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SECURING MEDICAID'S FUTURE: SPOTLIGHT ON MANAGED CARE

ROUNDTABLE

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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SECURING MEDICAID'S FUTURE: SPOTLIGHT ON MANAGED CARE

WEDNESDAY, SEPTEMBER 13, 2006

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

A Committee Roundtable was convened, pursuant to notice, at 10:06 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Gordon H. Smith (chairman of the committee) presiding.

Present: Senators Smith and Kohl.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, CHAIRMAN

The CHAIRMAN. Thank you all for coming to this, I think, very important discussion. Senator Kohl and I share a very similar position when it comes to Medicaid and understanding its centrality as part of our safety net to the poor, the disabled, the elderly, and those particularly with difficult cases of chronic disease. Yet, I think we both recognize that as it was structured in 1965, Medicaid is not sustainable. But notwithstanding that, we have got to preserve it.

Senator Kohl and I, I think, voted the same way on the budget reduction package because my belief was that there was a right way and a wrong way to pursue Medicaid reform. I wasn't persuaded that a budgetary number was the right way to do it if we are going to be sincere about protecting our most vulnerable Americans.

I know there are many different opinions about managed care, or managed anything, frankly. It tends to divide people along ideological lines, and yet I recognize there is a need for Medicaid reform. I am sure Senator Kohl will speak for himself, but I think everybody sees the awful arithmetic we are facing, and so we are looking for ideas.

I would very much like to produce a legislative package which represents Medicaid reform as it ought to be done, and managed care is being done successfully by some companies in my State and certainly I think the State of Arizona represents a fairly remarkable model. But I have got many questions and I think you all have ideas that can help shine a light on this subject in a way that we can take the best ideas as they are being developed around the country and put them into a legislative package to incentivize States to pursue this in a way that we can keep the promise of Medicaid and be fiscal stewards of this Nation in a way that is fair to our children.

So that is the purpose of this roundtable. Again, it is not a hearing in the traditional sense because I want this to be conversational. I want it to be just more open and I want everybody to feel comfortable and at home here because whatever your perspective is, I think we all share the common desire to preserve Medicaid and reform it in a way that is careful and thoughtful.

So each of you will have time to make a presentation and Senator Kohl and I will ask questions, maybe even interrupt you to make sure we fully understand the points you are making and glean from you the ideas that are going to be so necessary to what we inevitably have to do, which is Medicaid reform the right way, not just a budgetary way. So we value your time and we thank you very much for your presence here today.

With that, I will turn it over to Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Well, we thank you, Mr. Chairman, and along with you we welcome all of our distinguished participants here today.

There is no question that the current trends in Medicaid growth and spending are not sustainable for the Federal or the State governments. We all agree that we need to cut costs. The question, of course, is how to do that without endangering the most vulnerable people in our society.

We are pleased to have with us today a distinguished panel of experts as we explore Medicaid managed care for our high-cost populations such as dual-eligibles, the disabled and people with chronic conditions. We look forward to hearing your recommendations to improve the care they receive through better coordination of services, while at the same time looking for ways to reduce costs.

So we thank the Chairman and we thank all of you for being here, and I am sure this will be an enlightening roundtable experience.

The CHAIRMAN. Thank you, Senator Kohl, and you all may already know each other, but let me just read an introduction. The most formal part of this is just going to be to read who you are here.

Anthony, or Tony Rodgers, if I can call you Tony, is the director of the Arizona Medicaid program known as the Health Care Cost Containment System.

Ron Pollack is the executive director of Families USA. He is a well-known Medicaid advocate, and it is probably not well known that he is a friend of mine. Thank you, Ron, for being here.

Jeff Crowley is an expert on disability policy and senior research scholar at the Health Policy Institute at Georgetown University. Thank you, Jeff.

David Ford is the president and CEO of CareOregon, a Medicaid managed care company in Oregon, and a constituent.

Dan Hilferty is the president and CEO of AmeriHealth Mercy, a large multi-State Medicaid managed care company, and we thank you for being here as well.

Senator KOHL. We have with us Greg Nycz, who is here from Wisconsin. He is the director of Health Policy for Marshfield Clinic, and also the director of the Family Health Center of Marshfield, a

federally funded community health center in Wisconsin. Greg has been involved with the planning for and operation of the Family Health Center of Marshfield for over 33 years. He has extensive experience in Medicaid managed care, having had primary responsibility in the initial contracting for Medicaid managed care in north central Wisconsin. He continues to serve on many State advisory groups dealing with Medicaid managed care contracting.

Thank you for being here.

The CHAIRMAN. I didn't introduce you, Greg, because you are his constituent. I didn't want you to feel left out here.

So, Tony, why don't we start with you and let's see what we can learn from Arizona. We did have your Governor via teleconference recently and we appreciated her participation in our hearing.

STATEMENT OF ANTHONY RODGERS, DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, PHOENIX, AZ

Mr. RODGERS. Well, thank you, Chairman Smith and Senator Kohl, and I appreciate the opportunity to participate in this roundtable, although this isn't quite a roundtable, but that is OK, and to have an opportunity to discuss our Medicaid managed care model in Arizona. It is my hope that my written testimony and the insights that we provide during the discussion will provide some direction for Congress in terms of some solutions for Medicaid.

The Arizona Health Care Cost Containment System, called AHCCCS, for short, was established in 1982. Its principal goal was to provide quality of care, at the same time cost containment. We believe these are not mutually exclusive. Over the years, AHCCCS has been recognized as one of the best-run Medicaid programs in the United States and we have learned a few lessons in that time.

I would like to first talk about financial accountability and cost controls—one of the areas that we have learned that, as the name implies, cost containment is really important in Medicaid. We have an underlying belief that unnecessary and untimely medical care, medications, emergency care and in-patient care drives costs up in the Medicaid program.

We have learned that the best-performing health plans have invested in medical management information systems and the capability of their organizational core competency to effectively managed members' care, especially the chronically ill or those who have high-cost medical conditions. We have found that about 20 to 25 percent of our members generate about 80 percent of our medical costs. Effective case management of those members has a significant impact on controlling Medicaid costs.

Another lesson I would like to share with you is that we have had a great deal of success with our drug management programs through our health plans. We have the highest generic use of any Medicaid agency and this is because our plans use generics first before they go to the most expensive brand, if a generic is available. Effective drug management is a hallmark of our Arizona Medicaid program. It was supported in a report that was done by the Lewin Group that compared Arizona Medicaid to other Medicaid programs, and it found that in our acute care program our average cost was $14.75 per prescription, compared to an average of $47.10 per prescription for Medicaid fee-for-service programs. In long-term

care, our average generic use was 76.5 percent and a prescription cost of $38.91, compared to 29 percent in other Medicaid fee-for-service programs and $69 per prescription in those programs.

One of the basic tenets of the managed care program in Arizona is that paying capitation to managed care health plans that is based on a per-member, per-month reimbursement schedule needs to be actuarily sound. You have to realize that we transfer full medical risk to our health plans. To make the capitation work, you need two things. You need adequate membership and you need the ability of the plan to manage its medical risk, and larger memberships or assuring adequate membership helps them to do that.

But you also have to realize that we don't encourage our health plans to capitate their provider groups. We would rather them pay them fee for service and set appropriate rates. In fact, we probably are one of the few States that is able to set rates at or close to the Medicare rates for our members.

Additionally, I would like to just quickly talk about actuarial soundness. Actuarial soundness is an important principle that is, in essence, a contract between the State and the health plan that we are going to provide actuarily sound rates to them. This allows them to have stable financials, as well as it stabilizes our provider network.

In terms of what happens when you have a stable provider network, we just have a recent study by Arizona State University that shows emergency room use in our Medicaid program was lower than the incidence of emergency room use in commercial plans. So, actually, our Medicaid program had lower emergency room use than other commercial plans in our State.

I would like to talk a little bit about our fraud and abuse program. One of the other benefits of having health plans is that they also participate and collaborate in fraud and abuse detection, and this helps us really rout out and prevent fraud and abuse in our program.

Then, finally, Arizona has the opportunity to make a quantum leap, achieving even greater program efficiency, patient care quality and cost transparency. Because of our Medicaid managed care, Arizona is well organized in its provider networks and its integrated medical management processes. That positions us to more rapidly deploy information technology and to exchange critical personal health information of our Medicaid members to our provider networks.

I look forward, Mr. Chairman, to this dialog. I think it is an important dialog and I appreciate this opportunity. Thank you.

The CHAIRMAN. Tony, I live in a very rural part of Oregon and most of my Udall cousins live in eastern Arizona, in places like Safford and Thatcher. I guess one of the concerns I have as a rural Oregonian is how capitated managed care works in rural communities.

I imagine, David, you would probably admit there is not a lot of managed care in eastern Oregon. It is only where the people are. So how do we take care of rural folks in Arizona?

Mr. RODGERS. Mr. Chairman, we have actually found that it stabilizes the network in the rural area because we can verify who the members are. Because we are shifting them from hospitalization

and emergency room use of hospitals into the provider network, it actually gives primary care physicians and others revenues from our program because we have contracts with those rural health organizations, everything from our rural health community clinics to individual providers.

Because we pay fee-for-service, those individual providers are able to sustain their practices out in those rural areas. So it has really worked to the benefit of our rural communities because without Medicaid in those communities, if there were a number of uninsured, those providers would not be able to stand in terms of financial stability.

The CHAIRMAN. It might have taken a little longer to get to rural Arizona, but it is there now?

Mr. RODGERS. Yes. Actually, we have been mandatory Medicaid since the inception. So from the beginning, we have had plans that have specialized in those rural communities and have learned how to work with the providers. Because we are able to integrate health care between the rural communities and sometimes the tertiary care centers, it really works to control costs because our goal is to give every person a primary care physician that is going to be their normal place that they will go and get care, whether that is a community clinic or whether that is an individual community provider. So it has worked very well.

The CHAIRMAN. Can you speak a little more specifically to what incentives you have provided, what oversight you provide, you know, contract negotiations that, on the one hand, allow you to capitate things, but on the other hand I think the concern of many is corners are not cut when it comes to care, and particularly those with chronic disabilities, dual-eligibles and the like?

Mr. RODGERS. Well, I think there are three underlying strategies or operational processes that really help our process with our health plans. No. 1, we set rates that are actuarily sound, so we do look at utilization and we look at cost, and we escalate our rates or increase our rates based on what we are seeing in the care of members. If we have members at risk or high risk in a plan, there is an adjustment that is given to those plans.

In addition to that, our plans over the years have developed sophisticated medical management programs and case management, and so they do a lot of prevention especially in long-term care. Especially with our dual eligibles, there are a lot of touch points that our plans have with those individual patients, and the reason is that they are at risk for the costs and they know if they do early detection, prevention and get the member to see their primary care physician, it reduces emergency room use and it reduces in-patient care.

In addition to that, over time, it has allowed a whole network of home and community-based services to develop in both the rural as well as the urban areas because we are funding those services. So, over time, we have been able to elevate the resources the communities in those communities as well.

The final thing is that our plans pay fee for service, and physicians in our communities and the other providers like fee for service. Capitated relationships with providers is much more difficult for them to manage. But by paying fee for service and us over-

seeing that they are paying correctly and that they are paying on time, it has made it possible for our provider network to be very stable. We have about 85 percent of the Arizona providers participating.

The CHAIRMAN. Do you know Ron Pollack, next to you?

Mr. RODGERS. Yes, Ron and I have met.

The CHAIRMAN. Do you have a Ron Pollack in Arizona, somebody who is an advocate for care?

Mr. RODGERS. We have a number of organizations that advocate for care. One of them is our children's health alliance or children's alliance. They do a lot of focused effort around children's insurance programs and they have been a great supporter of AHCCCS. I understand why advocates feel concerns about managed care. If it is done poorly, it does create a lot of problems. So it is important that the States that are getting involved know how to manage managed care, and if they do, it actually works better for access to providers.

One of the problems we saw in the early days when I was in California—I ran a county hospital—we would often get people who would say I can't find a doctor who will take Medicaid. In managed care, all the doctors are under contract, so you know they are going to take Medicaid. So that has really helped our members quite a bit.

The CHAIRMAN. So Arizona's version of Ron Pollack—if they were here, they would like what you are saying and they would agree with it?

Mr. RODGERS. I believe so.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Go ahead.

[The prepared statement of Mr. Rodgers follows:]

Senator Smith's Medicaid Roundtable
Testimony of Anthony Rodgers
Director Arizona Health Care Cost Containment System
September 13, 2006

Thank you, Chairman Smith for this opportunity to participate in this roundtable and discuss the key issues facing the future of Medicaid. It is my hope that my testimony will serve to provide insight not only into the problems facing Medicaid but the potential solutions.

As the Director of the Arizona Health Care Cost Containment System, I am proud to lead one of the best run Medicaid programs in the United States. AHCCCS, pronounced ***access***, has operated under an 1115 demonstration waiver since its inception in 1982.

Twenty-five years ago, Arizona was not even part of the Medicaid program, choosing to finance indigent care with only state/local funding. Needless to say, the escalating cost of care and the demand for wider access to health care providers created a strong incentive for the Arizona legislature to rethink its opposition to being part of the Medicaid program. Still, the thought of creating a traditional fee for service Medicaid program was unacceptable to the Arizona legislature and Governor at that time. The Arizona legislature and Governor devised a program that would be different than the traditional fee for service Medicaid program operating in every other state. TheArizona Medicaid program would be organized to avoid the financial and operational problems plaguing other state Medicaid programs. It would be built around the principles of managed care to control costs, assure quality of care, and provide access to primary care.

As the name implies, the Arizona Health Care Cost Containment System was established on the principle that quality of care and cost containment are not mutually exclusive outcomes. AHCCCS integrates the principles of managed care throughout acute care and long term care programs. Contracts with health plans require that a managed care organization (MCO) is capable of delivering all needed services in return for a prepaid monthly capitation. Admittedly, it was only after some initial ups and downs, that the Arizona Medicaid managed care program has become a model for other states.

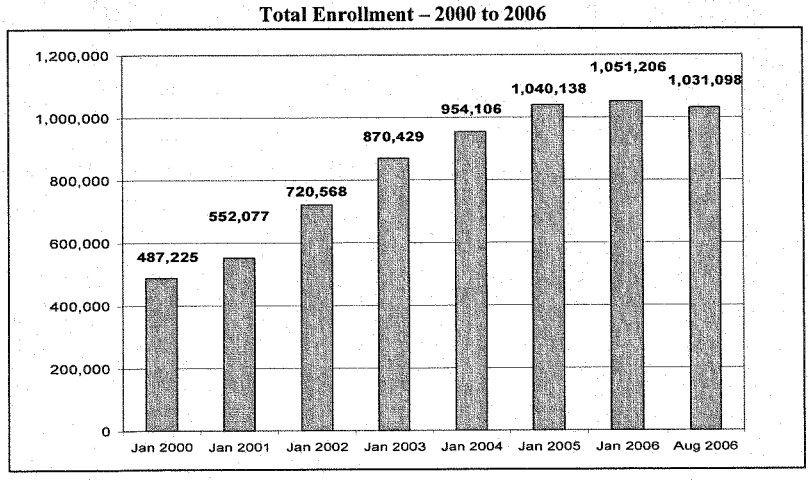
Arizona's Medicaid managed care program was expanded in 1989, via another 1115 waiver, to include long term care beneficiaries. This was another first for Arizona and represented how confident Arizona had become in providing both Medicaid acute care and long term care services using managed care as the primary health care delivery model.

Over the years many states have attempted to duplicate Arizona's success with Medicaid managed care but with mixed success. Arizona has learned a few things along the way that has helped to assure that Arizona Medicaid managed care is sustainable and has widespread credibility as a well run Medicaid program. The lessons learned in managing managed care can be categorized under the headings of financial accountability and cost control, quality of care improvement, access to primary and preventive care, contract management and innovation in health care delivery.

Chart 1
Who Does AHCCCS Serve?

Program	Enrolled Members	Member Profile as of August 1, 2006
Acute	931,152	Primarily children and women with children.
ALTCS (Long Term Care)	42,128	Individuals with developmental disabilities, physical disabilities, or over 65 years of age.
KidsCare	57,818	Children through the age of 18.
Healthcare Group of Arizona	22,027	Employees of small businesses. Member count not included in Chart 2.
Total	**1,0531,25**	

Chart 2
Total Enrollment – 2000 to 2006



Financial Accountability and Cost Control

As the name implies one of the fundamental values of AHCCCS is cost containment. However, this value is never at the expense of quality medical care or access to needed care. It is an

underlying belief that cost containment comes from being able to verify that the health care services provided were necessary to assure the wellbeing and health maintenance of the beneficiary. It is unnecessary or untimely medical, pharmacy, emergency, or inpatient care that drives up cost in Medicaid.

Utilization Management

Lesson Learned: Successful Medicaid managed care organizations have mature information systems and medical management infrastructures.

AHCCCS contracts with managed care health plans that are accountable to manage care and control costs, using appropriate managed care utilization management tools. The ability of the MCO contractor to manage medical risk is a prerequisite to a successful managed care program. The contractor must be able to assure enrolled members have access to a primary care services. This has been proven to reduce unnecessary emergency room utilization and inpatient care by early identification and medical management of chronic illnesses and disease. The primary care provider becomes the primary source of care for the enrolled members rather than the emergency room.

The MCO's ability to manage unnecessary utilization is critical to effective cost containment. This requires the managed care organization to have adequate medical management information systems that provide computerized utilization and case management tools for staff involved in the case management of those in the hospital or who are being medically managed for chronic illness and disease. Managing the 20% of high risk medical cases is the primary focus of Arizona's MCOs. When they do this well cost is contained.

One of the major out of control costs that plagues many Medicaid programs is the cost of drugs. Drug cost management is another area of utilization management that mature MCOs are adept at managing and controlling. This is accomplished not by denying needed medications, but by using generic drugs first before prescribing more expensive brand drugs. Because MCO contract with providers, they are able to create cost effective drug formularies and educate providers on providing "step therapies" that use generic drugs first before managing the patient with a more expensive brand drug. According to a 2004 *The Lewin Group* report on pharmacy cost management in Arizona's Medicaid program, AHCCCS had the nation's most cost efficient pharmacy cost management of any other State Medicaid program. Table 1 provides a cost comparison of pharmacy cost based on the findings in the Lewin Report.

Table 1
Cost Comparison of Drug Cost and Utilization

Drug Cost and Utilization Comparison	Medicaid FFS	Other State's Medicaid Managed Care	AHCCCS
Acute Care Generic Use	38.1%	86.0%	93.1%
Acute Care Average Cost Per Prescription	$47.10	$28.16	$14.75
Long Term Care Generic Use	29.3%	38.8%	76.5%
LTC average cost Per Prescription	$69.00	$76.63	$38.91
TANF Beneficiaries	0.69 PMPM	0.56 PMPM	0.41 PMPM

AHCCCS managed care model has produced outstanding pharmacy cost management results in several areas without having to place benefits restrictions or limits on the number of prescriptions beneficiaries can be given. Generic drug use is the highest in the nation, cost per prescription is the lowest, and average prescription per beneficiary is also lower than any other state. This cost effective performance is a direct result of Arizona's Medicaid managed care model.

Member Enrollment and Capitation

Lesson Learned: Size matters. MCOs need adequate membership to remain financially solvent and manage high risk high cost cases.

One of the basic tenets of managed care is paying capitation rather then fee for service to managed care contractors who are at full risk for managing the patient care within the per member per month capitation payment. In Arizona most, if not all, of the MCO contractors reimburse their network providers on a negotiated fee for service rate for the care provided. This assures that claim encounters are submitted to the plan. The provider does not receive reimbursement unless the claim is submitted. A claim is essential to assure care has been rendered at the appropriate cost. Paying capitation to MCOs is a very effective way to align incentives between the Medicaid agency and the MCO contractor. The MCO is at financial risk for managing patient care cost effectively. The Medicaid Agency does not have to create sophisticated claims and medical management systems. Having more than one health plan contractor competing for member enrollment enhances business discipline and creates an incentive for MCOs to assure beneficiary and provider satisfaction with the performance of the MCO.

Capitation of Medicaid physician groups or hospital system providers has proven less successful. In many cases it has been a financial disaster for capitated provider groups. Inadequate or poorly managed capitation reimbursement has led many Medicaid providers into financial default. Most provider groups, but especially Medicaid provider groups, are ill equipped to manage capitation. These groups seldom achieve the membership enrollment critical mass effectively manage the medical cost risk under capitated arrangement.

This was a lesson AHCCCS learned very early on in its history. To remain financially solvent, an acute care MCO must have an enrollment of at least 25,000 beneficiaries and a LTC MCO at least 1,500 members. When enrollment in the MCO is below this threshold, the plan is at a greater risk of adverse selection and financially unsustainable medical losses. To assure that each plan has a large enough beneficiary pool to mitigate the medical cost risk of high cost patients, AHCCCS uses auto assignment of members that choose a plan to the MCO which is below the threshold. Contracting with too many MCOs will often create this critical mass problem. One role that the state Medicaid agency must play is to assure the competitive playing field is level. Having a significant disparity in MCO membership size does not create the necessary environment for positive market driven competition.

Some states have implemented Medicaid managed care by contracting with a number of local community health plans. Many of these local health plans formed specifically to contract for Medicaid managed care. Unfortunately, many of the community health plans never grow large enough to make capitation reimbursement work. It has been our experience that local plans, which are often organized around safety net providers, must be given a reasonable opportunity to reach the critical enrollment threshold. It is the state's responsibility to create administrative rules and processes that support that result.

Actuarial Soundness

Lesson Learned: Actuaries may be boring but they know the numbers. We have learned that manipulating capitation to meet a predetermined budget target, without reducing the MCO's medical cost exposure, will eventually destroy a Medicaid manage care program.

MCO capitation rates must be actuarially sound. States that do not adhere to sound rate setting principles eventually destabilize their MCO contractor's financial position. This is one reason many private health plans have left state Medicaid managed care programs. AHCCCS employs a staff of actuaries to consistently review and validate capitation rates. They use sophisticated cost and medical trend analytical tools to evaluate paid claims data and utilization from the MCO contractors. We have learned that it is critical to the financial viability of our MCO contractors that AHCCCS accurately and consistently set capitation rates based on sound actuarial principles. To set capitation rates correctly you must take into account both utilization trends and medical cost inflation factors. It is a very short-sighted strategy to establish rates based on a predetermined budget figure. It may work for a year or so but will eventually create deterioration of managed care plan effectiveness and participation. It is better to reduce benefits, increase co-payments or place caps on membership growth than to set rates that will eventually lead to financial insolvency for MCO contractors. This philosophy has made AHCCCS successful over the years and has actually helped AHCCCS control capitation rate inflation over time. One

additional benefit to setting actuarially sound rates is that more providers are willing to participate in the program. Having better provider network choice leads to better primary care access and beneficiary satisfaction, which we find reduces emergency room use.

Charts 3, 4 and 5 provide additional reference information.

