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EXAMINING THE EXTENSION OF SPECIAL NEEDS PLANS

WEDNESDAY, JULY 26, 2017

House of Representatives

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Michael Burgess [Chairman of the Subcommittee] presiding.

Present: Representatives Burgess, Barton, Shimkus, Murphy, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Green, Schakowsky, Butterfield, Matsui, Castor, Schrader, Kennedy, Cardenas, Eshoo, DeGette, and Pallone (ex officio).

Also present: Representative Costello.

Staff present: Paul Edattel, Chief Counsel, Health; Jay

Gulshen, Legislative Clerk, Health; Katie McKeough, Press Assistant; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Jeff Carroll, Minority Staff Director; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C. J. Young, Minority Press Secretary.

Mr. Burgess. Very well. I will ask all of our guests and members to take their seats. The Subcommittee on Health will now come to order. The Chair recognizes himself 5 minutes for an opening statement.

Today the committee moves forward with its work in regular order to examine extending and improving the Medicare Advantage Special Needs Plans. Special Needs Plans enjoy bipartisan support because of their successful record in providing comprehensive coordinated care to two million Medicare beneficiaries.

This committee is especially interested in understanding how we can help improve Special Needs Plans for dual eligibles, since the majority of Special Needs Plans enrollees are dually-eligible beneficiaries who are enrolled in both Medicare and Medicaid. Dual-eligible beneficiaries often have multiple chronic conditions, physical disabilities, and cognitive impairments. Yet, too often, these very beneficiaries are forced to navigate two government programs with benefit structures, rules, and incentives that are often less than simple or intuitive.

Today, we embark on our process to try to not only extend the Special Needs Plans, but improve the tools that states and plans have to help these beneficiaries. So in addition to hearing from our three experts before us, we also invite stakeholders' feedback on a bipartisan discussion draft recently released. The goal is simple. We want detailed feedback from stakeholders on the policies and specific language in this draft. We all share the goal of helping improve health outcomes, enhance quality, and improve the patient experience for Special Needs Plans enrollees who are some of the most vulnerable, high-need beneficiaries in Medicare.

As a starting place, the discussion draft includes a number of provisions including reauthorizing the Institutional Special Needs Plans permanently, and extends the dual-eligible Special Needs Plans for 5 years. It streamlines Medicare and Medicaid benefits through one process so it is easier for duals to navigate their benefits. It improves access to supplemental benefits for patients with chronic illnesses through the inclusion of a bipartisan proposal supported by various members, including the gentleman from New Jersey, Mr. Lance. It enhances quality by directing HHS actions and holds us accountable for results, by requiring a number of studies so Congress receives appropriate feedback on policy changes.

I hope members will thoughtfully engage in today's discussion, examine the policies carefully, and provide feedback to committee staff as we move forward.

Thank you to each of our witnesses. We certainly look forward to hearing from each of you this morning.

I would yield to the gentleman from Kentucky, but he is not here. Let me yield back my time and I will yield to the gentleman from Texas, the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement, please.

Mr. Green. Thank you, Mr. Chairman, and thanks to our witnesses for being here this morning. We are here to discuss the extension of the Special Needs Plans that serve some of our most vulnerable and highest need Medicare beneficiaries. The Medicare, Prescription Drug, Improvement and Modernization Act of 2003 established a new Medicare Advantage coordinated care plan, options specifically for individuals with special needs. This type of MA plans known as Special Needs Plans, or SNPs, are authorized to target enrollment to one or more types of individuals with distinct healthcare needs. Specifically, institutional SNPs, or I-SNPs, are largely enrolled beneficiaries who live in nursing homes; dual-eligible SNPs or D-SNPs, enrolled beneficiaries who are eligible for both Medicare and Medicaid; and Chronic Condition SNPs, or C-SNPs, enroll beneficiaries with certain severe and disabling chronic conditions like end-stage renal disease.

Since the enactment of the Affordable Care Act, all new and expanded D-SNP plans are required to have contracts with the state Medicaid agencies to coordinate and deliver benefits and the ACA created a subset of D-SNPs known as fully integrated, dual eligible, FIDE SNPs.

Mr. Chairman, we have to keep up with all these short-term things.

More than two million Americans are enrolled in 600 SNPs nationwide. There is a great amount of variety across SNPs and how they work in each state. Since the ACA, SNPs have been extended four times, more recently in the Medicare Access and CHP Reauthorization Act or MACRA in 2015. Authorization of the program is currently set to expire at the end of the calendar year. Discussions about SNP reauthorization has largely focused on duration of the authorization, with a growing number of stakeholders advocating for permanent authorization.

Today, I look forward to learning more about the advantage of long-term or permanent authorization of SNPs and I am also interested in how we can address challenges to integrating benefits and providing high-quality care for complex patients with health and socio-economic needs. The SNP extension is an opportunity to complement other efforts in Medicaid to integrate the delivery of benefits and improve care coordination and quality.

Finally, I would like to acknowledge the debate going on now in the Senate and actions the House took earlier this year will cast a shadow on the total discussion. The American Health Care Act and the Better Care Reconciliation Act both devastate

Medicaid, ultimately cutting funding by 35 percent. Medicaid cuts will harm the ability of states to integrate in SNPs and other long-term services and support offering. Cuts in Medicaid will undermine these successes and harm our most frail citizens.

While Medicare provides critical benefits, Medicaid wraps around that coverage and fills in the gaps. I hope my colleagues will abandon the pursuit to return to meaningful bipartisan work to improve our health system, like improving and extending SNPs.

Thank you, Mr. Chairman. I look forward to today's discussion and if anybody on my side wants my last minute and 50 seconds? No. I yield back, Mr. Chairman.

Mr. Burgess. Will the gentleman yield?

Mr. Green. Sure.

Mr. Burgess. So I have been contemplating introducing a bill that would modify or perhaps prohibit TLAs of the future. Three-letter acronyms. Does anyone else on the majority --

Mr. Green. I would be glad to co-sponsor it.

Mr. Burgess. Does anyone else on the majority side seek time for an opening statement? Anyone else on the minority side seek time?

The chair apparently concludes with opening statements. The chair would like to remind members pursuant to committee rules, all members' opening statements will be made part of the record.

We do thank our witnesses for being here today, taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement, followed by a round of questions from members.

This morning, we will hear from Mr. Chris Wing, the CEO of SCAN Health Plan; Dr. Larry Atkins, President, National MLTSS Health Plan Association; and Ms. Melanie Bella, who has been to this committee before, I believe, consultant and former Director of the Federal Coordinated Health Care Office, Centers for Medicare and Medicaid Services.

We appreciate all of you being here this morning. Mr. Wing, you are now recognized for 5 minutes to give an opening statement, please.

STATEMENT OF CHRIS WING, CHIEF EXECUTIVE OFFICER, SCAN HEALTH PLAN; G. LAWRENCE ATKINS, PHD, EXECUTIVE DIRECTOR, NATIONAL MLTSS HEALTH PLAN ASSOCIATION; AND MELANIE BELLA, CONSULTANT AND FORMER DIRECTOR, FEDERAL COORDINATED HEALTH CARE OFFICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

STATEMENT OF CHRIS WING

Mr. Wing. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you very much for the opportunity to testify today.

When it comes to SNPs, SCAN covers the waterfront. We are the only fully integrated dual eligible SNP in California. We have an Institutional SNP in California. We also have three chronic illness Special Needs Plans in California.

Like patient advocates, SCAN supports permanence for all SNPs. SCAN does come at the subject from a special vantage point. SCAN was a Social HMO for 22 years before the demonstration project evolved into SNPs. We have seen over 3 decades how tailoring care to meet the special needs of seniors with complex conditions is the right approach. The care is better for the beneficiaries and the cost is less. Let me give you one example. Several years ago, SCAN asked the research firm Avalere Health to compare SCAN's dual-eligible population in California to fee-for-service duals. Using the CMS' five percent sample, Avalere found 5,500 fee-for-service duals in California who had similar risk characteristics as our 5,500 duals. We tracked them for over 2 years. We called it a Doppleganger study.

What did it find? Hospital admissions were 14 percent less for the SCAN population. And re-admissions were 25 percent less. Not only did the extra care provided by SCAN provide better care for the beneficiary by eliminating hospitalizations and re-hospitalizations, but it saved the government a significant amount of money.

It is clear that duals, who are the system's most in need and most expensive group of patients, are significantly helped by fully integrated D-SNPs. That is why SCAN supports permanency for D-SNPs. We also strongly support moving all D-SNPs on an expedited schedule toward full integration.

