



Statement for the Record

From Medicaid Health Plans of America and the Association for Community Affiliated Plans

On the hearing entitled

**Dual-Eligible Beneficiaries: Improving Care While Lowering Costs**

Senate Committee on Finance

Wednesday, September 21, 2011

Chairman Baucus, Ranking Member Hatch, and members of the Committee, the Association for Community Affiliated Plans (ACAP) and Medicaid Health Plans of America (MHPA) is pleased to submit the following statement for the record regarding the important role that coordinated care can serve for people who are dually eligible for Medicare and Medicaid.

Together, ACAP and MHPA represent 143 health plans that serve more than 22 million Medicaid beneficiaries – one of every 3 Americans who receive health care coverage through Medicaid.

MHPA and ACAP recognize America's current fiscal crisis and understand the need to address the national debt. We also understand that Medicare and Medicaid are two of the largest programs in the Federal government and are responsible for a significant amount of government spending. Getting the country back on the right fiscal path will require changes to address these two programs.

However, ACAP and MHPA believe the debate should be about policies that improve the programs for beneficiaries and should not be driven by the budget. Arbitrary budget cuts that strangle these programs will only serve to undermine the larger effort as costs are shifted to health plans, providers, and beneficiaries with little consideration of improvement in the quality and coordination of care.

To achieve meaningful program improvements while saving significant dollars, MHPA and ACAP believe that expanding the flexibility of states for those populations dually eligible for Medicare and Medicaid will help to produce innovative models of care integration. While this expanded flexibility should not come at the expense of reducing coverage for vulnerable populations, we do believe that giving the states options to expand coordinated care will help improve the quality of care for dual eligibles.

The attached report from the Lewin Group entitled "*Increasing Use of the Capitated Model for Dual Eligibles: Cost Saving Estimates and Public Policy Opportunities*" finds that Medicaid health plans are well positioned to effectively serve the dual eligible population. Lewin finds that:

*“Many MCOs – as well as many state Medicaid agencies – now have extensive experience serving high-need populations through an integrated care model, and the “industry’s” sophistication in designing, implementing and overseeing such programs has improved substantially throughout the past decade. Historically, few coordinated care programs for high-need subgroups existed, and the “coordinated care” aspects of these programs focused on assigning individuals to a “medical home” primary care provider, encouraging proper use of the MCO’s provider delivery system, and deploying utilization review practices such as prior authorization for expensive services. While these techniques remain in use and of value, current Medicaid MCO programs for high-need subgroups (e.g., the Medicaid-only SSI population) typically go far beyond this traditional approach...*

*For example, states now often require Medicaid MCOs to demonstrate an effective process for assessing each new high-need enrollee’s health care needs, housing situation, family structure and social support system, then developing and continually adjusting individualized treatment and care coordination plans. Care coordination has advanced to provide more individualized care planning and effective approaches to identify emerging health conditions in order to avoid crisis based interventions. Such requirements and coordinated care techniques do not exist in the fee-for-service environment across the acute, chronic and long term care parts of the health system.*

*States have also become increasingly adept at putting effective MCO contract requirements in place for high-need subgroups, and monitoring MCO performance aggressively.”*

In addition, the report finds that:

*“...large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. The clinical and eligibility characteristics of the dual eligibles population are exceptionally well-matched to the strengths of a fully integrated care program operated by at-risk health plans. For any given dual eligibles subgroup moved into a capitated setting, encompassing the fully benefits package of Medicare and Medicaid covered services, we estimate initial... net savings (across the Medicare and Medicaid programs) of approximately 3% per year, growing to nearly 6% per year as of CY2024. Given the large baseline size of the per capita spending on dual eligibles (more than \$7 trillion nationwide across the upcoming 15 years), these relatively modest percentage savings translate into rather massive dollar amounts. Nationally, each percentage point reduction in dual eligibles’ spending will yield more than \$70 billion in savings across the 2010-2024 timeframe.”*



Given the findings of this report, we believe that policy changes that expand care coordination for dual eligibles will yield significant savings to both Medicare and Medicaid while also providing high quality care for this population.

We do recognize concerns among some advocates about the expanded use of health plans to serve dual eligibles and we stand prepared to work, side-by-side, with patient advocates to expand the use of coordinated care while also protecting choice, access to care, and benefits for the most vulnerable among us. We should not let such differences prevent us from improving the services provided to these populations.

Thank you for your consideration of this statement. Please do not hesitate to contact us if we can be of any further assistance to you.

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