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**BUILDING UPON THE SUCCESS OF MEDICAID MANAGED CARE  
FOR DUALY-ELIGIBLE BENEFICIARIES**

**TESTIMONY BEFORE THE  
U.S. SENATE SPECIAL COMMITTEE ON AGING**

**JULY 18, 2012**

Chairman Kohl, Ranking Member Corker, and Members of the Special Committee, thank you for the invitation to discuss Arizona's use of managed care to improve the lives of individuals enrolled in both the Medicare and Medicaid programs.

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's single state Medicaid agency. AHCCCS is currently working with the Centers for Medicare and Medicaid Services (CMS) on the national effort to integrate care for individuals enrolled in both Medicare and Medicaid.<sup>1</sup> This is the first opportunity of its kind to address longstanding concerns regarding the coordination of care for the so called "dual eligible" population.

Who are the dual eligible members? In Arizona, duals represent:

- 9% of the State's Medicaid population.
- 82% of the State's elderly and physically disabled population that is at risk of institutionalization.
- Almost 50% of our members with serious mental illness.
- Over 5,000 members with a developmental disability.

Dual members are some of the most vulnerable members in our program and they heavily depend on critical Medicaid services, like long term care support services and behavioral health.

This opportunity is timely and exciting. For decades, we have asked the dual eligible population, among our nation's most frail citizens, to navigate three (sometimes more) complex, massive systems of care – Medicare, Part D and Medicaid. These systems are also operated as separate programs with no financial alignment, which means there is less incentive to coordinate care than in a model that holds one entity at risk financially. The result is exactly what one would expect – poorer health outcomes and higher costs. The status quo of poor health outcomes and system fragmentation is not only unacceptable, it is unsustainable.

Recently, we have seen a great deal of confusion and misinformation surrounding managed care and the role of Medicaid health plans in the provision of care to Medicaid and dual eligible beneficiaries. A great deal of this confusion is based on a lack of understanding of how managed care benefits dual eligibles. My message to the Committee today is that the managed care model being pursued by many states has proven to be a success in Arizona. Medicaid managed care is not an experiment. Arizona is a success story and a model of how managed care can work for everyone.

Arizona has maintained a system of managed care for its entire membership, including dual eligibles, since the State joined Medicaid in 1982. Arizona built its Medicaid program on the principles of member protection, competition, choice and accountability. The vision underlying Arizona's program is to place accountability for management, oversight and care delivery with one entity, the managed care health plan. Arizona's model works through private health plans that engage in a competitive bidding process and are financially at-risk to coordinate care for their members. It is a public/private partnership built on managed competition that leverages the private healthcare market to the greatest extent. Members have their choice of health plan and

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<sup>1</sup> See the AHCCCS Duals Demonstration proposal at:  
<http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx>.

doctor. Health plans establish their own provider networks, which are monitored by the AHCCCS administration to ensure those networks are adequate to address member needs. This allows us to mainstream AHCCCS members into the broader healthcare system, avoiding reliance on Medicaid mills.

This partnership, however, requires proper oversight. AHCCCS staff oversees health plan performance and ensures the appropriate member protections and health plan accountabilities are in place. Arizona takes its role of member protection and fiduciary of public dollars very seriously. Accordingly, we have made the right investments in personnel, systems and data. AHCCCS has an entire division of 70 staff whose sole responsibility is oversight and monitoring of health plan performance. Staff is comprised of doctorate-level quality experts, actuaries, coders, clinicians, attorneys, bio-statisticians, data experts, economists, and people with health plan experience, among others. The State has also invested in systems that allow us to house claims and encounter data to monitor utilization, track trends and set rates.

This model has been a success for dual eligibles, as well as the broader Medicaid population. Holding one health plan responsible for the provision of all covered services to an individual member allows for a greater emphasis on prevention and early intervention, coordination of care, case management and disease management – all processes that are well integrated into the current AHCCCS model. AHCCCS health plans conduct health risk assessments and use predictive modeling to target appropriate interventions. AHCCCS health plans also incorporate evidenced-based guidelines, medical homes, health coaching and education and medical management into ongoing efforts aimed at managing chronic disease as well as maintaining good health. Through thirty years of experience with dual eligible managed-care enrollment, AHCCCS has confirmed that it is precisely these most frail individuals who require the care coordination and additional supports managed care offers.