C-SNPs have also succeeded in giving patients better care through added benefits and specialized networks. We think C-SNPs have also earned permanency.

We are happy that the committee is proposing to make I-SNPs permanent as well. However, let me point out one flaw with the current I-SNP structure.

SCAN runs an Institutional SNP in California, meaning that we strive to keep our nursing home eligible beneficiaries in their own homes in the community and not in the nursing home. However, our plan has shrunk dramatically because we are not allowed by law to give beneficiaries the home and community-based services they need to stay in the community and lead independent lives. To get those long-term services and supports, they have to spend down their assets and go on Medicaid and being dually-eligible.

To rectify that, we strongly urge the committee to consider including bipartisan legislation introduced in the last Congress by Representatives Leonard Lance and Kurt Schrader, here on Energy and Commerce, as well as Representatives Linda Sanchez and Pat Meehan on Ways and means. It would create a demonstration project to target a limited amount of Medicare funding toward frail individuals who are in the cusp of spending down their income and becoming dually eligible. It would allow them to receive home and community-based services, which is now allowed today. This demonstration would allow these individuals to stay in their homes, where they and their families want them to stay, preserving their dignity and comfort and would be a first step towards cost savings and entitlement reform.

Finally, we want to strongly support the provision in your bill which grants increased flexibility to all plans, not just SNPs, to use supplemental benefits for non-medical services.

We appreciate you folks very much. Thank you.

[The prepared statement of Chris Wing follows:]

**********INSERT 1**********

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. Dr. Atkins, you are recognized for five minutes for an opening statement.

STATEMENT OF G. LAWRENCE ATKINS, PHD

Mr. Atkins. Thank you, Mr. Chairman. Chairman Burgess, Ranking Member Green, and members of the subcommittee, thank you for the opportunity to testify on reauthorizing the Special Needs Plans.

My name is Larry Atkins and I am the Executive Director of the National MLTSS Health Plan Association which I am sure the chairman will be happy to know does not fit into a three-letter acronym. Association members are the managed care plans that contract with states to manage long-term services and supports. Member plans are in 18 of the 22 states that have MLTSS and enroll nearly a million members in MLTSS plans and 175,000 in duals demo MMPS, the Medicare-Medicaid Plans.

Managing LTSS focuses on helping individuals with functional needs and their families, attain their goals by obtaining the assistance they need either in institutions or in their homes and communities. We partner with our states to achieved shared objectives of rebalancing from institutions toward more home and community-based settings and integrating beneficiaries in the community and managing Medicare expenditures.

SNPs, in particular, SNP for dual eligibles, the D-SNPs, improve our success with dual eligibles through opportunities to engage in fully-integrated programs where we can bring

Medicare's medical benefits together with the MLTSS benefits that we provide to provide a fully integrated and coordinated care for the individual.

We fully support SNP reauthorization and urge the committee to consider a permanent reauthorization at this time. The cycle of repeated reauthorizations since 2003 has created uncertainty about the future of SNPs that deters plan investment and beneficiary enrollment in SNPs. D-SNPs, in particular, are a critical building block for integrating plans.

Why is integration so important? Managing care for people with the most complex care needs is the key to controlling healthcare spending overall. Only six percent of Medicare beneficiaries use LTSS. They account for 43 percent of the spending, much of it medical in Medicaid.

Providing better support in the home and community can prevent the failures that trigger unnecessary and expensive hospitalizations and institutional admissions that make up a lot of our healthcare spending. To do that, plans need to be able to manage both medical and non-medical resources to communicate and share information between care managers and LTSS and medical providers and to capture savings on the medical side that can support the necessary services on the LTSS side. For duals, this means combining Medicare and Medicaid and right now, only a small proportion of duals are actually in integrated plans.

We need an aggressive effort to expand integrated plan availability and enrollment. A barrier to integration is the difficulty of aligning Medicare and Medicaid coverage, that is, enrolling an individual in the same organization's Medicare and Medicaid plan. Most states auto-enroll Medicaid participants in their Medicaid managed care plan. On the Medicare side, beneficiaries choose. And in the SNP program, it allows for monthly decisions about election of plans' coverage. And they often remain in traditional Medicare or in another organization's Medicare plan which limits the MLTSS plan's ability to manage and coordinate care and share information among provides.

The fully integrated dual SNP, the D-SNP, the FIDE SNP, and the MMPs, put the two plans together and offer them to beneficiaries as a single package. Only a handful of states have opted for either of these models to date. The problem is they use voluntary enrollment or passive enrollment with an opt out, either of those two approaches, which is actually acting to keep integrated models from reaching a large share of the duals' population.

We urge the committee to permanently authorize SNPs. We support the effort to expand FIDE SNPs in more integrated approaches and we recommend that the Congress allow states to require duals that are in an MLTSS plan to be enrolled in an aligned MA plan.

For the future, we propose adopting a common legislative and regulatory framework for plans that integrate Medicare and Medicaid to try to get around some of the alphabet soup that we have. To this end, we support creating a unified appeals and grievance process for integrated plans. We also support expanding the authority of the Medicare and Medicaid Coordination Office to encompass oversight of all integrated plans.

Finally, we thank the committee for moving quickly on SNP reauthorization. SNPs alone though cannot drive the expansion of coverage under integrated plans. We look forward to continuing to work with the committee on strategies to bring the benefits of fully integrated plans to a larger portion of the population in need of LTSS. Thank you.

[The prepared statement of G. Lawrence Atkins, PhD follows:]

**********INSERT 2**********

Mr. Burgess. The chair thanks the gentleman. Ms. Bella, you are recognized for 5 minutes, please, for an opening statement.

STATEMENT OF MELANIE BELLA

Ms. Bella. Chairman Burgess, Ranking Member Green, members of the committee, thank you for having me this morning. My name is Melanie Bella. My background is in Medicaid and duals. I have been fortunate to serve as a Medicaid Director and more recently ran the Office of Duals within CMS.

Today, as you know, there are a little over 11 million people who are eligible for Medicare and Medicaid. We spend about $350 billion annually on their care. The majority of those individuals are not in programs that integrate their Medicare and Medicaid. However, there are promising models that bring those two programs together.

Three such models are the Special Needs Plans that we are talking about today; Medicare-Medicaid Demonstration Plans, and the PACE program. Of note, PACE is the only permanent program. This means that for all of our 11 million dual eligibles, we have 1 option that is permanent to integrated clinically and financially the Medicaid and Medicare programs.

We need to do more. We have an opportunity to do more and one such opportunity is before you today with the permanent authorization of Special Needs Plans. My remarks today will focus on the dual eligible plan specifically.

There is three things I want to kind of plant in your mind today. Number one, is that this takes investment. This is an active choice to make an investment of time and resources, and there is an opportunity cost to choosing this path that is pretty complicated over others. It is much easier to make investments in things when they are stable. So authorizing this, giving permanency to this program, allows states, plans, and even beneficiaries who are choosing to be in these programs the assurance they need that they are not going to worry every few years, that the program might be going away.

The second is that full integration is really difficult. There is no doubt that the bar should be high and that if we want to have Special Needs Plans and dual eligible Special Needs Plans, we should have an expectation that there is full integration of Medicaid and Medicare. But what that means is that we have to help state Medicare agencies get their long term supportive services and behavioral health services into managed and integrated products so we can pair those together. So what we should be doing is continuing to break down any barriers that stand in the way of doing that.

In my written testimony, I have included examples of areas where the duals office within CMS could be given authority to break down many of those barriers, largely administrative, that make it really difficult for states and plans to bring those two worlds together.

Lastly, we have to talk about states. States have to be our full partners in this. They are already resource constrained, and so they need incentives and capacity to be able to do these things. They also need tools to ensure that if we have these aligned programs that people are actually in them. So today, there are a few states where you have fully-aligned programs, where Medicaid and Medicare are available, say if I am the dual eligible beneficiary. But large numbers of people aren't in those plans. And so there are tools that we could be using to help facilitate those choices. One example where CMS could be very helpful just today would be to lift the moratorium on something called seamless conversion which is something that allows states and plans to ensure that people are getting their services from the same entity.

So to reiterate an earlier point, states are in the same bucket of wanting assurance that this program is going to be stable and it is not going away which is another reason in support of permanency for these programs.

In closing, this is I think my favorite subject in the world, so I would like to thank the committee for taking it on. This is a really important step. There are many more we could take, but the opportunities here really are ones that lend themselves very well to, I think, areas where we could have bipartisan agreement, so I appreciate the opportunity very much.

