stuff has been extraordinarily costly to the system and the number of administrative dollars we are wasting and the chaos we periodically create in that area is really appalling. So would you like to point out the primary legislative barriers that you think we need to address and how we might address them this year?

Mr. WALLACK. You can go first on that one.

Mr. MEINERS. I think Stan did hit on some. That is why I was yielding to him, the 50–50 rule and the several others you mentioned.

I think what comes to mind most readily for me is this issue with HCFA about choice under Medicare. I know that the States are very concerned about their ability to link onto the Medicare system because HCFA has been so adamant about the requirement of choice. Now, I will add that, chatting with my mother this weekend, she agrees with HCFA, so it is not an insignificant issue for seniors—she is 83 and lives in Wisconsin, by the way.

But I do think that there are arguments that can be made and mechanisms that can be used to assure that people get good care,

but how choice is viewed is a real stumbling block, as to whether the systems of care can be constructed through the gerry-rigged processes that the States are having to go through. That has been part and parcel to some of the difficulties of getting movement toward integration between acute and long term care systems. I think we need to work on a clear understanding of what choice means and how to really capture what is good about the elements of choice.

I think Minnesota would argue that, to a great extent, the way they have done it that apparently is not going to be allowed in other States is not unlike a point-of-service situation, where if somebody goes out of network, they are responsible for paying some of the costs. Now, admittedly, for vulnerable populations who do not have a lot of resources, that is maybe not a very good answer.

So that is one area we need to resolve. Whether that is a legislative fix or whether that is one that we continue to work on with HCFA, I am not sure. But my impression from discussions with States and what they have gone through in their waiver approval process is that it may well have to be a legislative fix. We always come back to this incredible learning process we are going through, making sure that the demonstrations that we are working on are able to go forward in a somewhat more sympathetic fashion so that we can learn what we can recommend to you with regard to that and not violate the important principles of choice for vulnerable populations in particular.

Mrs. JOHNSON. On this particular issue, we did bring this up in our hearing last week at some length, and it is discouraging that the administration felt that allowing a point-of-service option, I think Ms. Buddo's comment was, it makes it too much like an insurance product. Well, if the government guarantees that the HMO delivers all Medicare services and oversees quality in that system if someone wants to buy a point-of-service option, they should be allowed to do so. They can now under Medigap, it just costs more.

So it is a very constraining view that does not allow choice to develop within the system, although choice is there at a higher cost through Medigap alternatives. Would you say that was accurate?

Mr. MEINERS. Yes, I would. Minnesota is not the only place. We have had both Colorado and Florida are two other States that we are working with under the Medicare-Medicaid Integration Program that we have got going with the Robert Wood Johnson Foundation and they are doing things a little bit differently. They are both working with TEFRA HMOs, but both also are faced with special requirements regarding this choice issue.

In the case of Florida, as we sort through a very difficult discussion, it almost seems like they are online to create what is almost like a shadow option out there so that choice exists, and it has gotten so confusing that it really gets in the way of implementing the programs. The waiver process can oftentimes take as much as 2 years, and when you think about these programs, it just eats up a lot of resources and energy before you ever get to implement.

I think that is one of the reasons. There are two reasons why I think a lot of these social experiment programs that we have, like SHMOs, PACE, the Partnership Program, do not get as big as we would like them to. First, time, energy, and resources are eaten up

so much in getting the programs off the ground, and second through that process, there is sort of an aura that it does not work or that there are problems with the programs. Finally when we give consumers the choice to opt in, they are at best confused, if not thinking that it is a bad thing. I think we need to turn that around because these programs really are useful and worthwhile for people to seriously consider but that message does not get to them.

Mr. WALLACK. I would add that one of the things I try to say in my testimony, which is somewhere in there, is that if we want to develop programs around the elderly, around the frail elderly, around the disabled, what we need are organizations that really have that as their service mission, to be involved.

One of the problems we have is we are looking at HMOs, which are pediatric models of care and primary care models that are designed to take care of an elderly population and a disabled population. By dropping this 50–50 rule, by not loosening but by having more reasonable standards by which we can contract and some of these other service restrictions, so we can have flexibility in services, which HMOs do, by the way, under TEFRA. They can offer different kinds of services.

What we will be able to do, though, is bring in the personal care systems, the VNAs. We will be able to bring in the long-term care providers. We will bring in people who are dedicated to serving older people and disabled people, and by doing that, we will open up the options, it seems to me, through the States who deal with those people and also through those providers that serve the Medicare/Medicaid population. We are missing those organizations that are focused and dedicated, and I think if we bring them in, we have a chance to make some real progress.

Mrs. JOHNSON. I understand. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS [presiding]. Let me ask you just one question about the financing, because, obviously, the administration has proposed over a 5-year period a gradual reduction on the TEFRA risk from 95 percent to 90. Given your payment structure at 100 percent of the AAPCC, does it seem possible that you could follow a reduction pattern, albeit at the appropriate distance, as we reduce regular HMOs, or not?

Mr. WALLACK. Do I think we could follow it? Yes, I think we could follow it. Again, it follows from my argument, what I told you before, why the AAPCC has gotten so high and such an easy target for HMOs is on this postacute side.

Chairman THOMAS. Is it also an easy target toward ratcheting down the HMOs?

Mr. WALLACK. Yes, it could be, sure. But I do not think it is the appropriate—I mean, ratcheting down the AAPCC does not seem to me the appropriate way to deal with this problem because it is the whole Medicare Program that is the issue here.

Chairman THOMAS. I understand that. But absent addressing the entire Medicare problem——

Mr. WALLACK. I would think you would have to keep the equity, yes.

Chairman THOMAS. If we get some commitment on equity, that, to me, argues for a desire to continue. You started your testimony off by saying that, so far, only PACE has a life and that you are interested in the others having a life and I am trying to build a case for the reasonableness of continuing these models and expanding them, so your testimony helps.

Dr. Meiners, I assume you would agree that given the way in which we pay, that we could probably find some savings without destroying the program?

Mr. MEINERS. Yes. I definitely think that. I think these programs are really examples, sort of incremental steps that we need to take. They are not parts of the big fix, but, frankly, long-term care is a very local community type of issue. So I think programs like Social HMOs and PACE are good steps in the direction. I think the Minnesota Senior Health Options is another example.

I think the point is that we are on the right track if we can get behind looking to these programs for what they can teach us, as Stan has suggested, working with the right players and helping them happen rather than standing in the way. This hearing, can contribute to that.

Chairman THOMAS. I appreciate your testimony. Are there any additional comments by any members? Thank you very much.

The next panel, we will ask to come forward. It consists of Judith Baskins, president, National PACE Association and also director of Geriatric Services of the Richland Memorial Hospital in Columbia, South Carolina; Eli Feldman, executive vice president and chief executive officer, Metropolitan Jewish Health System and Elderplan, Brooklyn, New York; Richard J. Bringewatt, president and chief executive officer, National Chronic Care Consortium, Bloomington, Minnesota; and Dr. Malcolm Adcock, Commissioner of Health, Cincinnati Health Department, Cincinnati, Ohio, on behalf of the Municipal Health Services Program, including San Jose, California.

I thank you all. Any written testimony that you have will be made a part of the record, and in the time that you have, you can address us in the way in which you see fit, starting with Ms. Baskins and we will work across the panel.

STATEMENT OF JUDITH PINNER BASKINS, PRESIDENT, NATIONAL PACE ASSOCIATION, AND DIRECTOR, GERIATRIC SERVICES, AND PALMETTO SENIOR CARE PROGRAM, RICHLAND MEMORIAL HOSPITAL, COLUMBIA, SOUTH CAROLINA

Ms. BASKINS. Good morning, Mr. Chairman and Members of the Subcommittee. My name is Judy Baskins and I am the director of the Palmetto Senior Care Program, which is a PACE Program operating in Columbia, South Carolina, since 1990, under the auspices of Richland Memorial Hospital, which is a 649-bed regional community teaching hospital.

PACE, as you know, is the acronym for Program of All-Inclusive Care for the Elderly. I am also president for the National PACE Association and am pleased to testify today on behalf of its members, the community, and the public organizations that have been committed to meeting the unique medical and social services needs of the frail elderly.

I also would like to introduce Ms. Jennie Chin Hansen, who is the executive director of On Lok Senior Health Services on which the PACE Program is based, and Ms. Chris Van Reenen, who is the executive director of the National PACE Association.

On Lok originated the essential components of the program in 1972, and today, 11 of the 12 PACE Programs across the country oversee and essentially provide the entire spectrum of health and long-term care services to enrollees without limits as to duration or dollars. Since 1983, PACE Programs have served a total of approximately 6,000 frail older people.

Before I explain a little bit more about PACE, I would like to express our appreciation for the strong bipartisan support of Congress for PACE over the last 15 years, including concerned support from many of the Members of this Subcommittee, especially Congressman Thomas. I would like to thank you, Congressmen Stark, Cardin, and Bilirakis for the introduction of H.R. 1464. We greatly appreciate your efforts in moving this forward.

PACE Programs differ from other managed care entities and long-term care providers in the following way. PACE enrolls only individuals who meet their State's eligibility criteria for nursing home level of care, thereby totally focusing on serving a very frail high-cost subset of the elderly population. PACE provides a comprehensive range of primary, acute, and long-term care services, and our ability to weave the medical and social services into a comprehensive health care delivery system allows individuals to remain within the PACE Program regardless of their changing needs and to continue to receive much of their care from providers with whom they have developed a longstanding, trusting relationship.

Interdisciplinary teams consisting of physicians, nurses, social workers, physical, occupational and recreational therapists; dieticians; and home care workers integrate the delivery of acute and long-term care. Within PACE, integration of services is achieved through the daily face-to-face interaction between program enrollees and the professionals and para-professionals who provide their care. The PACE approach allows for health professionals to respond immediately to the changes in enrollees' conditions, which are frequent, sudden, and often serious in the case of frail elderly.

PACE Programs receive capitated payments from Medicare and Medicaid and private pay sources. These payments are pooled at the program level, allowing health care providers enormous flexibility in developing treatment plans that respond to the enrollees' needs rather than the reimbursement regulations.

PACE Programs assume total financial risk and responsibility for all medical and long-term care without limitations and without copayments and deductibles.

Often in large health care systems, the individual patient is lost within that system. In contrast, in PACE, the intimate relationship between the health care providers, the participant, and their families allows for autonomy and decisionmaking about health care issues, ranging from polypharmacy to end-of-life decisions.

PACE can legitimately be called a creature of Congress. In 1986, Congress initiated an authorization of waivers for up to ten nonprofit community-based demonstration sites with the objective of determining whether On Lok's experience in San Francisco could

be replicated nationally. The number of authorized demonstration sites was increased to 15 in 1990. Together, the 11 programs now under Medicare and Medicaid waivers have accumulated more than 60 years of operating experience. Here is some of what the experience has been and what it has taught us.

In short, the demonstration has proved that the successful replication of the On Lok Program based in San Francisco is, indeed, possible. Among more specific findings, PACE participants experienced lower rates of hospitalization admissions and overall utilization of nursing home and hospital care than they do for comparatively frail individuals outside of PACE.

A dramatic example of PACE's efficiency is hospital utilization among PACE participants as measured by hospital days per 1,000 per annum in PACE, which is quite comparable to that of the general Medicare population, at approximately 2,400 days per 1,000 per annum. This is astonishing, considering the level of frailty and medical complexity of the PACE population in relation to the general Medicare population.

In South Carolina, with one of the frailest PACE populations currently enrolled, we have reduced hospitalization rates among our enrollees to less than 1,000 days per 1,000 per annum and we have done this by substituting community-based services for traditional care that is usually provided in hospitals. This has substantially improved the quality of care and the quality of life while maintaining clinical and functional outcomes comparable to, if not better than, the traditional institutional management.

The quality of care provided by PACE enrollees to date has been high. It is never sacrificed in pursuit of lower cost. In South Carolina, a recent survey was conducted by the South Carolina Department of Health and Human Services that revealed that 83 percent of the respondents found their health care provided by Palmetto Senior Care to be very good or excellent. But more importantly, they found that 87 percent of the participants believe that their quality of life has improved as the result of enrollment in the PACE Program.

To assume that PACE Programs maintain quality of care and quality of life experienced by participants and their care givers at its current level, the National PACE Association is developing standards of care for the PACE Program.

In terms of cost effective of PACE relative to Medicare and Medicaid, a recent study commissioned by the National PACE Association concluded that PACE generates approximately 12 percent savings to Medicare relative to Medicare's expenditures for a comparable population for the fee-for-service system. States estimate savings of 5 to 15 percent relative to current per capita long-term care expenditures. None of the dollar savings measure the enhanced quality of life in terms of improved function and the ability to remain in the community.

Building upon the years of experience and findings of the demonstration, it is time to expand the availability of PACE services to many more qualified frail elderly individuals throughout the United States. We request your support of H.R. 1464 that would make PACE available to those Medicare and Medicaid beneficiaries who could benefit from these services. H.R. 1464 proposes a

thoughtful, deliberate approach toward expanding PACE, one which builds upon the lessons learned over the course of the 11-year history of the demonstration.

Although we clearly realize that PACE is not the only answer to meeting the needs of frail elderly beneficiaries, it is one of just a handful of operational programs which integrate the entire spectrum of acute and long-term care services and it has withstood the scrutiny that comes with a high degree of visibility. We strongly believe that the efforts to expand PACE should be built directly upon the demonstration experience.

We must retain the distinguished characteristics of the PACE model that have been successfully addressed. They include a staff model in which PACE staff deliver the majority of the services provided to the enrollees.

A community-based orientation for programs, not only with respect to the location in which services are delivered, but equally important, the active participation of community representatives from governing bodies in key committees of PACE Programs, such as ethics committees. PACE Programs serve frail elderly individuals who are expected to die within three to 4 years of enrollment. It is essential that program operations be visible and accountable to members of the local community and subject to public scrutiny.

The absolute distinction between service allocation decisions and financial considerations at the individual care planning level should be a strong part of this. Care planning decisions must be made focusing on patient needs and not financial considerations.

Capitated financing, which places the provider at risk for all services. Unless the provider is required to assume risk for all services, the incentive always exists to utilize services for which one is not financially responsible, thereby shifting cost.

We appreciate the interest that the Subcommittee has expressed in PACE over a period of years. We also appreciate the commitment to PACE by the administration and HCFA. That commitment was evidenced most recently by the inclusion of language to expand PACE in the administration's current budget.

PACE, we hope, creates an opportunity to work together to improve the delivery of services to a subset of the most needy Medicare and Medicaid beneficiaries.

Thank you.

[The prepared statement and attachment follow:]

Statement of Judith Pinner Baskins, R.N., B.S.N.
President, National PACE Association
Director of Geriatric Services, Richland Memorial Hospital,
Columbia, SC

Mr. Chairman and Members of the Subcommittee:

Good morning. My name is Judy Baskins; I am the Director of Palmetto Senior Care, a PACE program that has operated in Columbia, South Carolina since 1990 under the auspices of Richland Memorial Hospital, a 649-bed regional community teaching hospital. "PACE" as you know is the acronym for "Program of All-inclusive Care for the Elderly." I also am the President of the National PACE Association and am pleased to testify today on behalf of its members, community and public organizations committed to meeting the unique medical and social service needs of frail, elderly Americans. The current PACE model was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco. On Lok originated the essential components of the program in 1972. Today, 11, soon to be 12, PACE programs across the country oversee and essentially provide the entire spectrum of health and long-term care services to their enrollees without limit as to duration or dollars. Since 1983, PACE programs have served a total of approximately 6,000 frail, older people.

Attached to my statement is a list of current PACE programs operating under waivers as well as a list of organizations that are in various stages of formal development of PACE.

Before I explain more about PACE, I want to express our appreciation for the strong bipartisan support in Congress for PACE over the last 15 years, including concerned support from many members of this Subcommittee.

PACE programs differ from other managed care entities and long-term care providers in the following ways:

- PACE enrolls only individuals who meet their states' eligibility criteria for nursing home level of care, thereby totally focusing on and **serving a very frail, high-cost subset of the elderly population**. The average age of our enrollees is over 80; and they have an average of 8 serious medical problems each, including heart disease, peripheral vascular disease, diabetes, hypertension and dementia. The principal objective of PACE is to maximize the function and independence of enrollees. By doing this, PACE is able to minimize institutional placement, that is, to delay or prevent it altogether.

- **PACE provides a comprehensive range of primary, acute and long-term care services**. We provide the majority of services, including medical care, adult day care, home care, rehabilitative therapies, personal care, transportation, meals and prescription drugs, to enrollees in the community -- either in the PACE Center or in individuals' homes. If, ultimately, institutional care is required, PACE participants are not dropped from our program. We cover that care and, in all cases, closely follow the patient's progress in the institution to assure receipt of proper care at the proper time. We don't abandon our participants.