Consider Arizona's elderly and physically disabled population that is at risk of institutionalization. Most of these members (82 percent) are dual eligibles. The model of care for this population in many states today is focused on nursing homes and institutional placement. However, our members wanted to receive their care at home or find alternatives that would allow them to stay in the community. Over the past decade, the AHCCCS program has progressed from 40 percent of its elderly and physically disabled members in the home or community to 72 percent, allowing Arizona to save \$300 million this past year. In addition, 98 percent of AHCCCS members with developmental disabilities who are at risk of institutionalization live at home or in the community. The United Cerebral Palsy's 2012 report, *The Case for Inclusion*, ranked AHCCCS as the number one Medicaid program serving individuals with intellectual and developmental disabilities.

These percentages of Medicaid members living at home or in the community are among the highest in the country and they account for millions of dollars in annual savings. More importantly, these efforts increase member satisfaction and offer higher quality of life. Providing the right kinds of care management and care coordination to keep people at home is a uniquely Medicaid skill set, an area in which Medicare has no experience.

We also know that passive enrollment works. In Arizona, we have aggressively aligned the health plans of our dual eligible members. When Medicare Part D was created, Arizona actively encouraged existing Medicaid plans to become Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs). On January 1, 2006, approximately 39,000 members were passively enrolled with their Medicaid plan to provide better continuity of care for Part D implementation. Arizona has developed strong transition planning protocols, which ensured member protection and minimal disruption during this enrollment process.

The D-SNP option has allowed 40,000 of Arizona's 120,000 dual eligibles to choose their AHCCCS health plan for both their Medicare and Medicaid benefits. This alignment improves care coordination and lessens the burden that members and their families experience in navigating the system. Members are satisfied with their health plan and are obtaining quality care. In fact, only 3 percent of more than 1.2 million total AHCCCS members change their health plan each year. Furthermore, in January the plans that provide services to 25,000 long term care members (82 percent of which are duals) had a total of 10 members file a grievance; the month before that, 5 members filed a grievance.

The benefits of this alignment are clear. Nationally, dual eligibles are 15 percent of Medicaid's enrollment but represent 39 percent of the costs. Arizona's experience shows a different result; dual eligibles are 9 percent of the State's Medicaid enrollment and account for 18 percent of AHCCCS costs. Furthermore, according to Federal Funds Information for States (FFIS), when Part D was created, Arizona's drug costs for dual eligibles were \$166 per member/per month (PMPM) compared to a national average of \$266 PMPM. A study conducted by the Lewin Group showed that health plans were not withholding care but rather effectively using generic and lower cost drugs. Without this appropriate management of the drug benefit, Arizona would have spent \$90 million more per year for dual eligible members (assuming the national spending average).

To look at the benefits of managed care even more closely, Avalere Health LLC recently completed an analysis of the model of care coordination on health outcomes for dual eligibles enrolled in Mercy Care Plan, one of the AHCCCS contracted health plans that is also a D-SNP.<sup>2</sup> Avalere compared 16,000 integrated dual members enrolled in Mercy Care Plan to the nationwide, Medicare fee-for-service (FFS) dual eligibles. To ensure a fair comparison between the populations, Avalere created a risk-adjusted model for the Mercy Care Plan population. The results showed that Mercy Care Plan performed better than FFS across all of Avalere's measures. Compared to the total national FFS dual eligibles and adjusted to match the risk of FFS duals, the study showed that Mercy Care Plan's members exhibited:

- 31% lower rate of hospitalization;
- 43% lower rate of days spent in a hospital;
- 19% lower average length of stay in a hospital;
- 9% lower ED use;
- 21% lower readmission rate; and
- 3% higher proportion of beneficiaries accessing preventive/ambulatory health services.

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<sup>2</sup> Murugan, V., Drozd, E., Dietz, K. Analysis of Care Coordination Outcomes: A comparison of the Mercy Care Plan Population to Nationwide Dual-Eligible Medicare Beneficiaries. July 2012.

The Avalere analysis supports our own experience that the AHCCCS care coordination model provides quality, cost effective care.

Not only are costs contained by keeping people out of the hospital but, clearly, the quality of individuals' lives is improved if, with the support of a health plan, they are able to manage their own health. AHCCCS also separately monitors health plan performance related to the quality of care provided to AHCCCS members. Managed care health plans must maintain processes that effectively track and trend issues and result in investigation and resolution of quality of care concerns. For instance, AHCCCS monitors the long term care plans for gaps in attendant care services. Out of 1.9 million hours of attendant care authorized, there were only 836 hours where there was a gap in care. In addition, AHCCCS health plans overall measured above the national Medicaid HEDIS mean in 17 out of 25 performance measures.

AHCCCS health plans are also responsible for:

- Regular quality of care reviews and medical record reviews of primary care, high volume specialists and placement settings.
- Monitoring and improving access to evidenced-based care.
- Coordination with the state licensure agency regarding care concerns in facilities.
- Performance improvement projects utilizing data to identify focus areas.
- Reporting of any cases of abuse or neglect to ensure prompt action by the State.
- Discharge planning, coordination of care and monitoring to identify over- and under-utilization of services.