[The prepared statement of Melanie Bella follows:]

**********INSERT 3**********

Mr. Burgess. The Chair thanks the gentlelady. The Chair thanks all of the witnesses for your testimony. We will move into the members' questions portion of the hearing. I want to begin by recognizing the gentleman from Illinois 5 minutes for questions, please.

Mr. Shimkus. Thank you, Mr. Chairman, and welcome. This is an interesting topic.

And Ms. Bella, you mentioned, I have listened to all of the testimony, but my first question was going to be on seamless conversion which you talk about, but I was going to direct to Dr. Atkins and then Ms. Bella, you can follow up.

The question is on the seamless conversion, can you tell us how this helps ensure coordinated care for beneficiaries and whether you think or not, I know Ms. Bella thinks this is something we should address or will be involved in the legislative fix.

Mr. Atkins. The seamless conversion operates on the Medicaid side that states can move beneficiaries because the beneficiaries are automatically enrolled in Medicaid managed care plans in most states. States can move them to a different -- reassign them to a different plan, but it aligns with a D-SNP.

Arizona, for example, has had a pretty aggressive program to realign their Medicaid beneficiaries with their D-SNP coverage. The problem is that they can still move, the beneficiaries can still change their coverage on a monthly basis on the Medicare side. So the fact that as long as there is this complete flexibility and freedom of choice on the Medicare side, it is very difficult to achieve full alignment.

Mr. Shimkus. So, and I can ask anyone, so is this something that you think we should try to address legislatively and fix on the Medicare side?

Mr. Atkins. Yes.

Mr. Wing. Yes.

Mr. Shimkus. Ms. Bella?

Ms. Bella. Yes.

Mr. Shimkus. Okay, good. Let me go to, I think Mr. Wing and Dr. Atkins again, and of course, Ms. Bella, if you want to chime in. So the Medicaid CHP Payment and Access Commission, because I don't like these acronyms, especially, can you imagine somebody listening to these opening statements and not knowing what any of these terms are? They would be thinking we are talking in a foreign language.

The Medicaid CHP Payment and Access Commission noted that dual eligibles may often be enrolled in up to three health plans, a SNP, a Medicaid plan, and a limited benefit plan such as behavioral health or long-term services and supports. While we know how that has evolved, I think that the discussion here is that integrated care should be integrated care. And it is kind of silly financially to have to go through, for the individual consumer very confusing.

Can you speak to the degree to which the committee's draft legislation addresses this issue of the possibility of three different plans and whether there are additional steps the committee should take?

Mr. Wing. We believe in full integration. And we still have a lot of work to do. SCAN has been dealing with dual eligibles for 40 years, as I mentioned. One of the areas, and you mentioned one, is behavioral health. Thirty years ago, the industry made a mistake about separating the medical component of care from the medical component of care and we now have pilots, especially if we have permanence, it makes a lot of sense. We are not a not-for-profit, but we have to be diligent with our capital deployment. But we now have a pilot in anticipation of either a 5-year permanence and we have a pilot in Riverside where we are actually coordinating bringing a telephonic Skype-based telemedicine that is focused exclusively on behavioral health. So from SCAN's perspective, we need to integrate this so it is totally seamlessly integrated for the beneficiaries, for the state and for the plan.

Mr. Shimkus. Dr. Atkins?

Mr. Atkins. I think the legislation helps. It creates much more of a push toward FIDE SNPs which is really the only full-integrated approach. And then you know, I think the challenge is that in many states you don't have the managed LTSS or you don't have managed behavioral health to be able to integrate with the D-SNP. So you can't get everybody into a FIDE SNP if you don't have the managed LTSS and behavioral health.

And then I think you spoke to the issue of a managed Medicaid plan, just generally, and then often these separate MLTSS or behavioral health plans, but I think if the states can be moving more directly to integrating on the Medicaid side, then I think the challenge comes down to trying to find a way to get that alignment to happen on the Medicare side.

Mr. Shimkus. Ms. Bella, do you want to add anything to this?

Ms. Bella. I would say it is an important incremental step. It is taking us one step further. It is still not getting us to a point where we have one program fully integrated without all the incentives, but to do that, we have a lot of enrollment and other financing issues to tackle. So it is an important step. It is not the end game.

Mr. Shimkus. Thank you very much. I yield back, Mr. Chairman.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman. Ms. Bella, you noted that the clinical and financial integration are both critical to actually achieving true coordination between Medicare and Medicaid. As part of your testimony, you also highlighted that even in states where fully aligned plans are offered, sometimes beneficiaries do not enroll in these plans. You mentioned specifically that improved enrollment processes and enhanced outreach to promote aligned plans could address some of these issues.

Ms. Bella, can you provide an example of what you mean by improved enrollment processes?

Ms. Bella. Sure. I think part of the challenge is these are difficult programs to explain to people who are eligible for them. And we make it more difficult with having a different set of requirements for Medicaid and a different set of requirements for Medicare that complicate.

We also have different processes for reviewing and approving those materials, so the end result is to talk to real people. The information isn't as clear as it could be. So it is sort of one set of things around materials and processes. It is another set of things around and this is probably more detailed than we have time to go into today, but the Medicaid program looks at people one way and has one set of eligibility rules, and the Medicare rules look at that exact same person a different way. And so we have conflicts in terms of how people are enrolled, how long they are enrolled, when and how often they can make enrollment choices and all of those things just they create problems for people and they really just erode a continuity of care and being able to keep people in a plan.

Mr. Green. Do you have any examples of how we can improve that outreach?

Ms. Bella. Yes, there are examples. There are examples of how you can coordinate member materials, so requirements on the Medicare-Medicaid side around summary benefits, annual notice of coverage. So some of that is being tested in the demonstration states and in Minnesota right now, tested well.

There is examples of how you can have joint review of those materials. What was just discussed about seamless conversion, allowing that to proceed, lifting the moratorium on that would be important. So I would be happy to present some more explicit examples outside of the hearing, but there are definitely concrete things, many of which are being tested today.

Mr. Green. If you would give that to us so we could include it in the record, I would appreciate it.

Ms. Bella. Sure.

Mr. Green. Thank you, Ms. Bella. Finally, there are certain states that Congress should look to as models that have been very innovative and promoted integration between Medicare and Medicaid. Do any of the panelists have thoughts on certain states that we might look at, whether it be Minnesota or someone else?

Mr. Atkins. Well, there is certainly, you know, there are the states that started first with full integration. Massachusetts, Minnesota, Wisconsin were the early states. And Massachusetts is another state to look at for their FIDE SNP. They have a senior care options program for the seniors and they have an under-65 -- they are in the duals demonstration for the under-65 population.

But I think a lot of the states now who have gone either to adopt MMPs or have pushed more on integration, there are a lot of states out there that I think coming at it from very different perspectives have done a great deal in this space. The ones that are now sponsoring FIDE SNPs are an example.

Mr. Green. Ms. Bella, I have another question. It seems like there is a menu of options available to dual- eligible and chronically-ill beneficiaries. I think we need a basic review of the system of care as it stands for these beneficiaries so that we better understand how the pieces fall together.

What are the options a dually eligible or chronically ill beneficiary is available to them in any given state? For the record, what is a D-SNP, a FIDE SNP, and what is a duals demo and the PACE program and how do all these different care options fit together.

Ms. Bella. Are you asking what each of them is for the record?

Mr. Green. Yes, for seeing how they all fit together.

Ms. Bella. I think of it as sort of menu of integration. So you start with sort of -- your goal is to get to full integration which means Medicare Medicaid benefits are delivered by one entity and they have financial integration, too. So the financial alignment duals demonstrations integrate the services, the payment. One entity gets a set amount of money every month to provide that care.

One step down from that are the FIDE SNPs, the full integrated dual eligible SNPs. so they have a contract with Medicare as a Special Needs Plans. They have a contract with a Medicaid agency for long-term care and behavioral health. They manage those two separate contracts. They get two separate funding streams, but they are still responsible for everything, just not quite as integrated as the Medicare/Medicaid demo plan.

One step down from that is a regular dual eligible SNP, so they have contract with Medicare as a SNP. They may or may not have a contract with Medicaid and so they are not quite as integrated as the FIDE SNP, because they are not managing the long-term care and the behavioral health benefit.

And then one step down from that would be a regular MA plan because there are many duals that are in regular MA plans. They have no relationship to Medicaid at all.

And I erred by saying PACE should be over here beyond the MMP plan, because PACE is completely clinically and financially integrated with both Medicaid and Medicare.