  Our ability to weave medical and social services into a comprehensive health care delivery system allows individuals to remain in the PACE program, regardless of changing needs, and to continue to receive much of their care from providers with whom they have developed a long-standing, trusting relationship.

- **Interdisciplinary teams** consisting of physicians, nurses, social workers, physical, occupational and recreational therapists, dietitians and home care workers **integrate the delivery of acute and long-term care**. Within PACE, integration of services is achieved through daily, face-to-face interaction between program enrollees and the professionals and paraprofessionals who provide their care. This close personal attention contrasts with models which attempt integration via contracts and telephone contact. The PACE approach allows for health professionals to respond immediately to changes in enrollees' conditions which are frequent, sudden and often serious in the case of the frail elderly. PACE's emphasis on preventive care and immediate response to change is integral to its success.

- **PACE programs receive capitated payments from Medicare, Medicaid and private-pay sources.** These payments are pooled at the program level, allowing health care providers enormous flexibility in developing treatment plans that respond to enrollees' needs rather than reimbursement regulations. Incentives inherent in the fee-for-service system to provide more and more, regardless of efficacy, do not exist within PACE. At the same time, because PACE programs retain complete responsibility for enrollees' care, usually until they die, the incentive to underserve -- a criticism of managed care in general -- is minimized. A further control on underservicing is our community and public sponsorship which affords high visibility and accountability.

- **PACE programs assume total financial risk and responsibility** for all medical and long-term care without limitation and without copayments and deductibles.

Often in large health care systems the individuality of the patient is lost within that system. In contrast, in PACE the intimate relationship between the health care providers, participants and

their families allows for autonomy in decision-making about health care issues ranging from polypharmacy to end of life decisions.

PACE can legitimately be called a "creature of the Congress." In 1986, Congress initiated authorization of waivers for up to 10 nonprofit, community-based demonstration sites with the objective of determining whether On Lok's experience in San Francisco could be replicated nationally. That number was expanded to 15 in 1990. The first of the demonstration programs to open their doors have now been operational for seven years. Together the 11 programs now under Medicare and Medicaid waivers have accumulated more than 60 years of operating experience. Here is some of what that experience has been and what it has taught us.

In short, the demonstration proved successful replication of On Lok's program based in San Francisco is indeed possible by non-profit entities operating under various auspices in a variety of communities across the country. These programs have enrolled an exclusively frail population and succeeded at helping enrollees to maximize their function and independence in the community, thereby avoiding nursing home or long-term hospital placement. Again, unlike any other type of provider, these organizations have assumed complete responsibility for each enrollee's total needs without limit in terms of the type, number or intensity of services provided to any individual enrolled in the program. Further, notwithstanding an aversion among huge health systems to assuming risk for this subset of the Medicare population, PACE programs, among them comparatively small community-based providers, have proven their ability to assume full financial risk for not just Medicare-covered services, but for both Medicare and Medicaid benefits.

Among the more specific findings, PACE participants experience much lower rates of hospital admissions and overall utilization of hospital care, and lower utilization of nursing home services than do comparably frail individuals outside PACE. PACE programs use savings from reductions in inpatient utilization to expand the range and intensity of ambulatory care services in the community that in turn yield lower rates of inpatient utilization. Generally, any revenues in excess of costs are allocated to reserves to cope with unusual and unanticipated medical needs of our participants.

A dramatic example of PACE's efficacy is hospital utilization among PACE participants. As measured by hospital days per thousand per annum, the rate in PACE is quite comparable to that of the general Medicare population (approximately 2400 days/1000/annum). This is astonishing considering the level of frailty and medical complexity of the PACE population in relation to the general Medicare population. The general Medicare group includes a very large proportion of healthy individuals. These findings are substantiated in HCFA's evaluation of the PACE demonstration.

In South Carolina, utilization of hospital services is even lower than the PACE average. We have reduced hospital utilization among our enrollees to less than 1000 days/1000/annum. How? By substituting subacute care, home health and PACE Center services for care traditionally provided in the hospital. This has substantially improved the quality of care and quality of life for our participants while maintaining clinical and functional outcomes comparable to, if not better than, more traditional institutional management.

For example, over the last two years, our average length of hospital stay for treatment of hip fractures has been only two and one-half days. Hospital care is followed by intensive rehab -- usually in a subacute setting, although sometimes in the PACE Center or at home -- overseen by the center-based PACE team. The transition back to less intensive services is individualized and based on participant, caregiver, environmental and medical circumstances and can be completed in as little as three weeks to as long as three months. In almost all cases, the functional ability has returned to at least the pre-event level. Clinical outcomes are not compromised by this shift from acute to community-based care; in many cases outcomes are actually improved.

The quality of care provided by PACE programs to date has been high and is never sacrificed in pursuit of lower costs. Federal and state review processes, an independent review by the Community Health Accreditation Program in 1993, ongoing consumer satisfaction surveys at individual PACE sites, and the findings of HCFA's evaluation verify the high quality of PACE care.

In South Carolina, for example, a recent survey of PACE enrollees and their caregivers conducted by the Department of Health and Human Services revealed that 83% of respondents found the health care provided by Palmetto Senior Care to be very good or excellent. The remaining 17% evaluated their care as fair or good. Perhaps even more importantly, 87% of Palmetto's participants believe their quality of life has improved as a result of enrollment in PACE.

To assure that PACE programs maintain quality of care and quality of life experienced by participants and their caregivers at its current level, the National PACE Association (NPA) is developing standards of care for the PACE program. A National Accreditation Advisory Committee made up of experts in the field of health care, quality assurance and accreditation is helping the NPA to complete a final set of standards by the end of this year. These standards will provide the basis for an accreditation program which we hope to pilot at several existing PACE sites in 1998 and expand to all PACE sites in the future.

In terms of the cost-effectiveness of PACE to Medicare and Medicaid, a recent study commissioned by the NPA (undertaken by Dr. Leonard Gruenberg, President of the Long-Term Care Data Institute,) concluded that **PACE generates approximately 12%**

savings to Medicare, relative to Medicare's expenditures for a comparable population in the fee-for-service system. With regard to Medicaid, each state participating in the demonstration establishes a Medicaid capitation rate for PACE based on the state's expenditures for comparable long-term care recipients in its traditional Medicaid long-term care system. **States estimate savings of 5-15% relative to current per capita long-term care expenditures.** None of the dollar savings measure the enhanced quality of life in terms of improved function and ability to remain in the community.

Building upon the years of experience and findings of the demonstration, it is time to expand the availability of PACE services to many more qualified frail, elderly individuals throughout the United States. Efforts toward this end began in the 104th Congress with legislation introduced by Senators Dole, Inouye and others. "The PACE Provider Act of 1995"--S.990-- sought to expand the number of PACE programs, and move qualified existing and future PACE sites from demonstration to provider status. Unfortunately, despite broad bipartisan support for the legislation, it was not enacted by the last Congress.

Consequently, we request your support now for legislation that would make PACE available to those Medicare and Medicaid beneficiaries who would benefit from PACE services. We propose a thoughtful, deliberate approach toward expanding PACE, one which builds upon the lessons learned over the course of the 11-year PACE demonstration. This approach includes mechanisms to insure that the expansion yields desired results. In particular, a key provision of S. 990 was that only programs found by the Secretary to be lower in cost than what would otherwise have been paid by Medicare and Medicaid could secure provider status. We strongly urge inclusion of a similar mandate of cost-effectiveness in any implementing legislation.

Although we realize that PACE is not the only answer to meeting the needs of frail elder beneficiaries, it is one of just a handful of operational programs which integrate the entire spectrum of acute and long-term care services. It has withstood the scrutiny that comes with a high degree of visibility. We are very proud of the fact that not a single PACE program has throughout the years been accused of fraudulent or abusive practices by federal or state governments.

We believe PACE has proven itself in addressing the needs of beneficiaries, providers and payers. While it is not all things to all people, we are proud of its identity. We also are enormously concerned about the welfare of the very frail individuals enrolled in PACE and believe that concern warrants a careful and deliberate approach to expanding the availability of PACE. We strongly believe that efforts to expand PACE should build directly upon the demonstration experience. We must retain the distinguishing characteristics of the PACE model that have successfully addressed the needs of PACE enrollees. These include:

- **A staff model approach in which PACE staff deliver the majority of services provided to PACE enrollees**, as opposed to contract providers. The staff model is crucial to assuring the level of integration which is a trademark of PACE.

- **The community-based orientation of the program**, not only with respect to the location in which services are delivered but, equally as important, the active participation of community representatives on the governing bodies and key committees of PACE programs, such as ethics committees. PACE programs serve frail elderly individuals who are expected to die within three to four years of enrollment. It is essential that the program's operations be visible and accountable to members of the local community and subject to continuing public scrutiny.

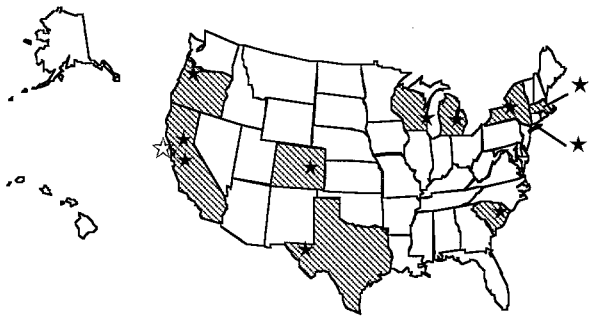
- **The absolute distinction between service allocation decisions and financial considerations at the individual care planning level**. Care planning decisions must be made focusing on patient needs, not financial considerations.

- **Capitated financing which places the provider at risk for all services**. Unless the provider is required to assume risk for all services, the incentive always exists to utilize services for which one is not financially responsible, thereby shifting costs.

The question has been raised recently as to the possible ultimate inclusion of for-profit organizations among future PACE-type providers. To date, PACE programs have been limited to nonprofit or public entities. Consequently, all our experience under the demonstration has been with these types of organizations. For-profit organizations were never denied the opportunity over the years to propose PACE-type demonstration programs or to develop nonprofit subsidiaries within which PACE could be developed. We are not opposed to for-profit organizations ultimately entering the program, but we believe they should also be required to demonstrate, just as we have, their ability to focus effectively and exclusively on the frail elderly in terms of quality of care and cost-effectiveness.

We appreciate the interest that the subcommittee has expressed in PACE over a period of many years. We also appreciate the commitment to PACE by the Administration and HCFA. That commitment was evidenced most recently by the inclusion of language to expand PACE in the Administration's current budget. PACE, we hope, creates an opportunity to work together to improve the delivery of services to a subset of the most needy Medicare and Medicaid beneficiaries.

PACE is replicating the On Lok model . . .



Organizations with Waivers to Operate PACE as of May 1997:

CALIFORNIA
- ☆ On Lok Senior Health Services
  San Francisco
- ★ Center for Elders Independence
  Oakland
- ★ Sutter Health's Sutter SeniorCare
  Sacramento

COLORADO
- ★ Total LongTerm Care, Inc.
  Denver

MASSACHUSETTS
- ★ East Boston Neighborhood Health Center's Elder Service Plan
  East Boston

MICHIGAN
- ★ Henry Ford's Health System's Center for Senior Independence
  Detroit

NEW YORK
- ★ Beth Abraham Hospital's Comprehensive Care Management
  Bronx
- ★ Rochester General Hospital's Independent Living for Seniors
  Rochester

OREGON
- ★ Sisters of Providence's Providence ElderPlace
  Portland

SOUTH CAROLINA
- ★ Richland Memorial Hospital's Palmetto SeniorCare
  Columbia

TEXAS
- ★ Bienvivir Senior Health Services
  El Paso

WISCONSIN
- ★ Community Care Organization's Community Care for the Elderly
  Milwaukee

Organizations Delivering Services under Medicaid Capitation as of May 1997:

CALIFORNIA
Altamed Senior Buena Care
Los Angeles

HAWAII
PACE at Maluhia
Honolulu

ILLINOIS
Chicago REACH
Chicago

MARYLAND
Hopkins Elder Plus
Baltimore

MASSACHUSETTS
Elder Service Plan of the Cambridge Hospital
Cambridge

Elder Service Plan at Fallon
Worcester

Elder Service Plan - Harbor Health Services
Dorchester

Elder Service Plan of Mutual Health Care
Roxbury/Dorchester

Elder Service Plan of the North Shore, Inc.
Lynn

NEW YORK
Eddy SeniorCare
Troy

OHIO
TriHealth SeniorLink
Cincinnati

VIRGINIA
Sentara Senior Community Care
Norfolk

WASHINGTON
Providence Elderplace of Seattle
Seattle

WISCONSIN
Elder Care Options
Madison

Organizations Delivering Services Under Medicaid Capitation Beginning in late 1997:

NEW MEXICO
St. Joseph Healthcare
Albuquerque

NEW YORK
Independent Living Services
Syracuse

PENNSYLVANIA
University of Pennsylvania School of Nursing
Philadelphia

St. Agnes / CHI-East
Philadelphia

Organizations Exploring Feasibility of PACE Development:

CALIFORNIA
Huntington Memorial Hospital
Pasadena

Life Steps/Daniel Freeman Hospital
Los Angeles

St. Joseph Health System
Fullerton

COLORADO
Centura/CHI
Colorado Springs

CONNECTICUT
Hebrew Home and Hospital
West Hartford

Masonicare
Wallingford

Mc Lean
Simsbury

DELAWARE
Catholic Health Initiatives - East
Wilmington

FLORIDA
Florida Hospital
Orlando

Miami Jewish Home & Hospital for the Aged
Miami

GEORGIA
Candler Health Systems
Savannah

Wesley Woods, Inc.
Atlanta

IOWA
Mercy Hospital Medical Center
Des Moines

KANSAS
Via Christie Health System
Witchita

KENTUCKY
Christian Church Homes of Kentucky, Inc./
Sanders Brown Center on Aging
Lexington

MASSACHUSETTS
St. Lukes/Charlton Memorial Hospital
Fall River

MISSOURI
Health Midwest
Kansas City

Heartland Hospital
St. Joseph

St. Louis Regional Medical Center
St. Louis

NEBRASKA
Alegent Health
Omaha

NEW JERSEY
Bergen Pines County Hospital
Paramus

Caring, Inc.
Pleasantville

Community-Kimball Health Care System
Toms River

Catholic Health Initiatives - East
Trenton

St. Joseph's Hospital and Medical Center
Patterson

Visting Nurse Service System
Runnemede

NEW YORK
Arden Hill Life Care Center
Goshen

Catholic Charities of Buffalo/
Sisters of Charity Hospital
Buffalo

Mercy Health System of Western New York
Cheektowaga

Weinberg Campus, Inc.
Getzville

NEVADA
Washoe County Senior Services
Reno

NORTH CAROLINA
Cape Fear Valley Medical Center
Fayetteville

OHIO
Akron General Medical Center
Akron

Concordia Care, Inc.
Cleveland

PENNSYLVANIA
Allegheny General Hospital
Pittsburgh

Doylestown Hospital
Doylestown

Forbes Health System
Pittsburgh

Lutheran Affiliated Services
Mars

Pittsburgh Mercy Health System
Pittsburgh

Visiting Nurse Association of Greater Philadelphia
Philadelphia

TENNESSEE
Alexian Brothers Health System
Signal Mountain

TEXAS
Parkland Memorial Hospital
Dallas

VIRGINIA
Inova Health Systems
Fairfax

WEST VIRGINIA
Raleigh County Commission on Aging
Beckley

Chairman THOMAS. Thank you, Ms. Baskins.
Mr. Feldman.

STATEMENT OF ELI FELDMAN, EXECUTIVE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER, METROPOLITAN JEWISH HEALTH SYSTEM, AND ELDERPLAN, BROOKLYN, NEW YORK

Mr. FELDMAN. Thank you, Mr. Chairman.

Mr. Chairman, I appreciate the opportunity to testify for all Social HMO sites on an innovative model of care. In addition to Elderplan, there are two other first generation sites, including Medicare Plus Two, sponsored by Kaiser Permanente, which serves residents in Oregon and Washington States, and Scan Health Plan of Long Beach, California.

The SHMO model should be of great interest to the Committee for several reasons. First, it provides a cost-effective alternative for serving high-cost populations, such as the aged, the disabled, and dually eligible.

Second, it represents a more rational approach to cost containment than across-the-board rate reductions. SHMOs restructure benefits and service delivery design and realign provider and payor financial incentives. Further, SHMOs use health risks adjustors in structuring payment levels.