Chart 3
Example of Capitation Rates Paid by AHCCCS to MCOs

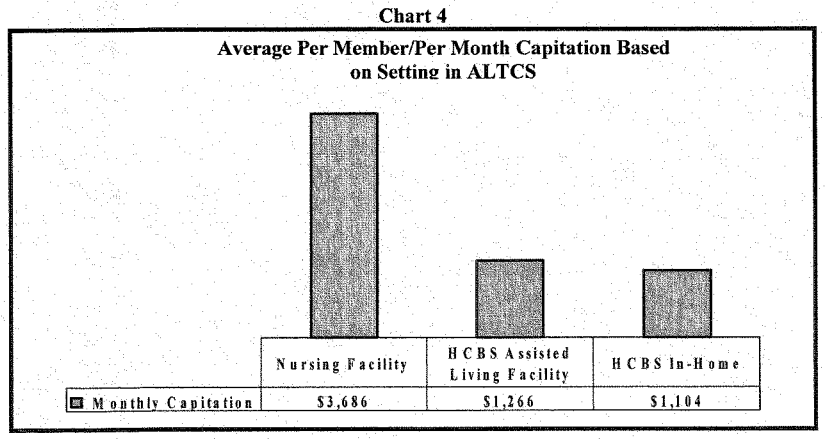
- Acute capitation payments made to the health plans are based on the age and sex of the enrolled member (effective 10/1/04)

For example:

• 6 year old child	$ 97/month
• 26 year old woman	$172/month
• 45 year old man	$343/month
• 65 year old woman with Medicare	$265/month

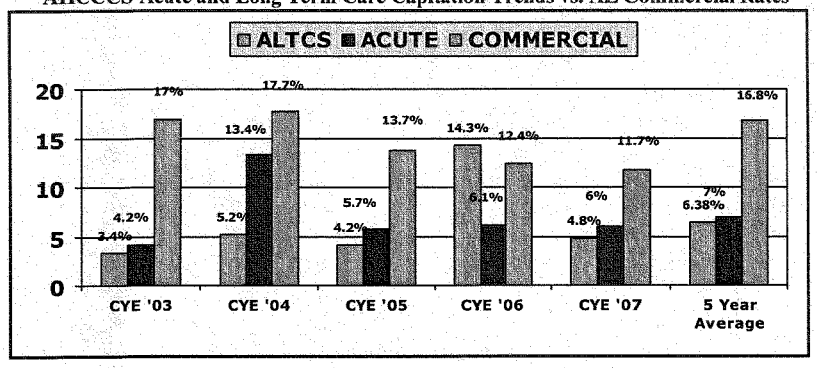
- Arizona Long Term Care System Capitation $2,766/month
- AHCCCS regulates compliance with contract terms including quality of care and fiscal accountability.
- Evaluations sponsored by the federal government have consistently shown that AHCCCS saves money.

Chart 4



A. Rodgers 09/13/06

Chart 5
AHCCCS Acute and Long Term Care Capitation Trends vs. AZ Commercial Rates



Comparative MCO Financial and Quality Data

Lesson Learned: You cannot manage what you cannot measure. Financial accountability and quality of care accountability are the two pillars of successful Medicaid managed care.

AHCCCS uses a number of analytical tools and measures to compare the performance of MCO contractors. Being able to compare performance between plans is critical to market competition and driving both quality and cost containment. AHCCCS maintains a data warehouse with five years of AHCCCS eligibility and claims encounter data. This allows AHCCCS management staff to not only evaluate historical and programmatic trends but to evaluate MCO performance year to year.

Managing managed care plans requires setting operational, financial, and quality targets for the plans and having the staff with the core competency and analytical tools to measure performance against target.

Encounter Data Reporting

Lesson Learned: Not having good encounter data is like driving a car blindfolded. There are only two outcomes that can result and both of them are bad. 1. Crash 2. You end up where you did not want to go.

As a condition of the 1115 Waiver, CMS requires AHCCCS to submit specific information regarding services provided to Medicaid and KidsCare members. These records, known as claims encounter data, are submitted to AHCCCS for institutional, professional, dental and prescription drugs. AHCCCS requires all contractors (Health Plans for acute and Long Term Care) to submit encounter data through electronic media within 240 days after the end of the month in which the service was provided. This is critical to assure we can measure both cost and quality of care.

Claims Encounter Reporting supports:

- Evaluation of health care quality and cost effectiveness
- Evaluation of individual contractor performance
- Development and determination of capitation rates paid to the contractor
- Determine Disproportionate Share payments to hospitals
- Develop FFS payment rates
- Pay reinsurance to the contractor

AHCCCS performs annual validation studies on acute care, long-term care and behavioral health encounter data to ensure that the data reported is timely, accurate and complete. We take the submission of encounter data very seriously and we will sanction plans for non-compliance with submission of the plan's encounter data.

Financial Reviews and Operational Reviews

Lesson Learned: As every school kid knows they probably would not work on their studies very hard if they did not have a final exam. The financial and operational reviews are MCO's annual final exam.

AHCCCS requires that all Health Plans, Program Contractor, and ADHS and its subcontracted Regional Behavioral Health Authorities (RHBAs) adhere to standards expressly stated in their contract with AHCCCS. Health Plans, Program Contractors and RHBAs may not gain financial advantage by under-serving enrolled members. Therefore, each Health Plan, Program Contractor and RBHA must:

- Disclose ownership and related third party transactions;
- Post performance bonds for insolvency protection;
- Prepare contingency plans in the event of insolvency;
- Meet stringent financial management standards established by AHCCCS; and
- Contract for an annual certified audit performed by a certified public accountant.

Semi-annually, AHCCCS completes operational and financial reviews of Health Plans, Program Contractors and ADHS Behavioral Health Services. These site visits review contractors' general administration, including:

- Business continuity plans;
- Cultural competency compliance;
- Staffing;
- Corporate compliance;
- Quality management processes, including provider credentialing;
- Handling of quality of care issues and complaints;
- Care coordination and case management processes;
- The delivery of maternal and child health services;
- The grievance system;

- The delivery system;
- Member services;
- Reinsurance;
- Finances;
- Claims processing and payment;
- Encounter processing and submission; and
- Behavioral health coordination.

AHCCCS has established financial and operational standards that all MCO contractors must meet. Based on these standards, AHCCCS examines MCO profitability and administrative performance through an analysis of five financial viability standards. The following is a brief explanation of each standard and the Health Plan results of the most recent financial audits conducted.

1. Current Ratio - This standard measures whether a Contractor can pay current obligations as they come due.

2. Equity per member - This standard measures a Contractor's ability to withstand adverse utilization over a one-year period.

3. Medical Expense Ratio - This standard shows how well a Contractor manages care. If the medical expense ratio is too low, under-utilization of services may be a problem. If it is too high, the Contractor may not be managing utilization appropriately.

4. Administrative Cost Percentage - This standard measures the percentage of AHCCCS capitation premiums spent on non-medical expenses. Too much money spent on administrative cost may indicate MCO inefficiency.

5. Days of Claims Workload on Hand and Received but Unpaid Claims (RUC) - This standard shows if claims are being paid in a timely fashion. This standard may suggest cash flow problems if Contractors are slow in paying bills.

In addition to the five financial viability standards mentioned above, AHCCCS monitors on a minimum quarterly basis, the operating income or loss of the Contractors as well as the Incurred but Not Reported (IBNR) claims estimates. The IBNR estimates the dollar amount of claims for which the Contractor has provided the service but has not received the actual claim.

Member and Provider Grievance System

Each MCO is required to process grievances in a timely manner. They must communicate denials of grievances in writing to the member or providers. AHCCCS handles grievances not resolved at the MCO level to the satisfaction of the member or provider.

The AHCCCS Office of Legal Assistance (OLA) provides legal counsel to the AHCCCS administration, is responsible for the Agency rulemaking process, and oversees the Grievance System for the AHCCCS Program. Major components of the Grievance system include,

scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions subsequent to recommendations made by Administrative Law Judges.

During the last year, OLA received 8,941 matters, including member appeals, provider claims disputes, ALTCS trust reviews, and eligibility appeals. OLA issued 4,005 Director's Decisions after State Fair hearings were held. OLA was able to resolve 5,783 cases at the informal level, alleviating the need for a State Fair Hearing. Of the 8,941 total cases received by OLA, 736 were member appeals, 5,667 were provider claim disputes, 455 were ALTCS trust reviews and 2,083 were eligibility appeals.

Fraud and Abuse

Lesson Learned: Fraud happens. The best defense is vigilance and a big stick.

The AHCCCS Office of Program Integrity (OPI) is responsible for combating fraud and abuse in the Arizona Medicaid program. OPI consists of three Units: Audits, Member Fraud and Provider Fraud. OPI has developed a comprehensive approach that focuses on strengthening program safeguards, assessing areas of potential vulnerability and investigating allegations of fraud and abuse.

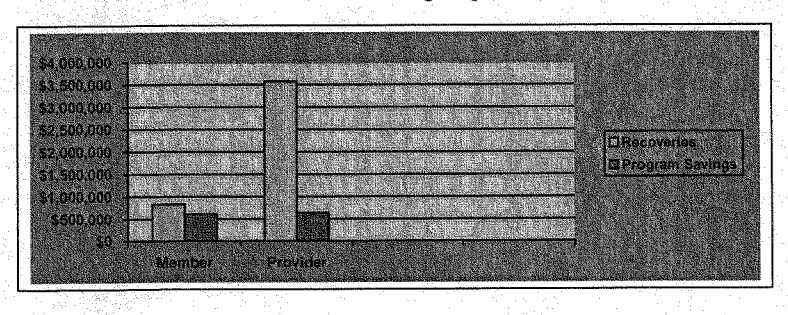
OPI visited AHCCCS Contractors on-site to discuss the development of formal compliance programs. In light of the new requirements and to promote development of effective compliance programs over the next year, OPI has worked with the Division of Health Care Management to strengthen contracts by requiring the formation of Compliance Committees and written criteria for selecting a Compliance Officer. OPI also participates in all the scheduled Operational and Financial Reviews to further strengthen the Fraud Waste and Abuse program. The AHCCCS fraud and abuse policy provides requirements for MCO Compliance Officers. MCOs must report potential/suspected fraud and abuse within ten working days of the discovery of the incident.

OPI continues to host fraud and abuse work group meetings, now called "Compliance Officer Network Group" meetings. Subjects include program safeguards designed to limit abuse and diversion of prescription drugs by AHCCCS members and discussions on any methods to strengthen and improve efforts to prevent, detect and report fraud and abuse in the State's Medicaid Program. Additionally, the Director of Program Integrity and the Director of the Medicaid Fraud Control Unit of the Attorney General's Office have conducted several joint fraud awareness presentations to AHCCCS Contractors.

For example, a major behavioral health audit was conducted during 2005 by OPI's Office of Audit Services (OAS). Specifically the OAS chose two Regional Behavioral Health Authorities (RHBAs) and one of their providers. The audit was generated from a finding of concern about improper coding for services based on a separate investigation conducted by OPI on a RHBA and their provider. The Audit Unit routinely utilizes the "Medicare Fraud Alerts" to determine if the AHCCCS program is vulnerable to the schemes identified in the Alerts.

In another, a member fraud investigation was initiated after a review of claims data and medical records, OPI took five staff to a small Arizona community on the Mexican boarder to validate members receiving care were the same persons that were originally made eligible for AHCCCS. OPI staff went to the residence listed on each AHCCCS member's application to verify that the person lived at the residence and was the same person who AHCCCS had originally made eligible for service. These investigations are only undertaken when there is probable cause to believe fraudulent use of Medicaid is occurring. Most OPI work is focused on prevention. AHCCCS has earned the confidence of taxpayer because of the vigilance assuring state and federal money is being spent for the right person and on the right services.

Chart 6
Member and Provider Totals for Recovery and Program Savings
October 2004 through September 2005



Quality of Care Improvement

Lesson Learned: Managed Care Organizations will improve performance over time if you show them the data and give them their score card compared to other health plans. Eventually, low performing MCOs lose members to high performing MCOs.

AHCCCS ensures that each contracted MCO has an ongoing quality assessment and performance improvement program for the services furnished to its members, consistent with regulations under the Balanced Budget Act (BBA) of 1997. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services.

Acute-care Performance Measures

Each year AHCCCS measures performance of MCO contractors against previous years' performance and in comparison to the other MCOs' performance.

The results reported here should be viewed as *indicators* of utilization of services, rather than absolute rates for how successfully AHCCCS and/or its Contractors provide care. Many factors affect whether AHCCCS members use services. By analyzing trends over time, AHCCCS and its

Contractors have identified areas for improvement and implemented interventions to increase access to, and use of, services.

Methodology

AHCCCS uses the Health Plan Employer Data and Information Set (HEDIS®) as a guide for collecting and reporting results of these measures. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. Table 2 show results for 2004.

Results

Table 2 shows aggregate results from AHCCCS MCOs. Some MCOs performed better than the aggregate and some worse. All acute-care measures except one improved in the most recent measurement period. Results by measure were as follows:

Table 2

Measure	AHCCCS Current Rate (%)	Previous AHCCCS Rate (%)
Children's Access to PCPs – Medicaid	77.3	75.7
Children's Access to PCPs – KidsCare	79.1	77.7
Adults' Access to Preventive/Ambulatory Health Services – Medicaid	77.8	76.2
Well-child Visits in the First 15 Months of Life – Medicaid	66.9	68.4
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – Medicaid	56.4	51.5
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – KidsCare	61.0	56.7
Adolescent Well-care Visits – Medicaid	32.6	30.9
Adolescent Well-care Visits – KidsCare	37.2	34.6
Annual Dental Visits – Medicaid	53.9	48.5
Annual Dental Visits – KidsCare	63.5	57.8

- **Children's Access to PCPs** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels since AHCCCS began measuring these rates.
- **Adults' Access to Preventive/Ambulatory Health Services** – This measure also increased by a statistically significant amount.
- **Well-child Visits in the First 15 Months of Life** – The overall rate for this measure showed a relative decline of 2.1 percent (the rate includes only Medicaid members, as most children in this age range qualify for AHCCCS under this program).

- **Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels.
- **Adolescent Well-care Visits** – Overall rates for both Medicaid and KidsCare members showed statistically significant improvements from the previous measurement period.
- **Annual Dental Visits** – Rates for this measure also improved significantly, reaching their highest levels ever for both Medicaid and KidsCare members.

The Litmus Tests of Managed Care:

Litmus Test #1: Improved Immunization Rates
The monitoring of AHCCCS immunization rates is critical to identify under vaccinated populations and increase coverage levels, both in children and adults. For children enrolled in managed care plans, nine of ten immunizations evaluated by AHCCCS and recommended by the Centers for Disease Control and Prevention have shown improvement. They include immunizations for diphtheria, tetanus, measles, mumps and rubella, among others. Immunizations and pneumococcal vaccination under the Arizona Long Term Care System also have shown improvement. All seven ALTCS Program Contractors attained rates above the AHCCCS performance standard (APB) for influenza immunizations in HCBS settings, and six obtained ratings above the APB in nursing facility settings. For pneumococcal vaccinations, six contractors were above the APB in HCBS settings and five attained this rating.

Litmus Test #2: Preventive Care
Compared with the most recent national HEDIS means (averages) reported by NCQA for Medicaid health plans, AHCCCS Medicaid rates were higher than the national means for some measures and lower for others. Most notably, the AHCCCS Medicaid rates for Well-child Visits in the First 15 Months of Life and Annual Dental Visits were well above the HEDIS national Medicaid averages for these measures. And, despite the small decline in the current measurement period, the rate for Well-child Visits in the First 15 Months of Life was equivalent to the most recent HEDIS average for commercial health plans, which is much higher than the Medicaid average.

Consistent with previous measurements, children enrolled with AHCCCS Contractors through KidsCare have higher overall rates of preventive services than those enrolled under Medicaid. Depending on their income, parents of KidsCare members may pay a premium for coverage and therefore, may be more likely to ensure that their children receive covered benefits, including well-care visits. These parents also may have a higher level of education and a better understanding of the value of preventive health care.

Driving MCO Performance by Setting Standards and Requiring Constant Improvement

Lesson Learned: To become good at pole vaulting you need to keep raising the bar. AHCCCS has learned that raising the performance bar generates competition and innovations.

AHCCCS has established performance standards for contracted health plans for various quality and access measures. Contractors should meet the AHCCCS *Minimum Performance Standard* for a particular measure and should try to achieve higher goals established by AHCCCS. Every year or

two AHCCCS has raised Minimum Performance Standards in order to encourage Contractors to continue improving their rates. Typically we raise target performance based on the best MCO performance in the previous reporting period.

AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard for any measure, or that show a statistically significant decline, even if they met the minimum standard. Contractors that fail to show improvement may be subject to sanctions. Some Contractors already have corrective action plans in place for Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services. On an ongoing basis, AHCCCS staff will monitor Contractor rates for each measure, especially for those plans that have not met Minimum Performance Standards.

AHCCCS provides technical assistance, such as identifying new interventions or enhancements to existing efforts, to help Contractors improve their performance. For example, AHCCCS began leading a collaborative effort that includes Contractors and some community agencies in early 2004 to improve well-child visits among children 3 through 6 years of age and to support health-related goals of the Governor's School Readiness Board. It appears that this focused effort has contributed to improvements in the rate of well-child visits among this age group during the most recent measurement period. In order to continue improvements in this area and meet AHCCCS goals, the agency has researched evidence-based strategies for improving well-child visits and is working with Contractors to identify and implement a new standardized intervention.

Arizona Long Term Care System (ALTCS) Performance Measures

Lessons Learned: Successful long term care MCOs have learned that it starts with effective case management and mature chronic care management processes.

Diabetes Care

AHCCCS used HEDIS specifications as a guideline for measurement of diabetes care services provided to elderly and physically disabled (E/PD) members. Three indicators, Hb A_{1c} testing, lipid screening and retinal exams were measured.

Methodology

This study measured services provided from October 1, 2003, through September 30, 2004. It included a representative, random sample of ALTCS members who were diagnosed with type 1 or type 2 diabetes, were 18 through 75 years of age, and were continuously enrolled with one ALTCS Contractor for the entire measurement period.

Results

Hb A_{1c} testing – AHCCCS measured the percentage of members who had one or more glycosylated hemoglobin, or Hb A_{1c}, tests during the measurement period. The overall rate of ALTCS members with diabetes who received one or more Hb A_{1c} tests was 76.7 percent.
Lipid (LDL) screening – AHCCCS measured the percentage of members who had one or more fasting lipid profiles performed during the measurement period or the preceding year. The

overall rate of lipid screening during the measurement period or the preceding year was 69.2 percent.

Retinal exams – AHCCCS measured the percent of members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year. The overall rate of members with retinal exams was 50.1 percent.

Performance Standards and Improvement

All Contractors are meeting the current AHCCCS Minimum Performance Standards for diabetes care and most have exceeded current goals. Compared with the most recent HEDIS data for Medicaid health plans, most ALTCS Contractors exceeded national averages for Hb A_{1c} testing and eye exams. It also should be noted that some AHCCCS Contractors are achieving rates of diabetes preventive care services that are comparable with HEDIS commercial health plan averages.

In order to assist ALTCS Contractors with performance improvement efforts, AHCCCS has compiled information on barriers to effective diabetes management and successful strategies for increasing the use of preventive-care practices. AHCCCS is continuing to work with Contractors to improve performance in these indicators.

Measuring Home and Community Based Services (HCBS) Placement

AHCCCS measured the percentage of newly placed HCBS members who received selected services within 30 days of enrollment. Examples of these services include adult day health care, attendant care, home-delivered meals, home health nursing and homemaker assistance.

Methodology

The study covered the measurement period from October 1, 2003, through September 30, 2004. A representative random sample was selected for each Contractor. Data were first collected from AHCCCS encounter data. When services within 30 days of enrollment for a particular member were not found in AHCCCS encounter data, Contractors were asked to provide service delivery information from medical or case management records, or their claims data.

Results

The overall rate of initiation of services was 89.2 percent, a statistically significant improvement from the rate of 83.7 percent in the previous measurement period.

Performance Standards and Improvement

All seven ALTCS Contractors exceeded the AHCCCS Minimum Performance Standard in the current measurement period.

Given the variety and complexity of members' needs and personal situations when they enroll in the ALTCS program, Contractors' case managers face distinct challenges in ensuring that enrollees have prompt access to home and community based services that fit with their individual choices. These services are designed to help long-term care recipients maintain or improve their health and functional status, and enjoy a greater degree of independence. AHCCCS Contractors are effectively meeting this challenge, with some health plans achieving rates of 90 percent or better for this measure.

Performance Improvement Projects (PIPs)

In addition to Performance Measures, AHCCCS requires Contractors to conduct Performance Improvement Projects (PIPs), as defined under BBA regulations. These PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time. PIPs may be conducted in clinical or non-clinical areas that are expected to have a favorable effect on member health outcomes and satisfaction. Contractors design and conduct their own PIPs, and are required to participate in at least one AHCCCS-designed and mandated PIP.

Management of Diabetes

One of the mandated PIPs under way is designed to assist diabetic members and their physicians with establishing and maintaining control of blood-glucose (glycemic) levels, in order to prevent or minimize complications of the disease. This PIP, implemented in CYE 2002, measures annual Hb A_{1c} testing and laboratory levels of selected members.

In CYE 2005, AHCCCS conducted a re-measurement of performance to determine whether Contractors that showed a statistically significant improvement from the baseline measurement to the first re-measurement had sustained that improvement for an additional year. In the first re-measurement, 14 of 15 Acute-care and ALTCS Contractors demonstrated improvement from the baseline measurement and/or were performing at the optimal benchmark established by AHCCCS. All of those Contractors sustained that level of performance in the second re-measurement. The remaining Contractor demonstrated improvement in the second re-measurement, and will continue participating in this PIP until it shows sustained improvement.

Children's Oral Health

The purpose of this AHCCCS-mandated PIP is to increase the rate of annual dental visits among children enrolled in AHCCCS. This project specifically focuses on children who are 3 through 8 years old, as this appears to be a critical time in a child's life to ensure that he or she receives regular dental care. Contractors participating in this PIP include acute-care health plans, CMDP, DDD and ALTCS health plans that serve elderly and physically disabled members.
All Acute-care Contractors except one showed statistically significant increases from the baseline measurement and/or exceeded the goal of 57 percent.

Validation of Performance

Lesson Learned: It is not what you say about yourself that validates you, it's what others say about you that validates you.

AHCCCS has been evaluated by numerous federal agencies over the years, including the United States Government Accountability Office (GAO), Office of Management and Budget, EQROs, and CMS program auditors and consultants. Reports have been positive and have praised various components of the program, including the quality of care and the overall cost-effectiveness when compared with traditional FFS programs in other states.

In addition, AHCCCS has received numerous commendations and awards over the years. Some of these include the Leadership Award for Medical Quality from the American College of Medical Quality, a Health Care Financing Association (HCFA) National Customer Service Award for collaboration with Native Americans, the Council of State Government Award for Eligibility Fraud Prevention Program, and *Health Affairs* cited AHCCCS as one of the few prudent purchasers of health care in the nation.

AHCCCS has been visited by health care system and public health officials from the England, Australia, Mexico and even Afghanistan's Ministry of Health to better understand our model of market competition based managed care contracting.

AHCCCS has also been looked to as a Medicaid managed care model by other state Medicaid agencies. The agency was recently asked to present testimony before Congress on methods to improve the management of Medicaid and health care programs. On May 9, 2005, as the Director of AHCCCS, I presented on the success of AHCCCS to staff of the United States House Energy and Commerce Committee. On June 22, 2005, I was invited to appear before the Health Subcommittee to testify about AHCCCS' success related to "Medicaid Prescription Drugs: Examining Options for Payment Reform." While the presentation was focused on Arizona's management of the prescription drug benefit, testimony was solicited on a variety of other successes accomplished by the agency. On October 27, 2005, I was invited to share Arizona's successful results with the Medicaid Commission recently appointed by Secretary Leavitt. The agenda referred to Arizona's session as "Best Practices on Program Innovation Through an 1115 Waiver." The agency is proud that Arizona's model is looked to as a roadmap for success.

Another important measurement for CMS and other observers was the overall cost of the AHCCCS program when compared with traditional FFS programs in other states and the quality of care provided by the Nation's first statewide managed care program. The following reports, evaluations and surveys reinforce that managed care constrains costs without sacrificing quality of care.

1995 GAO Report

The GAO report in 1995 stated that Arizona's Medicaid program, operating under a waiver from certain federal requirements, has succeeded in containing costs while providing beneficiaries access to what State officials and health providers describe as mainstream medical care. Arizona's AHCCCS program can serve as a model for other Medicaid programs. Rapid escalation in

Medicaid costs has prompted many states to search for new ways to control spending, including moving more beneficiaries into managed care delivery systems. No state, however, is as advanced as Arizona in using market forces to control cost growth. Although each state Medicaid program is unique, states converting from a FFS to a managed care program can learn from Arizona's experience.