Mr. Green. Thank you.

Mr. Atkins. Is it all right if I comment on that? I think PACE has a lot of features that would be beneficial for other integrated plans and the other thing is that the MMPs have a three-way contract between the state, the Federal Government, and the plan. And that actually is the plans have reported, and I think the state and Federal Government feel the same way, that that has enhanced the level of communication that goes on between the three entities and it is really moved to a much higher level of coordination. So I think the three-way contract is another interesting piece.

But we advocate for eventually a single kind of over-arching design for integrated plans and to try to allow these different modalities, but to bring them in under a kind of a common architecture because I think they are really are there because that is the way they have evolved. They are not there because that is the way that makes the most sense.

Mr. Green. Thank you. Thank you, Mr. Chairman. I appreciate the information as we look at this legislation.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from

Pennsylvania, Mr. Murphy, 5 minutes for questions, please.

Mr. Murphy. Thank you, Mr. Chairman. This just sounds like one of the biggest Rube Goldberg messes the government could come up with. So let me try and peel back a little bit here.

Mr. Wing, I was fascinated by what you talked about with some of these patients through telemedicine. I am assuming you have some sort of telepsychiatry consult. We know that people who have a chronic illness or acute illness doubles their risk for mood disorder, depression. When that is untreated, it increases their costs.

Who does that, the work that you talked about in your plan, who actually does those teleconsults?

Mr. Wing. Actually, right now we have a pilot. I am under a nondisclosure agreement, but we have a pilot.

Mr. Murphy. I don't mean what the group does, I mean is it a psychiatrist, psychologist, social worker?

Mr. Wing. Well, actually, it is everything above. I can discuss the intervention.

Mr. Murphy. Briefly.

Mr. Wing. I came from a physician group that did a really good job, DaVita Medical Group. But diagnosing opioid abuse, substance abuse, and depression is easier said than done. So in this modality, the primary care physician is given an iPad and when he even suspects that there is opioid abuse, substance abuse, or bipolar disease, put the patient in a private exam room, give them an iPad that is connected to Skype to a specialized geriatric nurse practitioner. She is the one that does the better assessment and then she can then connect the patient through telehealth through a national network in behavioral health.

Mr. Murphy. Let me ask a couple of things that would make it even worse. Are you aware that even in that, that primary care physician because of a regulation put forth in the Nixon administration, if that person is already in treatment or receiving methadone or Suboxone, that doctor may not have access to the records and therefore may prescribe an opioid for his pain or the treatment, they don't even know that person is in treatment because of this thing called the 42 CFR Part 2. Are you aware of that?

Mr. Wing. Yes.

Mr. Murphy. It is another mess that we have to fix. Plus, we also have a strange thing that even those psychologists may do the work, they have to bill through the psychiatrist and so which adds administrative costs and takes the psychiatrist away from their work. So it is another expense that we add to the system. So let us continue to build on Rube Goldberg.

And in this, too, I want to ask all of you, if you are aware, too, what we find is that a true coordinated care model is the physician can really understand we have a complex case. You have a person, dual eligible, so they already are having multiple problems. And we even know, when you have got the flu it is hard to manage your flu. But when you are dealing with a chronic illness and perhaps mental illness on top of that, behavior and physical medicine have to be integrated together, but that requires a lot of work. But even in that context, I want to make sure I understand, because my understanding is Medicare doesn't pay for these services that are needed. For example, responding to a patient's phone call about a symptom or problem may not be paid for; or communications between the primary care physician and specialists to coordinate a care isn't paid for. Communicating between community physicians and emergency room isn't paid for or providing proactive telephone outreach to high-risk patients to say we want to make sure we see how you are doing, be aware of these symptoms, etcetera, how is your medication going, not paid for. Spending time with a patient in shared decision making to map out a game plan for them isn't paid for. Hiring nurses or another staff member to do education, patient education on medication, treatments, anything else isn't paid for. Providing palliative care isn't paid for. And even such things as getting the patient to the doctor's office. I have heard of one program in Miami that actually does this. They actually bring the patients to the doctor's office and deliver medication and guess what? Patient compliance goes way up.

So is it your understanding, too, or am I getting this right, in a coordinated care plan with these very, very difficult cases, these things aren't paid for, but we know that those things save money.

Mr. Atkins. Can I comment on that? I think this is a critical issue because Medicare actually is much more restrictive about what can be covered and not covered than Medicaid is. Medicaid is more flexible, but neither one of them is particularly flexible. And when you put the two together, you still have to deal with limitations on coverage, coverage restrictions and things that are built in the statute.

So what we would advocate for is that as we go toward these more integrated models, that in the context of an integrated system where you are fully capitating across all of these services and supports, behavioral health, long-term services and supports and the medical, that you give the plans the flexibility to be able to provide the services that make the most sense in the case that they are dealing with, understanding that they are financially at risk for the overall cost of care for that patient. But if they see the possibility of providing a service, whether it is a counseling service or whether it is an in-home service that would help to reduce the medical costs on the medical side, they have the opportunity to do that.

Mr. Murphy. So this goes back to eliminating Rube Goldberg and saying if we empower the physicians to work closely with the patient and make some determines what they need and work more directly with that, and have a system of payment that is designed to cover that patient, let the medical practice decide what is best, we can actually save a lot of money and it is quite frankly, I believe more compassionate and works toward better health care.

Mr. Atkins. And I would urge you to include the fact that it is just not medical because for a lot of these people, the more significant services for them really are the services and supports that help to reduce medical expenditures.

Mr. Murphy. Yes, I add to that also psychological behavioral services. Thank you very much. Mr. Chairman, I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Florida, Ms. Castor 5 minutes for questions, please.

Ms. Castor. Well, thank you very much for calling this hearing, Mr. Chairman. And thank you to our witnesses for your expertise here.

You all, based upon your testimony you say that not enough dual eligibles are enrolled in the Special Needs Plans, correct? And you have made recommendations to improve that, remove barriers, work with states to improve the enrollment there.

Do you all agree that as we move in this direction, the

Government could see substantial cost savings?

Mr. Wing. This is Chris Wing. The answer is yes. In our fully integrated D-SNP, we actually have two products. We have more of an ambulatory program for the aged, blind, and disabled, dual eligible. It is called Connections.

We have another program in California. These members have to meet the California standards for being certified for nursing home eligible. In our program, for the seniors that in that Connections at home, all of them nursing home certifiable, we keep 96 percent of them, 96 percent in the community and outside of nursing homes. And if you do the math, this isn't a DRG where it is $12,000 or $14,000. This could be a 7 year length of stay and $4,000 or $5,000 a month. The savings to the system are very, very profound, coupled with a better quality of life, better quality of care for beneficiaries.

Ms. Castor. And I am going to ask you a little bit more about that, but do you all agree?

Mr. Atkins. Yes, if I could just reinforce that. HHS released a study this spring of the MSHIL program in Minnesota which is a fully-integrated program and it was a comparison of the people who were in the MSHIL program to people who were just in MLTSS alone without the integration with Medicare. They found a very substantial reduction. I don't know the figure on top of my head, but there is a very substantial reduction that is possible.

Ms. Castor. And Ms. Bella, do you agree? And then how do we keep track? What measures are in place? How do we keep track of cost savings over time so we are investing where we need to invest?

Ms. Bella. Well, I do agree there is cost savings, but they are not immediate and they accrue more immediately on the Medicare side for things like hospitalization, readmissions, better prescription drug management. It takes more time to see on the Medicare side and that is part of the problem is that we have a mismatch between when the savings happen and how the payers benefit. And so that is why you haven't seen as much take up of some of these so that is one of the things we need to address. We track that by looking at outcomes, the hard utilization outcomes that are measurable around key utilization areas that are driving costs, around all the in-patient buckets. And then on the Medicaid side it services all the long term care and how much of that can be moved into home and community-based settings and how are we seeing those shifts. So there is ways of tracking.

Ms. Castor. And that is the responsibility of CMS?

Ms. Bella. It needs to be the responsibility of CMS and the states, but also MedPAC and MACPAC also play an important role because they can bridge those data together and help do some of the academic pieces of that that the governments aren't necessarily staffed to do.

Ms. Castor. So we are really struggling with the escalating cost of prescription drugs all across the board and all kinds of insurers. Is this a way where we can realize cost savings as well for prescription drugs paid by the government under Part D and Medicaid and how would that work?