Third, it offers the States a model for developing a Medicaid managed care program for seniors and reducing spending on the dually eligible population.

Social HMOs integrate the full spectrum of primary, acute, and long-term care services for seniors. Beyond traditional part A and B benefits, SHMOs cover, for example, eyeglasses, hearing aids, prescription drugs, and up to $1,000 per month in home and community-based services.

The SHMO programs have achieved several important goals since their inception. They have produced a model for integrating the full range of primary, acute, and community-based long-term care services to more closely parallel the needs of our aging population. They have enhanced coordination of seniors' health services through uniform care management policies and geriatric care protocols, simplifying seniors' access to a broader range of more appropriate services.

And, they have produced Medicare and Medicaid cost savings in several ways, by eliminating duplication of function across multiple provider settings, through better coordination of care, by improving health outcomes through high-risk screening and appropriate followup interventions, and through a flexible benefit design which allows SHMOs to substitute lower cost services.

For example, Kaiser research shows that a home and community care benefit produces savings by delaying or preventing long-term nursing home admissions and reducing nursing home lengths of stay. For every month we delay nursing home entry in New York City for a dually eligible person, Elderplan saves the government about $5,700. Instead, we spend about one-tenth that amount in home and continuing care benefit services under Elderplan's chron-

ic care benefit. If we delay admission for 1 full year, the public sector achieves net savings of about $68,000 annually.

Additional savings could be produced by more effectively integrating Medicaid long-term care services under managed care financing arrangements. The SHMOs collectively have encountered regulatory barriers in this area.

For example, since New York State's managed care waiver currently is limited to the Aid for Dependent Children population, there is no mechanism for Elderplan to receive Medicaid capitation for long-term care benefits. Accordingly, we must continue to provide Medicaid long-term care services under a separate fee-for-service structure.

SHMOs can serve as the bridge to link acute and long-term care benefits for dually eligible persons under managed care arrangements. The Federal Government already has made a substantial investment in developing Medicare managed care options under the TEFRA Program and has produced an effective infrastructure for integrating acute care services and financing.

To achieve systemwide savings, however, Medicaid long-term care benefits need to be integrated fully into the structure, as well. SHMOs provide the model for bridging the Medicare, Medicaid, and acute care long-term care gaps in the current system.

Waiver authority for the SHMO demonstration will expire at the end of this year if no further action is taken by Congress or the administration. We are currently awaiting a 1-year administrative extension from HCFA. In addition, the President included a 3-year legislative extension in his fiscal year 1998 budget proposal. While we remain hopeful that the administrative extension will be enacted by the end of the year, this is obviously only a stopgap measure.

Mr. Chairman, as you develop your Medicare budget proposals, we request that you give serious consideration to the following recommendations. First, at a minimum, extend SHMO waiver authority for 3 years, to December 31, 2000. Second, as part of a larger Medicare restructuring initiative, grant SHMOs permanent provider status and extend this option to other Medicare beneficiaries nationwide. And third, identify incentives encouraging States to fully integrate Medicaid long-term care benefits with Medicare HMO acute care benefits for the dually eligible population to maximize integration efforts and cost savings potential.

Thank you, Mr. Chairman.

[The prepared statement follows:]

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TESTIMONY OF ELI FELDMAN
EXECUTIVE VICE PRESIDENT & CEO
METROPOLITAN JEWISH HEALTH SYSTEM AND
ELDERPLAN

before the

WAYS & MEANS HEALTH SUBCOMMITTEE

April 29, 1997

I. INTRODUCTION

Mr. Chairman and distinguished Members of this Committee, I am Eli Feldman, Executive Vice-President & CEO of Metropolitan Jewish Health System of Brooklyn, New York which sponsors Elderplan, one of the original Social Health Maintenance Organization (Social HMO) demonstration sites. I appreciate the opportunity to testify today on behalf of all Social HMO sites and to discuss an innovative program for integrating health care financing and delivery for the full spectrum of services needed by seniors. The timing of this hearing is critical, since Congress is beginning to draft Medicare and Medicaid reform legislation which will include provisions to expand managed care options. The Social HMOs have valuable insights regarding the benefits of managed care programs such as enhanced coverage at lower costs for consumers, greater flexibility for providers and cost-savings for public payors. The information we share today provides important guidance to you and your colleagues in shaping Medicare and Medicaid reform proposals. The Social HMO offers a viable model for expanded managed care options because it:

- provides a cost-effective alternative for the highest-cost segments of the health care population -- chronically-ill seniors and dually eligible persons;
- represents a more effective strategy for reducing Medicare and Medicaid expenditures than simply reducing provider payments since these programs restructure financing and delivery approaches and align provider and payor incentives with respect to clinical and financial goals;
- includes reimbursement methods that reflect the additional risk incurred by the frail, eliminating disincentives to enrolling higher-cost beneficiaries;
- provides states a blueprint for developing acute and long-term care integration models for the Medicaid and the dually eligible populations.

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

My testimony today will address the following areas:

- an overview of the problems of the chronically-ill and dually eligible;
- a description of Social HMOs as an innovative model for integrating primary, acute and long-term care services for these two populations; and

- removing barriers to expanding and improving access to integrated systems of health care financing and delivery.

II. PROBLEMS OF THE CHRONICALLY ILL AND DUALLY ELIGIBLE

A. Chronic Illness

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

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

B. Dually Eligible

Individuals who are eligible for both Medicare and Medicaid benefits are referred to as "dual eligibles." In 1995, there were approximately 6 million such persons in the U.S. and this number is expected to double by 2030. Dual eligibles include the frail elderly, low-income non-frail elderly, and non-elderly disabled persons. The nonelderly disabled and elderly persons aged 85 and older are the fastest growing segments of the dual eligible population. The dual eligible population experience significant physical and cognitive health problems, and are much more likely to become chronically-ill than non-dual eligibles. Consider the following examples:

- over one-third of dual eligibles experience limitations in activities of daily living, compared to only 10% of the non-dually eligible;
- 62% of dual eligibles have one or more limitations in instrumental activities of daily living (IADLs), while 70% of the non-dual eligibles have no IADL limitations;
- twice as many dual eligibles have had a stroke or suffer paralysis and two and a half times as many are likely to have a broken hip as non-dual eligibles;
- more than one quarter of dual eligibles use inpatient care each year compared to less than one-sixth of Medicare only beneficiaries; and
- dual eligibles are eight times as likely to be living in an institution.

While the dually eligible account for a small percentage of the total Medicare and Medicaid populations, they account for a sizable proportion of the expenditures. This population represents 16% of the total Medicare population, but about 30% of all program expenditures. They make up about 17% of the Medicaid population, but consume about 35% of total spending. In it estimated that about $110 billion was spent on the dually eligible in 1995, evenly divided between Medicare and Medicaid expenditures.

C. Implications

The chronically ill, which comprise a large share of the dually eligible population, require a wide range of primary, acute and long-term care services. Because such persons require multiple services delivered by a wide array of health care professionals, ranging from social workers to physicians, there is a critical need for coordination of their care. Coordination of care affects quality and health care outcomes as well as cost-effectiveness. We pose the following challenges to our current health care system and policymakers to evolve a model of care appropriate to the chronically-ill and dually eligible. The Social HMOs have accepted these challenges and have taken them to heart in the development of their financing and delivery systems.

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

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

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

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

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

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

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

III. SOCIAL HMOS

A. History

The Social HMO demonstration was authorized under the Deficit Reduction Act of 1984 (DEFRA) and subsequently was extended by Congress in 1987, 1990 and 1993. In addition, the 1990 legislation provided authority for additional sites which are in various stages of implementation. This demonstration was established to test innovative financing and delivery models for integrating acute and long-term care services, and in the process, reduce health care costs and improve quality and appropriateness of care. The three original SHMO sites currently operating include Elderplan, Inc. in Brooklyn, New York; Kaiser Permanente Health Plan in Portland, Oregon; and SCAN Health Plan of Long Beach, California. The program currently serves over 22,000 seniors through three of the original Social HMO sites. Since the program's inception, more than 50,000 seniors have been served.

B. Goals

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

- producing Medicare and Medicaid cost-savings -- which could be used to increase service capacity in a budget neutral fashion -- through operational efficiencies, the provision of more appropriate levels of care and the downward substitution of lower-cost services;
- integrating the full range of acute and community-based long-term care services and providers to expand the continuum, more closely parallelling the needs of our aging Medicare population;
- consolidating services and professionals to enhance coordination of services and to generate norms of practice in caring for the frail elderly which would be applied uniformly across the spectrum of providers/settings;
- enrolling a cross-section of well and frail elderly to create an insurance risk pool for spreading the costs of care and reducing the burden on any one individual; and
- pooling funding sources for the dually eligible to eliminate barriers to effective clinical decision making -- such as the 3 day prior hospitalization requirement for Medicare SNF eligibility -- and allow providers to allocate resources based on individual enrollee needs.

C. Social HMO Benefit Package

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

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

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

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

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

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

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

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

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

D. Consumer Benefits

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

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

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

The burden of providing continuous care for an elderly relative can take a tremendous physical, emotional and financial toll on informal caregivers. Some 12% of caregivers are forced to quit their jobs to provide full-time care to aging parents. Three significant problems faced by informal caregivers which the Social HMO helps to alleviate include fragmentation of our current health and long-term care systems; the absence of financial support for long-term care services; and the paucity of assistance available to negotiate the complex web of services frequently needed by a person with multiple disabling conditions. To personalize the benefits of the Social HMO, we have included three case studies below.

Case Study 1

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

Case Study 2

Gladys lived an extremely active life until age 86 when she was diagnosed with cancer. Although she initially recovered from cancer treatment, she became increasingly frail and forgetful and eventually was unable to continue living alone. Her granddaughter Lynn was considering leaving her job to care for Gladys when she discovered Kaiser Permanente's Social HMO. Kaiser initially provided adult day care services for Gladys twice weekly, provided homemaker services and installed an electronic response system, paying for 90% of related costs. Eventually, expanded care services were changed to adult day care five days per week at a foster home near Lynn's house and respite care to relieve Lynn of caretaking responsibilities periodically. Gladys was able to remain independent with Kaiser's support until she passed away, never being forced to leave Lynn's home and Lynn was able to maintain her employment.

Case Study 3

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

E. Cost Savings Potential

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

There are a number of built-in mechanisms to reduce or minimize health care expenditures which we believe have substantially reduced system costs. The Kaiser Permanente Center for Health Research conducted a study focusing on nursing home use between 1986 and 1988 which revealed substantial savings under this model. Part of the cost-savings are achieved through the structure of the benefit which caps annual long-term care services at about $7,500 to $12,000, depending on the site. In addition, the model uses short-term nursing home benefits to supplement to the community-based service benefit to pay for short-term respite stays, convalescence after Medicare nursing home coverage expires, or to cover the first portion of a permanent admission. We attribute the successful use of the long-term care benefit to our highly effective care management system which continuously monitors the health status of those at risk for nursing home placement, coordinates informal support services with those of paid services

and maximizes the use of the Medicare skilled benefit which is otherwise unavailable to Social HMO members.

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

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

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

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

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

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

Service Credit Banking is an exciting new approach to mutual aid. It is based upon volunteers earning and spending Service Credits. Service Credits are a local, tax-exempt, computerized currency that utilizes time as the medium of exchange. Service Credits enable an individual to convert personal time into additional purchasing power by providing service to others. With this model, it is possible to generate large amounts of service without payment in money and,

therefore, to operate a social service barter system on a scale much larger than ever before. Since the program's inception in June 1987, the Member-to-Member program has provided over 56,500 hours of service to almost 3,000 service recipients through the voluntary efforts of 238 volunteers. To provide some sense of the economic value of these services, in 1995 alone, this volunteer program delivered $161,701 worth of preventive and supportive services at a cost of about $74,000.

F. Health System Benefits

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

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

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

IV. ISSUES RELATED TO THE DUALLY ELIGIBLE

The Social HMOs were designed to accommodate both the Medicare population and those dually eligible for both Medicare and Medicaid services. To date, however, all sites have had difficulty in fully integrating Medicaid benefits into the program and achieving significant enrollment of the dually eligible population. Barriers to integrating Medicaid coverage have emerged in the areas of plan administration and finance. Discrepancies between Medicare and Medicaid regulations, and the need to develop parallel administrative tracks for the same population, in areas such as quality assurance measures, grievance procedures (e.g. differences in definitions, timelines for appeals, etc.), and risk contracting requirements make it cumbersome to administer an integrated benefit. Financial barriers have created an even greater road block. All three sites have experienced difficulties with state Medicaid programs in negotiating capitated payments for Medicaid enrollees.

Elderplan has experienced difficulties in both establishing enrollee incentives and obtaining the waiver necessary for Medicaid to pay Elderplan a Medicaid capitated payment. While New York has a 1915(b) waiver enabling them to provide managed care services to the Medicaid population, the state is phasing in enrollment of various populations, staring with the AFDC group. The SSI disabled and elderly currently are excluded. Although the state plans to begin

enrolling additional populations in the future, there is no mechanism for the state to make capitated payments to Elderplan for long-term care services. New York did receive approval to make small capitated payments to Elderplan for Medicare copayments and deductibles under the Social HMO waiver authority (as opposed to the 1915 program), but not long-term care services. To address this shortfall, and work toward a fully integrated package acute and long-term care benefits, Elderplan has initiated discussions with a PACE program operating in New York. PACE could subcapitate Elderplan for a portion of the long-term care benefit. The adult day model would enhance the quality of life for some Elderplan members living alone by providing socialization. Also, the substitution of adult day services for personal attendant services actually could be more cost-effective.

Elderplan also is disadvantaged by the absence of financial incentives for dually eligible elderly New Yorkers to enroll in Elderplan due to the structure of the state's Medicaid benefit. A dually eligible recipient in New York State receives 100% coverage of primary, acute and long-term care services between Medicare and Medicaid benefits without any deductibles, copayments or premium payments. Accordingly, these individuals have less incentive to join Elderplan strictly for the long-term care benefit. What the dually eligible don't receive, however, are the care management and service coordination aspects of the Social HMO program -- assistance in accessing needed services. Further, dually eligible who receive Medicare benefits from an HMO and Medicaid benefits in the fee-for-service sector continue to experience fragmentation by virtue of the dual system. The Federal and New York state governments are disadvantaged since the lack of service and financial integration and the absence of preventive and care management services all contribute to a higher cost system.

Kaiser Permanente attempted to establish a Medicaid capitation contract for several years in Oregon. The state program did not want to pay a capitated rate for low income seniors for community-based care unless the person was already receiving benefits, thereby undermining the insurance structure of the Social HMO model. Medicaid members in Oregon, however, are allowed to keep the premium paid to Kaiser Permanente, and enroll in the Social HMO as a private pay member. If a Social HMO Medicaid member becomes frail and is eligible for home- and community-based services, Kaiser Permanente becomes the first organizer and payor of services. The county's Aging Services Division agreed to pay the 20% copayment for the home- and community-based services received by the Medicaid client. Aging Services recognizes that the Social HMO is providing services that they would be responsible for if the person was not covered by the comprehensive benefits of the Social HMO.

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

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

The Social HMOs strongly encourage the Federal government to address conflicts and duplication regarding administration and oversight requirements under the Medicare and Medicaid programs for the dually eligible population. We believe that significant savings could be achieved through the streamlining of these requirements and the establishment of uniform oversight and data collection requirements, enrollment and grievance procedures and other administrative functions. As more and more states apply to HCFA for managed care waivers for the Medicaid program, pressure to streamline these requirements for the dually eligible population can only increase. We know HCFA has taken a first step toward uniform procedures

for this population in granting waivers for the Minnesota Senior Health Options program and suggest that the variances made for Minnesota be made available to other states as well.

The Social HMO represents an important vehicle for bridging the gap between Medicare and Medicaid service integration for the dually eligible population and controlling costs for this expensive beneficiary group. The Federal government already has made a substantial investment in developing managed care approaches for Medicare beneficiaries through standard Medicare HMOs (TEFRA risk-contracting entities) and numerous demonstration programs like Medicare Choices. Congress clearly is interested in further expanding managed care approaches for senior citizens as illustrated by the plethora of legislative initiatives introduced in recent years.

TEFRA HMOs have created an effective infrastructure for integrating acute care benefits for the dually eligible. But Medicare HMOs provide coverage for only a portion of the total service package required by senior citizens. Until Medicaid long-term care benefits are fully integrated under managed care approaches, dually eligibles will continue receiving services in a fragmented fashion and the Federal and state governments will continue forgoing a golden opportunity to reduce Medicaid costs. The Social HMO model with its chronic care benefit and care management structure bridges the gap between acute and long-term care benefits financed under the Medicare and Medicaid programs. It is incumbent upon Congress to optimize their investment in Medicare HMOs and managed care demonstration programs by eliminating barriers to Medicaid integration.