Auditor General Report

Published in the last quarter of the federal fiscal year, the Arizona Auditor General reported results of five reports conducted during the year. Four Performance Audits were conducted measuring Medical Services Contracting, Division of Member Services, Rate Setting Procedures and Quality of Care. The fifth audit, the Sunset Review, provides information about the 12 Sunset Factors the Legislature is to consider in determining whether to continue the Arizona Health Care Cost Containment System (AHCCCS).

The Legislative Reference Committee responsible for recommending extension of the agency unanimously approved recommending that AHCCCS be extended for another 10 years.

The Committee not only recommended that the agency be continued, but also added a formal commendation to the agency for its effective service to the public. The report indicates a continued need for AHCCCS, notes that AHCCCS has met its overall objective and purpose and summarizes the four performance audits conducted on AHCCCS that identify opportunity for improvement.

ACUTE CARE EVALUATIONS

Laguna Research Associates' Final Report, published in February 1996, included the following findings for the acute care program:

- Review of the mature AHCCCS acute care program (years 6-11) indicates continued success for the program.
- Cost savings are increasing, the market place is getting more competitive, utilization of services is appropriate and management information system development has stabilized.

As Americans today look for ways to rationalize the delivery of medical care services, capitation appears to demonstrate one viable option. Findings from the evaluations of the AHCCCS programs have indicated success in delivering services statewide to Medicaid eligibles of all eligibility groups.

In July 1996, the **Kaiser Family Foundation** produced The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid which was based on CMS contracted reports produced by Stanford Research Institute (SRI) and Laguna Research Associates. The report highlights areas where states which are implementing programs similar to the AHCCCS acute care program and ALTCS program should focus their attention.

Two of the findings of the report were:

- The experience of AHCCCS demonstrates that capitated Medicaid can be successful in providing high quality, accessible care of costs lower than traditional Medicaid to beneficiaries of all eligibility groups in both urban and rural areas.
- AHCCCS saves money overall even though its administrative costs are higher; states should look beyond the initial investment and higher operating expenses toward future overall cost savings and more effective program management.

The cost effectiveness of the AHCCCS program has been well documented, but less systematic research has been done on quality of care, including members' satisfaction with the program. To make sure that Health Plans are evaluated on other factors in addition to cost, AHCCCS places a high priority on quality monitoring. In an effort to determine the quality of acute care from the perspective of AHCCCS members, AHCCCS conducted telephone interviews of more than 14,000 members to gather information for the first general member survey of its type, the 1996 Member Satisfaction Survey.

The survey provided considerable insight into member satisfaction as evidenced by the following results:

- 75 percent of respondents gave a rating of "good" or "very good" in six areas that were identified to summarize the overall quality rating of the program.
- Office nurses and primary care providers were viewed by the respondents as being the most courteous and respectful with 89 percent of respondents giving the highest rating.
- Over 87 percent of the respondents rated the availability of appointments, whether for checkups or illness, as being satisfactory or very satisfactory.

ALTCS Performance Evaluations

The success of the ALTCS program rests principally on the cost effectiveness of quality HCBS and an effective PAS process that ensures persons who become eligible for ALTCS are at risk of institutionalization.

In 1992, William Weissert, Ph.D. completed a CMS-funded evaluation of HCBS cost-effectiveness in the ALTCS program. As a result of the Weissert study, CMS removed the HCBS cap on enrollment. However, as a condition of removing the HCBS cap, AHCCCS was required to conduct a cost-effectiveness study of HCBS as a follow-up to the earlier study. As anticipated by AHCCCS, Dr. Weissert's conclusions were the same in 1998 as they had been in 1992.

- The ALTCS program appears to be maintaining eligibility standards at about the level they were during the program's early years. This analytical approach demonstrated cost-effectiveness then and it again shows cost-effectiveness now.
- In spite of the fact that a higher HCBS cap is in place, the present study did not find evidence to support the assumption of a woodwork effect large enough to offset savings from substitutions of HCBS for nursing facility care.

The Final Report completed by Laguna Research Associates in February 1996 summarized their evaluations of the AHCCCS program by saying:

- In summary, both the AHCCCS acute care program and ALTCS seem to be successful in producing cost savings.
- Cost of the program as compared to a traditional Medicaid program is 7 percent less per year for the acute care program averaged over the first 11 years of the program, and 16 percent less per year for the long-term care program for its first five years.

In 2002, the Nelson A. Rockefeller Institute of Government called AHCCCS a "smashing success" and cited Arizona as the "gold standard" for the nation as a model purchaser of health care services.

Chart 7
Increase by Program

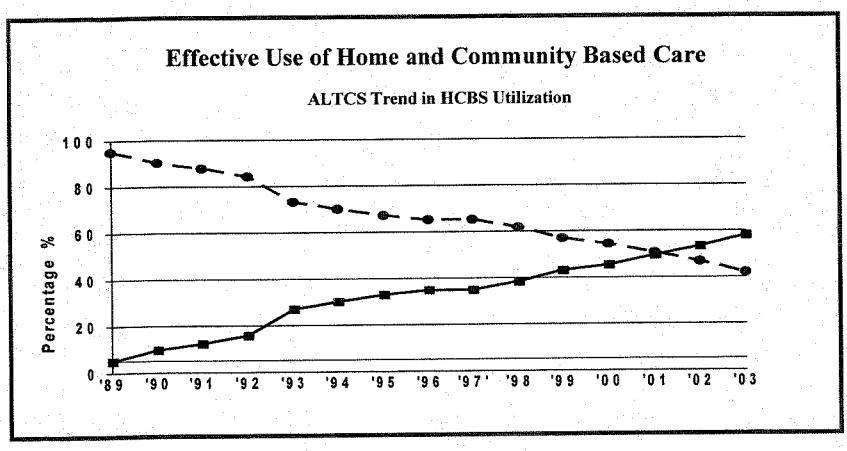
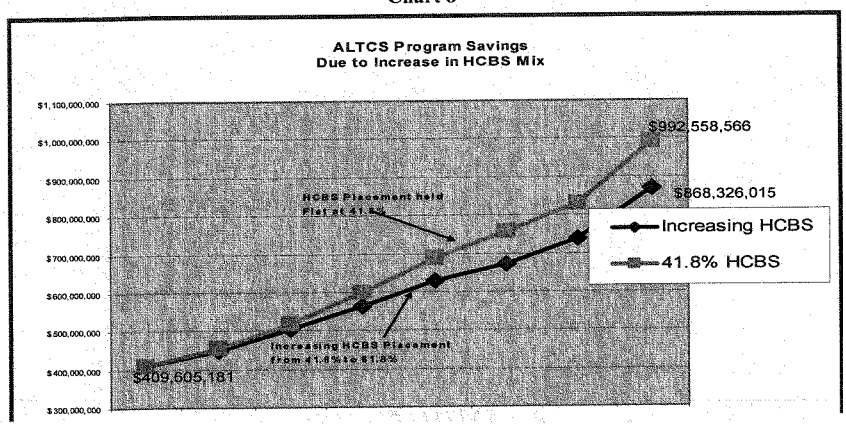


Chart 8



Innovations

1. **HAPA, the Hawaii project**. The project between Arizona and Hawaii allows the two states to share database information and resources, thereby providing better service to the people of each state. HAPA stands for Hawaii and Arizona PMMIS Alliance. The PMMIS (Prepaid Medical Management Information System) is AHCCCS' comprehensive computer system designed specifically for Arizona's managed care Medicaid program. Under the agreement, Hawaii would be able to use the PMMIS for its own Medicaid program and bear most of the expense of the project, also sharing the cost of improvements to the system.

2. **Web Technology**. Two major projects fall under this category: The Health-e-Arizona project and the Provider Web Project. Health-e-Arizona is a web-based application designed to interview and screen applicants for Medicaid, KidsCare and community-based health care programs. It offers English and Spanish versions in an application that is fully compliant with ADA. It is a partnership between AHCCCS, the Department of Economic Security (DES) and the Community Health Centers Collaborative Ventures. Health-e-Arizona users include Arizona FQHCs, several hospitals, other health care clinics and a variety of agencies. Once potential eligibility for Medicaid or KidsCare is identified, imaged documentation of eligibility and electronic signatures are forwarded through the web site to the appropriate Medicaid and/or KidsCare offices. DES is currently working with its partners to add screening for Food Stamps and TANF.

   The Provider Web Project is a pilot project using a website that allows AHCCCS providers to verify member eligibility and enrollment electronically. It is yet another alternative providers can use for eligibility verification rather than calling by telephone.

   AZ 2-1-1 was implemented by AHCCCS to create a public web portal for health and human services information to provide a single source for Arizonans to access information about public and private health and human services programs and resources available in their communities. AZ 2-1-1 also serves to provide emergency and disaster resource information during a declared emergency.

3. **Health Insurance for Small Business.** Healthcare Group of Arizona is a self-funded health care coverage insurance for small business administered by AHCCCS. Healthcare Group is able to use the AHCCCS buying power to offer affordable health coverage options to businesses with 50 employees or less.

4. **Electronic Health Information Exchange.** AHCCCS is currently participating in a public private effort to develop a statewide web based health information exchange utility portal for providing electronic personal health record access to providers, hospitals, long term care facilities. AHCCCS is developing the health information exchange utility for Medicaid beneficiaries.

The CHAIRMAN. Ron Pollack, take it away.

STATEMENT OF RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, DC

Mr. POLLACK. Thank you, Mr. Chairman. Thank you, Senator Kohl. I want to thank you before I begin on two counts, one for conducting this roundtable or——

The CHAIRMAN. Square table today.

Mr. POLLACK [continuing]. Or square table discussion.

The CHAIRMAN. We will be square pegs instead of round pegs today.

Mr. POLLACK. I appreciate the opportunity for the give-and-take that this affords. This is a very important issue because it affects as many as approximately 12 million people. They are the people who need health care the most, and so I deeply appreciate that.

But I would be remiss not to thank you for the leadership you have steadfastly provided in terms of the Medicaid program and protecting and strengthening the program. I think next year is going to be a challenging year on that score and we look forward to working with you next year and for many years in the future.

The CHAIRMAN. It will be my pleasure to work with you on it.

Mr. POLLACK. Thank you. I want to start off by just mentioning that it is important to put in perspective who this population is that we are talking about today. This critically important group constitutes less than a quarter of the Medicaid population and it is the population for whom Medicaid is literally a lifeline. They also constitute the people who consume two-thirds of the cost of the program.

By the way, this is not so surprising. There is a recent book published that was written by Katherine Swartz at Harvard where she talked about the overall population in terms of health care, and her findings were that 10 percent of the American population consume 70 percent of all costs. Actually, the lowest 50 percent of the population that consumes the least consumes only 3 percent of the cost. So it is very important for us to have this conversation today.

Before I go to the heart of what I want to say, I would like to offer two prefatory comments. The first is that the primary consideration as we deal with the populations who are dual-eligibles or eligible for SSI or SSDI is to improve quality of care. That clearly has to be our top consideration.

I think it is very possible, with improved coordination of care, to improve quality of care. This is especially important because this population tends to have multiple chronic conditions. It is not just one condition for which they go to see numerous specialists, and to have care coordination is critically important.

The second prefatory comment I want to make is that, if we improve quality of care, we might get some cost efficiencies. That is a far better way to go about trying to deal with budget-related issues applicable to Medicaid than arbitrarily cutting eligibility, cutting benefits, or increasing cost-sharing. My hope is we can wed together improvements in quality of care and make some cost efficiencies in the process.

Now, Mr. Chairman, you opened up this hearing by saying that this issue often is viewed as an ideological issue. I am very much

with you in hoping it is not an ideological issue. I think we do a disservice to everybody if this is an ideological issue.

The CHAIRMAN. I am not saying it should be.

Mr. POLLACK. No, no, no, I understand. That is why I am saying I agree with you that it should not be an ideological issue. It should be a practical question and we should try to make sure that we do something that is going to improve the quality of services and, hopefully in the process, improve the Medicaid program.

Now, there are several key protections that already exist for people who are in Medicaid managed care and I will mention those in a moment. Then I would like to mention some key protections that I think are important if we extend Medicaid managed care to this vulnerable population.

Under the Balanced Budget Act of 1997, there are some key protections that are provided to people who are in Medicaid managed care and they are very important and they should be extended to this new population as well. First, enrollees should have a choice of plans and they should be able to change plans within the first 90 days and they should be able to switch every year.

The CHAIRMAN. On that point, Ron, can I ask Tony, do they have a choice of plans in Arizona?

Mr. RODGERS. Yes, they do.

Mr. POLLACK. Second, with default enrollments, we should make sure that we protect existing provider relationships. That is also critically important. Third, we need to provide meaningful information for people so that they know what their choices are, their rights, the benefits, cost-sharing, and the grievance procedures. Finally, emergency services should be available without prior authorization using the prudent layperson rule, so that people who have an unexpected emergency can go to the nearest facility and get care.

In my testimony, I suggested about a dozen different areas of additional protections that should be established. I just want to focus quickly on four; I will mention them and for time considerations be real brief about it. First, it is critically important that there be serious care coordination. What is very important is that there be a sufficient number of care coordinators available so that they realistically can serve this population.

One care coordinator for 1,000, 2,000 people does not cut it, and we shouldn't just have care coordination when emergency circumstances occur. There has to be a reasonable ratio of staff for care coordination. There need to be reasonable standards for care coordination, and I think some real benefits can come from that and hopefully that will result in some cost savings and improved care.

Second, I think it is very important to have some type of ombudsman services so that an individual who is dealing with some significant health problems can go to a trusted adviser who can help them understand what their choices are, what their rights and responsibilities are, and if there are grievances, can help them with those. Texas and Minnesota have experimented with it very successfully and I think it is very well worth doing.

Third, we need to make sure there are specific quality measures so we make sure that this kind of managed care actually improves

the condition of people. We need to have assessments about improvements in the functional status of enrollees, access to care coordination, preparation for care transitions, and access to behavioral health services that are very important.

Last, you asked the question about rural parts of a State, like in Oregon. We need to make sure that, before we require and implement managed care for this population, the geographical areas are truly prepared to serve these people, that there are good primary care networks, and that specialist networks, and that there are no disruptions in care.

So, in sum, I would say I think the prospects of doing something in managed care are very well worth pursuing. They have to be done carefully and we have to make sure that the end results improves quality of care.

The CHAIRMAN. Ron, I want to ask which States, in your view, in your judgment, are doing it well sufficient that you would be comfortable with their models, if incentivized on a national basis.

Mr. POLLACK. I think there are some positive things that you can see in a number of States and some things you need to be cautious about in a number of States. No State is perfect, no State is doing a horrible job. So my hope is that given that we have had some States that have experimented with managed care for this population we can take the best of what States have done and try to emulate that. I don't think any single State would be the model in totality.

The CHAIRMAN. That is very good. We will keep the dialog up as we try to put together a legislative package of incentives to States. Obviously, we have got to find ways to save money, but I want to state for the record I share your priority, which is frankly quality care, and one can't be sacrificed to the other.

Mr. POLLACK. It might well be, Senator, that for those States or those areas where managed care is being introduced for the first time, there is going to have to be some investment, because you have to invest in creating an infrastructure, and so there may be some short-term costs. But, hopefully, you will see reductions in emergency care. We will see more people taking generic drugs. We will hopefully make sure that there is coordination among the different specialists who are treating somebody, so that one specialist is not causing a problem in yet another area that they do not specialize in. Hopefully, we will have more home and community care rather than institutional care. All those things offer promise, but they also require investment in infrastructure.

The CHAIRMAN. When you think of investment in infrastructure, one of my other committee assignments is on the Commerce Committee and there are just some really exciting things out there in terms of medical technology and telecommuting. I don't know if you are familiar with the Veterans Administration health system, but I was at Roseberg, OR, the other day and literally watched a physician through a computer and videoconferencing literally treat a man for everything he needed right there, and did it almost, I suppose, with all of the effectiveness of if the guy were in his office and he was doing it from hundreds of miles away.

I don't know if that is what you have in mind or if that meets the standard of infrastructure you think is necessary.

Mr. POLLACK. Clearly, those kinds of things require investment before they can truly be implemented, and so it is very important not to be impatient about this. You can't just throw managed care into a place that is not prepared to do it, and so short-term, there probably are likely to be some additional costs. Hopefully, in the long term, it not only will improve quality, but also will achieve some efficiencies.

The CHAIRMAN. Very good. Thank you so much.

[The prepared statement of Mr. Pollack follows:]

FamiliesUSA
The Voice for Health Care Consumers

Testimony of
Ron Pollack
Executive Director, Families USA

Before the
Senate Special Committee on Aging

September 13, 2006

On behalf of Families USA, I thank Chairman Smith, Ranking Member Kohl, and members of the Senate Special Committee on Aging for the opportunity to present testimony to this round- table discussion on Medicaid managed care. This Committee plays a critical role in exploring ways the federal government can improve health care services for our low-income seniors. The expansion of managed care within the Medicaid program creates some important opportunities for improved care—but managed care must be implemented with care and caution to ensure that the most vulnerable populations of all ages are protected.

Our testimony focuses on 1) the potential of managed care to produce better health outcomes for Medicaid recipients and better coordination between Medicaid and Medicare, and 2) the important consumer protections that are needed to ensure the care of the most vulnerable Medicaid populations.

Our role here today is on behalf of health care consumers, including the more than 50 million Americans who rely on Medicaid for their health care. Medicaid plays a critical role in our nation's fragile health care system, and Families USA is committed to strengthening and preserving the program on behalf of everyone who relies on it. We understand, however, the need to look for efficiencies, where possible, and to maintain the integrity of the program. We applaud the Special Committee on Aging for continuing this dialogue.

Unfortunately, Medicaid—in particular, its financing—has been under attack in recent years. There have been proposals to convert the program from an entitlement to a block grant and efforts to reduce benefits and eligibility in the name of saving money. Sadly, too few conversations have been focused on how to serve the needs of the beneficiaries and how to provide streamlined and effective care.

Managed care is not a magic bullet for Medicaid; nor is it a panacea for health care in general. However, when implemented carefully and effectively, managed care may provide better care and may be one possible tool for achieving better coordination of care. In the process, it may create efficiencies that have a positive fiscal impact.

I am heartened that this conversation is focused on good policy changes that protect beneficiaries and

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provide for supports and systems that will improve the care of the most vulnerable Americans—and not on cutting services or eligibility. In the long run, more preventive care, early intervention, and appropriate levels of care may yield long-term savings.

Today's discussion focuses on the expansion of the role of managed care in Medicaid to new populations: to people eligible for both Medicaid and Medicare (the so-called "dual-eligibles") and Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) recipients. When dealing with such vulnerable populations, thoughtful deliberation is essential. At least 11.7 million people receive Medicaid services based on their age or disability—maybe more as some children who receive Medicaid are recipients but would not be included in this count. Of these, 7.5 million are dual-eligibles; the remainder are not duals and may only receive SSI or SSDI.

The dual-eligibles and other disabled recipients make up almost 23 percent of the total Medicaid population, but account for about 67 percent of total Medicaid expenditures. Clearly, this is a population that has very complex health needs and for whom the entire panoply of health and long-term care supports and services is needed. Good managed care for these beneficiaries could result in quality care and better health outcomes.

There are several important considerations that should be taken into account when expanding Medicaid managed care to new populations, in particular the consumer protections that are necessary. Dual eligibles and SSI/SSDI recipients often have multiple or complex conditions and needs that may require dedicated specialty care. Since only about 35 percent of dual eligibles are already in some form of managed care, an expansion could transfer an additional 4.9 million dual-eligibles into managed care. However, depending on how this expansion is implemented and the type of changes made to the system, it is very possible that all 11.7 million dual-eligibles and beneficiaries receiving SSI would experience some type of disruption or change to their care.

I urge the Committee to focus on who the individuals are who fall into this population: the sickest and frailest seniors; children with complex health needs; and people who require carefully coordinated care to maintain their health. I urge you to consider these changes in light of the larger Medicaid debate and to work towards preserving and strengthening the Medicaid system as a whole.

Background On Medicaid Managed Care

Currently, states can mandate enrollment of some populations directly into Medicaid managed care, but states cannot mandate the enrollment of people eligible for both Medicaid and Medicare (dual eligibles), children receiving Supplemental Security Income (SSI) benefits, some other children with special health care needs, or American Indians except in specified circumstances. These populations may remain in traditional fee-for-service Medicaid or voluntarily enroll in managed care.

Nationally, in 2003 (the last year for which data are available), about 35 percent of dual eligibles were in some form of Medicaid managed care. In many of these cases, however, the plan was only responsible for primary and acute care; the state still paid for long-term care on a fee-for-service basis.

Only a handful of states have experimented with managed long-term care. In fact, there is very little experience in the private market with managed long-term care on which to build. So far, studies have *not* shown great savings to states from these arrangements. It is not clear whether managed care for physical and acute services for dual eligibles and other vulnerable populations will result in major savings for Medicaid, particularly now that drug costs are paid through Part D. Plans have very little room, if any, to achieve savings by cutting provider reimbursements. Already, in many states, Medicaid reimbursement

rates are less than Medicare allowable charges. A number of state Medicaid programs do not pay 20 percent copayments to providers because of this rate difference, and advocates across the nation report that this impedes access to providers.

States should look at the potential of managed care to better coordinate physical and long-term care services, encourage home and community-based services instead of institutional care, and integrate Medicare and Medicaid funding to achieve better care. In time, this may result in long-term savings to the program. For example, savings could come be realized—and better care provided for the dual eligible population—but only if managed care plans actively provide care coordination services and states and the federal government integrate Medicare and Medicaid administrative and regulatory systems. The potential to expand managed long-term care only exists in states with relatively high managed care penetration and willing, comprehensive provider networks. Rural states and those states with low managed care penetration will present particular challenges requiring careful attention.

Needed Consumer Protections

The special needs of the vulnerable populations who rely on Medicaid and Medicare make it extremely important to ensure adequate protections are in place in order to guarantee comprehensive appropriate care. The Balanced Budget Act of 1997 (BBA) contains a number of consumer protections related to Medicaid managed care. All of these protections continue to be vital to ensure the protection of beneficiaries in Medicaid managed care and must remain in effect if Medicaid managed care is expanded. Among the consumer protections that currently exist under the BBA:

- Enrollees must have a choice of plans; and they must have the right to change enrollment within the first 90 days and once every 12 months thereafter;
- Default enrollments must take into account existing provider relationships;
- Information must be provided to enrollees and prospective enrollees about rights, benefits, cost-sharing, grievances, quality, and what benefits are provided outside of managed care;
- Emergency services must be provided without prior authorization using the prudent-layperson definition and plans must reimburse out-of-network emergency providers as well as in-network emergency providers;

Due to the unique needs of the dual-eligible and SSI recipients, there are additional protections that must be written into federal law if more populations are to be moved into a managed care system.

- **Ombudsman:** There is a need for neutral counseling about Medicaid managed care and how it can coordinate with the various Medicare plan options, as well as counseling to help beneficiaries navigate the programs. Dual-eligibles and SSI recipients should have access to an ombudsman outside of the managed care plan who can help them navigate care and assert their rights; this ombudsman should be familiar with both Medicaid and Medicare enrollment, certification and administration requirements. CMS has required this in a number of states with waivers to enroll Medicaid beneficiaries in managed care, and it has proved important. In Texas, for example, people on SSI and dual-eligibles make up the highest proportion of callers to a nonprofit that contracts with the state to provide ombudsman services. Minnesota, one of the states experimenting with integrated care for dual-eligibles, uses an ombudsman; administrators and advocates alike believe that its function is extremely important.