Ms. Bella. Certainly, prescription drugs is an area that when the two programs aren't talking to each other, the costs can go up because there is no coordination, there is no one managing the meds, and there are all of those things. So the integrated program where you have one entity responsible who is seeing everything that that person is getting, yes, they have an opportunity to improve the medication management and presumably drive costs down.

Ms. Castor. Are there incentives in place to do so?

Ms. Bella. The health plans have incentives. I mean the health plans are fully capitated have incentives to make sure that the dollars are being used wisely. Those incentives don't always flow back to the states and the Federal Government, and so again, there is sometimes mismatches in where investments are being made and where savings are being recouped, but the health plans have incentives across the board when they have responsibility for both pots.

Ms. Castor. Did you want to comment on that, too?

Mr. Wing. The answer is that we have the risk. We are going to work with our providers to profile aberrant prescribing patterns and also try and work with the patient to make sure we understand what their desires are, what their goals are, we meet their desires so they will be more compliant.

Mr. Atkins. There is also, I think, an issue of medication adherence which is that very often we have spent a lot of money in this country on prescriptions that people either don't take or don't take properly and they really don't have the effect that they need to have. So one of the advantages of an integrated program is that there is a lot of emphasis on medications.

Ms. Castor. And there has also been increased recognition of the importance of social determinants, things like social supports and an individual's physical environment and that is how we can help create positive outcomes and cost savings and this is something that Medicaid has worked on for a while and I am glad to see Medicare learning from Medicaid here.

Mr. Wing, SCAN, I understand, has been very innovative in its thinking about social determinants of health and how nontraditional services and interventions can help. Tell us a little bit more about that.

Mr. Wing. You know, we were founded to focus on complex seniors especially dually eligible. And it is amazing what small things can really make a profound difference.

I came from DaVita Medical Group and doctors do a great job, but oftentimes, they don't know what is going on in the home. So we have a program where we put social workers and care navigators into the home to take stock, do an HRA, but take stock as far as the whole social determinants of health, and report back to the doctor. We don't only provide the transportation back to the doctor which often is a barrier for dually eligible, but oftentimes we have a care navigator go with a patient and make sure the doctor knows the social determinants and everything else that is going on in the home.

One case, if I can, about 2 years ago, we videotaped a member who was socially isolated, living by himself, a Latino gentleman. He already had Parkinson's, but he had glaucoma. Our community health navigator, not a high cost, in the home identified -- the member was doing the best he can to put the eye drops in, but couldn't do it. A $12 wrist guard, a $12 wrist guard. The doctor thought the member was doing his best, but did not know he couldn't do it. A $12 wrist guard, all of a sudden this patient now can slow the delay of the glaucoma and fast forward in 5 years, if he had gone blind, had Parkinson's, if he showed up in ER, he is going to get admitted. But that is not the worst outcome.

The worst outcome is when he was about to be discharged. He is not going to be discharged back to the community. He is going to go to custodial care the rest of his life. So these social determinants probably predict anywhere between 20 to 80 percent of health outcomes. And when you are totally integrated like SCAN is for a fully integrated D-SNP, we have all the incentives to work with the doctors, but also make sure we are in the home and we know everything that is going on with that patient, their care givers, and their family situation.

Ms. Castor. Thank you.

Mr. Burgess. The gentlelady's time has expired. The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions, please.

Mr. Lance. Thank you, Mr. Chairman. As the chairman indicated, I am one of the sponsors in the bill that would enable expanded supplemental benefits to meet the needs of the chronically ill, Medicare Advantage enrollees.

I want to work with the entire panel on this issue. New Jersey has struggled with behavioral health and substance abuse issues. Dual eligibles who are in the program, we have in New Jersey, try to address the whole person, both physical and mental health.

In the panel's opinion, does this kind of dual payment integration foster clinical integration?

Mr. Wing. Again, the answer is yes. You know, for our Medicare Advantage plan, not for our SNPs, we are prohibited from offering non-health type of services. Let us take the individual who needed a $12 wrist guard, boy, would that make a difference in somebody who is in a Medicare Advantage population? Yes.

We all know about the hip fractures for seniors often lead to bad outcomes, whether it is nursing home care, institutional care, but if we could provide solid grips in the bathrooms, by the toilets, that would make a profound difference. But right now, Medicare Advantage plans cannot offer, by law, Medicare benefits to a Medicare Advantage only audience.

Mr. Lance. Well, thank you. And I want to continue to work with the panel on this and other issues because I think this is an incredibly important area and I commend those on the other side of the aisle, including Congressman Schrader, who is working with me on this issue and it is to be continued.

Mr. Chairman, I yield back the balance of my time.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions, please.

Mr. Cardenas. Thank you, Mr. Chairman, Mr. Ranking Member. I would to thank you for holding today's hearing and allowing the committee to shine a light on a program that is helping to improve the lives of so many medically-vulnerable Americans.

Too often in these discussions, we lose track of the real-world effects of our decisions. The conversation today is not about some obscure policy provision. It is about real people with real needs.

One of those real people lives in my district. Let us just call her Cassandra. Cassandra is 73 years old and has several chronic conditions including congestive heart failure, diabetes, and hypertension. For anyone unfamiliar with diabetes testing, a blood glucose test, or an A1C score above 8 is considered uncontrolled. This can lead to range of negative health effects including amputations, kidney failure, and loss of vision.

Before joining the Special Needs Plans, Cassandra had an A1C reading of 12. This is dangerously high. This, along with her other poorly controlled conditions, led to at least seven hospitalizations over the course of just 1 year. Cassandra joined an SNP in 2014 and today her A1C level is just 7.6. Cassandra has also only been to the ER once since her enrollment and has only been hospitalized for one scheduled surgery. Cassandra's care is coordinated by her care team and she has regular meetings with her primary care provider and nutritionalist to keep her conditions under control. For the first time, Cassandra is getting healthier as she gets older, and her quality of life is much, much better. Cassandra is just one example of the millions of people benefitting from these specialized plans. We owe it to these patients to provide the certainty that these plans will be there for them in the future and that is why I believe it is so important to reauthorize them permanently to make them more effective and more efficient. Bottom line, better quality of care.

One of the many populations that are treated through Special Needs Plans and are end-stage renal disease, otherwise known ESRD patients, so I have a question for Mr. Wing. 21st Century Cures took the first steps in developing ESRD specific quality measures for ESRD C-SNPs. As you know, not all quality measures are applicable to such a specialized patient population due to the uniqueness of the ESRD patient population and the type of specialized care they receive.

So Mr. Wing, do you believe ESRD C-SNPs could better measure the quality of care provided if more specialized measures were developed?

Mr. Wing. The answer is yes. And actually we have an ESRD Special Needs Plans in Riverside with DaVita Medical -- actually, DaVita, the parent. And it is amazing here. Not just we have the quality metrics. We can always improve quality metrics. We think the stars measures have fundamental changed the conversation between health plans' providers because there is the economic incentives now. We always think there is improvement. Well, boy, when you talk to the nephrologists, when you talk to the patients, when you talk to the nurses about the care that dialysis patients get, ESRD Special Needs Plans, the savings are there, but again, the beneficiary satisfaction, the patient satisfaction is there as well. So the answer is we do applaud the current measures, but we can always improve upon them.

Mr. Cardenas. Mr. Wing, I have been listening to your answers today and I really appreciate you sharing your expertise with us. But one of the things that seems to be the common thread in all of this that you have been explaining and that is the communication between human beings. I mean we have all been incredibly impressed with the technology and the advances and the efficiencies of being able to be more accurate when it comes to seeing what is really going on with a patient down to the molecular level, but at the same time it seems like every single one of your answers seems to point toward we need to make sure that our human beings are actually able to communicate with each other and share information and that seems to be the driving factor to having much, much better results. Would you agree?

Mr. Wing. I would agree. Hopefully, I am not a one- trick pony, but I think there is two tricks, integration and risk-bearing entities will always strive to innovate for better care, better quality and better financial outcomes. But I am always amazed, when we put people into patients' or beneficiaries' homes to find out what is going on, the doctors, as good as they are, as committed to quality as they are, they don't know what is going on in the home. We have to have eyes and ears in the home to translate to the doctors. So communication and risk-bearing entities I think are a large part of the solution for this type of population.

Mr. Cardenas. And unfortunately, in this modern world, the human element seems to be in so many systems that want to get eliminated. This one we have to be very careful to understand how important that that human touch is. Thank you so much. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Missouri, Mr. Billy Long, for 5 minutes for questions, please.