V. CONCLUSION

Mr. Chairman, we request your assistance in helping preserve and expand access to innovative programs such as the Social HMO demonstrations for our nation's elderly, chronically-ill and disabled citizens. As I indicated at the outset of my testimony, the waiver authority under which the Social HMOs operate will expire at the end of this year if no further action is taken. On behalf of the existing sites and plan members, we urgently request your intervention to include in the budget bill provisions to include:

- at a minimum, a three year extension of the Social HMO demonstration through the year 2000;
- permanent waiver authority for existing Social HMO sites, assuming these sites demonstrate the ability to operate in a budget neutral fashion and to meet Social HMO rules regarding benefit structures, case management protocols and other key elements of the Social HMO program;
- mechanisms to streamline administrative and oversight requirements for Medicare and Medicaid to eliminate barriers to serving the dually eligible through managed care programs; and
- strategies to eliminate barriers to the integration of Medicaid benefits within the existing Medicare HMO managed care framework.

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

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Chairman THOMAS. Thank you, Mr. Feldman.
Mr. Bringewatt.

STATEMENT OF RICHARD BRINGEWATT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL CHRONIC CARE CONSORTIUM, BLOOMINGTON, MINNESOTA

Mr. BRINGEWATT. Mr. Chairman and Members of the Subcommittee on Health, I appreciate the opportunity to testify at today's hearing regarding the need for greater coordination of health care and related services for seniors.

Nowhere is the need for coordination more evident than for persons with chronic diseases and disabilities. People with chronic conditions, such as Alzheimer's disease, heart disease, strokes, and hip fractures, represent health care's highest cost and fastest growing service group.

In 1995, nearly 70 percent of the nation's personal health care expenditures were for direct medical costs of persons with chronic conditions. Chronic illness cost our country about $660 billion in 1995 [sic], $425 billion in direct medical expense and the remainder in lost productivity. The dually eligible which account for about 6 million people, represent an expensive subgroup of this population. Their health care costs represent about 30 percent of Medicare and 35 percent of Medicaid expenditures.

These high costs can be attributed in large part to four factors. First, we develop policies in managed care as if the problems of Medicare and Medicaid beneficiaries are acute rather than chronic. We focus on issues of cure more than care, on issues of disease more than disability, and with a significant focus on institutional services and a successive use of high-cost technology.

Second, we develop policies in managed care around settings, such as hospitals, physicians, nursing homes, and care providers instead of around the ongoing problems of people whose problems require care that crosses time, place, and profession. We look at cost and quality one piece at a time without a sense of their cumulative cost or care effects. We fail to recognize that care for people with chronic conditions requires the involvement of multiple care providers working together to achieve common quality and cost objectives over an extended period of time.

Third, we finance care only after a problem has reached a crisis proportion with few incentives for preventing, delaying, or minimizing the progression of disease or disability over time.

Fourth, we develop policies in managed care as if there were little or no relationship between Medicare and Medicaid and a host of other public and private programs. We establish rules and regulations under each payment source one program at a time without regard to issues of cost shifting or the cost of duplicative and conflicting requirements.

As a foundation for addressing the problems in Medicare and Medicaid over the long term, we recommend that Congress consider legislation which would lay a foundation for containing the accumulation of Medicare and Medicaid costs while maintaining America's commitment to quality. NCCC's model legislation would establish a national policy agenda for chronic care that would recognize the relationship among programs and payors serving the chronically ill and the importance of controlling chronic disease cost to preserving the Medicare Trust Fund.

The Chronic Care Act also would streamline oversight for Medicare and Medicaid by establishing a simplified and uniform set of rules and regulations for governing administration, data collection, care management and planning functions, reporting, quality assurance, and so forth.

Third, it would enable payors and providers to move beyond demonstrations and establish new methods of operations in the marketplace with incentives for functioning as part of an integrated network of care with special capabilities for serving people with chronic disease and disabilities.

During a 3-year period, PSOs and dedicated providers of chronic care services would be subject to specific capacity criteria and would be evaluated on their ability to meet cost and quality objectives. Those who do would be designated as qualified chronic care networks, operating under a uniform set of oversight rules and paid under shared risk financing arrangements involving health status adjustments representative of the high-risk population being served.

Fourth, the Chronic Care Act would enable the public and private sectors to redirect existing research and technical assistance resources to help transform existing structures to better serve people with chronic disease and disability. Examples would include developing capabilities to better track and analyze financial and clinical data for chronic disease and the management of care; assisting in restructuring financing approaches, using risk-based adjustment payment that recognized the high cost of chronic care; and identifying and disseminating best practice tools that can help expedite the use of more cost-effective care technologies.

If America is going to preserve the Medicare trust over the long term, it is critical that we establish a foundation for national health policy built upon the problems of the future rather than problems of the past and problems of people rather than problems of providers. It is critical that we move beyond demonstrations to creating real incentives for a fundamental transformation under marketplace conditions with cost containment and quality treated as interdependent objectives.

Thank you.

[The prepared statement follows:]

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TESTIMONY OF RICHARD BRINGEWATT
PRESIDENT & CEO
THE NATIONAL CHRONIC CARE CONSORTIUM

before the
HOUSE WAYS & MEANS HEALTH SUBCOMMITTEE

April 29, 1997

I. INTRODUCTION

Mr. Chairman and distinguished Members of the Committee, I am Richard Bringewatt, President & CEO of the National Chronic Care Consortium (NCCC). I appreciate the opportunity to testify today and to share with you recommendations regarding health care reform for persons with chronic diseases and disabilities, many of whom are dually eligible for Medicare and Medicaid. The NCCC is a national nonprofit organization representing 30 of the leading-edge health care organizations operating integrated delivery systems in the U.S. and Canada. All NCCC members provide the full array of primary, acute and long-term care services to commercial, Medicare and Medicaid populations. Because our membership represents the full continuum, we are not invested in promoting the interests of any single provider or professional designation. Rather, we are committed to testing and implementing innovative models of health care financing and delivery which are targeted to fully integrating providers, professionals and payors at every level of the health care system -- from governance structures to clinical programs to administrative and financing mechanisms.

My testimony today will focus on four key areas:

- problems of the chronically-ill and dually eligible populations;
- regulatory barriers to integrating the full spectrum of health and related services;
- an innovative health care model integrating care for dually-eligible, chronically-ill nursing home residents; and
- model legislation by NCCC to eliminate barriers to integrating primary, acute and long-term care services, resulting in better care for consumers and cost savings.

II. PROBLEMS OF THE CHRONICALLY ILL AND DUALLY ELIGIBLE

Since our health care system was formed several decades ago, the nature of illness in our country has shifted from a preponderance of acute care illnesses to a preponderance of chronic conditions. Chronic illness represents the highest-cost, fastest growing segment of our health care sector. Examples of chronic conditions include Alzheimer's Disease, arthritis, heart disease, strokes, hip and other fractures, hypertension, and renal diseases. In 1995, approximately 100 million Americans were afflicted with chronic conditions. In the next 25 years, the size of the chronically-ill population will increase by about 35 million. While we often think of chronic illness primarily as a problem of the elderly, persons of every age are afflicted. Of those living in the community, about 64% are under age 65, while 26% are aged 65 and above. The elderly are more likely, however, to experience multiple chronic conditions. About 69% of those 65 and above have multiple conditions, while only 17% of those under age 17 and 29% of those aged 18-44 have more than one condition.

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

hospital admissions and 80% of hospital days were attributed to the chronically-ill who had average lengths of stay of 7.8 days compared to 4.3 days for those with only acute conditions.

An important subset of the chronically-ill are the dually eligible, of which there were 6 million in 1995. This group experiences many more health problems than those eligible only for Medicare and are more likely to have multiple chronic conditions. For example, over a third of dual eligibles have limitations in activities of daily living compared to only 10% of non-dual eligibles, 2.5 times as many have hip fractures and twice as many have strokes. The large majority of dual eligibles are elderly (71%), virtually all of whom are eligible for Medicare and many, for Medicaid, as a result of costly health care expenditures. Because the dual eligible are, by definition, low-income, this subset of the chronically-ill population consumes enormous public health care resources. In 1995, Medicare and Medicaid medical expenditures alone were $110 billion for this group. Further, while dual eligibles represent a relatively small share of total Medicare and Medicaid caseloads, they consume a substantial proportion of total expenditures. This population represents about 16% of all Medicare beneficiaries, but consume about 30% of total program expenditures. It represents about 17% of Medicaid beneficiaries, consuming approximately 35% of total Medicaid costs.

The health care costs of the chronically-ill and dually eligible only can grow exponentially, given demographic trends. The elderly -- particularly those 85 and above with the greatest health care needs -- are the fastest growing segment of the population and also most prone to multiple chronic conditions. Health care cost containment demands three critical steps. First, policy makers must establish a comprehensive national policy agenda that considers the interrelationships among all public and private sector programs serving the chronically-ill population, with special regard for Medicare and Medicaid enrollees. Rules governing these programs should be streamlined and made uniform and conflicting financial disincentives removed. Policies regarding the plethora of other Federal and state programs also should be integrated into a national chronic care policy, such as the Older Americans Act, Veterans Administration programs, Title XX block grant programs, HUD low-income rental assistance policies, etc. Federal and state laws related to other health care financing vehicles for the Medicare population also must be carefully examined to assure consistency, such as rules governing the Medicare Select program, Medigap insurance policies, private long-term care insurance policies, etc. Until we take a comprehensive view of all public program and financing policies, we will continue to suffer the social and economic consequences of a fragmented system.

Second, the Federal and state governments must start focusing on both the interdependence among the chronically-ill and dually eligible and the public programs that finance them. These include Medicare and Medicaid. Recognizing this interdependence is essential to: removing regulatory barriers to integration; eliminating the cost-shifting occurring between these programs due to conflicting financial incentives; improving continuity of care for those receiving benefits under programs often using different contractors and providers; and containing health care inflation. I submit that Congress and the White House could take the first step in this process by undertaking Medicare and Medicaid reform together -- instead of considering these programs as separate budget functions.

Third, policymakers must begin examining the interrelationships among chronic conditions and the implications for managing the relationship to care and cost as people with these conditions seek services that cross the spectrum of primary, acute and long-term care providers. While the chronically-ill consume a disproportionate share of acute care expenses in the early stages of disease, they also consume many more long-term care services in the later stages of illness. For example, we know that hypertension, diabetes and osteoporosis (all chronic conditions in themselves) are precursors to other chronic conditions. For example, persons suffering from osteoporosis are more likely to incur a hip fracture and persons with hypertension are more prone to strokes and heart disease. We also know that there is a direct relationship between strokes and hip fractures and long-term care service use. Conversely, greater emphasis to quality medical care in nursing homes can also reduce acute care costs (e.g., through reduced hospitalizations). From a health systems perspective, these interrelationships call for greater attention to a care strategy that prevents, delays or minimizes the progression of disability over the long-term and, thus, reduces the accumulation of costs over time. From a public policy perspective, these interrelationships suggest the need to develop administrative and financial policies that recognize the interdependence between Medicare and Medicaid and that focus on

linkages among primary, acute and long-term care services and their relevance to long-run aggregate cost savings.

III. REGULATORY BARRIERS TO HEALTH SYSTEMS INTEGRATION

A. Overview

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

Managed care approaches hold promise for helping to rein in the costs of care for the chronically-ill and dually eligible populations. While about 30% of Medicaid and almost 13% of Medicare beneficiaries are enrolled in managed care programs, however, only 3% of the dually eligible receive services from HMOs and like entities. Federal demonstrations like the Social Health Maintenance Organization (SHMO) and Program of All Inclusive Care for the Elderly (PACE) and state demonstrations like the Minnesota Senior Health Options and Wisconsin Partnership programs represent important steps toward better meeting the multidimensional, longitudinal needs of the chronically ill and dually eligible more effectively. Each of these programs integrate, to varying degrees, the financing and delivery of health and related services for these populations.

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

B. Systems-Based Approach

While managed care approaches are intended to reduce costs by enabling patients to receive care in the most appropriate and lowest cost care settings, current regulations are replete with restrictions and disincentives to this approach. To reduce costs, we must move from an acute care to chronic care orientation -- an interdisciplinary approach which recognizes the multidimensional and progressive nature of chronic disease. Care for the same person frequently is provided by multiple organizations with little or no incentive to work together to meet common goals regarding patient outcomes and cost-containment. Cost containment and quality of life for persons with serious and persistent chronic conditions are both significantly dependent upon the full array of primary, acute, and long-term care providers working together to prevent, delay or minimize disability progression and its associated costs.

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

C. Payment Reform

For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. We must move beyond containing costs within isolated health care sectors such as hospitals and nursing homes and

toward establishing administrative, clinical and financial incentives for managing aggregate costs across time and settings.

Most cost-containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk-arrangements. Control is organized around issues of service amount, frequency, and duration for specific care segments, rather than based on aggregate costs and cumulative effects. There is little or no incentive for providers to collaborate in cost-savings across the continuum of care. This approach is likely to actually increase aggregate costs in the long-run, not decrease them. Even managed care organizations engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service basis -- one provider at a time. The result is risk management on a piece meal basis by negotiating the lowest-priced contract for each provider or service. The result is a high cost administrative structure and ineffective delivery model for serving people with chronic conditions -- the largest and most costly care segment in America.

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

D. Uniform Administration and Oversight

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

To date, policymakers have focused almost exclusively on Medicare and Medicaid financing reform as the solution to containing health care costs. Even if we move our health care system to managed care financing tomorrow, however, we may very well miss cost savings opportunities. Health care cost containment also is dependent on a restructuring of health care administrative and delivery systems. Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the chronically-ill. All network providers should be allowed to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes.

IV. FAIRVIEW PARTNERS: A CASE STUDY

A. Fairview Partners

Fairview Partners is a provider-based managed care initiative designed to enhance the quality of health care services for individuals residing in nursing homes. Building on long-standing collaborative relationships, 14 local long-term care facilities worked with Fairview Physician Associates and Fairview hospitals to develop Fairview Partners, an integrated care system for nursing home residents. Medica Health Plans is Fairview Partners' first payor contract. Medica has both TEFRA and Prepaid Medical Assistance Risk Contracts which it combined to create a single stream of funding for the elderly, dual eligible population.

Fairview Partners was founded to address a number of the problems regarding systems fragmentation discussed above. Nursing home residents often fall between the cracks" of the health care system. Although the nursing home provides housing and basic health services, each resident has his/her own primary physician. This results in varied approaches to primary care

-- even within a given nursing home. When you add the confusing combination of health benefits and underlying financial incentives for individuals, physicians, nursing homes and hospitals, a fragmented system emerges that promotes the use of hospitals for the care of nursing home residents during episodes of illness.

The Medicare and Medicaid financing systems collide in the nursing home. Since the average nursing home has two thirds of their residents covered by both Medicare and Medicaid, nowhere are the gaps, restrictions and barriers produced by these two systems more evident. Doctors get paid more when the patient is cared for in the hospital than if the patient is cared for in the nursing home. Often nursing home residents' coverage of therapy services requires a recent hospital stay. Nursing homes often get paid more to take care of a resident if they have just returned from the hospital. Nursing homes don't get any additional reimbursement if they are taking care of a resident who is ill. But, ironically, if a resident is in the hospital, Medicaid pays the nursing home for the empty bed.

The current system is cumbersome and expensive and it is organized around rafts of regulation and financing rules rather than the unique needs of this special vulnerable population. Hospitals have developed an enormous amount of technical and clinical expertise over the years. Those skills, however, have been oriented to technology and cure and have not, by and large, been focused on the health issues that are so prevalent in the nursing home population -- chronic conditions like Alzheimer's disease and congestive heart failure. Technology won't fix those -- and they don't need the full power of the high tech hospital of the 1990's. What they do need is a system that is oriented to chronic care -- one that focuses on disability management and function rather than cure. Nursing homes carry the expertise here. And, they have developed an increased technological capability in the past decade. Certainly we will still need the hospital -- we just need to work to assure that it is used only when needed. We must get past the financial disincentives that keep the provider systems separate and move to a system that rewards us for working together to provide better care.

