CHCS Center for Health Care Strategies, Inc.

Thank you, Mr. Chairman and Senator Martinez.

My name is Melanie Bella. I am Senior Vice President at the Center for Health Care Strategies, Inc. (CHCS), a non-profit health policy resource center near Princeton, NJ. CHCS has three priorities:

1) to close the gap in the quality of care received by Medicaid beneficiaries;
2) to build the leadership capacity of state Medicaid directors and other key Medicaid stakeholders; and
3) to integrate care for low-income beneficiaries of publicly financed care, especially those with the complex chronic conditions associated with advanced aging and disability.

CHCS promotes innovation, evaluation, and dissemination of best practices in each of these areas and most of our work is in cutting-edge states like Colorado, New York, Pennsylvania, Washington, Wisconsin, and others.

Because Secretary Timberlake has already described Wisconsin's managed long-term care (LTC) program, Family Care, one of the more exciting and innovative programs in LTC nationally, I will spend my time with you highlighting two other major areas of opportunity in caring for those with chronic medical and long-term supports and services needs:

- fully integrated care for the dual eligibles; and
- coordinated patient-centered home and community-based services.

For many in the field of publicly financed care, myself included, integrated care for the dual eligibles represents the single most important opportunity for reforming the current U.S. health care system. It is tantamount to a Holy Grail that has been pursued literally for decades. The first efforts to integrate care for dual eligibles began in the early 1980s with efforts like the On Lok/Program of All Inclusive Care for the Elderly (PACE) program and social HMOs, and eventually the state-based Medicare-Medicaid integration waivers in Massachusetts, Minnesota, and Wisconsin.

While there are gems among all of these programs, after 30 years most remain relatively small in scale. More that 95 percent of the dual eligibles who could benefit from fully integrated approaches are still in various forms of *un-integrated* and *un-managed* care. Even among those who could benefit the most, the highest risk duals with multiple acute and long-term care needs, the percentages in integrated care are truly discouraging. This is the case, although most experts you could bring here to testify would assert that truly integrated care could significantly improve the lives of beneficiaries and reduce the growth in Medicare and Medicaid costs for taxpayers. To underscore that last point, the seven million full dual eligibles (about 18 percent of all Medicaid beneficiaries) consume over 42 percent of Medicaid resources and 24 percent of Medicare resources. That is more than $250 billion in FY2008.

What do I mean by truly integrated care? In its purest form, it is where one entity is programmatically and financially responsible for providing all Medicare and Medicaid reimbursable services. That means both acute care and long-term supports and services as is the case with PACE, Wisconsin's Partnership Program, New Mexico's Coordination of Long-Term Services, Minnesota's Senior Health Options, and a limited number of other model programs. There are a set of core elements in each of these programs:

- Patient-centeredness;
- Hands-on care coordination;
- Direct linkage between primary care and other clinical, behavioral, and supportive services;
- An emphasis on home and community-based services rather than institutional care;
- Performance measurement; and
- Risk adjustment and other ways of aligning financing to incentivize appropriate care.

Each of these elements has been forged and tested in the groundbreaking work being done in the states I have mentioned. I call your attention to the chart attached to my prepared statement that provides more detail on some of the model programs.

As policy makers, I imagine that your major interest is in understanding how to help spread these good works to benefit more than three or four percent of dual eligibles. Under current law, the most promising option, though not "true integration," is to promote virtual integration through Medicare Special Needs Plans (SNPs), wherein dual eligibles enroll in the same managed care organization for their Medicare services and, given a contract between the SNP and the state Medicaid agency, their wrap-around acute *and* long-term care supports and services. In addition to the original Medicare-Medicaid integration states (MA, MN and WI), others like Arizona and New Mexico have made substantial progress along these lines. Even so, these virtually integrated plans are providing a full set of Medicare-Medicaid services to only about 120,000 beneficiaries.

Why are the numbers so low? In part because SNPs are relatively new to seniors and, as well, to state Medicaid agencies. Further, Federal Medicare and Medicaid officials have not been able to overcome many of the countless regulatory and administrative barriers that continue to separate these two programs even when it would be in the interest of both the beneficiaries and federal and state government to do so. With support from the Robert Wood Johnson Foundation and, more recently, The Commonwealth Fund, CHCS has worked closely with Centers for Medicare and Medicaid Services (CMS) and state officials to identify and address these barriers (e.g., ranging from different marketing and enrollment rules to divergent grievance procedures), and hopes to see even greater opportunities for doing so in the new Administration. Finally, SNPs and managed care in general are not prevalent in a number of states and in more rural regions of other states.