- **Care Coordination:** Plans should assign care coordinators within the plan to each beneficiary to help coordinate care received by multiple providers and to help find the appropriate people to contact for care within the plan. Care coordination is probably the most

important service a managed care plan can offer to improve services to the dual-eligible population and to ensure duals a full continuum of care. It is essential that plans have realistic staffing standards for care coordination. Some states only assign duals to care coordinators once problems emerge; or they assign 3,500 cases to one "exceptional needs care coordinator" —an untenable caseload. Possible solutions are to set standards about the number of cases per worker or how often care coordinators must be in touch with members (e.g., a Texas plan requires that, for people with chronic conditions not under control, care coordinators visit weekly or monthly and that, for people with chronic conditions that are under control, care coordinators phone monthly.)

- **States should meet "readiness" standards before expanding Medicaid managed care to new populations:** For example, they should have quality standards in place appropriate to populations with disabilities; be able to show that there are enough interested HMOs that have the capacity and equipment to serve special needs populations—including adequate primary care and specialty care networks, physically appropriate facilities, and equipment, etc; show that they will not disrupt existing care arrangements; and show that they are able to pay a capitation rate that encourages care.

- **Meaningful consumer input:** The government should accept and review consumer input on draft requests for proposals for managed care plans serving duals and special needs populations and should encourage plans to develop consumer advisory committees. States should show that they have provided a public input process for their overall plans to expand Medicaid managed care to duals and special needs populations.

- **Require that services be considered "medically necessary" if they maintain, improve, or prevent the deterioration of functioning:** Plans and providers need to define "medical necessity" as appropriate to the needs of people with disabilities in order to authorize home and community-based care that preserves or helps people attain maximum functioning, not just restorative services. For example, many elderly people and consumers with disabilities use personal care services to help them with activities of daily living or use physical therapy to keep their ambulatory skills from further deterioration. Plans should continue to authorize these services (absent a change in the person's condition) as long as the services continue to assist the person to maintain functioning, rather than requiring the person to show physical improvement.

- **Establish a coordinated appeal system for Medicare and for Medicaid services that affords the right to continued benefits pending a hearing decision:** Currently, the Medicaid hearing process affords more rights to beneficiaries than does the Medicare hearing process. The right to continued benefits is essential to low-income people who have no means to pay for care up front pending the outcome of an appeal. Further, beneficiaries need one coordinated system through which to pursue appeal rights—they should not be expected to sort out which insurer should handle an appeal.

- **Make sure that the beneficiary does not get caught in payment disputes between Medicaid and Medicare:** The state or plan should bill Medicare as appropriate and handle any disputes about payment, rather than leaving the beneficiary without a service such as home health that the plan or state thinks should be reimbursed by Medicare.

- **Prohibit "passive enrollment" into Special Needs Plans:** As Medicare Part D was implemented last fall, Medicaid managed care enrollees in some states such as Pennsylvania were "passively enrolled" into Special Needs Plans under which all of their Medicare services were furnished through managed care. Previously, many of these consumers had used Medicaid managed care plans for their non-Medicare covered services but had used either traditional Medicare or other Medicare Advantage plans to pay for doctor visits. Many duals found that the doctors they had always used were not in the new plans' networks, and the passive enrollments thus resulted in great disruptions in care and were the subject of a lawsuit, *Erb v. McClellan.*

- **Require specific quality measures for the dual and special needs populations.** Regularly examine a plan's performance and conduct audits to make sure that rate structures and provider payments are appropriate. The Center for Health Care Strategies has developed good recommendations for performance measures for the dual population, including measures of their functional status, access to care coordination, preparation for care transitions (that is, were they adequately prepared to move from a hospital to another care setting and did the next facility receive appropriate information about their care needs), and access to behavioral health services.

- **Exceptions for the spend-down population:** People spending down to Medicaid, who may go on and off of Medicaid rolls periodically, should not be required to enroll in plans that will only serve them while they have Medicaid.

- **Out-of-network care:** Under current rules, plans are required to reimburse out-of-network emergency providers under some circumstances. Using similar concepts, plans that provide long-term care should be required to reimburse out-of-network long-term care facilities under some circumstances. For example, plans should be required to pay out-of-network nursing homes that members must use to be close to family, or that continue care that people received before spending-down to Medicaid, or that offer specialized services not available within the network.

Thank you for the opportunity to testify before you today. The expansion of managed care within Medicaid may be an important component to improving health services for the most vulnerable seniors, but only if implemented properly. We urge the committee to ensure current consumer protections remain in place and to further expand protections if managed care expands to cover dual eligible seniors. Families USA looks forward to continuing to work with the Special Committee on Aging to explore ways to improve and strengthen the Medicaid program and to improve health care for America's low-income seniors

The CHAIRMAN. Jeff.

STATEMENT OF JEFFREY S. CROWLEY, SENIOR RESEARCH SCHOLAR, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Mr. CROWLEY. Mr. Chairman, Senator Kohl, thank you for the invitation to provide a disability perspective as you consider these issues. I also want to echo what Ron said. I know the range of disability and HIV groups I work with are really appreciative of the leadership of both of you over the last year and hope it that will continue as we go forward.

From my vantage point, it appears that much of the current policy discussion related to managed care is really about how to apply managed care to have greater managed long-term care and how to use this to integrate acute and long-term services for dual-eligibles. I recognize that this creates some real opportunities, but I really approach this conversation with great trepidation.

Today, I don't think we have proven large-scale models for delivering long-term services and supports in the managed care environment. Arizona is the only Medicaid managed long-term care program that operates both statewide and on a mandatory basis. A number of States have established managed long-term care programs, but they remain quite small in scale.

Turning to integrated care for dual eligibles, I would say many of the same things. Large-scale and proven models for integrating care just simply do not exist yet. So since these fields are really in their infancy and seniors and people with disabilities are quite vulnerable, States should not be permitted through waivers or other initiatives to mandate participation in these new programs. Further, I think seniors and people with disabilities need to be engaged in meaningful partnerships in developing these new programs.

Now, it feels like in the past we have seen that States and managed care organizations, or MCOs, don't really know how to work with beneficiary representatives or they don't really believe that they have the technical expertise needed to really provide a meaningful contribution. But when we look at developing workable managed long-term care programs, I think it is actually the beneficiaries that have expertise related to their own service needs or how to efficiently provide those services that managed care organizations simply don't have on their own.

So, in short, I would say encourage States to experiment in these areas, but please recognize that it is really premature to think about mandating participation or about giving States more flexibility that essentially means waiving essential beneficiary protections.

Now, in the context of managed acute care services, I think over time a number of tools have evolved to help us ensure accountability for what we are purchasing, and this includes a number of things like the development of clinical practice standards, adoption of consumer protection systems and the development of performance measures that allow us to measure how well MCOs are meeting their obligations. Comparable tools for managed long-term services do not exist at this time.

So one thing I think the Congress could do is play an important role in encouraging the development of performance measures for long-term care. So if we are talking about moving to managed care and constructing a system based on contracts where these companies will deliver services, let's develop the tools to make sure we are getting what we pay for.

The CHAIRMAN. CMS has none of that at this point?

Mr. CROWLEY. No. There is a private group called the Center for Health Care Strategies that has begun some of this work, but I think we really need a larger-scale effort to do this. I would say performance measures for long-term services maybe are more difficult to develop than acute care. In the acute care environment, maybe it is easy to say, if you are a new enrollee we expect you to be screened within a specific period of time, or we can demonstrate how often we want you to be able to see your doctor. We are not really sure what we are talking about, and we are probably talking about less clinical measures for long-term care when we are talking about people that come into people's homes and provide personal assistance. It is just a very different situation.

I would also say that much has been learned over the past decade about how to do managed care and how not to do managed care for people with disabilities, and some of things I am going to say might sound self-evident, but let me just run through what I think are some key lessons from the past.

The first is go slowly in implementing managed care programs. The second is that we have to ensure that payments to MCOs and providers are adequate, and I would really like to support many of the comments that Mr. Rodgers made about the importance of actuarially sound payment rates. I think that is really a critical issue.

We also need to ensure that States maintain an adequate Medicaid administrative infrastructure. I think some States 10 years ago maybe thought that managed care was going to allow them to just wash their hands and turn over the headaches of running a Medicaid program. I think we have learned that that is not the case and to do managed care right we need to have people in Medicaid offices actually managing what the MCOs are doing.

I also think an important area from a disability perspective is promoting disability care coordination organizations as a way to use managed care. There are a relatively small number of these programs that operate around the country and they coordinate publicly funded medical and social services and they blend attributes of both social services and health care organizations. These may be a way that States could apply the managed care tools to serve people with disabilities, but minimizing some of the drawbacks we have seen when States have tried to just serve people with disabilities in statewide managed care programs developed for the general Medicaid population.

Then, last, I think we need to consider strengthening consumer protections. Among other things, this may include more protections to ensure access not just to qualified providers, but also experienced providers, requiring States to demonstrate their capacity before implementing managed long-term care programs and strengthening beneficiary appeals protections.

So in closing, I would just like to say I am encouraged that the Aging Committee is considering these issues, and I would encourage you to look for opportunities, but also protect beneficiaries, and also the large Federal financial investment to make sure that we don't rush into new, maybe irresponsible or wasteful approaches to managed care that don't really help anybody and may promise more than they can deliver.

So again thank you for inviting me to participate in the roundtable.

The CHAIRMAN. You had a number of really important points that we should remember in any legislation that we are able to produce. If you wanted to highlight just one that you just have to have in any legislation going forward that encourages managed care, what would that be?

Mr. CROWLEY. One consumer protection?

The CHAIRMAN. Yes.

Mr. CROWLEY. I guess I would say ensure that beneficiaries have a right to get access to the providers they need, and so that means a number of things. It is making sure we have the networks that are adequate, but there might be very specific cases where there might be only one qualified or experienced provider for an individual in their community and they could be outside the network. So we need structures to allow people to get outside the networks to get what they need. That is not about saying everybody needs those rights. We are talking about really providing a safety valve for those very specific cases.

The CHAIRMAN. Of dual-eligibles and chronic——

Mr. CROWLEY. Right, exactly.

The CHAIRMAN. You talked about contract specificity. Do you think that was the result of poor training, lack of knowledge or just States wanting to wash their hands of Medicaid and their responsibility and turn it over to——

Mr. CROWLEY. Yes. Some of this I said more in my written statement about the importance of well-written contracts, and I think what we have seen is that managed care is a major shift and when States first got into it, they were learning and they didn't really know what they were doing. I think over the last decade, we have seen that they have learned that they are actually purchasing a product and to get what they are paying for, they have got to be very specific in writing down in this contract what they expect. I think that has actually been a major sign of progress that we have seen over the last decade is that States have gotten much better at doing this.

The CHAIRMAN. Tony, does that ring true to you and is that Arizona's experience?

Mr. RODGERS. Mr. Chairman, absolutely. The management of managed care, which is the State's responsibility, does require core competencies of the State employees on how to look at the performance of a health plan. Over time, you develop your performance measures and your control points. The contractual relationship has to be monitored and when a plan is not meeting their contractual relationship, there has got to be sanctions.

Some States have kind of—and I have talked to other States about this—a fear factor of, well, we don't want to be too tough.

But the managed care organizations respond to this because each of the managed care organizations that is performing has invested. If you allow a managed care organization not to perform, you are, in essence, penalizing those who are performing. So that is an important role that the State plays and you have to have the core competency.

I agree it does take time to build that, but the benefits later—you really begin to see increase in community-based services. You see a stable network, and then you can start to build on that—new quality measures, new performance requirements—and really do best practices. One of the major concerns I have is there is no comparability between States in terms of how they are paying into their care and whether it is justified. I look at what other States are paying PMPM and I just wonder how is that justified compared to what we are paying PMPM, so to speak.

[The prepared statement of Mr. Crowley follows:]

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Statement of
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Medicaid Managed Care Roundtable

Before the Special Committee on Aging
United States Senate

September 13, 2006

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Mr. Chairman, Senator Kohl, and Members of the Committee,

Good morning. I am Jeffrey Crowley, a Senior Research Scholar at the Georgetown University Health Policy Institute. Thank you for inviting me to provide a disability perspective as the Aging Committee considers issues related to Medicaid managed care. I am reminded of a series of forums conducted by the Aging Committee related to Medicaid managed care more than nine years ago that led to critical leadership by members of the Committee when managed care reforms were enacted through the Balanced Budget Act of 1997 (BBA). I hope that this series of roundtables proves to be equally as valuable.

I would like to offer a pragmatic and responsible framework for how to approach managed care recognizing the significant improvements that better management of care can bring to Medicaid beneficiaries with disabilities. I must start, however, by reminding the Committee of the experience of many Medicaid beneficiaries with disabilities, not all of which have been positive. Indeed, ten years ago, if asked, I would have said that in ten or fifteen years, managed care could lead to improved care for Medicaid beneficiaries, but that a lot of vulnerable individuals could get hurt until we resolved some of the challenges of applying managed care models to people with disabilities. Looking back on the past decade, I can say that, through hard work, many states have made great progress and managed care has strengthened some states' efforts to manage services for people with disabilities, but progress has been uneven and not all state experiments with managed care have been successful. I would also say that a lot of people have been hurt by the way in which some federal and state officials embraced managed care as a magic bullet for controlling Medicaid costs—and in some cases pushed managed care reforms forward in a rushed way, ignoring prominent pleas for a careful, well-planned approach to implementing such a major change.

Background on Medicaid Beneficiaries with Disabilities

Medicaid beneficiaries with disabilities have diverse and extensive needs that create unique challenges for managed care organizations (MCOs).

According to the Kaiser Commission on Medicaid and the Uninsured, 14% — or 7.7 million — of Medicaid's 55 million beneficiaries were non-elderly people with disabilities in 2003.[1] They are disproportionately costly, responsible for 43% of benefits spending in that same year.[2] On a per person basis, an average of $11,659 was spent on services for beneficiaries with disabilities in 2003, compared to $10,147 for seniors (who are generally people with disabilities over age 65), and this was significantly more than the $1,410 spent on children or the $1,799 spent on non-disabled adults.[3] Even among Medicaid beneficiaries with disabilities, there are large differences in average costs. Indeed, in 2001, the highest cost beneficiaries with disabilities that comprised just 2% of overall Medicaid enrollment were responsible for 25% of overall Medicaid spending.[4] Large differences in costs reflect large differences in the level of need for services and the complexity of their needs. Therefore, any evaluation of managed care must take into consideration its ability to respond to different needs and different issues among beneficiaries with disabilities.

In the early and mid-1990s, there was a level of excitement about the promise of managed care as a tool to assist states in managing cost increases in Medicaid.[5] Further, many policymakers looked to the experience of commercial managed care in the private market and believed that capitated managed care was a proven model that simply needed to be applied to Medicaid's high cost groups—seniors and people with disabilities. While managed care models still hold potential to improve the management of care for Medicaid beneficiaries, and management techniques that were first widely employed by managed care are still being implemented (even if not necessarily in conjunction with capitation), states' embrace of managed care and commercial insurers has diminished somewhat. The number of states with Medicaid managed care programs for people with disabilities rose about ten years ago, but has receded recently. From 1995 to 2002, the number of states with managed care programs focused on people with disabilities declined from 31 to 22.[6] Further, there has been a retrenchment in the role of commercial managed care plans in managing care of Medicaid beneficiaries. Writing in *Health Affairs* in 2003, Hurley and Somers report that a profitability downturn in the managed care industry has altered interest in public-sector lines of business, and commercial plans began to withdraw from Medicaid as they purged low- and no-margin business lines.[7]

Therefore, while commercial managed care plans may have pushed to enter the Medicaid market in the 1990s, the role of these plans appears to have diminished in Medicaid.

Challenges in Implementing Managed Care for People with Disabilities

Caring for beneficiaries who have a broad range of disabling conditions and large variations in the types of and scope of necessary services can be difficult. The shortcomings of efforts by states and MCOs to adapt managed care to serving people with disabilities have been documented. In a 2001 report, the Kaiser Commission on Medicaid and the Uninsured stated,

> "Enrollment of elderly and disabled populations into managed care is increasing, but is complicated by difficulties in setting appropriate capitation rates, limited plan experience in providing specialized services, and lack of systems to coordinate Medicare and Medicaid benefits for those covered by both programs. The future success of Medicaid managed care depends on the adequacy of capitation rates and the ability of state and federal governments to monitor access and quality."[8]

In a study of 36 states with Medicaid managed care programs for people with disabilities, researchers at the Economic and Social Research Institute found that most managed care programs for people with disabilities are mainstream programs.[9] These programs include Medicaid beneficiaries with disabilities in the same design that is used to serve people with occasional or acute needs. Generally, states have not designed special features to account for the special challenges facing children and adults with disabilities. The study also found that MCOs are paid through capitation rates that frequently do not reflect the varying risk profiles of different categories of enrollees, or are not adequately increased over time to account for rising costs. Further, states have generally not held managed care plans strictly accountable for implementing basic features of a good managed care model such as requiring MCOs to identify

enrollees with special health care needs and provide such people with a comprehensive health care assessment within a reasonable period.

Researchers at Lake Snell Perry and Associates conducted a series of focus groups with Medicaid beneficiaries with disabilities in two states in 1999. Beneficiary concerns in these states were consistent with findings of other research.[10] Focus group participants observed that:[11]

- **Nobody is managing their care**
  Many indicated that they would welcome the assistance of their primary care providers, but that they do not believe that they have the time.

- **Case managers are not helping much**
  Some complain that there is too much turnover among case managers to form a relationship with them.

- **Too few providers participate in their plans**
  This leads to long waiting times for appointments, or because of their special health care needs, requires them to go out of network for care.

- **The referral process is confusing**
  Many say they do not understand when and why they need referrals. They also feel strongly that persons with chronic conditions should not be required to continually obtain referrals to see specialists.

- **Important benefits are hard to obtain or coverage is insufficient**
  Beneficiary participants cited problems accessing pharmaceuticals that included inconsistent policies for whether specific drugs were on a formulary and problems tied to 30-day supply limits on medications; they indicate that they cannot get enough speech, occupational, or physical therapy and they are frustrated that they must "show progress" in order to continue therapy; they believe that MCOs create barriers to obtaining durable medical equipment; they indicate that dental care is inadequate and hard to find providers who accept Medicaid; home health needs go unmet; and they say that transportation services are inconsistent and this causes missed appointments and problems getting prescriptions filled.

Managed Care Consumer Protections for Medicaid Beneficiaries with Disabilities

When Congress enacted the BBA, it considered the challenges of appropriately serving Medicaid beneficiaries with disabilities and other special health care needs in managed care programs. Congress demonstrated its concern through BBA requirements that:

- Exempt dual eligibles and children with special health care needs from mandatory enrollment in managed care (unless a state receives a waiver to mandate this enrollment);

- Established new statutory provisions to protect Medicaid beneficiaries in managed care; and
- Instructed the Secretary of Health and Human Services to conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled in Medicaid MCOs are adequately met.[12]

These provisions resulted in a significant updating of the Medicaid law and provided important new consumer protections for Medicaid beneficiaries. I should note, however, that the Bush Administration retracted Clinton Administration regulations implementing the managed care provisions in the BBA and issued new regulations in 2001. Beneficiary advocates were disappointed by this change because a major area of difference in the rules was the elimination of regulatory protections recommended in the BBA's Report to Congress for people with disabilities and other special health care needs.[13] Nonetheless, BBA regulations that are currently in force guarantee that Medicaid beneficiaries have a choice of MCOs, require MCOs to provide enrollees and prospective enrollees specific information to make an informed choice of plans, provide for emergency room coverage using a "prudent layperson" standard, and require MCOs to demonstrate adequate capacity to provide contracted services, among other protections.

Learning from Past Experience with Medicaid Managed Care

Much has been learned over the last decade about how and how-not to implement Medicaid managed care programs for people with disabilities. In my view, the following are key lessons from recent experience with Medicaid managed care for people with disabilities:

- **Go slowly**

Some of the worst experiences with managed care have come when states have tried to implement wholesale managed care transformation. Instead, I think the most promising managed care programs have been those that have developed slowly. Often, successful programs were tested first as small pilot programs, and after careful evaluation, they have been gradually expanded. For example, New York's Medicaid program entered into a contract with Independence Care System (ICS), which serves people with disabilities in three boroughs of New York City, starting in 2000. ICS is committed to growing at a modest pace that allows them to develop an adequate provider network and hire and retain staff that are committed to developing a greater understand of members unique needs. Their membership has grown to 700 members now and they plan to grow to serve 900–1000 individuals over the next 3 years. This assumes that ICS is able to attracted additional members to participate in this voluntary program.[14]

I understand that the Committee heard from Governor Napolitano over the summer about Arizona's Health Care Cost Containment System (AHCCCS). I agree with the Governor that Arizona can provide some important lessons for how to use managed care to deliver quality care to Medicaid beneficiaries, including beneficiaries with disabilities. I would note, however, that the program is not perfect, and it has evolved and improved over time. The AHCCCS program

was established in 1982 and its long-term care program was added in 1989. It took more than two decades for the program to get to where it is today. I do not believe it would be possible for another state to quickly adopt the "Arizona model" without a long-term planning and implementation process that takes into account the health care system as it currently exists in a specific state. We have experience with states that have tried rapid, massive transformations, but these experiments have often ended badly.

- **Payments to MCOs and providers must be adequate**

A key requirement for managed care to work well is to ensure that MCOs and providers are paid sufficiently to provide the level of services that Medicaid beneficiaries need. Given that many states have embraced managed care primarily to save money, this lesson cannot be overemphasized. While it is possible that MCOs and providers can fall short on delivering quality care when they are paid sufficiently, it is not reasonable to expect MCOs or providers to sustain a high quality delivery system to Medicaid beneficiaries with disabilities who are potentially costly, and with highly variable costs, unless Medicaid programs provide adequate payment. Mental health professionals and advocates have stated that the Medicaid managed care experience with the competing approaches of integrating mental health services with physical health services and carving out mental health services to be provided in a separate behavioral health system have both produced many circumstances where managed care programs provided grossly inadequate access to services. A common denominator, however, has been that many states appear to have underpaid for mental health services and this has lead to serious access constraints for pharmaceuticals and psychiatric services.

A key federal policy that has been particularly important in this regard is the concept of actuarially sound payment rates. In 2001, a key beneficiary protection in the Bush Administration's BBA managed care regulations was the requirement that all payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.[15] I understand that some states have advocated for new flexibility to not comply with this straightforward requirement that requires states to pay MCOs rates that are established using generally accepted standards and that take into account the populations being served and the services to be covered. I urge the Congress to resist making any changes in this regard.

- **States must maintain a sufficient Medicaid administrative infrastructure**

In the mid 1990s, I believe that part of the allure of Medicaid managed care for some governors or other state policymakers was the idea that they could hand off responsibility for Medicaid to private entities who would then be responsible for all of the headaches of managing a Medicaid program. One thing that has become clear is that, as a matter of law, states cannot contract away their responsibilities to comply with the Medicaid Act...and this is as it should be. What this means, however, is that no matter what promises the managed care industry makes to states, at the end of the day, states remain accountable for operating their Medicaid programs according to the law and providing high quality services to their beneficiaries. Another lesson for states has been that to effectively operate Medicaid managed care programs takes a considerable administrative investment. Moving to managed care should not provide an excuse for states to cut state employees. I believe that states such as Arizona that have made long-term investments

in managed care would concur with this view. Further, federal officials at CMS should be prodded to collect and publicly report more detailed information about the experience of specific populations with Medicaid managed care.