B. The Structure

Proactive, primary care serves as the basis for the care delivery system. The primary care providers are gerontological nursing practitioners working collaboratively with physicians. Individualized care plans and Clinical Pathways are used to guide providers at all service settings to assure consistency and continuity. Efforts are made to deliver services in the nursing home setting whenever clinically appropriate. The clinical model that has been developed is focused on disability prevention and interdisciplinary practice. Care management is a shared accountability between the primary care team and the nursing home staff. Episodes of illness are managed with fewer hospital admissions and less disruption to the resident. The overall results should be an improvement in clinical quality, resident satisfaction and a reduction in costs. Early outcomes are very encouraging.

At its foundation, this project has fundamental restructuring of the financial incentives through use of a capitation approach using Medica's standard TEFRA Medicare Risk and Prepaid Medical Assistance contracts. Fairview Partners bears total financial risk for the care delivery for enrollees. Within Fairview Partners, organizational providers share that financial risk through risk sharing arrangements. Appropriate financial incentives are created throughout the care delivery continuum. However, diligence has been exercised to avoid placing inordinate financial risk on individual physicians. The financial model created a mechanism to pay providers for services based on existing Medicare and Medicaid systems (adjusted to reflect and incent clinical practice changes). These payments would be made out of a "common pot" of funds resulting from an overall Fairview Partners capitation amount. If there is an overall deficit or surplus in the "common pot" after provider payments have been made, that surplus or deficit will be shared among the providers in a prearranged manner. The model creates a reserve fund as a mechanism to fund deficits and a special reward pool to incent specific clinical practice changes.

Special approaches must be made to assure that the consumer perspective is imbedded in Fairview Partners' planning and delivery. In addition to the more standard approaches to measuring member satisfaction and appeals processes built into the health plan arrangements, Fairview Partners conducted two focus groups of family members of residents within the first six months of operation. One focus group was comprised of enrollees' family members and

another of family members of residents who declined to enroll in Fairview Partners. Members reported very high satisfaction; those who declined did so primarily because of loyalty to their previous physician. As a result of these focus groups, several changes were made in the enrollment process and are now being implemented.

C. How Does Fairview Partners Look Different?

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

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

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

This story combines several facets of Fairview Partners approach. It describes a good use of health care dollars to buy services (1:1 nursing assistant care) which is not otherwise reimbursable but allows hospitalization to be avoided. In the "old model" of medical management, Mrs. LK would very likely have been hospitalized – creating costs for ambulance, emergency room, hospital care and specialty physician care by several physicians. She would likely have been restrained and her dementia significantly increased. As you can see in this example, quality of care was enhanced <u>and</u> costs were saved through the approach taken by Fairview Partners.

V. THE CHRONIC CARE ACT OF 1997

A. Overview

The NCCC has developed a legislative proposal for restructuring the Medicare and Medicaid programs which we believe can effectively address barriers to the integration of primary, acute and long-term care services for the chronically-ill. "The National Chronic Care Act of 1997" ("The Act") would establish national policies that:

- recognize chronic illness as the highest-cost segment of health care;
- promote integrated delivery systems and managed care payment methods as effective vehicles for improving healthcare outcomes and controlling costs;
- provide a broader range of managed care options with special capabilities for serving the chronically ill;

- streamline Medicare and Medicaid requirements to reduce duplication and fragmentation of care among primary, acute, and long-term care providers;
- create incentives for providers to prevent, delay, and/or minimize the progression of disability for people;
- establish public/private sector partnerships to create new business technology to restructure our current financing and delivery systems.

B. Benefits

The NCCC believes that numerous benefits would accrue to each of The Act's intended "stakeholders," including consumers, providers and payors and the Federal and State governments:

- **Consumers** would benefit through simplified access to and use of services; increased ability to control their own health care decisions; and improved quality measures and health outcomes.
- **Providers** would benefit through increased flexibility in the way they practice medicine and less burdensome regulatory requirements; opportunities for direct contracting with Medicare; and technical support in systems integration through a National Resource Center.
- **Public & Private Payors** would benefit from simplified oversight of the Medicare and Medicaid programs, operating under a compatible administrative structure; and a more rationale approach to long-run cost savings and control; i.e., health systems restructuring would replace rate setting and coverage limitations.

C. Regulatory Simplification

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

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

The Advisory Committee would be required to examine program rules in a variety of areas such as payment methods and billing procedures; Medicare and Medicaid contracting requirements under risk-based financing arrangements; record keeping and reporting requirements; enrollment and coverage rules; health screening and risk identification and care planning functions; admissions and discharge rules and other case management functions; quality assurance and professional certification criteria; and consumer protection. Based on its assessment of Federal and state regulations, the Advisory Committee would develop recommendations to Congress regarding statutory and regulatory changes needed to streamline the current regulatory process and promote the goals of the Chronic Care Act with respect to health systems integration. The recommendations would also provide the basis for establishing a single provider certification for managing problems of chronic disease and disability. "Provider-Sponsored Organizations" (PSO) and dedicated chronic care providers would be designated as "Chronic Care Networks" (CCN) based on their demonstrated capacity without requiring a predefined structure or process for the administration and delivery of care. The qualifications for certification as a CCN are outlined below.

D. Integrated Provider Networks

a. Chronic Care Networks

The Act outlines a process for establishing innovative health systems which better meet the needs of the chronically-ill. We call these integrated delivery systems "chronic care networks" (CCNs). Although we envision a specific type of provider designation for CCNs, as we currently have for HMOs, CMPs and other managed care entities, the Chronic Care Act would move Congress away from creating additional rigid structures governed by highly prescriptive protocols and towards a certification which measures systems capacity instead of defining organizational structure. Similarly, instead of implementing CCNs under a demonstration model, The Act outlines a process for quickly mainstreaming innovative models and best practice methods. Under this model, providers would be given a specified period of time to restructure the way they do business, technical assistance in implementing organizational changes, and criteria for how they would be judged based on organizational capacity. Those meeting cost and quality targets would receive designation to continue functioning under an integrated program design.

There are several reasons to move beyond the demonstration approach:

- The rapid growth of the elderly population, the advancement of chronic conditions as the predominant and fastest growing health sector, and the acceleration of costs associated with these two trends.

- Demonstrations are implemented in an artificial environment, freeze in place research designs, and prevent organizations from modifying their systems as more effective practices are developed. The rapid deployment of best practices in quality and cost-containment is sacrificed for rigidity in the application of research principles.

- Demonstrations limit the number of health systems testing and refining particular frameworks at a given time and the number of consumers who can access benefits. It is difficult to get individual providers much less entire systems to modify the way they practice medicine for a small subset of their entire caseload.

b. Chronic Care Capacity

There is no single model that can meet the varying and multidimensional needs of the chronically-ill and disabled nationwide for a few reasons. First, the needs of an individual will be conditioned on the type and severity of their condition(s), the degree of informal support available, and the type of financing available for formal services (e.g., Medicare, Medicaid, Medicare supplemental, long-term care insurance, etc.) Second, health care is very much a local phenomenon and systems need to be structured to accommodate consumers' needs, local service capacity, state resource constraints, etc. In developing new managed care options, NCCC recommends that Congress focus on the development of capacity criteria which could be applied to any number of organizational structures instead of defining the structure itself. Final judgement about the continuation of a given approach would be made following a careful analysis of costs and quality in relation to other care approaches in the market place. We believe that the following capacity criteria are critical to the establishment of a fully integrated delivery system:

- **POPULATION-BASED PLANNING** where chronic care population subgroups are profiled and targeted for establishing an integrated continuum of services for a defined population.

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

- **SELF-CARE** information, assistance, and applied technology for clients and their caregivers to optimize functional independence and well being;

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

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

- **INTEGRATED INFORMATION SYSTEMS** that allow provides to track aggregate cost, utilization, quality, and satisfaction data across settings and time for chronic conditions;

- **INTEGRATED CONTINUOUS QUALITY IMPROVEMENT SYSTEMS** for monitoring system performance and for changing practice patterns in response to network performance trends;

- **POOLED, FIXED-DOLLAR SHARED RISK FINANCING** where fixed dollar payments limit aggregate costs, pooled financing reduces duplication of services and increased provider flexibility with resource allocation, and shared-risk methods create incentives for collaboration toward common clinical outcomes and cost targets;

- **CHRONIC CARE EXPERTISE** including common medical direction and leadership in other clinical areas and common in-service training in chronic care management;

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

E. Quality Assurance Guidelines

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

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

- risk factors and interventions associated with progression of disability;

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

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

- indicators of client satisfaction;

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

- patient encounter data across care settings; and

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

F. Payment Methods

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

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

G. Technical Support for Systems Transformation

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

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Chairman THOMAS. Thank you very much.
Dr. Adcock.

STATEMENT OF MALCOLM ADCOCK, PH.D., COMMISSIONER OF HEALTH, CINCINNATI HEALTH DEPARTMENT, CINCINNATI, OHIO; ON BEHALF OF MUNICIPAL HEALTH SERVICES PROGRAM

Mr. ADCOCK. Thank you, Mr. Chairman and members of the Health Subcommittee. I am Malcolm Adcock. I am the Health Commissioner for the City of Cincinnati. I appreciate this opportunity to present this testimony on behalf of the City of Cincinnati as well as the three other cities that participate in the Municipal Health

Services Program, those being Baltimore, Maryland; Milwaukee, Wisconsin; and San Jose, California.

My colleagues are with me today from Baltimore and San Jose. Also, Dr. Graham Atkinson, who performed the cost study on our programs, is here. They can certainly answer questions at your request.

The MHSP, or Municipal Health Services Program, is a forerunner of managed care programs which increases access to preventive care and ancillary services in a coordinated and cost-effective manner. We believe the Municipal Health Services Program is a common sense approach to health care which has demonstrated cost savings and a better level of care for the inner-city poor, underserved individuals that are eligible for our program. Therefore, we are requesting that the Subcommittee authorize an extension of the Municipal Health Services Program rather than allow this program to expire in December, as it would without Congressional action.

By way of historical background, the MHSP was established in 1978 to address the unique health care needs of vulnerable populations, underserved, low-income, and urban communities. HCFA, in fact, grants waivers of certain reimbursement limitations for Medicare beneficiaries to encourage a managed care approach.

The Municipal Health Services Program delivers cost-effective, coordinated managed care to individuals who otherwise would depend on emergency rooms and hospital outpatient care for basic medical services. In fact, that was part of the original mandate under an initiative through the Robert Wood Johnson Foundation.

Neither HCFA, in our opinion, nor the emerging managed care market have responded to the primary care needs of this elderly population which is served by our programs.

With regard to the overall control and management of the program, HCFA requires operational guidelines which are strictly adhered to through contractual arrangements. They require quarterly reports detailing patient utilization, coordinated care activities, quality assurance, and marketing activities. There are program guidelines which include service definitions, reimbursement procedures, and claims processing, cost reporting, among other mandated operational requirements. Through these efforts, HCFA maintains careful control over our programs.

There is an expanded set of benefits available to the beneficiaries under this program, which include primary and preventive care, prescription drugs, podiatry, comprehensive dental services, optometry, routine eye exams, laboratory, hypertension management, and other services. The copayments, except for eyeglasses, and the deductibles, are waived, encouraging use of the services. Transportation is provided, if needed.

Convenient access to routine health care services allow providers to manage care at an affordable cost. We believe it allows us to better manage chronic disease and other illnesses through routine primary care which saves costs on the inpatient and long-term care side of the equation.

The eligibility requirements are, again, strictly laid out by HCFA. Participants must be residents of the city in which the program operates, and must be eligible for Medicare part B. The services are provided in the clinics in which we operate.

The client profile certainly includes elderly, of course, and minorities, people who live alone, subsist on a fixed annual income, and, in short, are at increased risk for chronic disease and other illnesses and also likely to postpone care.

We believe that the justification for the extension of this program is that the services are needed to manage chronic and other age-specific illnesses. We believe that termination of this program could mean increased dependence on emergency room and other outpatient services, which would increase costs.

Which HCFA and Congress are potentially moving toward a managed care environment for Medicare, but as we stand here today, the HMOs in our localities do not target our urban low-income seniors and, in fact, we tend to think that they cherry pick the healthiest individuals for inclusion in their networks. To date, the HMOs that are operating in our locales have been unwilling to contract for provider-based contracts for our facilities.

As indicated in Dr. Atkinson's study, we believe the Municipal Health Services Program ultimately saves money. We disagree strongly with the cost estimates from HCFA that the program will cost $79 million in fiscal year 1997. We, in fact, believe that Dr. Atkinson's study is correct that the Municipal Health Services Program will save Medicare $27.4 million in 1996, an additional amount in 1998, and potentially $128 million over the course of a 4-year extension. On average, we believe the program saves Medicare almost $500 per user.

So, basically, what we are saying is that this program has a long history and a lot to teach us about managed care for this underserved population, and, we believe, this information has not been taken advantage of to this point. We also believe that these programs represent a critical provider network which will be required in any event if managed care is to move into the inner cities. We believe that a lot could be gained from looking closely at this program as we begin to look at how managed care could operate in that environment.

I would be happy to answer any questions.

[The prepared statement follows:]

TESTIMONY OF MALCOLM ADCOCK, Ph.D.
Before the Subcommittee on Health
Committee on Ways and Means
On Behalf of the
MUNICIPAL HEALTH SERVICES PROGRAM
April 29, 1997

INTRODUCTION

Good Morning. Mr. Chairman, Members of the Subcommittee. My name is Malcolm Adcock, Commissioner of Health for the City of Cincinnati, Ohio. I appreciate the opportunity to appear before the Subcommittee this morning to present testimony on the Municipal Health Services Program (MHSP), also known as the Medicare waiver demonstration program.

The statement I will present today is on behalf of the City of Cincinnati as well as the three other cities that participate in the MHSP -- Baltimore, Maryland; Milwaukee, Wisconsin; and San Jose, California.

MHSP, as a forerunner of managed care programs, provides outpatient primary care, including preventive care and ancillary services, with an emphasis on case management, to persons who might not otherwise have sought such care before experiencing a health crisis. This managed care program, like the private managed care programs which are evolving across the country, is reducing the costs of health care services while maintaining the quality of services delivered. And it is doing so in our urban settings with the most vulnerable population that is not being served by Medicare managed care plans. We request that the Subcommittee authorize an extension of the MHSP rather than allow this valuable program to expire in December as it will without Congressional action.

HISTORICAL BACKGROUND

In 1978, the MHSP was established to provide an alternative to the episodic care that was being received by underserved medically indigent residents in urban neighborhoods. It began as a collaborative effort of the U.S. Conference of Mayors, the American Medical Association, and the Robert Wood Johnson Foundation. MHSP later took on significance as a means to identify and explore new approaches to meet the needs of vulnerable populations in low-income, urban communities. The Health Care Financing Administration (HCFA) became involved in the demonstration program in 1979. HCFA granted necessary waivers of certain reimbursement limitations for Medicare beneficiaries in an effort to deliver cost-effective, coordinated managed care to individuals who otherwise would depend on emergency room and hospital outpatient care for basic medical services.

MHSP has been extended over the years and has demonstrated its effectiveness as a managed care program. It would be ironic if MHSP were terminated at a time when HCFA is encouraging movement toward managed care for the Medicare population.

PROGRAM PROFILE: ELIGIBILITY REQUIREMENTS AND BENEFITS

The cities participating in the MHSP operate under an Agreement with HCFA mandating their compliance with strict guidelines for program administration. Detailed program requirements are set forth in the MHSP Provider Manual. The cities must submit quarterly reports to HCFA summarizing such aspects as patient utilization, coordinated care activities, quality assurance and marketing activities. The guidelines and requirements specify service definitions (defining covered services), reimbursement

procedures, claims processing and cost reporting, among other mandated operational requirements.

Each of the four cities has made available expanded health care services not covered by the standard Medicare program. The services available through one or more of the MHSP programs include:

- Primary Care including Preventive Care
- Prescription Drugs
- Podiatry
- Comprehensive Dental Services
- Optometry and Routine Eye Exams
- Laboratory
- Hypertension Management
- Psychology and other Mental Health Services
- X-ray

Co-payments (except for eye glasses) and deductibles are waived. Such affordable primary and preventive health care services are offered at convenient neighborhood locations. Transportation from the patient's home to the center is provided if needed. As a result, there is an incentive for beneficiaries to seek routine care. Waivered services, and medication and dental care in particular, are tailored to the needs of these individuals who are vulnerable to chronic and other age-specific illnesses. As a result of that routine care, such illnesses are more controllable and can be managed more effectively by providers.

To participate in the MHSP, an individual must be a resident of one of the four cities in which the waiver demonstration has been awarded, and must be enrolled in Medicare Part B. Anyone enrolled in a Medicare Risk HMO is not eligible for services under the MHSP. Services are provided at contracted clinics (in some cases community health centers) and through contracts with a variety of health care providers.