True—or even virtual—integration in states without vibrant managed care markets will require alternative, non-SNP based solutions. Under current law, they will also quite likely require running the complicated federal waiver and/or demonstration gauntlet with CMS and OMB. One very exciting proposed innovation, the 646 Demonstration (under the Medicare Modernization Act) in North Carolina, appears to be on the brink of approval. It presents an

enormous learning opportunity on a number of fronts, but perhaps most important, it would test a gain sharing arrangement between the federal government and a non-profit entity connected to the state Medicaid agency. What is so significant herein is that it could pave the way for win-win financial realignments between Medicare and Medicaid, and between the federal government and the states. It could even lead to consideration of Medicare contracting directly with states for the risk-based management of all Medicare services for the duals—something that has been proposed under the label, "Medicaid Duals Demonstration," in a number of venues over the past several years.

Congress could dramatically accelerate progress in this arena by requiring CMS to test ways of overcoming the fragmentation of care for the dual eligibles. A reinvigoration of existing demonstration authority could certainly accelerate the pace of change. Or Congress could specifically request that CMS demonstrate progress in replicating "good" fully integrated care models by establishing the appropriate standards and safeguards and working with states to balance front-end funding needs with longer time horizons for achieving budget neutrality.

In the meantime, as I observed at the outset, states that start the ball rolling toward greater coordination of care by creating managed long-term care program's like Wisconsin's Family Care and Arizona's Long Term Care System should be encouraged by both Congress and the Administration. These programs do not get to scale overnight, so facilitating experimentation in the other states like Florida, New York, and Texas is crucial. These states and others are focusing their attention on this issue because the nation's current system of fragmented long-term supports and services is simply not good for beneficiaries or for state budgets.

Finally, it will be no news to the members of this Committee, but I must say that most of the scalable progress made in Medicaid's long-term care programming over the past 30 years is in the arena of Home and Community Based Services (HCBS). In many states, including my home state of Indiana where I served as Medicaid Director for three years, nursing homes still consume the lion's share of the funding. But a recent Kaiser Family Foundation paper reported a very encouraging statistic: 41 percent of Medicaid long-term care expenditures in 2007 were for HCBS, up from only 19 percent in 1995.

The development of HCBS is a tremendous illustration of Justice Brandeis' observation about states as laboratories for innovation. The ground-breaking work of states like WI, KS, OR, and WA, among others, has enabled the nation and frail-elders to shift away from overreliance on institutional care—even to the point of compelling nursing facilities to become more and more home-like, e.g., the Greenhouse model. Vermont, for example, launched its Choices for Care program, which establishes different tiers of need as a mechanism for rebalancing the system to increase access to HCBS services and decrease use of nursing homes. More recently, Tennessee has embraced efforts to expand access to HCBS as part of a fundamental change to its LTC delivery system. It is pursuing a fully integrated, mandatory, statewide LTC program designed to move people out of institutions and into the community.

Across the nation states are experimenting with ways to rebalance their systems; however, much more remains to be done to increase access to high quality, accountable home and community based services. Small policy changes by Congress to encourage the replication of successful past efforts such as Money Follows the Person and Medicaid Transformation Grants

would be a significant start. More substantial changes might include consolidating waivers so that a different one (with a different time horizon and different cost effectiveness test) is not required for each group of individuals, allowing states to manage all HCBS services (state plan and waiver) under waiver authority; and modifying some of the outdated payment and benefit policies. One might even imagine a world some day where a waiver is not required for a person to stay at home to receive needed services.

Today, across the country, there are many small pockets of innovation in states that -- out of necessity and ingenuity -- are doing their best to work around administrative and financing hurdles to deliver better and more cost-effective services and supports for those with chronic long-term care needs. But with the myriad of "boutique" programs and with no clear path for long-term care, there is not a strong sense of knowing what kinds of care work best when, where, and for whom. In medical care, an Institute of Medicine report spurred policy makers and clinicians alike to demand that the nation deliver the right care, to the right people, in the right setting, at the right time, and for the right price. It is time for similar expectations to be applied in caring for those with chronic medical and long-term supports and services needs. There is a gold mine of opportunities to improve health outcomes, better people's lives, and curb escalating costs related to fragmented and poorly coordinated care.

Thank you for the opportunity to testify.