- **Adequate provider networks, including specialty care, are essential and often neglected**

One of the most promising aspects of managed care for Medicaid beneficiaries is the idea that MCOs will be legally responsible for managing the care of beneficiaries—and ensuring access to providers. This is viewed by some as a way to address problems associated with limited access to providers caused by historically low Medicaid payment rates. For people with disabilities, however, the key issue is not having access to any provider; it is ensuring access to appropriate specialty care. In many instances, the critical challenge is not finding a primary care provider, or even a specific type of specialist; it is finding the right type of specialist with experience treating a specific condition. So, for example, for a person with HIV/AIDS, the challenge is not ensuring access to a primary care provider, or even an infectious disease specialist, but rather, ensuring access to an infectious disease physician who has experience treating people living with HIV/AIDS and with whom the individual can form a productive treatment relationship. By moving people with disabilities to a service delivery model that permits restrictive networks, even with strict numerical targets for the number or types of providers in a network, too many beneficiaries have found existing treatment relationships interrupted without having access of comparably experienced in-network providers. As another example, for a person with epilepsy who may have spent 5 years working with a neurologist to manage their condition, being forced to switch providers—even if their health plan makes available other neurologists—is not acceptable.

Given the current environment where Medicaid beneficiaries can be forced to participate in managed care, federal policymakers may wish to examine the issue of access to specialty care and may need to consider new protections to give individuals the ability to maintain access to existing providers or to receive services from non-network providers if it is necessary to maintain access to treating providers with current experience treating their specific conditions.

- **Well written and clear contracts can improve accountability**

The relationships between states and MCOs are subject to legally enforceable contracts. This means that if a state clearly defines its expectations for its contractors, it can improve the quality of care provided and improve accountability for the large amount of public funds invested in managed care. Over the past decade, states have grown increasingly sophisticated in their contracting with MCOs. The George Washington University Center for Health Services Research and Policy, with extensive public and private financial support, has contributed greatly to states' ability to develop well-written and clear contracts. For many years, they have conducted an extensive review of state managed care contracts and developed a broad array of model purchasing specifications for states around a number of different populations and issues. For example, the Center developed model purchasing specifications for specific disability populations such as people with epilepsy and people with HIV/AIDS, as well as specifications related to topics such as pharmaceuticals and also behavioral health services.[16] As managed care

approaches are applied to new issues, such as serving dual eligibles or providing managed long-term care services, federal policymakers should ensure that ongoing investments are made in developing purchasing specifications so that states retain the capacity to develop clear and enforceable contracts with MCOs.

- **Managed care can be used to improve care coordination for people with disabilities**

One of the most promising features of Medicaid managed care for people with disabilities is the concept of disability care coordination organizations (DCCOs). Earlier this year, the Center for Health Care Strategies published a synthesis of key lessons from seven of these organizations.[17] This report provides a framework for states that are considering promoting care coordination as part of their managed care strategy. These programs coordinate publicly-funded medical and social services and they blend attributes of social service and health care organizations. As a general rule, these programs coordinate most or all of an individual's benefits and for some people may provide non-Medicaid supplemental benefits, such as in-home wheelchair repair services. Key aspects of what makes these programs work effectively is that they are integrated into the disability community, they work with their clients in developing a person-centered plan of care, and they collaborate with a variety of agencies, providers and vendors to meet an individual's needs. Financing for these programs varies. Some of these programs receive capitated payments, and this gives these organizations the flexibility to offer supplemental benefits out of cost savings, but some programs operate on fee-for-service and primary care case management models. Another notable feature of these organizations is that they are relatively small, and none are owned or operated by commercial MCOs.

With the reduced interest in Medicaid managed care by some commercial MCOs and the unique challenges—and cultural competencies—needed to serve a diverse population of seniors and people with disabilities, DCCOs may be a way for states to apply the benefits of managed care approaches while minimizing the drawbacks and sometimes negative experiences of trying to meet the needs of people with disabilities in large statewide efforts developed for the general Medicaid population.

- **Strengthened consumer protections are needed**

As I mentioned at the beginning, Medicaid managed care has come a long way, but many individuals with disabilities have been hurt by rushed efforts to implement managed care. While Congress enacted significant beneficiary protections in the BBA, the issue of consumer protection remains critical.

A key area for federal policy attention should be to examine the past decade's experience with Medicaid managed care and consider additional consumer protections that are needed at this time. I recommend that Congress consider new protections related to topics such as ensuring that people with disabilities and others have appropriate access to care coordination services, requiring states to meet administrative readiness standards before they expand managed care to new areas such as managed long-term care, requiring states and MCOs to consider services medically necessary when they maintain, improve, or prevent the deterioration of functioning, and requiring states and MCOs to adhere to national performance measures for people with

disabilities and others in managed care programs. The early experience with managed behavioral health services has been particularly distressing, and federal policymakers should engage in a comprehensive review of state efforts to manage mental health services and consider establishing new protections to ensure access to current standards of care, including access to latest generation pharmaceuticals.

In any care delivery system that attempts to prevent unnecessary access to services, disagreements will arise between beneficiaries and their MCOs. One area of contention in the past has been the level of protection to afford beneficiaries in appealing denials of services. In my view, the Congress needs to re-visit this essential issue and consider giving beneficiaries greater grievance and appeal rights. In particular, beneficiaries may need new rights that guarantee that a failure by an MCO to provide services in a timely manner is eligible for an appeal; that ensure that MCOs clearly communicate to beneficiaries their appeal rights, including how to meet specific procedural requirements, such as how to request an appeal or fair hearing or how to request a copy of an enrollee's own records; and that create stricter time standards by which MCOs must resolve both standard and expedited appeals.

Current Opportunities for Using Managed Care to Strengthen Medicaid

I would like to turn to issues that may be at the center of the current policy discussion related to Medicaid managed care and this is the role of managed care in managing long-term services and supports and efforts to integrate the delivery of acute and long-term services for dual eligibles. There is no doubt that these issues hold great promise to improve the delivery of Medicaid services—and potentially to save Medicaid program resources. But, with the promise comes great risk. Dual eligibles and Medicaid beneficiaries that use long-term services are very vulnerable populations. And the federal and state governments spend a great deal of resources in providing services to these beneficiaries. I approach greater managed long-term care and efforts to integrate care for dual eligibles with great trepidation.

- **Increasing access to community-based long-term services**

The defining issue of Medicaid advocacy for the disability community is to end the institutional bias, the Medicaid policy that requires states to provide nursing home care to individuals, while permitting, but not requiring states to provide comparable community-based services. In 1999, the United States Supreme Court issued a decision in the case of *Olmstead v L.C.*, finding that the unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act of 1990 (ADA).[18, 19] The Court ruled that states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals determine that community placement is appropriate; when the person does not oppose such placement; and, when the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services. Despite the *Olmstead* decision, however, the size of Medicaid waiver waiting lists for community-based services has grown from 156,000 in 2002 to 206,000 in 2004.[20]

Managed long-term care creates opportunities for increasing compliance with the *Olmstead* decision because, on a per person basis, community-based services are generally significantly cheaper than institutional services. Better management of long-term services and supports could eliminate cases of unnecessary institutionalization.

I have great concerns, however, because we do not have proven, large-scale models for delivering long-term services and supports in a managed care environment. Arizona remains the only Medicaid managed long-term care program that operates both statewide and on a mandatory basis.[21] While a number of states have been able to start managed long-term care programs, the overall penetration rate for such programs in small, 1.7% in 2004.[22] Another significant challenge is that most MCOs do not have long-term care experience and most of the providers who are experienced in delivering long-term services do not have managed care experience.[23]

Recommendations: Federal policymakers should encourage further experimentation with managed long-term care. However, since this field is in its infancy and the seniors and people with disabilities are so vulnerable, states should not be permitted, through waivers or other initiatives, to mandate participation in these new programs. Further, federal policy should encourage states to reflect the principles of the independent living movement of choice and control. This means that states should be required to engage the senior and disability communities in meaningful partnerships to conceive and implement new experimental designs for managing long-term services. Further, states should be required to conduct person-centered individualized planning processes that maximize individual autonomy and consumer control. Additionally, Congress should insist upon an invigorated evaluation and monitoring component of any pilot or demonstration programs so that federal policymakers, other states, beneficiaries, and the public can learn from state efforts to innovate in this area.

- **Streamlining and improving care and services for dual eligibles**

More than seven million individuals are dual eligibles—individuals who receive both Medicaid and Medicare.[24] Dual eligibles account for one in seven Medicaid enrollees, including virtually all seniors who receive Medicaid and about one-third of non-elderly beneficiaries with disabilities.[25] Most dual eligibles are very low-income individuals with substantial health needs. Nearly one-quarter of dual eligibles are in nursing homes, compared to 2% of other Medicare beneficiaries.[26] Their health costs are nearly double those for other adults covered by Medicare and nearly eight times higher than what Medicaid spends on non-disabled children.[27] The absence of coordination between Medicaid and Medicare in providing overlapping services to these high need individuals—and associated complications arising from conflicting delivery systems, financing structures, and administrative policies—leads to missed opportunities to provide high quality care and potentially wastes billions in federal and state resources. This lack of coordination also likely permits cost shifting to Medicaid for services that may be legitimate Medicare expenses. If ways could be devised to bridge and integrate the Medicaid and Medicare delivery systems, there is significant potential to improve quality of care and save public resources. Managed care programs—which often include financing systems that pay MCOs a per person per month or a per case fee in return for delivering a specified set of services—may

offer flexibility to operate outside traditional fee-for-service regulatory structures that could contribute to integration programs.

For many people with disabilities, protecting access to the specialty services they need to manage their disabilities is so all encompassing that other health needs are neglected. I have heard of numerous stories of people with mental retardation and their families who focus so much on essential long-term services that enable them to live in the community, that more basic needs such as dental care are ignored. Or, I have heard of people with spinal cord injuries who focus all of their energy on protecting access to personal care that they neglect other needs that we must all address as we age such as cardiac health. Integrated care—that involves active management, and individualized care plans could address many of these concerns and lead to a major improvement in the lives of many people with disabilities.

At the current time, however, model programs do not exist. Implementing integrated care programs for dual eligibles has proven difficult for states, and many states have been unable to move from program design to implementation.[28] In 1996, the Robert Wood Johnson Foundation and the George Mason Center for Health Policy Research and Ethics established the Medicare/Medicaid Integration Project. The project has awarded grants to 14 states to develop integrated care programs for dual eligibles. To date, only 3 of these states have been able to implement these programs.[29] The Center for Health Care Strategies reports that challenges with implementing these programs include difficulties in obtaining federal approval, developing plan capacity to integrate care, and navigating operational differences between Medicare and Medicaid.

Recommendations: As with my recommendations related to managed long-term care, I believe that Federal policymakers should encourage further experimentation with integrated care programs for dual eligibles. At the same time, I strongly encourage the Congress to reject pleas for more flexibility to waive or disregard federal rules and beneficiary protections. From the perspective of states or MCOs, any federal requirement could be seen as unnecessarily burdensome. From a beneficiary perspective, however, federal requirements generally provide essential protections. As already stated, dual eligibles are an extremely vulnerable group of individuals. While the federal policymakers may believe it is desirable to move toward greater integration, we do not yet know where were are trying to move. It is completely premature to be considering flexibility for states to require dual eligibles to participate in integrated care programs or to give states even more flexibility in managing their Medicaid programs. Further, since there are so many obvious benefits for improved quality of care, if states develop voluntary demonstrations that address the real concerns of dual eligibles, attracting enough participants to test new experimental models should not be overly burdensome.

- **Holding service providers accountable for providing quality long-term services**

One of the features of managed care that is attractive to states is the ability to use managed care to eliminate waste and maximize the benefits from a very significant federal and state financial investment. Over time, in the realm of managed acute care services, a number of tools have evolved to help achieve this accountability. This includes the development of various clinical practice standards, adoption of consumer protection systems (including statutory and regulatory

protections and state oversight), the development of specific and clear contracts, and the development of performance measures by which MCOs, states, federal administrators, and the public can measure how well MCOs are meeting their obligations.

Comparable tools to measure the performance of MCOs and hold them accountable for delivering long-term services and supports do not exist. The driving force in MCO performance measurement is the National Committee on Quality Assurance's (NCQA) HEDIS measures, which are used to evaluate commercial, Medicaid, and Medicare manage care organizations nationally.[30] Key criteria for these measures are that they are broadly applicable, actionable, and measurable. While helpful, these measures only address a portion of the needs beneficiaries, particularly their acute care needs.[31] Further, there are some performance measures for specific populations such as frail elderly participants in PACE programs or persons with developmental disabilities, but no current measures are broadly applicable to all long-term services populations and none take a broad holistic approach to measuring MCO performance. The Center for Health Care Strategies has convened a work group of states and MCOs to begin the process of developing some of these measures. Importantly, a key goal of this process is the minimize reporting burdens on MCOs, states, providers, and beneficiaries.[32]

Recommendations: The Congress should consider specific steps it can take to spur the development of broadly applicable performance measures for long-term services and supports. Such an effort may be most properly conducted by the Agency for Healthcare Research and Quality (AHRQ), and while building on and collaborating with the Center for Health Care Strategies, would broaden the participation of additional stakeholders to ensure broader participation of a variety of beneficiary representatives and providers and lead to national acceptance of the new measures.

Conclusion

In conclusion, I am encouraged that the Aging Committee is giving its attention to critical issues related to Medicaid managed care and the challenges posed by using managed care to serve seniors and people with disabilities. There are many reasons why states may seek to use managed care programs to strengthen the delivery of Medicaid services—and there is an important role for the Aging Committee and the Congress in encouraging responsible uses of managed care. Nevertheless, managed care does not offer any magic bullets or quick fixes, and experience has shown that it also involves risks. I encourage the Committee to look for managed care opportunities while ensuring that the very vulnerable seniors and people with disabilities served by Medicaid are not placed at risk. I also encourage the Committee to protect the federal financial investment in Medicaid from rushed, irresponsible, or wasteful managed care initiatives that ignore the lessons from the past decade or that promise more than they can deliver.

Thank you very much for providing me the opportunity to participate in today's roundtable.

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The CHAIRMAN. Greg, take it away.

STATEMENT OF GREG NYCZ, DIRECTOR, FAMILY HEALTH CENTER OF MARSHFIELD, INC., MARSHFIELD, WI; ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Mr. NYCZ. Chairman Smith and Senator Kohl, what I hope to add to this conversation is the concept that managed care, does not always have to occur in the third-party environment. Growth in technology, electronic medical records and health care systems, provides opportunities to manage care at the provider point of contact level. This can be particularly important in some of those rural areas that you talked about.

Last year, as a federally funded community health center, we served over 45,000 low-income people, all of whom were under 200 percent of the Federal poverty level. Of those, about 6,000 were the folks you are most interested in today, the dual-eligibles and special needs Medicaid population.

I would really like to state my appreciation for what you are trying to do in launching this initiative. I was really excited to hear you were pursuing a more challenging and potentially more rewarding path than simply just cutting Medicaid spending. I think this is terrific.

I would also like to thank you for your support in expanding our Nation's community health centers which work as front-line providers to meet the health care needs of our Nation's most vulnerable residents. With the support of Congress and the President, we have had an opportunity to expand over the last few years and the privilege to now serve over 14 million of our Nation's most vulnerable citizens in over 5,000 center sites across this Nation.

If we are to add value for taxpayers and also protect and promote health for our neighbors with limited incomes, we must manage their care more effectively across the continuum of financing systems as people move from Medicaid to uninsured and back to Medicaid. If we forget about them when they are uninsured, they come back into Medicaid with much higher costs and needs, and a lot of work that was done in managing their care in Medicaid is lost in the interim when they go through an episode without insurance.

I believe that to achieve this we must pay attention to strengthening the primary care infrastructure and fully capitalizing on the value of the medical home concept, which was mentioned as important in the Arizona experience. By medical home I mean having a primary care provider who knows you and knows your circumstances and is your primary point of contact in the health care system.

I believe part of the backlash that we experienced with managed care among more affluent populations stems from the frequent disruptions in the patient-provider trust relationship that occurred as competing managed care firms sought to move market share from one provider panel to another. So as you seek to make greater use of the positive aspects of managed care for highly vulnerable populations, greater attention should be paid to exploiting the synergies that are possible in linking medical home concepts to third-party

managed care initiatives. Community health centers are clearly well-suited to partner with managed care firms for this purpose.

I would also encourage the Committee to invest in advancing best practices for optimizing health and functioning among special needs populations. As you seek to harness the potential of managed care for Medicaid special needs populations, there will be opportunities to gain experience with point-of-care management, third-party management and hybrid systems using State Medicaid programs as natural laboratories.

I would also ask the Committee to address of loss of State-level purchasing power related to the privatization of Medicare and Medicaid in the post-Part D era. If Medicaid drug rebates could be extended to Medicaid managed care arrangements, an estimated $2 billion over 5 years could be saved. Alternatively, pharmaceuticals could be carved out of managed care arrangements and paid directly by the States.

An example of this approach is the excellent system created by Wisconsin's employee trust fund which carved out pharmacy benefits from their managed care contracts and consolidated the purchasing power of employer-sponsored plans without disrupting care management activities because they used technology to feed back all the data to the HMOs as frequently as on a daily basis if the HMOs wanted it at that level.

My final point, all too frequently overlooked, is that we must end the historic neglect of oral health in low-income populations. A growing body of evidence links dental disease to systemic health problems like cardiovascular disease, diabetes, prematurity low birth weight, and respiratory problems in institutionalized patients. I urge the Committee to address oral health as key to better managing the care of Medicaid beneficiaries, particularly those with special needs.

Health centers have a lot to offer in efficiently managing the health care needs of vulnerable populations because they offer key services critical to improving and maintaining health. We define primary care to include not just medical services, but also services related to mental health, dental health and enabling services. Several studies have found that health centers save Medicaid 30 percent or more in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions, saving an estimated $3 billion in combined Federal and State Medicaid expenditures. The continued expansion of health centers means medical homes for more people and even greater savings.

Thank you very much for the opportunity to present today.

The CHAIRMAN. Thank you, Greg. I really compliment you and all in the community health care center community. I think it is one of the answers to our problem, and not the total answer, but I am a tremendous fan of the work that you do.

Have you seen a reluctance of managed care companies willing to work with community health centers?

Mr. NYCZ. In our State, no, but I know that goes on in other parts of the country.

The CHAIRMAN. Does it have to do with reimbursement rates and stuff like that?

Mr. NYCZ. It might, but I think Congress has done a great deal already to try to help that situation in terms of working it out with wrap-around payments under Medicaid and Medicare in ways that don't disrupt traditional contracting arrangements with HMOs. But Health Centers really do have, I think, a great potential to team with managed care firms because we can manage front-line care and get preventive care and enabling services to people, but we can't do it all. So linking with managed care firms is actually a very natural thing that could be very helpful for the most vulnerable people.

The CHAIRMAN. I need to understand better the point you were making about dental care as an indicator of some larger health care issues. Is that the point you were making?

Mr. NYCZ. That, and the fact that when I talk with folks in the disability community, one of the things they frequently tell me as a health center is we can help—by providing dental access. For instance, we have the PACE program which tries to get people out of institutions or living in home settings for a longer period of time. We are working with them and they are very excited about the construction of our new dental facility because they can't get the dental care they need for all their patients.

The studies particularly for institutionalized patients indicate that particularly with periodontal disease, the kind of bacteria that inhabits the mouth doesn't stay there and it can migrate in the body and cause infections, pneumonia, and so forth, and there is a growing body of scientific evidence on this topic.

So if you want to best manage care and you want to improve quality, we can't forget about mental health, we can't forget about oral health, and we can't forget that some people, particularly in very special needs populations, need what we refer to as enabling services. They need additional help in getting access to care and in managing that care, and health centers, are an important cog in the or better health care system that you are trying to build.

The CHAIRMAN. I think it is important to state for the record that if you don't have mental health, you don't have health, and I really appreciate your emphasis on that. Since I have a brother who is a dentist, thanks for including them, too.

Senator KOHL.

Senator KOHL. Go ahead.

The CHAIRMAN. Well, thank you very much, Greg. We appreciate the great model that Wisconsin is, and not just the Senator sitting over here, but in so many fields, but particularly in medicine. It is something of a trailblazer just like Oregon, and so we admire that very much.

[The prepared statement of Mr. Nycz follows:]

Testimony of Mr. Greg Nycz
Executive Director, Family Health Center of Marshfield, Inc.
To the Senate Special Committee on Aging

September 13, 2006

Chairman Smith, Senator Kohl and Members of the Senate Special Committee on Aging:

My name is Greg Nycz and I am the Executive Director of Family Health Center of Marshfield, Inc. We are a federally funded community health center. Last year we cared for over 45,000 low-income patients who reside in or around our 8,228 square miles service area, which is located in north central Wisconsin.

Let me begin by stating my deep appreciation for your collective efforts to proactively identify improvements in our system of care for the many vulnerable Americans who seek assistance through our nation's Medicaid programs. I have spent 34 years working to improve access to care for vulnerable populations. I was pleased to learn of your effort to pursue a more challenging, and potentially more rewarding, path than simply cutting Medicaid funding. As I understand it, you are seeking approaches that the federal government might take in combination with states and the private sector to improve the existing health care system in ways that add value not just to those in Medicaid programs, but also to those whose taxes finance that assistance.

As the Director of a federally funded community health center, I would also like to thank you for your support in expanding the capacity our nation's community health centers, who work as front line providers to meet the health care needs of our nation's most vulnerable residents. With the support of Congress and the President, we have had the opportunity to expand, and the privilege to now serve, over 14.1 million Americans from clinics located in over 5,000 communities across our nation. Because our focus falls largely on those with limited incomes, our collective efforts are very much aligned with your Committee's initiative. Our own experience in north central Wisconsin demonstrates that over time people with limited incomes frequently experience different combinations of private insurance, public insurance, and episodes of uninsured status. In two recent samples of uninsured patients who had been screened and determined not to be eligible for Medicaid we found that 17% in the first sample and 20% in the second sample became eligible for Medicaid within the year.

If we are to add value for taxpayers and also protect and promote health for our neighbors with limited incomes, we must manage their care more effectively across the continuum of financing systems. I believe this is best achieved by strengthening the primary care infrastructure in this country and fully capitalizing on the value of the "medical home" concept. By that I mean having a primary care provider that knows you and your circumstances and undertakes to be your primary point of contact in the health care system. If the same physician or clinic is caring for a privately insured diabetic patient through a period where that patient lost all insurance, and if that patient subsequently becomes eligible for Medicaid there is a greater likelihood that his or her diabetes will be better controlled upon entering Medicaid than it would have been if the individual had to rely on emergency room care during their uninsured episode. The likelihood that the illness would be well managed during an uninsured period would be even

higher with the increased accountabilities and attention to quality improvement associated with the unique partnership that exists between the federal government and individual communities under the community health center program.

My first suggestion to the Committee is that in your deliberations you please consider the importance of trust in your own relationship with your personal physician and ask yourself how important trust is in the healing process and how much more important trust becomes as one's disease burden increases. I believe part of the backlash against managed care among more affluent populations stemmed from the frequent disruptions in the patient/provider trust relationship that occurred as competing managed care firms sought to move market share from one provider panel to another in exchange for better contracting provisions. For Medicaid eligibles covered under private managed care firms, such dislocations can be even more burdensome and the loss of Medicaid eligibility may equate to a loss of access and a return to reliance on emergency room care. As you seek to make greater use of many of the very positive aspects of managed care for highly vulnerable populations, greater attention should be paid to exploiting synergies possible in linking medical home concepts to third party care managed care initiatives. Community health centers are well suited to partner with managed care firms for this purpose, in part because of legislation passed by Congress establishing federally qualified health center status under Medicaid and Medicare, and Congress's extension to FQHC's of federal best prices in the acquisition of pharmaceuticals under Section 340B of the Public Health Service Act.