MHSP clinics are reimbursed on a cost basis for covered services. The accuracy of reimbursable costs are assured by outside audits, the results of which must be reviewed and accepted by HCFA in arriving at the cost-to-charge ratios used to reimburse future services. Claims are filed electronically with HCFA on a monthly basis, and are reimbursed within about sixty days. No prospective payments are made under this system. Administrative and operational costs incurred by the centers are paid by HCFA based upon an outside audit of the center's MHSP expenses.

MHSP providers are well qualified in family practice and internal medicine and many are certified in gerontology. The turnover rate among providers is very low. Finally, and most importantly, patient satisfaction is very high.

CLIENT PROFILE

Individuals who benefit from the MHSP, in general, are low-income residents of inner cities who are 65 to 80 years of age or older. A significant number of these individuals are minorities, live alone, and subsist on a fixed annual income. Beneficiaries suffer from chronic illnesses and often need multiple medications. Without MHSP, these individuals would find it difficult to access health care facilities for basic medical services. MHSP's comprehensive services at single locations eliminate the involvement of numerous providers and the need for more than one trip to receive coordinated care.

JUSTIFICATION FOR EXTENSION OF THE PROGRAM

If the MHSP program is shut down next January, thousands of elderly Americans will be left without the primary managed care they need. MHSP has built the kind of public health infrastructure that enables beneficiaries to manage their illnesses and avoid the high cost of delayed treatment. Not having access to these services would mean the difference between the cost of routine treatment for high blood pressure and the cost of hospitalization and subsequent rehabilitation after the experience of a stroke or heart attack.

Ours is a common sense approach to health care.

When this program was last extended by Congress in 1993, one of the justifications for that extension was that comprehensive health reform legislation, then a prominent issue on the Congressional agenda, was going to address the gap in health care services available to this population. In addition, it was thought that the MHSP provided an invaluable resource for architects of health reform because of the characteristics of, and lessons learned from, MHSP-- namely, providers who truly know their communities, patients who are satisfied with the care they receive, a focus on prevention and primary care to avoid catastrophic costs, full access to services for a population which is often underserved by other parts of our health care system, and the effective use of personnel who provide high quality care at a lower cost than specialists.

Expectations of health reform legislation did not materialize. Nevertheless, the health care provider system is changing rapidly. However, risk-averse HMOs do not target the low-income seniors who reside in our urban communities. In general, the HCFA-approved Medicare HMOs tend to "cherry pick", or select the healthiest individuals for inclusion in their network, in an effort to lower their risk and cost. For example, in Cincinnati, marketing efforts by HMOs to recruit new beneficiaries have been targeted in the outlying, more affluent areas of the metropolitan region. As a result, the inner city elderly, thought to be less healthy and poorer risks for an HMO, tend to be excluded from the opportunity to participate in the managed care programs. The Medicare Risk plans which have been established in Santa Clara County, California, also do not recognize this need. None of the San Jose MHSP providers have been able to secure provider contracts with these HMOs. Overall, MHSP providers in all of the four MHSP sites report that HCFA-approved HMOs have been unwilling to contract for coverage of this population.

In addition, while the Milwaukee MHSP has maintained close ties to the Community Care for the Elderly, a PACE program which is also a topic of today's hearing, the initiative is referral-based for individuals who are unable to care for their needs at home without assistance; thus, the focus is too narrow to be a sufficient alternative to the MHSP.

BUDGET IMPACT

We are well aware of the budget constraints under which Congress must operate in making choices among a number of meritorious programs. However, this program provides better services at reduced cost. We believe MHSP ultimately **saves** money.

HCFA has estimated the MHSP cost at $79 million for FY 97. We dispute that figure. To the contrary, our cost analysis, performed using HCFA's own program data, found that MHSP **saved** Medicare $27.4 million in FY 96, and can be expected to continue to save similar amounts in future years, including an estimated saving of $32.6 million in FY 98. If MHSP is extended for four years, the Medicare savings will exceed $128 million. The study was performed by Graham Atkinson, a noted expert in health care finance who has consulted on health care for numerous hospitals and governmental bodies since 1981. The conclusion that there are savings from MHSP is

consistent with the conclusions reached by the first evaluation of the program which were published in both the Health Care Financing Review, (Vol. 8, No. 3, Spring 1987) and Medical Care, (Vol. 24, No. 7, July 1986), two respected journals.

The Atkinson study compared the cost of Medicare services provided to MHSP users to the cost of such services provided to a corresponding group of non-users. When HCFA's study made such a comparison, it showed that MHSP users of physician services cost Medicare $4665 in 1989, compared to an average cost of $5159 for non-users, a **saving** of $494 for MHSP users. The lower Medicare payments on behalf of MHSP users resulted from their much lower use of Medicare Part A services, as would be expected. It was only after HCFA applied flawed regression adjustments to that data that HCFA reached the conclusion that MHSP resulted in greater Medicare expenditures.

MHSP has resulted in a more cost-effective use of health services on the part of individuals. Moreover, all four MHSP sites make a concerted effort to keep costs down by continually introducing cost and resource management practices. Since 1992, for example, Baltimore has implemented quality assurance/utilization review procedures that include a retrospective review of high cost users in all services each quarter; pre-certification for mental health services; pre-authorization for dental prosthodontic procedures; and a mandated formulary for prescription drugs with generic substitutions.

In short, evaluation of the cost-effectiveness of the MHSP shows a net decrease in the costs to Medicare. Also, both the Atkinson study and the HCFA study found no evidence of over-utilization of extended health care services in the MHSP program. I am submitting the Atkinson study for review by the Subcommittee because there is such a significant difference between HCFA's estimates and that of the Atkinson study. It also discusses why Dr. Atkinson believes that HCFA's regression analysis is flawed.

CONCLUSION

Cincinnati, Baltimore, Milwaukee and San Jose request a four year extension of the MHSP waiver. Beneficiaries of this Medicare managed care program should not be cut off from the affordable health care services needed most, particularly if such services can be provided at a saving to the Medicare program. Likewise, urban communities cannot afford the increase in costs that would result if the medically indigent elderly population served under the MHSP were to revert to the use of emergency room and hospital outpatient care as their primary source for medical services. We also request that Congress continue to evaluate the effectiveness of HMOs as providers of alternative sources of primary medical care for all those who need it.

Thank you again for this opportunity to testify. I would be pleased to answer any questions you may have.

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[The report of Mr. Atkinson follows:]

April 24, 1997

Municipal Health Services Program: Update on savings to Medicare

Graham Atkinson, D.Phil.

1. Introduction

The Municipal Health Services Program (MHSP) has been evaluated at least twice to determine its impact on Medicare payments. The first evaluation[1] [2] found the MHSP to be highly effective in reducing costs to Medicare. The second evaluation[3], performed by Mathematica Policy Research, Inc. (MPRI) for HCFA, found that the MHSP resulted in additional Medicare expenditures, but only after application of a regression model which was biased against the MHSP because of the independent variables included in the model. Before the regression model was applied the MPRI report showed MHSP users to have lower Medicare payments than non-users. The purpose of this paper is to provide an updated estimate of savings resulting from the MHSP based on the MPRI analysis prior to the regression adjustment, using inflation factors in Medicare payments derived from HCFA data, and the most recent year's cost and utilization data available from the MHSP sites. A discussion is included in Appendix 1 to explain why the regression adjustments were inappropriate. It is worth mentioning that the first study also used regression adjustments to account for differences between the user and non-user populations.

2. Data and Data Sources

2.1 Data from the MPRI report

The MPRI report states at page 94 that MHSP users of physician services cost Medicare $4,665 in 1989, as compared with an average cost of $5,159 for non-users. The cost to Medicare for all MHSP services per MHSP user was $984 (Table II.1). It also states that new MHSP users of physician services in 1989 cost Medicare $4,184 in 1989, as compared with an average cost of $5,159 for non-users (Table III.14). The cost of MHSP services to these new users was $741. MHSP users who used the MHSP

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[1] Gretchen V. Fleming, Ph.D. and Ronald M. Andersen, Ph.D., The Municipal Health Services Program: Improving Access to Primary Care Without Increasing Expenditures, Medical Care, July 1986, Vol. 24, No. 7.

[2] Gretchen V. Fleming, Christopher S. Lyttle, Ronald M. Andersen, Timothy F. Champney and Tony Hausner, Impact of Municipal Health Services Medicare waiver program, Health Care Financing Review, Spring 1987, Volume 8, Number 3.

[3] Lyle Nelson, Cynthia Tudor, George Wright, Timothy Lake, Michael Haag, Marege Keyes, Norma Gavin, Final Detailed Report for the Evaluation of the Municipal Health Services Program Demonstrations, Mathematica Policy Research, Inc., August 25, 1993.

only for ancillary services (and started using the MHSP in 1989) had mean total Medicare expenditures of $3,685 in comparison with a non-user average of $4,029 (Table III.15 of the MPRI report). The average cost of MHSP services to these users of ancillary services only was $564. The lower Medicare payments on behalf of MHSP users resulted from much lower use of Medicare Part A services by the MHSP users, as would be expected, and as was found in the prior study.

In each of these three categories the MHSP users had substantially lower Medicare costs than the corresponding non-user group.

2.2 Trend data from HCFA

Medicare payments per enrollee rose by 35.2% from 1989 to 1994. From 1994 to 1996 they are estimated to have risen by 17%. This is based on total payments having increased by 21%, and enrollment growth of 4%[4]. Thus, the combined increase from 1989 to 1996 is estimated to be 58%.

2.3 Fiscal year 1996 data from the MHSP providers

Medicare payments to the MHSP providers in fiscal year 1996 and the number of Medicare users in 1996 are presented in the following table:

Fiscal year 1996	Medicare payments	Medicare users
Baltimore	$36,017,319	26,801
Cincinnati	$1,537,888	1,849
Milwaukee	$5,412,298[5] $8,486,000[6]	4,291(estimated[7]) 6,729(estimated)
San Jose	$8,765,081	6,439
Total	$51,732,586 $54,806,288	39,380 41,818

[4] Health Care Financing Review, Fall 1996, Volume 18, No. 1.

[5] This figure is payment to date. The final figure is expected to be at least 33% higher.

[6] This estimate was derived by inflating the 1995 payments by 7.1%, the average annual increase over the prior two years.

[7] Data on number of unduplicated users was not available from Milwaukee, so the number was estimated. The Medicare cost per user in 1989 of $830.10, from the MPRI study, was inflated by the increase in cost per user between 1989 and 1996 in the other sites (1320.08/868.91 = 1.5192) to arrive at $1,261.12 as the estimated payment per user in Milwaukee in 1996. This result was divided into the total Medicare payments to Milwaukee in 1996 of $6,908,499 to estimate the number of users in 1996.

3. Analysis

3.1 Projection of savings

The following table shows the savings in Medicare payments for each dollar spent on MHSP services, from the MPRI report.

	All MHSP users	New users of physician services	New users of ancillary services
Medicare costs for users (including MHSP costs)	$4,665	$4,184	$3,685
Medicare costs for non-users	$5,159	$5,159	$4,029
Savings per user	$494	$975	$344
MHSP cost per user	$984	$741	$564
Savings per MHSP $	$0.50	$1.32	$0.61

In all three categories of MHSP user the MPRI data shows that, before regression adjustments, the Medicare costs of the users were less than those of non-users. For all MHSP users that savings amounted to 50% of the amount Medicare paid to the MHSP providers. Based on this ratio, and given that the Medicare payments to the MHSP providers in 1996 were $54,806,000, the projected savings to Medicare in fiscal year 1996 as a result of the program were $27,403,000. That is, as a result of the MHSP Medicare saved $82,209,000(=$54,806,000 + $27,403,000) in payments for non-MHSP services. Medicare payments for MHSP services were $54,806,000, so there was a net savings of $27,403,000.

3.2 Alternative projection of savings

An alternative method of projecting the savings resulting from the MHSP program is to take the 1989 Medicare cost per user and non-user from the MPRI report and to project the Medicare payments to 1996 using the national percentage changes reported above in section 2.3.

Projected Medicare cost per MHSP user: $4,665 x 1.58 = $7,371
Projected Medicare cost per non-user: $5,159 x 1.58 = $8,151
Savings per user: $780
Number of MHSP Medicare users: 41,818
Total estimated Medicare costs for users including MHSP payments: $308,240,500
Total estimated Medicare costs for users in the absence of the MHSP: $340,858,500

Total savings to Medicare as a result of MHSP: $32,618,000

This $32,618,000 is a one year savings. A four year extension of the program would be expected to result in a savings of four times this amount, i.e., in excess of $120,000,000 in current year dollars.

3.3 Comparison of actual and projected Medicare payments for 1993

MPRI projected Medicare payments to each of the MHSP sites for fiscal year 1993. For Baltimore the projection was $30.3 million, while the actual payments were $29,650,000. For Cincinnati the projection was $1.6 million, with an actual of $1,122,753. For Milwaukee the projection was $4.1 million, with an actual of $6,908,499, and for San Jose the projection was $10 million with an actual of $8,421,674. The total projection was $46.1 million, with a total actual of $46.1 million, so the projections were quite accurate in total, although they were not very precise for the individual programs. These results, together with the actual Medicare payments and users in subsequent years, are presented in the following table:

	1993-MPR	1993 actual	1994 actual	1995 actual	1996 actual
Baltimore	$30,300,000	$29,650,000	$30,152,066	$32,371,081	$36,017,319
Cincinnati	$1,600,000	$1,122,753	$1,245,021	$1,296,742	$1,537,888
Milwaukee	$4,100,000	$6,908,499	$7,277,778	$7,923,485	$5,412,298[8] $8,486,000[9]
San Jose	$10,000,000	$8,421,674	$8,431,265	$8,134,455	$8,765,081
Total	$46,100,000	$46,102,926	$47,106,130	$49,725,763	$51,732,586 $54,806,288

4. HCFA scoring of budget impact of MHSP continuation

HCFA has estimated MHSP costs for federal fiscal year 1997 at $79 million. The total Medicare payments to the MHSP sites in 1996 were only about $55 million. Between 1993 and 1996 the Medicare payments to the MHSP rose by 12.2%, or 3.9% per annum. Thus, the $79 million HCFA estimate is a gross overestimate and Medicare MHSP payments in 1997 will actually be well under $60 million.

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[8] The 1996 payments to Milwaukee are payment to date and the final figures are expected to be about 25% higher.

[9] This is an estimate calculated by inflating the 1995 payments by 7.1%, which was the average increase in payments over the prior two years.

The replacement benefits of $37 million for 1997 would appear to be based on the MPRI estimate of 47 cents in reduced Medicare payments for each $1 spent on MHSP services. The problems with this approach have been discussed earlier in this paper.

5. Conclusions

The MHSP saved Medicare approximately $27.4 million in 1996. It can be expected to continue to save similar amounts in future years and the estimated savings to Medicare for 1998 is over $32 million. If the MHSP is extended for four years the savings to Medicare will exceed $128 million. The conclusion that there are savings from the program is consistent with the conclusions that were reached by the first evaluation of the MHSP, which were published in both the Health Care Financing Review and Medical Care, two respected, referred journals.

Appendix 1

Problems with the cost comparison model used by Mathematica

The MPRI report found that the users of MHSP services had lower Medicare costs than non-users before adjusting for differences between the nature of the population of users and the comparison population of non-users of the MHSP. They then adjusted for these differences using a regression model and found the opposite result. This analysis suffered from several problems: (i) it did not take account of the lower Medicaid expenditures that result from the MHSP program, which reduce both state and federal outlays on behalf of the participants, (ii) it did not adjust for the reduced out-of-pocket expenditures the beneficiaries incur, and (iii) the adjustment involved the use of a regression model which was biased against the MHSP.

One of the independent variables in the regression model is whether the patient is jointly eligible for Medicare and Medicaid, and it is noted in the report that a much lower percentage of the MHSP users are jointly eligible than the non-users. This is a strange result given the locations of all the programs. One possible explanation is that the Medicare MHSP users do not have a need to enroll in Medicaid because of the waiver of the co-payments and deductibles under Medicare, and the additional service coverage, particularly drugs, provided by the MHSP. These are the major costs which would be paid by the Medicaid program for jointly eligible beneficiaries in the absence of the MHSP. This variable is thus suspect. Another suspect variable is the need for health care described on page 104 of the report. This used as one of its components "hospitalization two or more times during 1987-88." Since the draft report shows, as did the previous evaluation, that the MHSP users have a much lower hospitalization rate than the non-users, the use of this variable automatically biases the regression against the MHSP demonstration. In fact, the report states "prior use of MHSP primary and preventive care services may have improved beneficiaries' health status, thus reducing their need for care." (page 104)

The quality review concludes "We found no evidence of overutilization of services by MHSP patients." (page 155). This suggests that, if additional care is being provided to the MHSP users beyond what would have been provided in the absence of the MHSP, then that care is appropriate. In fact, the report criticizes the MHSP providers for underprovision of services, e.g., "These findings suggest ... underutilization of needed lab studies among some beneficiaries." (page 139).