Mr. Long. Thank you, Mr. Chairman. And Dr. Atkins, in your testimony you discussed fully integrated, dual eligible Special Needs Plans. The uptake by states has been slow and enrollment has been relatively low, yet you state Congress should commit to advancing models that can fully integrate Medicare and Medicaid benefits.

There is a concern that if we move too quickly, we are trying to force rather than facilitate integration. How do you respond to this concern?

Mr. Atkins. Well, you know, the difficulty with the uptake has been just that we have a lot of states that don't have managed MLTSS and behavioral health. So trying to integrate, and you can't really do a FIDE SNP if you don't have integration -- managed care on both sides. So that is one of the challenges.

And then, you know, I think the enrollment issue has been a substantial challenge in both the MMP program and the FIDE SNP program. It is either voluntary enrollment that people voluntarily choose to enroll as beneficiaries in the combined plan or in the case of MMP, there has been passive enrollment with an opt-out and so people find themselves in the plans, don't really know quite how they got there and often are persuaded either by their physician or by an LTSS provider to opt-out of the plan without really understanding what the choice has been.

So I think the challenge has been to address these questions about enrollment because what we find is that when people do enroll in these plans, the level of satisfaction goes ways up. So in the disability community, for example, in the younger disability community, there has been some resistance to going into managed care. So there has been some resistance to going into these integrated plans, but a lot of that is built on a lack of understanding about what is going on in these plans. And when beneficiaries get in, they report they are much more satisfied with this experience. So I think it is going to be a lot of education.

I think in many cases, the MMPs were launched in the state without adequately communicating in advance what these plans were. And then when you look at the beneficiaries who get assigned to these plans, often these are very hard to reach beneficiaries and when they get into an MMP, it is the first time anybody has ever shown up and had contact with them about what is going on with their health care or what are their services and supports. And so it has been very difficult to kind of get to everybody and get the information out there, but I think that we need to have some strategies around how do we get more people to enroll in these plans.

Mr. Long. All that being said and talking about enrollment, could this lead to fewer comprehensive plans being offered?

Mr. Atkins. I am sorry, I didn't understand the question.

Mr. Long. I said could this lead to fewer comprehensive plans being offered, forcing rather than facilitating?

Mr. Atkins. If we go to a FIDE SNP, for example? I mean I think a FIDE SNP is incredibly --

Mr. Long. Trying to move too quickly, is that going to --

Mr. Atkins. Oh, if we go too quickly, are we scaring people away? Well, I think in each state where these products get launched, the state has to do the work initially. It may take a year or more to work with all of the groups that are affected.

Just as an example, in Kansas when they brought managed LTSS to the IDD population, intellectually and developmentally disabled population, which has been carved out of most of these in many states, at first blush, there was a lot of resistance because the state had not communicated what was going on to the population. The plans had to spend the first year just communicating with the advocacy groups, working with the service delivery system that was there, getting them to understand what was going on before they actually started to launch services and enroll people. So those are the things that just have to happen because there is so much lack of understanding.

Mr. Long. I have got one more question, it is again for you, Dr. Atkins. You also state in your testimony that facilitating full integration will only be possible initially in states that enroll dual beneficiaries in Medicaid managed plans, yet enrolling dual eligible in managed care requires a waiver and the process of retaining a waiver can often be long, challenging, and uncertain.

How can we, as a committee, facilitate integration, while not relying on states to get waives from CMS?

Mr. Atkins. Do you want to answer that?

Ms. Bella. Depending, there are ways that states can have their beneficiaries in managed care. They don't require -- they are not 115 waiver process. They can do it through a state plan process. And so depending on the path the state takes, there are more or less complex ways of doing that.

If you are asking are there ways that we could make it easier for states who want to do integrated programs --

Mr. Long. Right, as a committee, how can we assess?

Ms. Bella. Yes, there are ways to do that. They are somewhat state-specific, depending on how the states structure their program, but there are always ways that we can simplify and making these two programs work better together.

Mr. Long. Okay.

Mr. Atkins. But I will say that there is a very strong movement in this country right now toward managed LTSS. We have got three more states coming in this year. We have a number of states lined up starting the process for next year and beyond. And so we have expanded the number of states already that are involved in MLTSS and that movement is pretty strong because it is really to the states' advantage in trying to manage these costs to do these managed care contracts because they can really get their arms around trying to figure out how to keep the population that has been in institutions or is headed toward institutions really stabilized in the community.

Mr. Long. Thank you. Mr. Chairman, I have no time left, but if I did, I would yield it back.

Mr. Burgess. The chair appreciates the gentleman's offer. The chair recognizes the gentlelady from Colorado, Ms. DeGette, 5 minutes for questions, please.

Ms. DeGette. Thank you very much, Mr. Chairman. I want to thank Chairman Walden and Ranking Member Pallone for having this hearing on SNPs, and you, too.

I am really happy that the SNP Reauthorization Act includes this bill that I have been working on with Representatives Lance and Kennedy and also our colleagues on Ways and Means, Congressman Meehan and Congresswoman Sewell.

What this bill does, H.R. 3044, it expands supplemental benefits for chronically ill Medicare Advantage enrolless. What it does, under the bill, both traditional Medicare Advantage plans and SNPs, would be able to offer individualized benefits that meet the specific healthcare needs of chronically-ill enrollees. And I know you have all been talking about this today.

Supplemental benefits could include services that are not traditionally covered by health plans like meal delivery, as long as there is a reasonable expectation that such services will maintain or improve health. For example, somebody mentioned today that the new flexibility would allow plans to purchase air conditioning for COPD or asthma patients who couldn't otherwise afford it. Now even though that is not a traditional healthcare service, such a change in a patient's living environment could have huge health benefits. I think that this common-sense legislation will lead to better health outcomes and improve quality of life, including in my own state, 273,000 seniors.

And I just really want to thank the committee on a bipartisan basis for including our bill in this broader bill that we are considering today. And so I hope we can continue to work in a bipartisan basis to reauthorize the SNP program and include this common-sense bill that we have.

Mr. Wing, I was really struck by your testimony about the gentleman who had Parkinson's and glaucoma and how all you needed to get was a wrist band for him so he could put his eye drops in. This is true with so many seniors and what we end up doing, and part of it is because Congress doesn't really know how to look at budgeting for prevention and management. And it is very frustrating for our constituents. This is something that Chairman Burgess and I have actually been working on for a long time, trying to figure out how to incentivize prevention through the budget process, rather than just paying for more and more emergency services and whatever.

And so, I am just wondering, I know in your testimony, you said you strongly support provisions in the SNP Reauthorization Act that grant increased flexibility to use supplemental benefits of non-medical services. Do you have some other examples that you can share with the committee today?

Mr. Wing. Sure. Thank you for the question. I mentioned that the fall often necessitates a hip fracture and a hip fracture necessitates not only a hospital admission, but oftentimes long-term facility admission. Oftentimes, if you have just grips in the toilet, the shower, and solid flooring in the kitchen, solid flooring in the bathroom, you can negate the fall that precipitated the hip, and again, knowing what is going on in the home.

Oftentimes, a doctor is going to look for medical solutions, but oftentimes there is a social solution. Maybe a little bit of in-home support, a low-level person coming in and helping with food, with bathing, with activities of daily living for a member that is in a straight MA plan. We prevent them from having an ER visit, a hospital visit, and since we are at risk for the Medicare benefits want to give us the flexibility to prevent that and provide better care for the beneficiary and reduce costs for the system.

Ms. DeGette. Doctor, I see you nodding your head. Did you want to add to that?

Mr. Atkins. I think it is a very important move forward and given this flexibility in MA. Because we have to keep in mind that the only benefits we provide on long-term services and supports in this country are under Medicaid. And so we are serving a very small portion of the population that has fairly substantial LTSS needs. The more we can do to create more flexibility in the Medicare Advantage program in cases where the services that we are going to authorize the plans to provide actually help reduce the overall costs of the plan anyway.

Ms. DeGette. Right.

Mr. Atkins. So it is really improving outcomes and reducing costs. I think that is really important to try to explore as much of that as possible. And I know you are familiar with the Bipartisan Policy Commission. In fact, Council's report recently about other ways to do that.

Ms. DeGette. Thank you. Thank you very much. I yield back.

Ms. Blackburn. [Presiding] The gentlelady yields back. Mr. Carter, you are recognized 5 minutes.

Mr. Carter. Well, thank you all for being here, certainly an important subject.