Second, as you look to future, I would also encourage the Committee to invest in new knowledge generation that supports the articulation of best practices in optimizing health and functioning for special needs populations. An important consideration is whether it is better to employ the tools of managed care at the provider level or at a third party payor level. The answer will depend on the degree to which the delivery system is integrated and the level at which it has adopted health information technologies. In the future with fully developed electronic medical records and the full integration of genetic information, will people in this country be more comfortable with all of this personal information being available to the treating provider at the time of service or to a third party managed care insurer? The reality is, we have a diverse country with widely variable levels of delivery system integration. As you seek to harness the potential of managed care for the Medicaid special needs populations, there will be opportunities to gain experience with point of care management, third party management and hybrid systems, using state Medicaid programs as natural laboratories.

A third issue I would like to raise relates to the privatization of Medicare and Medicaid in the post Part D era. There is a loss of purchasing power that occurs when you move from state to private payment of pharmaceuticals under managed care. For young adults and children, this slippage is more easily made up by efficiencies in managed care because pharmaceuticals represent a smaller percent of their overall health care costs. However, special needs populations have a proportionately higher need for pharmaceuticals and the loss in purchasing power is much more difficult to overcome, potentially creating barriers to entry for managed care firms. As the Committee considers more fully integrating the special needs populations into capitated managed care, please consider these differences. A number of options seem available to overcome this problem. For example, the federal best price arrangement could be extended to Medicaid patients covered under managed care arrangements. If this is too

difficult to achieve politically, perhaps it could be limited to just Medicaid special needs populations. Alternatively, pharmaceuticals could be carved out of the managed care arrangement and continue to be paid by the states. Although there may be initial concerns about disaggregating benefits, technical solutions are available to maximize the joint cost saving potential of state purchasing power and quality management expertise of managed care firms. An example of this approach is the excellent system created by the Employee Trust Fund in the State of Wisconsin. They have carved out pharmacy benefits from their managed care contracts and consolidated purchasing power within an employer-sponsored insurance environment. The system was set up to provide customized turnaround passing all relevant data on prescription transactions back to the appropriate HMO for care management purposes. The system is geared to meet the managed care contractors needs be they for 24-hour or two week turnaround. It has generated significant savings to payors. More information on this innovative program can be obtained by contacting either Eric Stanchfield (608-266-0301; eric.stanchfield@etf.state.wi.us) or Tom Korpady (608-266-0207; tom.korpady@etf.state.wi.us).

My final point is one that is all too frequently forgotten at all levels. We should work to end the historic neglect of oral health in low-come populations. The Surgeon General referred to this as a silent epidemic of dental and oral diseases, pointing out that oral disease is disproportionately borne by the poor of all ages.[1] In children, oral pain has negative impacts on ability to learn, with estimates of up to 51 million school hours lost each year due to untreated oral health problems.[2] Productivity and earnings are impacted when low-income parents of sick children must cope with their pain and suffering and deal with the frustration of having no place to take them, which is all too often the case. Untreated dental disease can damage self-esteem and impact nutrition. In adults, poor oral health reduces employment prospects in many service related industries.

There is a growing body of evidence that links dental disease to systemic health problems. Dental disease, specifically periodontal disease which is characterized by chronic infection of the gums, may be linked to cardiovascular problems, difficulty in controlling blood sugars in diabetic patients, miscarriages, prematurity and low birth weight babies in affected pregnant moms and respiratory illness in institutionalized older adults. Access problems within the Medicaid population regularly results in visits to emergency rooms and urgent care centers that are not equipped to address the underlying disease process and are limited to prescribing medicines for pain and infection.

I would urge the Committee to embrace the need to address oral health as a key component in better managing the care of our vulnerable citizens on Medicaid. Wisconsin, I am proud to say, has a great history of providing comprehensive Medicaid benefits including adult dental. Unfortunately, low payment levels, coupled with paperwork burdens and high no-show rates, have prompted most dentists across the State to reduce or eliminate Medicaid patients from their panels. Wisconsin has attempted to deal with dental access issues in both its Medicaid fee-for-service and managed care programs. Unfortunately, a solution has not been found in either. The situation is critical. The latest figures I've seen indicate that the proportion of Medicaid recipients receiving dental care in any given year has fallen to the low 20% range.

While quick solutions to this problem seem elusive, Congress has taken steps to begin to address this problem through its support of the ongoing expansion of community health

centers. Subsequent to the Surgeon General's report on oral health, there has been a renewed commitment by health centers, fueled in part by the dollars provided through Congressional appropriations, to more fully integrate oral and mental health with medical care.

Health centers have a lot to offer in the form of efficient management of the health care needs of vulnerable populations within the fee-for-service environment because their financing mechanisms afford the opportunity to supply enabling services critical to improving and maintaining health. Historically, Medicaid claims data reveals that health centers provide care that is of equal or greater quality than that provided by more traditional provider types.[3] A host of studies have concluded that health centers save states money in their Medicaid programs. According to one recent study, preventable hospitalizations in communities served by health centers were lower than in other medically underserved communities not serviced by health centers.[4] Patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 people over three years than those in underserved areas not served by a health center[5]. Furthermore, Medicaid beneficiaries in five states who received care at health centers were less likely than other Medicaid beneficiaries to be hospitalized or visit emergency departments for ambulatory care sensitive conditions (ACSC) that are avoidable through timely primary care.

Several other studies have found that health centers save the Medicaid program 30 percent or more in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions.[6] Based on that data, it has been estimated that for FY2004 health centers saved almost $3 billion in combined federal and state Medicaid expenditures.[7] The continued expansion of the health center program holds the potential through the medical home concept of generating even greater savings. While the definitive cause and affect studies are not yet complete, it is likely, based on existing evidence, that the growing integration of oral health professionals into the health center workforce will yield additional savings through reductions in emergency room visits for previously untreated oral disease, as well as potentially significant medical care offsets if the early indications from research hold true regarding the impact of untreated oral disease on cardiovascular, respiratory, diabetic and birth outcomes.

In January 2006, the *Journal of Obstetrics & Gynecology* published an article entitled "Progressive Periodontal Disease and Risk of Very Preterm Delivery.[8]" The authors were reporting on a prospective study of obstetric outcomes entitled "Oral Conditions and Pregnancy." In their concluding comments, the authors note that their findings "indicate that maternal periodontal disease progression during pregnancy may, in part, contribute to deliveries at less than 32 weeks of gestation and that the maternal periodontal disease progression merits further consideration as a potential risk factor for neonatal morbidity and mortality." Consider that some of the highest cost cases in health care involve preterm births. Consider also that periodontal disease is easily treated. Think about the proportion of births that are financed by Medicaid. In Milwaukee, WI 58% of the birth cohort in 2004 were financed through the Medicaid program. While the Committee's focus may be on the other end of the age spectrum, capitalizing on program savings in any lifecycle strengthens and adds value to our nation's Medicaid program.

A key question is when to act when a growing body of scientific evidence is increasingly suggestive but inconclusive. The decision to take action should normally be predicated on

weighing the relative risks against the relative benefits of the action. Since the action contemplated with pregnant women with periodontal disease is the application of standard evidence based treatment for periodontal disease, there is no downside and the potential exists for the upside to soar beyond simply improved oral health to include possible significant improvements in birth outcomes with attendant reductions in medical care costs. This should be motivation enough for us to act. Wisconsin's health centers are currently planning an initiative that will help to raise awareness among those treating pregnant women about this issue and to provide them with a priority referral source for treatment through our network of health centers.

In closing, I would urge the Committee to: 1) recognize the importance of establishing a patient/provider trust relationship and protect that relationship for vulnerable populations; 2) don't limit your possibilities to third party level managed care interventions; 3) find a way to retain the states purchasing power for pharmaceuticals; 4) consider the Surgeon General's report and the growing body of scientific evidence that increasingly supports the notion that oral and systemic diseases are linked; 5) consider the mounting evidence on health center quality and efficiencies and recognize that the health center model represents a highly effective way of managing the combined medical, mental and oral health care needs of our most vulnerable residents; and 6) embrace the continued expansion of health centers as a key strategy to expand and extend managed care to our nation's Medicaid populations.

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[4] Falik, M., Needleman, J., et al, "Comparative Effectiveness of Health Centers as Regular Source of Care," *Journal of Ambulatory Care Management* 29(1): 24-35.

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[7] NACHC calculation, using FY 2004 Medicaid spending per enrollee (for children and non-disabled adults only), accessed from CMS website (www.cms.gov).

[8] Offenbacher, S., Boggess, K., Murtha, A., Jared, H., Leif, S., McKaig, R., Mauriello, S., Moss, K., and Beck, J., (2006), Progressive Periodontal Disease and Risk of Very Preterm Delivery, *Journal of Obstetrics and Gynecology* 107(1):29-26.

The CHAIRMAN. Turning to Oregon, David Ford, thank you.

STATEMENT OF DAVID FORD, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CAREOREGON, PORTLAND, OR

Mr. FORD. Thank you, Mr. Chairman and Senator Kohl. It seems like there is a lot of simpatico across the issues here.

My name is David Ford. I am the president and CEO of CareOregon, in Portland. I would like to focus my remarks pretty much on Medicaid and the SSI population, the blind, disabled and aged, because in a lot of states that isn't a covered benefit but we have been doing that in Oregon for 10 years, as well as in Maryland and a number of other States, but it is not widespread.

Because we are fully capitated and the capitation often doesn't keep up with medical inflation, we are driven to be innovative and take things and look at things in different ways with our benefit partners. One aspect of that is care management of the complex member. We are defining the complex member as the person that doesn't have just one disease, such as diabetes, they have got a heart condition, high blood pressure, and they may have some problems with their feet.

These are people with four or more comorbid conditions, and one of the issues that was brought up previously is focusing on where the dollars are spent. We found that in our 100,000 members across the state, 3 percent of the people use 30 percent of the services. That is an area that we have intensly focused on. We have grants from the Center for Health Care Strategies to develop methodologies working with our highest needs members.

Our view is if we can take people that are not well connected to either the medical system or the social system, add more services, not cut services, but add more services, we can actually stabilize them and manage them into a more chronic care state which is much more stabilized, and they use less services.

Before I came to Oregon 3 years ago, I ran Medicaid HMO here in Medicaid in the District and Maryland. The remarkable thing that I found to Oregon was the different SSI use of hospital services in Maryland compared with Oregon. After 2 years in Maryland, we dropped the hospital utilization rate from 2,300 days per 1,000 to 1,900 days per 1,000. That means for every 1,000 people, there were 1,900 days of hospitalization. In Oregon, we started with a base of 1,300 for the same matched population and dropped it to 1,000 days per thousand.

So the question is there: Why a 900 days-per-thousand difference between Oregon and Maryland for that same population? There are some reasons for it, but the question when I got to Oregon was how do you go from 1,000 days per thousand down to 800, and the issue really became looking at a framework for quality.

I think we are overlooking a lot of the work that we have done nationally at the Institute of Medicine. They published a book about 5 years ago called *Crossing the Quality Chasm.* In that, they have a number of explanations of why the health care system today is failing, and then recommendations, and actually a blueprint under that—and that is commented on in my amplification in the slides—about where to go.

We don't have to go all over. The concerns about quality and improving quality while creating more efficient health care is right before us and this model. So that blueprint is something that as you develop your rhetoric and work with your staff, we would consider you looking at.

A Johns Hopkins professor-doctor who has been doing work there for her whole career, Barbara Starfield, has done a lot of studies about when you have multiple conditions with four or more comorbid conditions, the complexity of care goes up and the cost just skyrockets. Things are out of control when we don't provide services.

In the previously mentioned grant that we have received, we have done pilots over the last 3 years with our complex members. We are in the beginning of the third year. The first year, we set up nurse care management for our complex members and did a lot of care coordination. We saved about $5,000 per member a year on a matched study. In the second year, we saved $6,000 per member a year.

One problem that we ran into with this program is a backdrop of this entire discussion—not enough trained medical professionals. To address this, we have evolved the model to a team-based approach where we have a social worker with a behavioral specialist, a nurse team leader, and two medical assistants helping coordinate care so that we can have a higher touch and broader reach. There is a huge demand for coordinating services, but we have got to find an economical way to reach out effectively.

It is not the care that people receive that is driving the cost of health care; it is the care that they don't receive. This is counterintuitive to the last generation of managed care where you put gatekeepers and road bumps between the patient and getting care. We are saying that is passe. We have got to get aggressive about knocking down barriers to services.

The CHAIRMAN. That has saved you money?

Mr. FORD. Hands down, no question about it.

The CHAIRMAN. Is that generally recognized among your competitor——

Mr. FORD. We have got 12 plans in Oregon, all local, and absolutely that is recognized. It is also the realization that it isn't just clinical services. A lot of services are provided by family members and others. So partly what we are looking at now is dialoguing with Intel, which has a digital care unit, around creating some software to integrate and create collaborative working systems for people who are very complex so that you can integrate between what the family is seeing and doing the care managers, the people in the community settings, so that the medical records, with privacy, are shared.

We can't coordinate and articulate this care if we can't see it and work together, and one of the failings of our system is it is so fragmented. We are seeing the opportunity to integrate care through effective software opportunities and we are beginning to experiment and dialog with that, until Intel announced its big layoffs.

This is not by any means a doomsday kind of scenario. The problem that was articulated by the Institute of Medicine in their book *To Err Is Human* is that healthcare is unsafe, it is fragmented, it

is inefficient, it is slow, it is inequitable. In *Crossing the Quality Chasm,* they come up with a series of solutions that prescribe how we get safe care, how we create efficient care, equitable and so forth. It is up to us to follow through on this blueprint we have developed, and care will go up in quality and it is better care and it costs less and it is more humane from my perspective.

The CHAIRMAN. David, how would you address the rural issue?

Mr. FORD. I think there needs to be more collaboration. We are involved in that now. Understanding there are manpower shortages, and there are maldistributions of workforce, I think you can integrate specialty care through what you saw in Roseberg in terms of some availability of technology. I think that we need to invest in manpower and dedicate financial incentives for caregivers to go to rural regions, because they do get burned out.

There are ways to integrate the system more effectively through capitation. I have done some work in Australia and Finland around the community taking responsibility for the care. I think we haven't put the dedicated effort like Tony was saying, into developing an expertise to do this. This is— a means problem, as well as lack of focus to actually do the work to create integrated systems.

We are not really using the words "managed care" as much anymore. We are really talking about—and I would like the roundtable to consider something like "managed collaboration." Through software, through collaborative work, through driven people, we don't have to leave everything a free-for-all and, you know, here is some money and it is up to you to negotiate your way through this difficult high-tech endeavor. We have got ways to collaborate with our members to articulate care much more effectively.

The CHAIRMAN. The Institute of Medicine—what is the name of this——

Mr. FORD. *Crossing the Quality Chasm* is the book.

The CHAIRMAN. If you had one recommendation as we try to develop legislation, we should go look at that book?

Mr. FORD. I would defer to Ron, but I think that a lot of us here would feel like that framework has a lot of backbone that we can flesh out further to come up with more explicit——

The CHAIRMAN. The provider community understands what they are saying and they respect it and they agree with it?

Mr. FORD. We actually took a study delegation to Alaska to look at some advanced primary care reform practice that the Native Alaskan health services are doing in Anchorage. It was knock-your-socks-off exciting in terms of how they have created team care and services, adding behavioral health at the point of service for people, and it was all based on this fundamental framework laid out in *Crossing the Quality Chasm*. They have been working with the Institute for Health Care Improvement for 15 years. This is not a new idea. It is just that it is not in the pair community very well and it is for some reason not incorporated as heavily into policy as it might be.

The CHAIRMAN. Senator Kohl, do you have any questions?

Senator KOHL. No.

[The prepared statement of Mr. Ford follows:]

United States Senate
Special Committee on Aging
Washington, DC

September 13, 2006

Testimony of David Ford
President & CEO
CareOregon

CareOregon

CareOregon

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David Ford
President & CEO

Dave Ford has been in health insurance leadership roles for more than 20 years. Since 2003, Dave has served as CEO of CareOregon, the largest Medicaid Managed Care Organization in the state, serving Oregon Health Plan members, Dual Eligibles, and SSI recipients. Previously, he worked as an executive with Aetna, NYLCare, and Blue Cross of Washington and Alaska. As CEO, he completed a turnaround for an HMO serving SSI recipients in Washington, DC and Baltimore, MD. He has also worked with a Venture Capital firm in Palo Alto, CA. Dave is married to photographer/writer, Phi Ford, and has three grown children. He has a degree from the University of California, Davis.

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CareOregon

United States Senate Special Committee on Aging
CareOregon Written Testimony

David E. Ford, President & CEO
September 13, 2006

Accompanying Slides

Mr. Chairmen, Members of the Committee. Thank you for allowing me to testify today on the expansion of Medicaid Managed Care. **1**

My name is David Ford. I am President and CEO of CareOregon in Portland, Oregon.

I'm here to talk about Managed Medicaid, especially among aged, blind and disabled, often referred to as SSI, from the ground level. We have been managing all lines of Medicaid for 10 years. Since we are fully capitated for our member's health care, we are able to innovate, even ***required*** to innovate, with our delivery system partners for the benefit of our member for less cost than fee for service. I will be focusing tightly on one of many facets of care management for the complex member, in the context of Oregon.

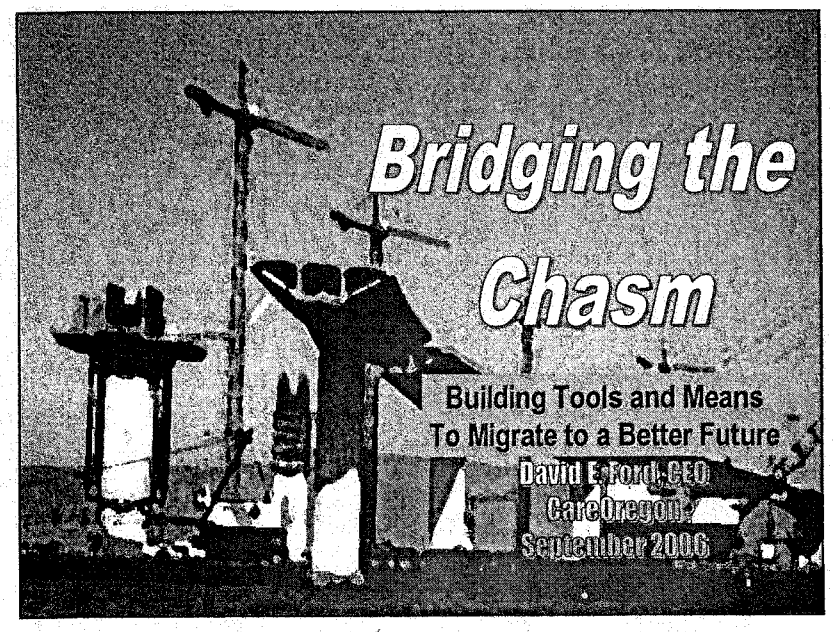
Complex care management is beyond Disease Management or Chronic Care Management. Complex care is for those people with 4 or more co-morbid conditions, i.e. diseases, [often complicated by depression or mental health issues], who are not well connected to social or medical support systems. We have received two grants from the Center for Health Care Strategies to develop the methodology and managed these complex members.

But first, CareOregon is a non-profit corporation founded in 1994 by Oregon Health Sciences University, Multnomah County Health Department and a number of Federally Qualified Health Centers to serve managed Medicaid Members. Thanks to Congressional action through MMA, CareOregon has grown to serve Dual Eligibles through our new Medicare Advantage Special Needs Plan. We are the largest of about twelve local managed care health plans. We serve 100,000 Medicaid and about 6000 Medicare Members. More than half of our members receive services through Safety Net Providers. The majority of our members are in the greater Portland area but we serve 16 counties throughout Oregon. **2** **3**

Personally, prior to coming to Oregon, I have been the CEO for two for-profit Health Plans which served Medicaid members; one in Washington State, and then one here in the Maryland/District of Columbia areas. In Maryland, we also served the SSI membership. One of my first observations, when I arrived 3 years ago in Oregon is how medically efficient Oregon is relative to Maryland for the same matched population. As the fourth illustration (slide 4) in the handout shows, for SSI recipients, the hospital days/1000 members in Maryland dropped from 2100 to 1900/1000 after 2 years of managed care. In Oregon, it dropped from 1300 to 1000/1000 days after two years of **4**

	Accompanying Slides
care management: *almost half the number of hospital days in Oregon vs. Maryland for a similar covered population.* The Dartmouth Atlas confirms this same efficient care pattern for Medicare compared to other national sites, as well.	**5**
This phenomenon drove us to look at how to further increase care efficiency and effectiveness in Oregon. First, we adopted the Institute of Medicine's Crossing the Quality Chasm as an operating framework for improving of the future for managed care.	**6,7,8,9**
Second, we studied our members' data with a data tool from Johns Hopkins University called the *Adjusted Care Grouper Predictive Model* [ACG-PM]. This is a big word for being able to understand how sick and complex our members' are, where our care resources is being spent, and what we might do to help them. We found 12% of our members used 60% of the resources. 3% of our members used 30% of the resources.	**10**
We also learned that the SSI members have many social, behavioral and mental health circumstances that influenced and complicated their medical conditions.	**11**
We learned from Dr. Barbara Starfield's research at Johns Hopkins, that people who have 4 or more co-morbid conditions (diseases), spike in resource use, so classic single disease management and managed care techniques were not enough.	**12**
So we developed a full set of strategies and tools to improve the efficiency and effectiveness of care for our members.	**13,14**
The Center for Health Care Strategies provides us two, 3 year research grants, to pilot methods to prove the business case for managing complex members. With a nurse driven case management system, in year 1 the savings were $5,000 per member per year, in year two this increased to $6000 per member per year. Care is more integrated, effective and satisfying.	**15**
That's the good news. The bad is that we can't find, hire or train nurses fast enough to reach all the members who can benefit from this. We are now experimenting with a changed care management model focusing on a team approach, which incorporates social workers, medical assistants and behaviorists.	**16**
We have learned several things. First, *it not the care people receive that drives the cost, it's the care they don't get that drives cost.* Lack of early preventive visits and too few monitoring visits and follow up calls are causing unneeded expensive emergency room visits, admissions and crisis complications. Second, much of the care received, actually and potentially, are in social systems, i.e. family, friends, neighbors, and church; **not** the medical systems. When integration, communication and collaboration among these systems are established, there are fewer costly acute and crisis interventions. More importantly, the patient remains more stable and connected to their 'normal' life' and safe from medical harm.	**17**
We are considering how we can electronically connect the full social and medical care community so they can collaborate on a single individual to improve timely, accurate and consistent communication for these complex members. We have been dialoging with Intel to see how we can use their 8,000 Portland employee base along with CareOregon as a "test bed" to rapidly develop this technology.	**18**
In closing, there are many things we could discuss. I've provided several ideas in the companion illustrations.	**19, 20**

Our capacity to innovate rapidly and effective has advanced profoundly in the last decade. Managed Care, which was once a barrier to care is now an enabler and facilitator of care. It is the right care, delivered at the right time, which drives down wasteful, unnessecary care and unsafe practices in our current system. Within our public expenditures of Medicare and Medicaid is where some of the most innovative, best advances in safe, efficient care are emerging. We would encourage your leadership to facilitate better care on a national scale by including more citizens in publicly sponsored managed care. I hope you will consider CareOregon a resource in helping this expansion move forward. Thank you for allowing me to participate in this discussion. I would be happy to answer any questions.