We have all heard the jargon around this issue, but what does managed care actually look like to the average member? To illustrate:

John was recently deemed eligible for services through the Arizona Long Term Care System (ALTCS), which is AHCCCS' program for individuals who are at risk of institutionalization. John is quadriplegic and lives in his own home in the Phoenix metropolitan area. John has a choice of one of three ALTCS health plans available in his county. John has elected Plan A as his health plan because he is already enrolled with Plan A for his Medicare services. Plan A has been notified that John has enrolled with the health plan.

Upon notification, Plan A contacts John to initiate the care coordination process (initial contact must occur within 7 days). At the point of initial contact, Plan A also determines whether John has immediate service needs and sets up the initial face-to-face visit, which must occur within 12 days of enrollment. The assigned case manager from Plan A meets with John and other parties chosen by John to participate in the assessment and service planning process. During the initial meeting, the case manager conducts an assessment of John's needs, discusses service and placement options, and develops his individualized service plan based on John's overall service needs as well as his preferences. Specifically, the Plan A case manager works with John and his team to address the provision of critical services, including attendant care, durable medical equipment and supplies, transportation, and behavioral health services. For any medical services, the case manager coordinates with the member's primary care physician to obtain the

appropriate medical order/prescription. For critical in-home care services, the case manager also works with John to develop a contingency/back-up plan, outlining who will provide care in the event that a provider does not show up as scheduled.

John's services are then initiated, as required, within a 30-day time frame. The case manager maintains ongoing contact with John to ensure that his service needs are being addressed and meets with John face-to-face at least every 90 days.

John's example shows the AHCCCS commitment to person-centered care. We also believe stakeholder engagement is critical, particularly as we embark on this journey to build upon the success of our model for dual eligibles. We remain committed to ongoing stakeholder involvement. Through an extensive stakeholder engagement effort, we heard one consistent message from dual eligibles and their families: the system is way too confusing. We agree. The current fragmented system means no one provider, health plan or system of care is seeing and serving the complete needs of the member. That means there is no single entity that is held accountable for their care.

We are firmly convinced that applying this proven and successful model of managed care to all 120,000 dual eligibles in Arizona through the duals Demonstration is the right thing to do for our members. Under the Demonstration, health plans will have the ability to assess the complete needs of and coordinate care for the whole person, not just the Medicaid half of the dual eligible. We also believe that the Medicaid health plans are best suited for the task of aligning care for dual eligibles. In addition to managing traditional "medical" services, these plans have the experience of providing home and community based services, behavioral health services and offering other needed supports that keep people at home and out of costly institutions for their care.

Based on our experience, we know that a single at-risk entity that is responsible for the full spectrum of care of dual eligibles will:

- Increase accountability;
- Build system efficiencies and minimize duplication;
- Improve care coordination;
- Reduce member confusion (one ID card, one place to call);
- Simplify the system for providers (one place to bill);
- Increase member satisfaction;
- Improve health outcomes by allowing health plans and providers to access all of the needed clinical information so they can work together to provide care to the whole person; and
- Bend the cost curve to create a more sustainable system.

I have been fortunate to be associated with the AHCCCS system for 20 years. For the past 10 years I served first as Deputy Director and now Director. Prior to that, I served in the Governor's Office for 10 years. I know the AHCCCS program is not an experiment. It is a proven model with documented success.

So for me, it is frustrating to hear others dismiss Medicaid managed care as an option for duals and suggest that states are either ill-intentioned or incapable of achieving success for this

population. This is not about achieving a budget target. States like Arizona want to move the system forward, improve care for our citizens and be responsible with the taxpayers' dollars.

To think, as I have seen some suggest, that Medicare can be the sole answer for dual members is simply wrong. Medicare has very limited knowledge and experience in home and community based services, community supports or behavioral health. States have managed these issues for duals and it is the states that understand their local communities best.

Equally disconcerting is this notion that states are moving too fast and the demonstrations are too big. We have had 45 years of fragmentation. Decades of comparison data show the shortcomings of the existing system. We do not need control groups in these duals demonstrations. We know the current system is not working for the people we serve or the taxpayers who are footing the bill. The current system is indefensible and unsustainable; we cannot wait to build upon a proven model.

We hope that Arizona's example will dispel the myths around Medicaid managed care and assuage the anxiety some may feel about using managed care to support care coordination for dual eligibles. Building upon a model with a proven track record of success makes sense and is the right step to address health care spending, improve our nation's system of care and do what is right for our most vulnerable citizens.