The comment is made on page 181 "If the MHSP demonstration is ended, virtually all of the MHSP clinics would qualify for participation in the FQHC Programs." And "Health centers participating in this program are reimbursed on a reasonable cost basis for services provided to Medicare and Medicaid beneficiaries." Thus in the absence of the MHSP demonstration most of the centers would continue to be paid on the same basis as they are currently being paid, and a significant portion of the co-payments and deductibles, drugs costs, etc. which are currently being covered by Medicare under the demonstration would become Medicaid costs. It is difficult to

see how this would result in significant savings to the federal government, particularly given the acknowledgment that no overutilization of services by MHSP users was detected, and alleged underutilization was detected.

The conclusion that the MHSP is costing Medicare money is based on a presumption that the MHSP users would have used significantly fewer resources in the absence of the MHSP demonstration than would the comparison group. This does not seem intuitively reasonable. If the Medicare HMOs were to be evaluated using the same criteria as have been used here for the MHSP, it is quite likely that a similar effect would be found. Medicare HMOs are currently being paid 95% of the AAPCC (Average Annual Per Capita Cost), while the MHSP users of physician services are currently costing Medicare only 90% of the average cost of the comparison sample, which was selected to be similar in demographic characteristics. The MHSP demonstration would thus appear to be a bargain compared with the Medicare HMOs.

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Chairman THOMAS. Thank you, Doctor. Yes, we will have some.

Ms. Baskins, one of the differences between H.R. 1464 as we have introduced it and the administration's proposal is that the administration includes additional payments from the Federal Government for operational losses in the startup years. We do not include that in our legislation because I am trying to figure out how that would work as an incentive, given the structure of the program, and if you do not have it coming to the program, how additional payments for losses would produce it in the startup years. So, it just made no sense to me.

As someone who is involved in the program, do you have any comment on whether or not it was appropriate that we left the startup loss coverage out of the bill?

Ms. BASKINS. In the initial demonstration, the risk mechanisms were important to us because we really were not sure what we were doing. We had small numbers changing effectively how a provider provides care under this system. It was a learning curve for us, and that risk reserve did give us some protection from that.

Now that sites have started up PACE Programs in a different way, they begin now as capitated for the Medicaid component only and then move into bringing the Medicare dollars down, those sites have been much stronger. Their learning curve has been on the Medicaid side, preparing and building the infrastructure necessary to manage the burden and responsibility for Medicare and I think the need for risk reserve has been less under that developmental phase.

But I am not sure how the provider legislation creates the opportunity to move immediately into dual waivers and the risk reserve may be needed as sites begin in their infancy to put all these pieces together.

Chairman THOMAS. It is hard for me to talk about the willingness to move toward a permanent program. If you still need all of the nurturing startup protections, then you probably are not mature enough to move into an ongoing program. Obviously, we can sit down and think it through, but, as I say, it seems to me some-

what incongruous or inconsistent to do both of those. If it is a demonstration program and it is not ready for prime time, then I understand that.

I just have a difficult time, and I will just say this as an aside, Dr. Adcock, and I will get to you with questions, that if you have had a demonstration since 1979, at some point you have to say, this thing either works or it does not. The longer you need a structure for a number of reasons, you begin to wonder whether you just let them sink or swim. We had testimony earlier about the sink or swim and that is going to be one of my broad questions to all of you in a minute.

The other thing that I am trying to resist, given the differences notwithstanding similar populations we are serving, but the differences between States, since you have to deal with match-ups, willingness of States to go forward, how much sense does it make if these folks are ready for prime time that we just let them go through the State regulatory approval process rather than creating a separate structure at the Federal level?

Ms. BASKINS. I think the ability to bring the Medicare dollars down is critical and that is going to require Congressional legislation. Being able to merge those two funding sources in one that is very flexible is key.

Chairman THOMAS. But if you create the structure that makes it work in terms of the licensure aspect of a program, do we also need to deal with that at the Federal level or can we deal with it at the States?

Ms. BASKINS. I think licensure can be dealt with at the State level, yes.

Chairman THOMAS. Mr. Feldman, I guess this is for everybody, but you focused on it. First of all, the first panel indicated that perhaps for Social HMOs—they may have been more academic, you have to deal with the bottom line maybe a little bit more—that instead of the 100 percent reimbursement, if we are moving TEFRA risk down from the 95 to 90 or some similar reduction, how uncomfortable would you be for the Social HMOs to follow a similar parallel reduction pattern?

Mr. FELDMAN. In speaking for the Social HMOs, I think that the issue of moving to 95 percent of the AAPCC is not as much an issue as the significant variations that take place in the AAPCC at the various locations.

Chairman THOMAS. Sure.

Mr. FELDMAN. But we have discussed it and we feel comfortable that within a certain process, I think that the AAPCC could be reduced to 95 percent and the efficiencies that we have learned over the years can be applied to produce what we need to do.

Chairman THOMAS. Yes. Obviously, the differential in the counties through the AAPCC does not make a lot of sense to us. We have examined it. We have talked about ways in which we can change it. Many of them simply make it worse. So, it is one of those situations where it is a lousy structure but we do not have a better one right now. Obviously, if we could get a risk assessment model and begin plugging those kinds of components in, as was indicated in terms of a desire for a data based system, and Mr. Bringewatt talked about that and I am very interested in comput-

erized patient profiles and others that can get us some good statistical data as we move forward, but that is for the future.

If you are willing to accept what is in essence now a TEFRA risk payment, what else do you folks need other than for us to say, forget the demonstration category. If you have to put the package together and you do it differently than someone else, why should we care?

Mr. FELDMAN. I think the issue is the nursing home certifiable component of the population, which is the unique component. We have 15 percent of our subscribers who are enrolled, nursing home certifiable that would normally have qualified to be in the nursing home and we care for them in the community.

We receive an additional adjustor for that population that is unique and we think that a 95 percent TEFRA with an adjustor for that particular group would probably work adequately at most of the sites. But the 95 percent of the AAPCC will not cover the service component for the long-term care and community-based benefits that are currently being provided purely through the 95 percent of the AAPCC.

Chairman THOMAS. Even with the obvious individual adjustor——

Mr. FELDMAN. With the current adjustors but without the nursing home certifiable.

Chairman THOMAS. Is this more New York specific as a problem or is it pretty general?

Mr. FELDMAN. I think it is general as a problem and I think that most projects, including the PACE projects, they have adjustors that are specific to certain types of populations that would not normally be included under a general capitation arrangement.

Chairman THOMAS. My concern is that I think we need fewer demonstrations that stretch out over decades and more fish or cut bait in terms of programs so that we can simply go out and see what happens.

Mr. Bringewatt, would you agree basically with that in terms of the 95 percent, coming down from 100? I know your testimony focused on that——

Mr. BRINGEWATT. Yes.

Chairman THOMAS [continuing]. And I know you want a complete legislative package which covers everything. It is an interesting experiment, but given the realities, if we reduce the money and structure it in a way that provided for that mix, I assume everybody here would love to move out of the demonstration category and into the sink or swim.

Dr. Adcock, I do not understand why since 1979 we do not know how many users there are in Milwaukee. There may be a very good reason for why they could not determine it, but it kind of amazes me.

Mr. ADCOCK. I am not sure of the answer to that and I do not believe anyone is here from Milwaukee today that can speak to that.

Chairman THOMAS. Well, they may be, based upon the way they count.

Mr. ADCOCK. But I do not have the answer to that question.

Chairman THOMAS. OK. Why does the only minimally successful area, again, since 1979, appear to be Baltimore? They have 26,000 folk, Cincinnati 1,800, Milwaukee 4,000 to 6,000, San Jose 6,000, according to the structure in your testimony.

Mr. ADCOCK. The sizes of the program were really dictated at the outset by virtue of how we started. The growth was really constrained by HCFA's requirements that we not expand beyond the fixed sites involved. We had strict constraints on advertising and so on. So it was a fairly controlled program at sites involved with the program.

Chairman THOMAS. If HMOs had a cost-based reimbursement for non-Medicare-covered health care services, do you think they would move into the area and serve the population?

Mr. ADCOCK. I think that is a possibility, although, a risk-based adjustment and capitation could also provide incentive. It is ironic. We feel that we have one of the longest cost histories going for doing just that in our sites, and so we would certainly invite HCFA to use our cost-based information to do that. We have successful programs. We feel that that information could be used to provide incentives.

Chairman THOMAS. Notwithstanding that, we have some studies that say it saves money and then we have a study that says it costs money. That concerns me in terms of reconciling methodology, because when you have that big of swing, something is going on that does not give us an immediate ability to understand the dynamics of this demonstration program.

Mr. ADCOCK. I understand, but the study that was done for HCFA essentially concluded that our programs were actually saving money and keeping people out of the hospital. They then did an adjustment on the study outcome assuming sicker populations, thereby causing it to appear that our cost was increasing. We never did agree with that and we never understood it.

Chairman THOMAS. The gentlewoman from Connecticut?

Mrs. JOHNSON. Thanks. I would like to pursue this point a little further. Why do you think HCFA would study your program and say it cuts costs and then what did they do to the study to change the outcome?

Mr. ADCOCK. They did a study in 1993, at least that is when it was released, to look at the overall cost of the program. Basically, what they found was that through our program, there was less hospital-based care and less specialty-based care. Therefore, the patients under our program were effectively costing less than nonusers of a comparable control group.

They then also concluded that the patients in our program were less sick than nonusers, and, in fact, they even made a statement that that might have been attributable to the managed care approach that we took. But the bottom line was they adjusted the illness severity for our group with another group and then concluded that, presumably, if our group was as sick as the other group, it might cost more. In fact, the group that we had under our care was not as ill and we believe it was because of the managed care approach.

After all, if we do not believe that managed care saves money, I think we are all going in the wrong direction here.

Mrs. JOHNSON. That really is quite interesting. Is there any more objective way of looking at the base population, a sense, before care?

Mr. ADCOCK. You could certainly probably do it on a prospective basis, and, in fact, I guess that to a certain extent, the first study that was done on the program attempted to do some of that and also concluded that the program saved dollars. So we believe that there is a fairly sound basis in making that statement.

Clearly, I think it will depend on the risk of the population that you are dealing with to begin with.

Mrs. JOHNSON. Dr. Adcock, why will not plans contract with you? How many managed care plans do you have competing in Cincinnati, because it seems to me that if you save money, managed care plans are going to want to contract with you because they need to have a certain volume of patients to be successful.

Mr. ADCOCK. That is one of the things that we are trying to get through to them now. In fact, we are discussing with them and attempting to contract with them for service to transition this program. The minute a person joins an HMO, they are no longer eligible for this program.

We believe that the HMOs that operate in Cincinnati, and I believe there are two at this point, do not understand. They believe that the inner-city poor represent a higher risk population and they do not understand what we have done to control that risk. They simply do not understand that.

I guess there is no reason for them to understand it, given the fact that inner-city poor do have a higher incidence of chronic disease and other illnesses.

Mrs. JOHNSON. These are HMO risk contractors?

Mr. ADCOCK. Yes.

Mrs. JOHNSON. If you have any suggestions as to how we can assure that HMO contractors under Medicare do not cherry pick, we would certainly be interested in that, because, frankly, if they are serving that region and they are not contracting with you, then they are not covering many people in that part of town.

Mr. ADCOCK. Right.

Mrs. JOHNSON. Maybe we want to look at HMO risk contractors to see what number of Medicare and Medicaid individuals they serve as just an indicator of possible skimming. I would be interested in your thoughts on that.

Mr. ADCOCK. That would certainly be one way. The other way would certainly be to work through the historical data, at least in our case, with them through HCFA to make sure that they understand what the risk is with our populations because I really do not think they understand it.

Of course, the other issue is if they perceive that the capitation is not going to cover their risk, then, clearly, they are not going to be amenable to moving into that market.

Mrs. JOHNSON. I think there is some urgency in trying to do what the Chairman wants to do, that is, move what you all are doing into, in a sense, the mainstream HMO contracting structure, because last year, we did pass premium deductibility for long-term care insurance, and as that takes hold, employer deductibility, as that takes hold, say in 10 or 15 or 20 years, you are going to have

people who are frail elderly and who are low income but who have long-term care insurance. So you are going to need a more flexible system that can target those populations in the cities and recognize their low-income status but also a variety of payor options.

Mr. ADCOCK. We absolutely agree and we are fully prepared as individual cities to move forward and transition toward that. Like I say, we are attempting to contract with the HMOs in Cincinnati. In fact, we sat down with them again this past week. I think we are beginning to make some inroads, but it is a tough sell at this point because they just do not seem to understand the situation with our MHSP Program.

Mrs. JOHNSON. But you also are sitting down with HCFA?

Mr. ADCOCK. We are attempting to, yes. Yes.

Mrs. JOHNSON. Thank you. Any other comment? My time is expired, actually. The red light is on.

Chairman THOMAS. That is right. Let me see if the gentleman from Louisiana——

Mrs. JOHNSON. While we are waiting for him, perhaps you could answer this question that I posed to the preceding panel. You have talked about a lot of barriers, and I know there are a lot of barriers, and what are the one or two we should focus on this session?

Ms. BASKINS. To reiterate, the 50–50 rule, I think, is an important one that needs to be resolved and addressed.

Mrs. JOHNSON. Would you all agree that the 50–50 rule is really the biggest problem?

Mr. BRINGEWATT. I would agree. I would also like to underline the importance of while we do some of these very important things in the short term, that we lay the groundwork for doing some things differently as we evolve over the next few years.

For example, moving away from the structure oversight relative to each piece of the system, whether it is the hospital, the nursing home, the home health agency—a micromanagement approach toward the process of simplifying how we approach regulation, moving more toward an outcome-based approach to monitoring and toward structures that finance care in relation to problems of people rather than simply costs associated with care provided in a specific setting.

Mrs. JOHNSON. Thank you.

Chairman THOMAS. Mr. Bringewatt, this may be hard for you to deal with mentally, but I want you to try it. If the Federal Government were a business and we were test marketing a product and we have done this now for 12 years on Social HMOs, first of all, the decision is, should we now go to market with product.

What should be done in terms of the process, the timing, and the decisionmaking to get a climate for these innovative products or at least get them out on the shelf without continuing to incubate them in demonstration projects? What is the downside risk for the taxpayers if we maximize the innovative process, coordinating with States as I believe Dr. Meiners said in terms of the laboratories of the States.

Yes, we will have some failed programs, but my problem is that given the mental set, and maybe I am more trusting than some others may be, but when we go back to the 50–50 rule, it is into the early seventies. I mean, you are dealing not only with a dif-

ferent mindset in the ordinary TEFRA risk but, frankly, when you spend any time at all with people who are involved in Social HMOs and with the PACE Program, these are not folk out there for a fast buck. They are desperate for an ability to put together programs that are more seamless and actually meet real needs rather than bureaucratically dictated box checking.

So what would be the downside if we just said, no more demonstrations. Go out there. Explain to us how we could facilitate the coordination of Federal Medicare dollars and Federal Medicare incentivizing the States for the State Medicaid portion, and most importantly, what do you think we need to do to get the private sector more participating in providing initial support, wrap-around, phase-in, any other kind of structures that are necessary? Obviously, this is available to anybody else.

Mr. BRINGEWATT. There are a number of pieces that I want to try to fold in here. One is, as a next step, I think it is critical that we do exactly what you are suggesting being done in terms of the demonstrations that we have already—that is, in fact, moving them forward into the mainstream as they are proposed. But——

Chairman THOMAS. But the thing that bothers me about HCFA is that we do not ever create a methodology which is a basic screening process that if met, you get the demonstration up and running. You create structure-specific demonstrations which, I think, have very limited value and, frankly, apparently are designed to maintain an umbilical cord structure. Witness this 20-year structure on a demonstration. So I have a very difficult time with the fundamental conceptual and methodological approach of HCFA on what they call demonstration projects but which I do not think would ever grow to a realistic use model. That is my problem.

Mr. BRINGEWATT. We at the Consortium would fully agree with that, and to put in place 3-year structures of demonstrations that have 2- or 3-year time lags for evaluation and then the time is already past and in the marketplace, changes occur increasingly in shorter cycles rather than longer cycles.