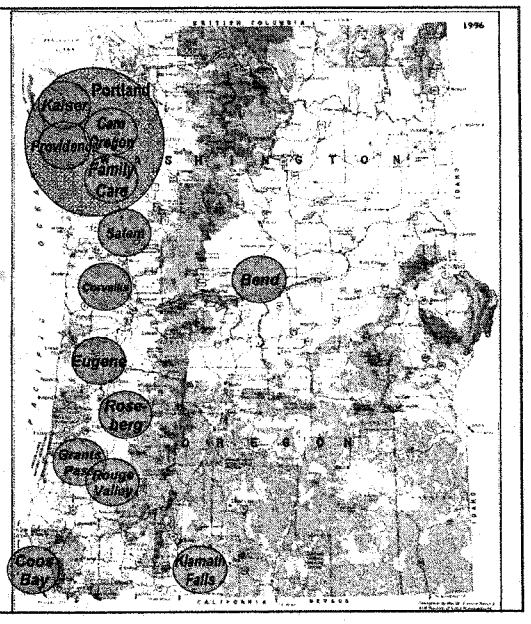
CareOregon Information

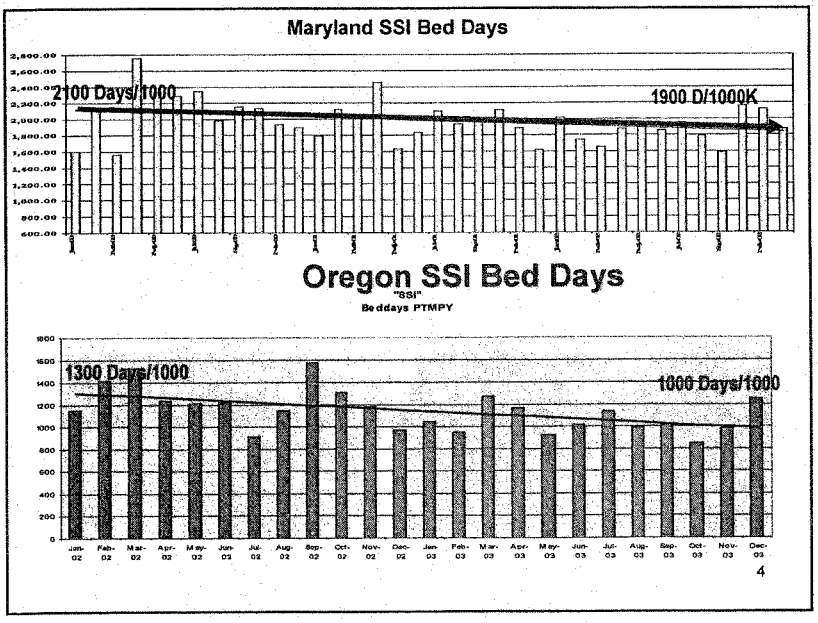
- Founded 1994 by Safety Net System
  - Oregon Health Sciences University
  - Multnomah Health Department
  - Federally Qualified Health Centers
- 100,000 Medicaid Members
  - Approximately 38% of State's MCO members
- 5600 Medicare Advantage Dual Eligible membes

2

Oregon's Local Integrated Systems

- Medicaid Delivery Systems
  - Coordinated Care
  - Physician Buy-in
  - Local Expertise
  - Local Data
  - Many:
    - Developing Community-wide EMR
    - Are Medicare Special Needs Plans





Dartmouth Study

MEDICARE REFORM

EXHIBIT 3
Comparison Of Medicare Spending, Supply-Sensitive Care, Preference-Sensitive Care, And Effective Care For Orange County, Miami, Minneapolis, And Portland Hospital Referral Regions, 1995–1996

Ratio to Minneapolis region

7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0

Specialist Visits
Medicare
Hospital Days
% ICU Admits
Effective Care
Preference Sensitivity Index

Minneapolis (MN)

Medicare spending | Specialist visits[a] | Hospital days[a] | Percent admitted to ICU[a] | Effective care index[b] | Preference sensitive care index[b]

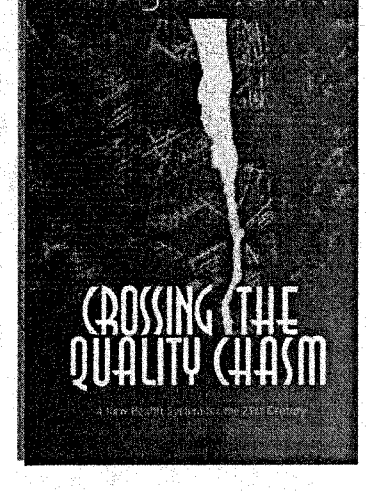
SOURCE: *Dartmouth Atlas of Health Care, 1995–96 database.*
NOTE: Ratios are given as ratio to Minneapolis hospital referral region (values as 1.0).
[a] Care provided per decedent in the last six months of life.
[b] See Exhibit 2 for definitions.

Oregon is An Efficient Care Market

Source: Health Affairs

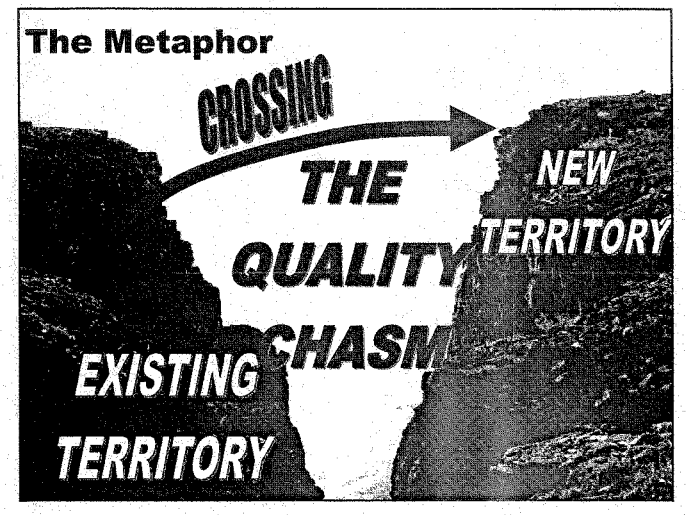
5

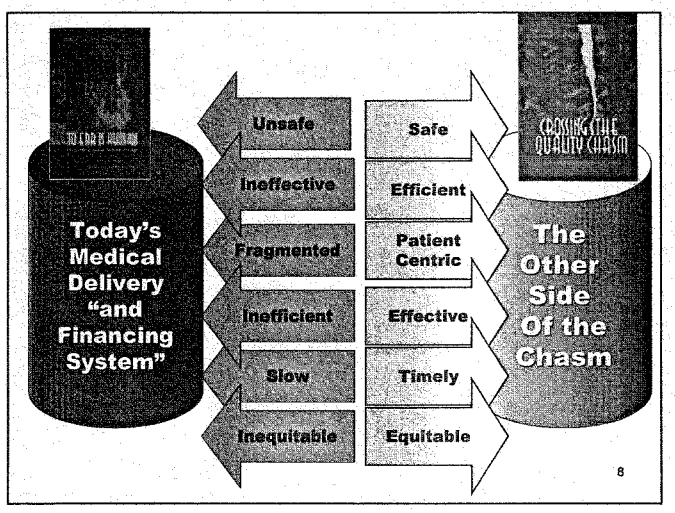
Major Call for Change

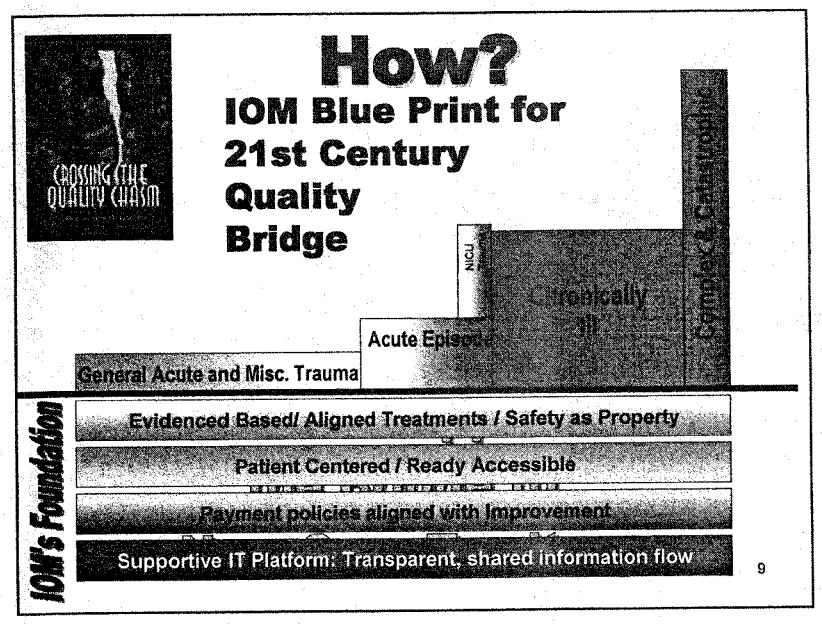


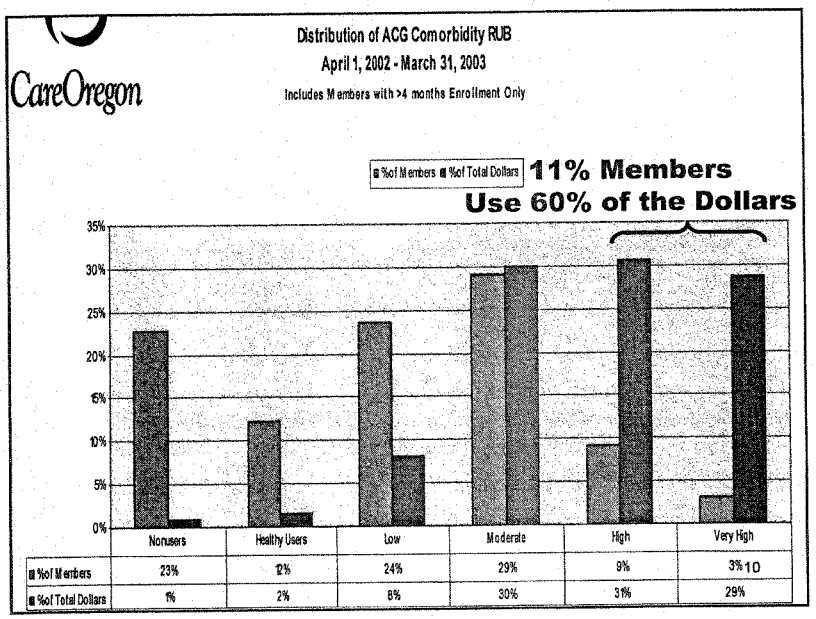
- 2000 Institute of Medicine Publication
- Critique of American Health System
- Blue Print for Change

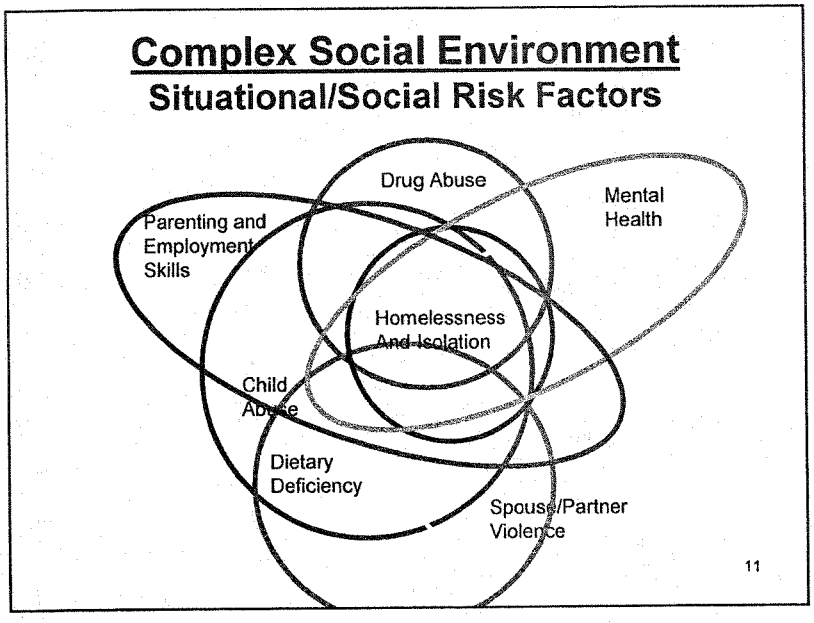
6

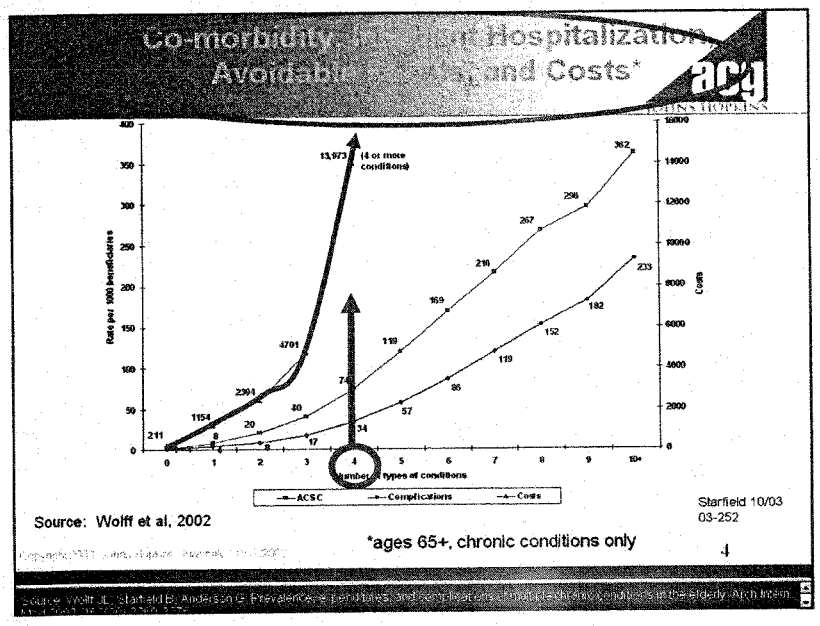

The Metaphor
CROSSING
THE
QUALITY
CHASM
NEW
TERRITORY
EXISTING
TERRITORY


Today's Medical Delivery "and Financing System"
Unsafe
Ineffective
Fragmented
Inefficient
Slow
Inequitable
Safe
Efficient
Patient Centric
Effective
Timely
Equitable
CROSSING THE QUALITY CHASM
The Other Side Of the Chasm
8


How?
IOM Blue Print for 21st Century Quality Bridge
CROSSING THE QUALITY CHASM
NICU
Chronically Ill
Complex & Catastrophic
Acute Episodic
General Acute and Misc. Trauma
IOM's Foundation
Evidenced Based/ Aligned Treatments / Safety as Property
Patient Centered / Ready Accessible
Payment policies aligned with Improvement
Supportive IT Platform: Transparent, shared information flow
9


CareOregon
Distribution of ACG Comorbidity RUB
April 1, 2002 - March 31, 2003
Includes Members with >4 months Enrollment Only
%of Members
%of Total Dollars
11% Members
Use 60% of the Dollars
35%
30%
25%
20%
15%
10%
5%
0%
Nonusers
Healthy Users
Low
Moderate
High
Very High
%of Members 23% 12% 24% 29% 9% 3%
%of Total Dollars 1% 2% 8% 30% 31% 29%
10


Complex Social Environment
Situational/Social Risk Factors
Drug Abuse
Mental Health
Parenting and Employment Skills
Homelessness And Isolation
Child Abuse
Dietary Deficiency
Spouse/Partner Violence
11


Co-morbidity
Hospitalization
Avoidable
and Costs*
13,973
(4 or more conditions)
Rate per 1000 beneficiaries
Costs
Number of types of conditions
ACSC
Complications
Costs
Source: Wolff et al, 2002
*ages 65+, chronic conditions only
Starfield 10/03
03-252
4

"Operationally Defining"
Disease, Chronic and Complex Care

April 1, 2002 - March 31, 2003
Includes Members with >4 months Enrollment Only

% of Members | % of Total Dollars

35%
30%
25%
15%
5%
0%

Chronic Care: Stable disease with co-morbidities. Object is to get and maintain patient within control range of multiple indicators Done with motivated patient and proactive care team.

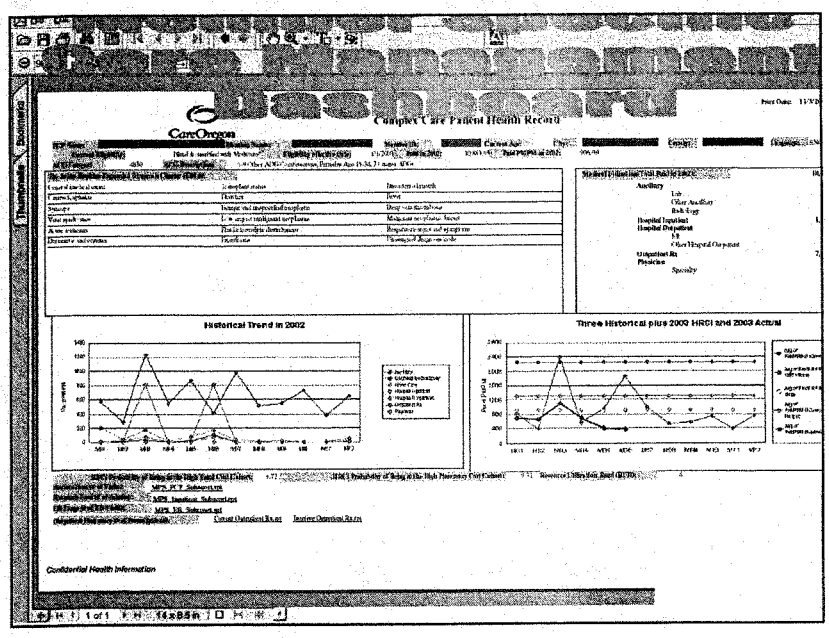
Preventive: Avoid or remove conditions or behaviors that generate disease.

Disease Management: Early Stages. Treated by Identification, Health Education, Monitoring and Proactive Passive Communication.

Complex Care: .5+ ACG-PM, medically and socially unstable, not connected well to the healthcare system. Facilitate treatment ready member with medical/social provider/plan based case management.

Non Users | Healthy Users | Low | Mod | High | Very High

13



Program Dollar Savings

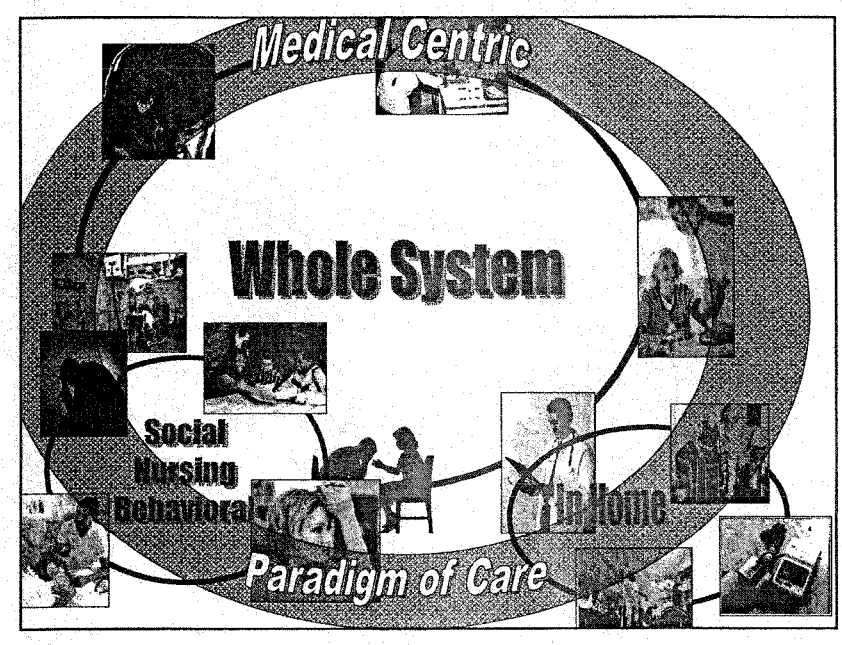
CM	Paid 2003	Paid 2004	Paid Change
Brief CM (n=1661)	$13,094,069.59 (pmpm $709)	$11,777,395.49 (pmpm $651)	-$1,316,674.10
No CM (n=59399)	$73,751,101.62 (pmpm $127)	$77,671,595.11 (pmpm $127)	$3,920,493.49
CM (n=326)	$5,272,876.82 (pmpm $1525	$3,765,855.28 (pmpm $1037)	-$1,507,021.54

~$5,000 Unadjusted Savings /case

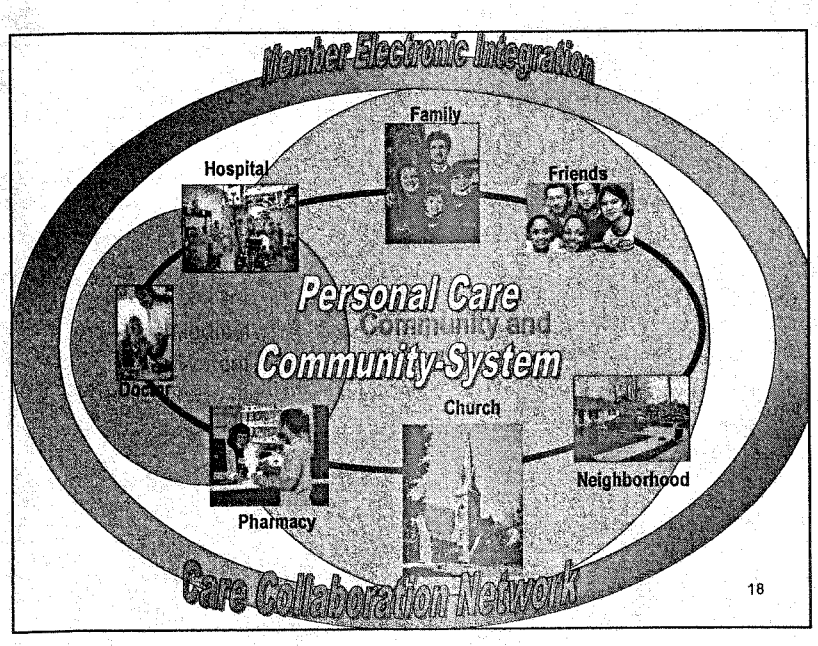
But: Are the Savings from Case Management?

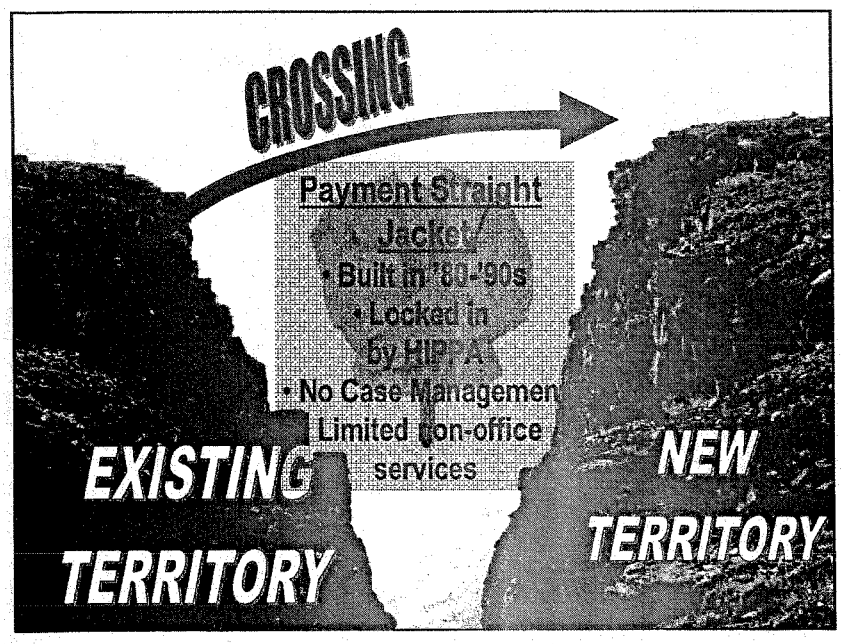
Did the sick members just get better?

15



Where Most Care Is Delivered
Family
Friends
Personal Care Community
Church
Neighborhood
17


Member Electronic Integration
Family
Hospital
Friends
Personal Care Community and Community-System
Doctor
Church
Neighborhood
Pharmacy
Care Collaboration Network
18



What More Can Be Done?