I want to start off with something that is bothering me. I get the SNPs. I get the Institutional in I-SNPs. I was a consultant pharmacist in a long term care setting for over 25 years. And I can understand and see how they work. And I can see the benefit of that. I can see the chronic, the C-SNPs. I can see the benefit there. I have witnessed that through my practice in retail pharmacy. I have seen how they are beneficiary.

What I struggle with and I have always struggled with is the dual eligible. Explain to me why we have to have dual eligible? Explain to my why we can't introduce legislation that says you have to be one or the other. You are not going to be both. I mean just simplify it for me.

Mr. Atkins. Well, one of the critical things is that Medicare doesn't really cover anything but medical expenses and for many of the people we are talking about who have very complex care needs, being able to address their non-medical needs can have more impact on their overall health than the cost of care for them than spending the money on the medical side. So Medicare is limited in its capacity to serve this population completely.

For those people who are in Medicaid and have the long-term services and supports covered in the Medicaid program, they have those services available to them. Where you have dual coverage --

Mr. Carter. Then why don't you just let them be Medicaid? Say you are going to be Medicaid. You are not going to be Medicare.

Ms. Bella. In 1965, the then Congress created two programs with two separate titles. These folks qualify under both title. So the only way to get rid of it is to have a new title that encompasses the medical --

Mr. Carter. Okay, I want to introduce a new title and it is going to be you are one or the other. Just explain to me. I just struggle. I have always struggled with it.

Ms. Bella. The challenge with this population is they, right now, they are eligible to get their medical needs met through

Medicare and their long-term supports and behavioral health and wrap-around services met through Medicaid. So you can't really put them in one or the other because they -- right now, the system gives them both. And so if you want to make a choice, then you have to make them ineligible for one or the other because today, they are eligible for both and they need both types of services, medical and non-medical.

Are they delivered in the right way? No. Is it efficient to have them delivered this way? No. Do we need a new title? Yes. Are these things that we are talking about today, are they important steps? They are, if we can align incentives which is part of what we are talking about today to put things together, give the money to one entity and start to fix some of these problems that have kept having accountability.

Mr. Carter. Is that what your PACE program is?

Mr. Atkins. Yes, that is what PACE is.

Mr. Carter. So that is the answer I am looking for here. Is we need PACE.

Mr. Atkins. Well, PACE needs to be --

Ms. Bella. They are two separate titles.

Mr. Carter. So we are just going to create another title.

Mr. Atkins. The only thing I would suggest, I think there should be a category of integrated plans and they should have their own statutory and structure and regulatory structure. But to get away from having two sources of money coming into these programs, one from the Federal Government and one from the combination federal and state government, the Federal Government would hay to be willing to essentially take the Medicare money for these people and give it to the states to serve that population.

Mr. Carter. And what would be wrong with that?

Mr. Atkins. Nothing.

Mr. Carter. Listen, the source remains the same.

Mr. Atkins. Right.

Mr. Carter. Whether it is Medicare or Medicaid, guess where it is coming from originally. It is coming from here, whether it is administered through the state.

Mr. Atkins. Right. In the MMP program we have a three-way contract with the Federal Government and the state and the plan all work together. If the Congress so chose, they could take that Medicare money and just essentially hand it to the states and let them run the contract, if that was what people wanted to do. But that would be a major shift from where we are today.

Mr. Carter. I can't imagine. I just have struggled with this for many years to understand this, why we can't simplify to it where you are on one or the other. And I get it. I know that people who are eligible for Medicare who are lower incomes need that safety net program to help them because there are services that are not covered, but still, I don't understand why and maybe I need to understand the PACE program. I have got 20 seconds left. Can you tell me how it is going to benefit and how it would help with this?

Ms. Bella. Both PACE and what he is referring to as the MMP, which is Medicare-Medicaid Plan, give an entity the payment for both Medicaid and Medicare services. There is one contract. So you are not kind of fighting two different regulators. You attempt to align the administrative requirement. So they are the closest things we have to sort of having it be seamless that there is really two programs behind it. So they are the models that you would use if you were trying to get away from having two separate programs that are constantly at odds with each other.

Mr. Carter. Okay. My time is up. I yield back. Thank you.

Mr. Burgess. [Presiding.] The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions, please.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate that. Dual eligibles is really the absolute gold standard by which I think healthcare delivery in this country will be judged if we are going to make improvements. They are the most expensive population, require the most attention, to my good colleague's comments earlier, the fact that we have got two different programs dealing with a complex population with many needs is confounding.

I would take a slightly different approach. I like what I was hearing from Mr. Atkins about, you know, starting over, an integrated model with over-arching rubric that the states could play into that combined the better aspects with one set of criteria, not two, with Medicaid having one set of eligibility requirements and Medicare having another. It seems like the time has come with the SNP programs, the MMP programs, come up with some sort of way that we could have a common standard by which the monies get delivered to one spot, however much money that is, and then the states again, under some over-arching rubric, come up with a better way, more efficient, more coordinated way that would be maybe up front a little costly, but over the long haul yield measurable, better outcome results that would decrease the cost for these very difficult patients going forward.

That would be fun to work on. I think based on the testimony I have heard so far, I think you would find a lot of willing participants, both sides of the aisle, across the political spectrum to do that.

Currently, the money that comes into these MMPs or the SNP, the dual SNP programs, is it the -- I am a little ignorant here also in terms of how the money flows. Is it always a case that the full Medicaid payment and the full Medicare payment come into these programs and are utilized by whatever program delivery system is there, Mr. Atkins?

Mr. Atkins. Well, yes, I would defer to my colleague who actually ran the program to be a little bit better informed on how the mechanics work. But go ahead.

Ms. Bella. Sure. The Medicare/Medicaid rate, the Medicare/Medicaid plans, the Federal Government and the states set the rate and they give Medicare and Medicaid money to the plan and it encompasses the full set of Medicare and Medicaid benefits.

In the arrangements where you have Medicare managed care and a SNP or a FIDE SNP, it varies by state. In the most integrated products, the same plan is getting capitated amount for all the Medicaid benefits and Medicare benefits?

Mr. Schrader. So how does the overall amount of dollars compare to the two separate payments that are out there?

Ms. Bella. In the MMP products, the two payers, we took those factors into account and assumed benefits of coordination and reduced duplication and took cost savings off the top of that.

Mr. Schrader. I think that has a lot of appeal to members on both sides of the aisle. Instead of having two big payments that add up to X plus, we have one that adds up to X or X minus because of that coordinated care. I think you a lot of willing participation.

Mr. Atkins. Yes, and one of the other issues is just when you are dealing with a very frail or a population with a lot of very complex care needs is the risk adjustment that goes into the payment to make sure that it adequately reflects the social factors that are binding on these populations as well.

Mr. Schrader. And risks gaming the system a little bit, not that anyone would do that, but everyone then would be compensated for the degree of risk that they are incurring given the complex needs of their particular people going forward.

I guess the other point I would make that Mr. Wing touched on a little bit is that there is a very fantastic bill out there that Mr. Lance and myself have to keep people from falling into, hopefully, the dual eligible situation, i.e., making sure low income Medicare patients can access some of the advantages of this integrated approach and I would hope that there is an opportunity as we go forward to include this type thing. Again, we are thinking of cost savings rather than having someone have to spend themselves down into Medicaid to be able to take advantage of the dual eligible MMPs or PACE or whatever the program is. We could start giving some of these in-home, community-based services earlier on and save a ton of money from having to pay for these very same people on a more institutionalized or more expensive setting going forward.

So I would hope the chair and ranking member would look forward to working with us on this, maybe going forward and see if we can't continue to improve a very good system that seems to be developing here. With that, I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from North Carolina, Mr. Hudson, 5 minutes for questions, please.

Mr. Hudson. I thank the chairman and thank you, panel, for being here today. It is very helpful helping us grapple with this very complex issue. You have touched on this in your testimony a little bit, but I have a question, sort of about the deadlines and time frames under our discussion draft. Do you think these time frames and deadlines for integrating benefits and providing services is realistic to states that need more time? I just ask if anybody has a comment on that.

Mr. Atkins. I think the way it is structured for states that haven't been able to do managed care on the LTSS and behavioral health side, there is a way to get around that and kind of be able to do it even with a fee-for-service kind of structure in place there. So I think that is an important carve-out because a lot of states aren't yet in the position to be able to have aligned Medicare and Medicaid managed care plans.

But I think the time frames, as far as what I have seen, in the legislation seem reasonable.