So our recommendation is that HCFA look toward making opportunities for providers who demonstrate certain capabilities to move forward with a 3-year transition period, where they would define their structure as it relates to serving a certain group of targeted organizations, and where the Federal Government's role would be in relation to defining a limited amount of expenditures that would be paid in relation to care that is either equal to or less than what is available under other arrangements and to monitor quality in order to ensure people do not get hurt.

Chairman THOMAS. If it is not costing any more money relatively, then your only other concern should be quality.

Mr. BRINGEWATT. Exactly.

Chairman THOMAS. And my problem is, we have no tool to measure quality except we want to make sure that it is not worse than what they are getting otherwise and I just think it is a priori not going to be worse with a good chance of being better. But at the same time, we are not moving toward a computer-based patient record so that we could begin to, at least on a comparative basis, measure quality. Instead, they place quality structures which are

hampering devices inside the demonstration which do not allow you to give it a good demonstration.

So maybe we are just sharing frustration, and that used to be the case when we were in the minority. Now that we are in the majority, I am interested in getting rid of some of my frustrations and we are going to——

Mrs. JOHNSON. It turns out not to be easy.

Chairman THOMAS. It turns out not to be easy, but it also turns out not to be impossible.

I want to thank you all for your testimony. I want to underscore the fact that notwithstanding the fact that we moved now with a stand-alone PACE bill, my biggest problem is I do not think we need necessarily narrow enabling legislation in other areas. I just think we ought to mainstream as much as possible, and so I would like to have staff and others talk with you about what changes we need to make so we're sure you have the maximum chance for surviving in a mainstream area.

Dr. Adcock, my biggest problem with your structure is not that we do not want to meet the needs of those inner-city folk but that what we need to do is figure out a glide path so that structures are available for them, whether they need to be innovative or not, but to maintain under a demonstration for two decades a cost-plus reimbursement halfway house model does not make a lot of sense to me, especially if you are hamstrung with your ability to grow so that you can prove your model to be successful or not. I guess what I am saying is, we may pull life support but we are going to make sure that there are alternatives available.

Thank you very much. The Subcommittee stands adjourned.

[Whereupon, at 11:29 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Bruce D. Thevenot, Vice President, Government Relations, Genesis Health Ventures, Inc., Kennett Square, Pennsylvania

Genesis Health Ventures, Inc. (Genesis) appreciates the opportunity to submit this written statement to the House Committee on Ways and Means, Subcommittee on Health on the important topic of coordinated care systems for the elderly.

Genesis was founded in 1985 and is committed to redefining care for the elderly, utilizing a comprehensive, coordinated approach to help older people plan and live a full life. Genesis provides a broad constellation of health and social services through eldercare networks established in five regional markets in the eastern United States and currently serves more than 75,000 customers and their families.

The rapid growth of the elderly population coupled with their complex and costly health needs compel policy makers and providers to examine better methods to care for the elderly in ways that retain their maximum independence and functioning in a cost effective manner. The present fragmentation and duplication of funding sources and provider structures impede the realization of better health outcomes at lower costs, and make the needs and preferences of consumers subservient to program design and regulatory imperatives. The PACE model is one example of an approach that successfully overcomes many of these problems.

Though its full replication has been limited to approximately 12 sites throughout the nation, PACE has been successful in reducing utilization of hospital and nursing center services, enabling some individuals who would have otherwise been institutionalized to remain in the community. Enrollment in PACE has also been associated with improved health status and quality of life (Abt Associates, November 1996). As such, Genesis applauds the introduction on April 28, 1997 of H.R. 1464, a bill that would take PACE from the status of a demonstration program to permanent provider status under both Medicare and Medicaid. We commend Reps. Thomas, Stark, Cardin and Bilirakis for their leadership in offering this legislation.

The expansion of the PACE financing and delivery model is an important step toward what we hope will be a broad scale initiative to make coordinated care systems for the elderly and disabled the rule rather than the exception as far as our nation's elder care policy is concerned. The lessons learned from PACE are vital to laying the foundation for a much more expanded coordinated care strategy for dually eligible beneficiaries, who represent a disproportionate share of Medicare and Medicaid expenditures, yet are particularly ill served by traditional care arrangements. Integration of funding and the use of coordinated care models are also of benefit to other older persons and can aid in forestalling their impoverishment from expensive hospital and long term nursing home stays. Although PACE is not the only answer to meeting the needs of frail elders, it is one of the only operational programs that integrates the entire spectrum of acute, ambulatory and long term care services.

As Congress considers this advancement, Genesis is pleased to offer some important issues for the Subcommittee's consideration:

Provider Eligibility for PACE Projects. Currently, provider eligibility is limited to public or private, non-profit community based organizations. We believe that all providers, regardless of tax status, who meet applicable standards of participation must have the ability to become a PACE provider. Qualified investor owned organizations not only bring the capacity to provide comprehensive health and social services to the elderly, but also provide access to sufficient capital to fund expansions of PACE provider sites. To this end, we are appreciative of the National PACE Association's support for the inclusion of for-profit organizations among future PACE providers.

PACE demonstration sites are currently established through waivers of certain requirements of the Social Security Act, as approved by the Secretary of Health and Human Services, and for a period of up to three years all sites must meet the established operating requirements , except that financial risk is shared between the provider and the federal/state governments during this period.

To streamline the process of moving from demonstration to regular provider status, Genesis supports the notion that **any** new qualified PACE site (regardless of tax status) be certified as a provider status type, following a three year trial period, by meeting and maintaining compliance with "conditions of participation" adopted by the Secretary through rulemaking. While Genesis welcomes the support of the National PACE Association's position for the ultimate inclusion of for-profit organizations among future PACE-type providers, we believe that all **new** entrants into the PACE program ought to be required to demonstrate their ability to effectively serve the frail elderly in terms of quality of care and cost-effectiveness in exactly the same ways. We do not believe that a separate demonstration process for taxable entities, as H.R.1464 proposes, is either necessary or justified.

Numerical Limits on PACE sites. H.R. 1464 proposes to limit the number of new PACE programs on an initial and annual basis. Some might consider it prudent to expand the number of PACE programs in a planned, thoughtful fashion by setting an annual upper limit on new sites developed in the first few years when all such sites would be in a trial period. We would suggest, however, that the Secretary of HHS be given authority, (perhaps after four years), to consider any number of new applications for PACE provider status, subject to specific established "credentialing" criteria , based on the response of the marketplace and of consumers to the PACE program.

Payment for PACE Program Services. Payment for PACE program services provided for eligible individuals are based on a current frailty adjustment of 2.39 X 95% of the AAPCC. While reductions in the rate may be contemplated (i.e. 90% of the AAPCC), it is essential to retain a frailty adjustment factor. It would also be prudent to consider the financial evaluation yet to be completed by Abt Associates, and expected to be released by early 1998, to understand the full impact of the current payment structure before modifications are contemplated. We concur that only programs found to be lower in costs than what would otherwise have been paid by Medicare and Medicaid should be acknowledged as viable, cost-effective sites.

Additional/Non-covered Services. Participating organizations should be permitted to offer additional services to qualified participants beyond those services encompassed by capitation payments or other program payments, and should have the option of entering into agreements with non-Medicaid customers for payments of such additional services. This agreement would not constitute a condition of eligibility for initial enrollment or continued participation in the program.

Financial Risk Assumption. Presently, organizations that sponsor PACE sites assume a gradually increasing share of the financial risk during the initial three-year phase-in period until it is a full risk based operation. Phasing in risk reduces a sites' financial loss exposure, while maintaining strong incentives to control costs.

While there might be a continuing rationale for gradual assumption of risk as sites achieve operational efficiencies and experience in managing care before assuming full risk for services, there should be flexibility to enable qualified providers to accept capitation earlier (on a full risk basis), if they can demonstrate the necessary expertise and financial capacity to bear such risk. For example, PACE sites with a greater number of enrollees across which to spread risk may be more interested in assuming full risk immediately, while smaller sites may desire to phase in greater risk over time.

Participant Eligibility. The original design of the PACE program focuses participant eligibility to frail, elderly individuals who are at risk for admission to nursing homes. All participants must be certified by the state as needing nursing center level of care. We believe that the merits of the PACE model -- integrated funding managed through proactive care coordination -- can be beneficial to a broader segment of the elderly population and achieve corresponding cost savings. New legislation should, therefore, grant the Secretary authority in the future to broaden the definition of elderly eligible for the program to include "moderate risk/near frail" persons who, though not at imminent risk of institutionalization, are determined to have risk factors that could be mitigated by

appropriate, proactive care coordination. Clearly, adjustments to traditional PACE capitation rates would need to occur to account for changes in the participant risk profile under any significant eligibility expansion.

Staff Model HMO. PACE subscribes to a staff model HMO structure, in which enrollees need to change their physician to the PACE provider in order to participate in the program. We support the provision contained in H.R. 1464 that would allow for experimentation with an IPA model of physician delivery to potentially help address participant enrollment issues.

Rural Replications. Each PACE replication is based on an adult day health care model that is integrated with primary care. Participants attend an adult day health center, with transportation provided as needed, for supportive, rehabilitative and social programs. This has made replications in rural areas difficult to succeed, due to excessive transportation costs and lack of a sufficient population base attracted to center services. We support the provision in H.R. 1464 that would allow for reasonable flexibility in adapting the PACE service delivery model in rural areas (i.e. further exploration in making adult day health care attendance voluntary), particularly if rural replications are to hold any promise.

The Chairman and members of the Subcommittee are to be congratulated for their commitment to streamline and expand the PACE program, and to encourage the further development of coordinated care systems. Our company has been built around the notion that the elderly should be served by a health care system that respects their dignity as individuals, and exists to help them live a full life as they define it. Genesis looks forward to sharing our eldercare expertise as we work together to make that dream a reality.

The Committee on Ways and Means, the Subcommittee on Health Hearing on Coordinated Care Options for Seniors April 29, 1997

Mr. Chairman and Members of the Committee, the National Kidney Foundation and its state affiliates appreciate this opportunity to discuss the proposal to include "dual eligibles" in a separate but fully-integrated delivery system. The Foundation's special concern is for the "end-stage renal disease" (ESRD) "dual eligibles." Our fear is that, during this debate, these unique "dual eligibles" will be either totally overlooked or generally grouped with the larger block of "dual eligibles," without consideration of their particular status and needs.

Mr. Chairman, we are not opposed to a PACE-like model for the management and coordination of care of high risk, high cost beneficiaries, such as ESRD patients, so long as the model is properly designed and implemented. For at-risk pre-ESRD and ESRD patients, a single coordinator of care (a specialist in nephrology) who will manage all medical care for these patients, under one system with multiple capitated payors, could be both good for the patient and cost effective. However, the model must be carefully designed, funded and tested, a process which will require time and thoughtful planning by both the federal and state governments.

Kidney disease patients are a separate, recognized population of "dual eligibles," based on their unique ESRD Medicare eligibility. ESRD is defined as "that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life." Because of the complexity and shortcomings of Medicare's coverage and reimbursement system, Medicaid often becomes an integral part of the care scheme for ESRD patients. For those eligible for Medicare ESRD coverage, Medicaid will often provide for outpatient medications and access to support services, such as transportation, which are necessary for the patient to receive life sustaining treatment. Medicaid may reimburse for such services whether these patients were initially Medicaid eligible or are "medically needy" or "spend downs." ESRD eligibles are often also Qualified Medicare Beneficiaries (QMBs) or Specified Low-Income Medicare Beneficiaries (SLIMBs). For these latter two classes of beneficiaries, the state Medicaid program must pay some or all of the cost sharing requirements of the Medicare program.

Medicare coverage for dialysis begins three months after the onset of ESRD. This delay necessitates continued Medicaid coverage for that period, for those who were Medicaid eligible. After Medicare coverage starts, these patients may continue to receive Medicaid benefits.

Medicare also covers kidney transplantation. For many patients with ESRD, transplantation offers the best opportunity for long term survival. Their survival rates are constantly improving because of pharmacological innovations, including the antirejection medications, and because of a better understanding of disease management techniques and outcomes.

Over the course of care, a successful transplant, including the costs of the expensive antirejection medications taken indefinitely, is less

expensive for the payor (Medicare or Medicaid) than a lifetime of dialysis, occurring three times a week. However, in the first year of transplantation, the costs of care of a transplantation patient can be twice as expensive as maintenance dialysis and attendant services. Due to these "front-end" costs of transplantation, it takes three to four years for the economic advantage to accrue in relation to the cost of lifetime dialysis. This savings over time must be considered in designing any program for kidney disease patients.

Medicare eligibility of transplant patients expires three years post transplant. Thereafter, many of these individuals become entirely reliant on Medicaid for all health services, but particularly for the life sustaining antirejection medications. While these drugs are expensive, the patient will have to be put on dialysis if the transplant fails because the drugs are not covered. The annual cost of antirejection medications is only a fraction of the reimbursement rate for three visits a week to a dialysis clinic.

In the United States today, there are 250,000 Medicare ESRD beneficiaries, and it is estimated that there will be close to 300,000 by the year 2000; between 40% - 45% of these are "dual eligibles." A number of Medicaid-only kidney patients must also be considered as you develop your model.

The Foundation and its affiliates have become increasingly concerned about this population as the states implement their mandatory Medicaid managed care programs. We are monitoring the states' efforts to include the "dual eligibles" and have raised our concerns with several of the state departments. Most of the states that have started their implementation have delayed the inclusion of the "dual eligibles," recognizing the complexity and danger of including them without proper planning and costing. However, some of the states are proceeding with immediate inclusion of the "dual eligibles" without a provision for coordinating either the delivery of care or payments from multiple payors. In addition, these states have not provided for risk adjustment for the expenses of these high cost patients, which will likely result in a reduction of either access or quality of care. For ESRD patients, the need to coordinate this care, particularly in the managed care environment, is crucial. In addition, most states have not made provision for the Medicaid-only kidney patients who have been mandated into Medicaid managed care programs.

These failures become even more devastating and potentially life threatening as the Medicaid system and, to some extent, the Medicare program move to a full-risk contract system for the delivery of health care. The problems faced by the states can be instructive as you consider whether, or how, to manage the "dual eligibles" and under which model. To insure care for the "dual eligibles," whether under the contract basis of the state Medicaid mandatory managed care waivers or, as suggested here, under a PACE-like model for specific populations, the design must include specific contract clause requirements and methods for coordination of payments.

The design must insure that the contracts are clearly written and specific with respect to the benefits and services to be provided under the contract and which will be subject to the capitation. The contract

must be absolutely clear regarding which party has the duty to provide the care, and whether any residual duty or liability is retained by the state or federal government. Each treatment or element of care must be defined as to scope, duration and frequency. There must be a clearly stated duty on the risk-taker that the treatment program use severity adjusted, clinically based best practices. These provisions are needed both to guarantee access and quality care on a continuous basis. Anything less will leave these already vulnerable populations even more vulnerable.

The design, regardless of the model selected, must also insure an adequate capitation for those taking the risk of providing the level of care needed for ESRD patients. The capitation must therefore relate the cost of care to severity adjusted outcomes. If the model allows beneficiary choice, that may result in a skewed enrollment, or permits mixed beneficiary pools, then the contract must include risk adjustment so that access and quality care are not lost for these high cost patients.

These are only some of the design questions that must be considered, and answered, before these populations are simply dumped into managed care. Most of the states have been cautious for good reason -- these are very difficult and expensive populations to manage. The result of an administrative misstep now may have life and death consequences for real people.

Mr. Chairman, for all these reasons, the Foundation urges the committee to delay the states' inclusion of "dual eligibles," especially the ESRD "dual eligibles," until a planned coordination of care model can be developed that will insure both quality of care and cost savings. Delaying the inclusion of "dual eligibles" in managed care must apply to both Medicare and Medicaid risk options. This is a request for a stay of inclusion, not a total prohibition. We believe, that at least for the ESRD population, we can develop a model that will meet both the budgetary needs and the patient care needs.

We have already started this design process. The National Kidney Foundation together with the states, the federal government and private companies are compiling and researching the data needed to structure both a plan of care and the needed capitation to make the model a success. The National Kidney Foundation has established the Dialysis Outcome Quality Initiative (DOQI) to create performance standards. Several academic medical institutions are doing serious work to develop quality standards, to measure cost components on a severity adjusted outcomes basis and to establish best practice standards. There is currently an ESRD capitation demonstration project, funded by HCFA, to test an ESRD managed care model in four managed care organizations. These efforts will give us valuable information that we need to proceed. We must have the patience to do this right and not rush into a program that could virtually mean life or death for many people -- particularly those with kidney disease.

The National Kidney Foundation and its affiliates would like to work with you and the states as these efforts move forward. We thank you for this opportunity to present our views.

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