1. **With Confidence, expand Medicaid to included SSI**
   - Been widely done
   - Great success for members and cost
2. **Integrate, where possible, Mental and Behavioral Health Care with Physician Medicine**
3. **Acknowledge social care and physical care work to create synergy**
   - Need to have integrated collaborative technology
   - Need more patient control and choice in care processes
4. **Change what we pay for: Cannot get to tomorrow with yesterday's Piece-work payment Process**
   - Need to pay for case management, phone calls, email, out-of-office care management
5. **Take Actuarial Soundness seriously**
   - The State legislative practice on arbitrary "policy-adjustment" to rates undermines incentives for innovation
   - Give CMS teeth and process to rapidly enforce

20

Better together

CareOregon

21

CareOregon

CareOregon is the state's largest Medicaid health plan specializing in care for low income Oregonians under the Oregon Health Plan. CareOregon's mission is to create a model of care that emphasizes prevention and primary care case management. We incorporate a variety of health care providers in an effort to deliver high quality, culturally appropriate, cost-effective care. Our members receive health care services through a network of community and private medical providers throughout the state.

Founded in 1993 as a collaborative effort by public and private health care providers, CareOregon is a 501 [c] 3 private nonprofit Managed Care Organization with a 10 member Board of Directors. The current Board is comprised of private practitioners, several health care providers, and representatives of two of the founding partners; the Multnomah County Health Department and Oregon Health and Sciences University.

When the Oregon Health Plan began, it increased the number of people eligible for Medicaid benefits, changed the way health care providers are reimbursed for service, and changed the way providers are organized to receive payment for serving Medicaid clients. CareOregon was established so that the founding organizations could continue to serve the low-income, vulnerable populations through the Oregon Health Plan.

In order to provide continuous coverage to all of our almost 100,000 members, on January 1, 2006, CareOregon began offering a Medicare plan to members with both Medicare and Medicaid coverage (i.e., "dual eligibility") in seven Oregon counties. CareOregon Advantage, a Special Needs Plan, serves approximately 6,000 dual-eligible members, only a third of whom are senior citizens. The majority of CareOregon Advantage members are adults with multiple illnesses and many are fully disabled.

To further our mission, CareOregon develops partnerships with providers and provider organizations that serve low-income people to create a community-based model of care. We are focused on improving the health status of our members and the communities we serve. To accomplish this goal, we support the efforts of the clinicians and advocates who care for our members; educate members on appropriate utilization of health care resources; and provide case management and exceptional needs care coordination.

CareOregon Member Information

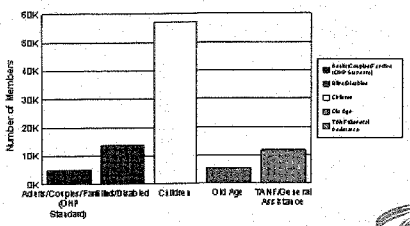
As of: August 31, 2006

Age Groups	Total
0-1	**6,503**
1-19	**53,659**
20-29	**8,140**
30-39	**6,525**
40-49	**6,187**
50-59	**4,980**
60+	**7,363**
Total	**93,357**

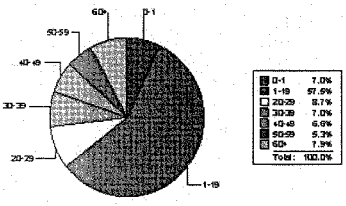
Gender	Total
Female	**51,943**
Male	**41,414**
Total	**93,357**

Eligibility Categories	Total
Blind & disabled with Medicare	**4,523**
Blind & disabled without Medicare	**9,147**
Childrens Health Insurance Program(CHIP) child < 1 year old	**156**
Childrens Health Insurance Program(CHIP) child between 1 and 5 yrs old	**1,931**
Childrens Health Insurance Program(CHIP) child between 6 and 18 yrs old	**6,589**
CSD children	**3,620**
OHP - adult < 100% poverty level	**1,306**
OHP - children < 1 year old	**6,372**
OHP - children between 1 and 5 years old	**17,104**
OHP adults and couples	**3,244**
OHP Families	**1,938**
OHP -I child between 6 and 18 years old	**21,410**
Old age with Medicare A and B	**3,094**
Old age with Medicare Part B only	**2,052**
Old age without Medicare	**405**
Poverty level medical - adult > 100% poverty level	**779**
Temporary Assistance for Needy Families - Adult	**9,426**
Temporary Assistance for Needy Families - Child 0-19	**261**
Total	**93,357**

Summary by Eligibility Category



Age Groups



CareOregon

The CHAIRMAN. Dan.

STATEMENT OF DANIEL O. HILFERTY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERIHEALTH MERCY AND KEYSTONE MERCY HEALTH PLANS, PHILADELPHIA, PA

Mr. HILFERTY. Good morning, Mr. Chairman and Senator Kohl. I appreciate being here today. I represent AmeriHealth Mercy Health Plan, based in Philadelphia. I also have the good fortune of being the Vice Chairman of the Medicaid Health Plans of America. MHPA is our Washington-based interest group and trade association, and with us today is our president, Thomas Johnson, who does a great job for us here on the Hill.

On behalf of my colleagues in Philadelphia, I really appreciate the opportunity to be with you today. The one good thing, coming last in such an august group like this, is I found myself learning a lot, but I also found myself checking off a number of the things that have already been said that I don't want to repeat.

The CHAIRMAN. But not everybody has said them, so go ahead.

Mr. HILFERTY. That is right. I am going to try to do it.

First of all, I would like to, on behalf of our association, thank the both of you for the leadership that you have provided in really bringing the discussion of Medicaid to the forefront. The bipartisan commission has gone a long way to making the discussion of Medicaid policy and Medicaid reform a household discussion. I find that for the first time my family and friends actually know what I do because they are reading about Medicaid on a regular basis.

Our organization and its affiliates work in 16 States. We managed the care in some way, shape or form for about 2 million Medicaid recipients. We have 23 years of experience in the industry and we are very proud of what we have learned. We feel that we really know the medical assistance population.

We started out basically working with the TANF population and the SSI population. Over time, States have moved more with their managed care models toward the aged, blind and disabled, and we have had an opportunity to really learn a lot about that business. What I would like to do is I would like to move off of my prepared remarks and focus on that more expensive population.

First, I would like to say I really agree with what Ron said about if you have a quality product, efficiencies might follow. I would adjust that slightly and say quality definitely leads to efficiency. Then I would like to focus on what David said about a small portion of the population eating up the large bulk of the dollars for care. We have found that with the aged, blind and disabled, those with chronic diseases, those with multiple chronic diseases, roughly 20 percent of our membership utilizes 80 percent of our costs. So you think of the disparity there.

So here we are as managed care spending a lot of time traditionally, the traditional denying care or making sure people get pre-authorization. Well, what we are saying is if we shift focus to coordinating care across the whole population base, but focus on that 20 percent, not only will we provide a higher level of quality of care for those individuals and their quality of life will improve, but efficiencies will be there as well.

So I would like to focus on—and I have this in here—I would like to focus on one of our programs. We really decided that if we were going to be effective, if we were going to survive and the State's ability and the Federal Government's ability to fund these programs decreases, we had to really shift from a gatekeeper perspective to more of a care coordination perspective.

We developed a program called PerforMED, which is an intensive case and disease management program, and we decided to look at those disease states that were really costing us. We identified them by category, then more specifically by member, and we put in aggressive case management, one-on-one regular dialog with the member, regular interaction with not only the primary care physician, but the specialist community.

David makes an excellent point. The key way to do that—and we talk about having real-time data in front of everybody so that you have got not only the managed care organization, you have got the provider, you have got the patient, you have got other organizations that interact with that member and their disease state. When everybody has real data, you make collaborative decisions, and we believe that collaborative decisions are usually better for the member and more efficient.

We have a program that I focus on in my written remarks that I would just like to comment on and it deals with juvenile asthma. We are seeing in our membership in many of our States that asthma is increasing dramatically across the board, and mainly in young people. So we started a program called Healthy Hoops. We saw that many of these children with asthma weren't participating in any athletics, dance, other activities. They were on the sidelines.

So we decided to put a program together where we would teach them basketball, but what we said was we have got to get the clinicians involved and we have got to get the providers involved. We formed a coalition. It isn't our program; it is the asthma coalitions in the regions in which we do it. We decided that we would teach them basketball, but in order for them to participate—it was more or less a carrot/stick thing—their parent and/or guardian had to participate in the program as well. So it was part classroom and part fun and games with local basketball legends who taught them the game of basketball.

What we found is that the parents were enthused about this program. They came on a regular basis. They learned about the children's meds, they learned about the need for nutrition, they learned about how to use the inhaler, what the problems are with the inhaler. They really got a grasp of the disease that they were dealing with. We felt that this put these children at an advantage where they could overcome some of the obstacles that they had. The fun of it is they have learned basketball. We have done it Philadelphia and we have done it in South Carolina. We are next doing it here in Washington, DC, and in Florida, in Broward County.

What are the results? The proof is always in the pudding. The results for us really show what has happened. The 2004 class—and the problem with it is each class is only about 500 children, so you have got to really expand it to have a national impact. But with that class of 2004, we found there was a 70-percent reduction in

emergency visits. That is significant. There was roughly a 13-percent decrease in use of emergency medications, which is pretty significant as well. We also found that once they got involved in the program, they were hooked on it for life.

So what I am saying is you take all the points that we have made across the board and if the quality is there and you focus on individual high-cost disease states and set up comprehensive, aggressive outreach and education programs, it leads to a higher quality of life, improved health status and, finally, efficiency, which we all know has got to be a key part of a program.

In closing, I would just like to say that the bipartisan commission—and you were talking about some program and you were saying, I think, only this group and a small group gets excited about the things that go on in Medicaid. But I was excited about the bipartisan commission. I really enjoyed hearing about the different perspectives. Well, out of the work of the bipartisan commission and Congress' deliberations in the past year, we are looking at $10 billion, roughly, in savings over the next 5 years in the program.

Well, MHPA sponsored a study by the Lewin Group which really shows that if managed care is implemented across the country for Medicaid recipients, whether it is a mandate or incentive-based, to get States to really move toward managed care models, the savings are roughly about $83 billion over the next 10 years. So what I am saying is it is not just about the dollars, but if you build those programs that focus on that 20 percent of the population—I am not saying ignore the other 80 percent; they have needs as well—but truly focus on those high-cost populations and do it in a quality way where the State monitors, measures and is involved in the process, you are going to get a higher quality of life. You are going to have folks who—there is a certain dignity around the way they are receiving their care and the program is going to be far more efficient. I am a believer in it, I get excited about it, and I ask you to really consider going in that direction.

Thank you.

[The prepared statement of Mr. Hilferty follows:]

U.S. Senate Special Committee on Aging

Testimony of Daniel J. Hilferty

Good morning, Chairman Smith and Members of the Committee. I am Daniel J. Hilferty, President and CEO of AmeriHealth Mercy and Keystone Mercy Health Plans, based in Philadelphia, Pennsylvania. I also serve as Vice Chair of the Medicaid Health Plans of America (MHPA), a Washington, D.C-based trade association representing the Medicaid managed care industry. I am pleased that you have asked me to appear before you this morning, along with other key stakeholders, at this public roundtable on Medicaid managed care.

Chairman Smith, on behalf of AmeriHealth Mercy and MHPA, we want to commend you for your leadership in ensuring that Medicaid will be adequately funded. We thank your for your leadership efforts during this Congress and over the years, including the formation of the bipartisan commission to study the Medicaid program.

AmeriHealth Mercy and its affiliates comprise the largest family of Medicaid managed care plans in the United States, touching more than 2 million lives in 16 states. AmeriHealth Mercy is driven by its mission, to help people get care, stay well, and to build healthy communities. AmeriHealth Mercy has 23 years of experience serving the Medicaid population. We know this population very well. We have extensive experience with voluntary and mandatory Medicaid markets, with the Medicaid TANF and SSI populations, and we also serve CHIP populations in three states. We operate four Medicaid-specific product lines, full-risk managed care; management and administrative

services; PerformRx, a pharmacy benefit management program for Medicaid and Medicare Part D; and PerforMED, our care coordination program.

AmeriHealth Mercy has proven that managed care works for Medicaid in the marketplace. We have met and exceeded the states' goals of improving quality of care, increasing access to care, and saving money. We have accomplished this through innovative approaches to care management, collaborative provider relationships, community outreach, and efficiencies through enhanced technology. I would like to share with you some of our success stories.

Initially, our health plans took on full risk for the health care of mostly women and children in the TANF segment of the Medicaid population. In the late 1990s, states began mandatory enrollment of the Aged, Blind and Disabled populations into managed care programs. In Pennsylvania, adding this population caused our pharmacy costs per member per month to more than double in one year, and we saw an immediate spike in the utilization of health services. We realized that we needed to change our approach to care management, or the costs of caring for this population would put us out of business.

This is what we learned about caring for people with chronic illnesses: these members were getting a lot of care, but it was not always good care, or necessary care. We started a program of intense care coordination called PerforMED that predicts which members will be high care utilizers, and we found that about 20 percent of our members accounted for 80 percent of our costs. By identifying these members using predictive modeling, we

can intervene to prevent acute care episodes. We saved 26 million dollars from PerforMED the first year it was implemented by reducing the need for acute care such as ER visits and inpatient admissions for the 2,500 members enrolled in the program.

We also developed our own Medicaid-specific approach to pharmacy management, PerformRx, to address the increase in pharmacy costs. By integrating medical management and pharmacy management, we have been able to reduce our annual pharmacy cost trend from 18 percent to 25 percent to less than 5 percent.

Our experience with the Medicaid population has taught us that you need to be in the community to reach the members. Healthy Hoops is a great example of our community outreach programs. Healthy Hoops uses the sport of basketball to teach children with asthma and their families how to manage the disease through appropriate medication usage, proper nutrition, monitored exercise and recreational activities. After four years of the program, we are able to measure clinical improvements for Healthy Hoops participants. For example, the 2004 program reduced ER admissions by 63 percent, decreased rescue medication use by 13 percent and decreased sleep disturbances by 70 percent.

Medicaid health plans have not only increased access and quality, they have also delivered cost savings and held down the rate of cost escalation. The role of our industry has been well documented in the Commonwealth of Pennsylvania. A study undertaken by The Lewin Group shows that Medicaid managed care under Pennsylvania's

HealthChoices program has worked "remarkably well" for all stakeholders, and its financial performance makes it a "national model." Our industry has delivered "massive savings" to the state, as Lewin estimated that Pennsylvania received 2.7 billion dollars in savings over a five-year period. Another Lewin study commissioned by the MHPA determined that expanding managed care capitation to Medicaid nationally could achieve 83 billion dollars in savings over ten years. If Congress and the President would mandate Medicaid managed care, this would save the government far more than proposed currently, and in the process would improve care for Medicaid recipients.

Medicaid is at a crossroads. There are unprecedented opportunities for program re-design that could build on existing care improvements and cost savings. There is an opportunity to provide incentives for Medicaid recipients and families to live healthier lifestyles, emphasize prevention and primary care, and manage chronic illness.

Managed care works for Medicaid. It has increased access, improved quality and prevention, and saved billions in taxpayer dollars, despite having to work within the constraints of Medicaid regulations designed for the old fee-for-service model. Managed care has also afforded people on Medicaid the kind of health care that you and I take for granted – access to quality care from top doctors and hospitals, provided with dignity. The time is right to fulfill the potential of Medicaid managed care. Benefit re-design can make managed care more effective by putting incentives into place to promote prevention and healthy lifestyles and by identifying and coordinating care for members with complex health needs. The public/private partnerships already exist to enable this.

My colleagues and I stand ready to continue our work in improving the health of Medicaid recipients.

Thank you again for allowing me to appear before the Committee this morning.

The CHAIRMAN. Thank you very much, Dan. I wonder if in this basketball program you have, if any of these kids are of sufficient talent that the owner of the Milwaukee Bucks ought to keep his eye on them.

Mr. HILFERTY. Well, maybe. I don't know, Senator, but I was going to talk to Senator Kohl. I would like to be a general manager someday. [Laughter.]

The CHAIRMAN. You operate in enough States. Do you have a perspective on the rural question that we began with?

Mr. HILFERTY. Yes, and I would just put a different slant on Tony's point. I thought Tony made the key point that it is about having a provider network; even though the distance between the various providers is longer, have a provider network that is under a cap system that is incentivized to really be part of the Medicaid program.

Then from our vantage point, much like we reach out to the populations that I discussed, the managed care entities have to have a program that overcomes the obstacles—once you have the provider network in place, that overcomes the obstacles to get people needed care. Sometimes that is transportation, sometimes it is the time of day that a physician or a clinic might be open for them to visit for care.

I guess what I am saying is if the States focus with the managed care plans on setting up the network of having adequate funding for the clinicians and they know they are going to get that funding, they will be supportive of the program. Then it is incumbent upon the plans, with oversight by the States, to make sure that those members get introduced on a regular basis, are educated on a regular basis, and overcome the obstacles to access that care.

The CHAIRMAN. Obviously, I think we have here people who run plans and programs that are very successful and are providing quality care, and also winning efficiencies and cost savings. But, obviously, you can't please everybody. There has got to be occasionally a patient who is just unhappy with an outcome, with a denial or whatever, and I wonder if perhaps Arizona can speak to that, and David and Dan. What recourse do your patients have if they don't like what you have done?

Mr. FORD. There is a whole structured call-in process and a grievance process that we are required to provide, and there is a fair hearing process by the State if it were to get to that level. But the other thing that we do is we have data that allows us to look at the continuity of care. We look at bad outcomes and we go to the hospital and the other providers and work on behalf of the patients around improved care.

But in the open system, nobody looks at that on the back side of that and we have committees of doctors from the community that look at adverse outcomes and we do remediation. We actually are now using this Institute of Medicine and the Institute of Health Care Improvements guidelines and we are saying this appears to be a problem with your drug reconciliation. Do you have a program? Here is what is going on. They often get back.

We talked actually last week about is that response back just sort of a paper response or will we look back in 6 months and say you said you would do this and then we would begin auditing that

kind of thing. We are all in favor of accountability. The burden of accountability is on us because there is no other place to get it.

Mr. HILFERTY. Senator, if you do Medicaid in one State, you do Medicaid in one State. I mean, each State has different ways of approaching it. Interestingly enough, we think as a plan that it is a benefit to keep a member in your plan for at least a year so that you can impact their health status. The flip side of that is some governments say, well, really, a member should have the right to opt out and move to another plan at any point.

What I would like to suggest is there is a happy medium there. In the Commonwealth of Pennsylvania, the plans don't market. There is a benefit consultant who works with an incoming member and helps them decide what is the best network for them, what is the best plan for them, and they choose that plan. That has worked very well because people coming in feel comfortable, seem to have less complaints and are ready to access the care of the plan.

On the flip side, there are folks that have the right to opt out of a plan and move to a competitor if they are not satisfied, if they exhaust all of the opportunities to really grieve or whatever it might be over care. So we believe that we can have a happy medium where we spend a lot of time up front educating members about what they will get from a particular plan and competition is good, No. 1, but No. 2, not make it so that a member can jump from plan to plan every month or every 3 months or even every 6 months, but build a period of time where a plan can really work aggressively with that member, with that family to make sure they are getting the services that they need to get. When that happens, there seems to be less complaints.

Mr. POLLACK. Mr. Chairman, can I add a few things?

The CHAIRMAN. Yes.

Mr. POLLACK. I think there are several things that are important. First, I think there needs to be a coordination of grievance systems between Medicare and Medicaid so that people don't fall through the cracks or have contrary systems for dealing with problems.

The CHAIRMAN. There is none now?

Mr. POLLACK. It is not adequate and we need much more adequate coordination.

The CHAIRMAN. Would that be done through CMS?

Mr. POLLACK. Yes.

Second, since this is a low-income population, to the extent any benefits might be withdrawn, there needs to be continued benefits during the pendency of a grievance claim. This is a fundamental right. It is actually something that was, in a different context, ruled on by the Supreme Court in the 1960's.

Third, I think it is critically important to have some help available to people. I mentioned ombudsmen before. Some people call them different names, but we need some people who can be of assistance to an individual. Remember, when benefits are potentially being terminated or reduced, the person is actually in some significant need of health care and they themselves may not be in the best position to deal with the problem. So they need some kind of help.

So I think those kinds of systems need to be in place, and then there is a matter of fundamental fairness: If there is a denial of certain services by a plan and you have gone through the internal grievance process, there needs to be, as part of this coordinated plan, an external system where the person making the decision was not involved in the original decision and has competence in that area of medical judgment.

The CHAIRMAN. Did you have anything to add to that, Tony?

Mr. RODGERS. Mr. Chairman, the process that we use starts with the health plan. One, they have to notify the beneficiary why they are denying care by sending them a letter that says this is a service we are not approving, et cetera. So that is the first place typically a beneficiary may learn about a denial of care, and that happens whether it is a benefit denial or there is a feeling that the services aren't required, et cetera, and that starts the process.

The health plan is the first level that we expect the dialog to occur, typically with the physician and the health plan. If the member is still not satisfied, we review the case and we have a unit that does that advocacy for the member, validating that we agree with the health plan. But, ultimately, they still have the right to go to a State fair hearing, where there is an administrative law judge. In those cases where we have a policy that our plans are following that they are challenging, that is typically what goes to the State fair hearing, where they are challenging the policies of the State.

So we do have this tiered process and what it does is it informs us on what the issues of our beneficiaries are. This is a very important part of how we actually improve our programs, and the best health plans are using that data to actually create either better networks or better understanding with their physicians, et cetera. We also allow the physicians to grieve. They can grieve a health plan, as well. So there are a number of ways that beneficiaries have their rights protected in our system.

The CHAIRMAN. Does anyone else have a comment?

Mr. CROWLEY. Just very briefly, I want to echo what Ron said. I think he got it right. I think it is important that most of what we are talking about is a sort of formal appeals system. For beneficiaries that often works well if they have a legal advocate, but we know most people don't have that. So I think we need to think more about ways that people can have an alternative without sacrificing their rights to really work with their doctors.

I can't point to this as a huge success, but in the Medicare Modernization Act there is this new exceptions process. While there have been problems implementing it, one thing that is attractive is that it is really meant to be an initial first step that is less formal than a formal appeal, where working with your doctor you can resolve some of these things. Most people don't have lawyers and they are sick and so they don't want to deal with it, but if there is an easier way, we could resolve some of these without requiring five steps of appeals and lawyers and everything else.

The CHAIRMAN. That may be a good model, then.

Mr. CROWLEY. Potentially, or learn lessons for how to improve upon it.

The CHAIRMAN. Greg, do you have a comment?

Mr. NYCZ. Well, more or less getting back to the rural issue, if you think about community health centers as being able to help work with the community to set up a clinic in a rural town that didn't have doctors, maybe didn't have mental health providers—you leverage health centers to create the infrastructure in that town that will help enable some of the managed care activities.

I look at it as a one-two punch. Where we have workforce issues, community health centers have been shown to stabilize and or create practices. I would note that it isn't even just in rural areas. In some inner-city areas that have seen a mass exodus of private doctors, you need to go back in there and set up that primary care infrastructure that is central to good care management.

The CHAIRMAN. Well, gentlemen, this is the first in a series of roundtables or square tables that I am going to do because I am very earnest about pursuing this as one of the ways to preserve Medicaid. So let me simply thank you for your time and your talents that you have shared with us today. We have taken it all down and you have certainly increased my understanding and I am going to do my level best to reflect that in creating new American law to strengthen, not weaken, Medicaid.

So this not being a formal hearing, I won't adjourn it, but just thank you very much, and have a very good day.

[Whereupon, at 11:30 p.m., the Roundtable was concluded.]

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