Mr. Wing. SCAN also believes that the movement to full integration for the D-SNPs is mission critical. Unless we have integration, there is no hope for savings, long-term savings, keeping people out of nursing homes for the state which is a big burden for the state. So I think it is 2021 and legislation and we support that.   We think if there is a FIDE SNP at any stage, there is a lot of FIDE SNPs like SCAN in the United States, we think a 4-year time frame is very, very doable and essential.

Mr. Hudson. Great. I appreciate that. Dr. Atkins, in your testimony, you know, what we have also heard from the GAO that there are not standardized measures for long-term services and supports that have been widely adopted or broadly used. However, it sounds like your association has initiated an effort to adopt quality measures that can meet the state requirements or yet not burdensome for plans. This sounds great to me, but I am wondering if you could tell me more about when you think the association will have more to report to us. Obviously, the more data points we have to deal with, the better.

Mr. Atkins. Thank you for that question. I will say that we have adopted a quality framework which is a list of the indicators that we would feel we were able to report in a reasonable time frame. We will hay to put all of this into effect, all the companies who participate will agree to put all of this into effect.

These are measures that we did not create. These are measures that have gone through the NQF process or are being developed by Mathematica for CMS or are generally out there in the home and community based consumer survey.

So there are existing measures that we believe that we can actually produce now out of our databases. So the process we are going through right now is to do what is called specification. We are actually digging down into each of our plans to see where the data is going to come from and how consistent we can get it to be across all of these.

Our purpose is not to do it unilaterally by ourselves, but to work with our states to encourage the states to essentially accept these measures that we would report as measures that are used in overseeing the quality, integrating with the quality reporting systems that they are going to have in place because it is a state function to report this.

Mr. Hudson. Right. I think that is critical for being able to determine the impact on the beneficiaries.

Mr. Atkins. We would be glad to come back and talk to you in a couple of months with some much more detail about where we are with it.

Mr. Hudson. I think it would be great, Mr. Chairman. I hope we can encourage that and I will yield back the balance of my time if anybody else would like to use it. Thank you.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman for holding this hearing and to the witnesses, thank you for your wonderful testimony. You bring enormous expertise to the hearing room and we all appreciate it.

I am fascinated by the question of our colleague from Georgia about why does it have to be this way? Do we need a new title? Why do we have part of Medicare? Why is it in Medicaid? And I can't help but think of the President saying "Whoever knew that healthcare could be so complicated." So we are dealing with the complications here and these hearings are targeted to specific areas, but they also broaden and deepen our understanding of the system that we have and how we want to improve it and what is important to do.

What stands out to me today is how important Medicaid is, I mean how essential it is. And so the broader context in terms of what we are dealing with, whether some of us like it and some of us don't like it is that the House passed a bill that fundamentally restructures the Medicaid program by implementing per capita caps and block grants and the Senate is debating a lot of things, but we know that Medicaid is on the chopping block.

Now this discussion about reauthorizing, I think we should reauthorize. I think that we need to make some changes and you have brought some very good ideas to the table, but the reality is that I think anyway, Medicaid is hanging by a thread. I think it is hanging by a thread. Forget the ACA. Medicaid itself as an entitlement is hanging by a thread.

So my question, I guess I will start with Ms. Bella, is what would that do to dual eligibles? I mean it is my understanding that 70 percent of the SNP plans have dual eligibles in them, so can you talk about what if there is, in fact, an implementation of per capita caps or block grants in the Medicaid program, how does that affect what we are talking about today? We are talking about improving it, but the larger picture is that it is up to a 35 percent gouge of Medicaid itself.

Ms. Bella. So I guess a couple of things. One, we are talking about improving it and improving it means we can put a full kind of cadre of Medicaid-funded services along with the medical piece.

Ms. Eshoo. I understand what those are. I worked on this years ago when I was a county supervisor for the dual eligibles. And we developed a capitated plan in the county.

You know what? I took care of my parents and they were blessed with a long life. And I know what is needed in the home. They are better off at home if, in fact, you can bring the kinds of services that they -- the particular services that they need. So while they weren't enrolled in Medicaid, they were Medicare beneficiaries, they had the beneficiary of their daughter, too. But in terms of the care, I understand it.

Ms. Bella. Right, so those services --

Ms. Eshoo. And the care for each one of them was unique.

Ms. Bella. Right, those are the services that are at risk with a per capita or some sort of Medicaid block grant. And it is those services that are keeping people in these integrated programs out of the hospital and out of other places.

Ms. Eshoo. See, thank you for saying that. I hope everyone is listening to this. Because we are dealing with frail, elderly people that are far more vulnerable. I have always thought -- I remember saying to the doctor when he said I think we need to take your father to the hospital and I said well, what are they going to do at Stanford Hospital that I can't do here at home for him? He said, you know, you have got a good point. So we kept him at home and in three and a half days, he was much better. But I think that in some ways we have got our heads in the sand here, because we are talking about how to do this, what it is, reauthorizing and meanwhile in the larger bubble, there is a wrecking ball that is going up against Medicaid. So we have got some choices here and I think we need to tell the truth about what is going on which is so frustrating to me. I am glad we are having the hearing, but you know what, we are pretending that everything is all right. And it is not because what is at hand is going to take a wrecking ball to what these people have come here to testify about. Thank you, and I will yield back.

Mr. Burgess. The gentlelady's time has expired. The chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions, please.

Mrs. Brooks. Thank you, Mr. Chairman, and I, too, thank you for providing your expertise to all of us.

I have heard a lot of discussion today about the need for more integration coordination, but one policy area I know there is often typically a lot of bipartisan interest in is the issue of telehealth and it is something that -- I represent a district that is urban, suburban, but very rural as well. I know that one school in a smaller community of Elwood, Indiana, has begun some telehealth with the school nurse and I know that this is something that I think could have tremendous benefits to citizens throughout the country.

So I am interested in each of you commenting on the policy idea that many Medicare Advantage plans have expressed an interest in, and that is to allow Medicare Advantage plans to offer telehealth as part of their bid, so they don't have to use rebate dollars to provide it. They have an incentive to be efficient in their bids and this flexibility could be particularly helpful with the frail, disabled, or homebound beneficiaries and beneficiaries in rural areas that I just discussed.

So I wondered if you could please share with us, if you think it would be useful to give special needs plans this authority, at least for the next 5 years, and to see how this tool could boost the health outcomes for patients and what each of your thoughts are on telehealth and these types of plans.

Mr. Wing?

Mr. Wing. I will start. I mentioned earlier that we have a pilot of behavioral health telehealth which we think is mission critical. And when you are dealing with the fully integrated D-SNPs, we are talking about a very vulnerable population and a lot of them, as you mentioned, are homebound. And so we need to figure out how do we bring the delivery system into their home?

In telehealth, the technology is there. The funding isn't, but the technology is there. And we are using it for telehealth, but for truly homebound members who don't have the financial wherewithal to go to a doctor, don't have the transportation to go to the doctor. They either have cognitive impairment or other reasons why they can't go to the doctor. We need to bring the delivery system there.

Now you can bring doctors to the home, but that is a very expensive proposition. Telehealth seems to hold the hope of bringing medical physicians, psychologists, psychiatrists, and other providers into the home at a fraction of the cost in real time. And oftentimes, these frail duals, they can't wait 15 days to get in to see a specialist. They need to see them now. So we are very supportive.

Mrs. Brooks. Any particular reason why you are only focused on behavioral health?

Mr. Wing. No. We are a small company. We happen to find this company out of Nashville and know that behavioral health, opioids is a really big issue of the senior population in aggregate. When you take the duals, it is a very pressing issue. I think 48 percent of our dually eligible have a clinical diagnosis of depression, 48 percent. When you see those numbers, you have to do something about it. And we can't bring a psychiatrist, a psychologist in a home. First of all, we don't even know the diagnosis yet. So we think telehealth is the right modality for behavioral health, but probably for a lot of other type of specialties.

Mrs. Brooks. Thank you. Dr. Atkins?

Mr. Atkins. I think Mr. Wing spoke earlier about the importance of eyes and ears in connecting the medical and non-medical parts of the delivery system and that is critical. I think that we have to explore a lot of technology solutions that are going to enable us to be better connected in people in their homes who have these very complex care needs. Telehealth certainly is going to be a major part of that.

Mrs. Brooks. Ms. Bella, do you see any impediments to us advancing telehealth in Medicare Advantage plans?

Mr. Atkins. No, especially if it is part of a broader push to recognize supplemental benefits generally that plans could be given more flexibility around when they are taking the financial risk.

Mrs. Brooks. Actually, building on that issue regarding supplemental benefits, could you give us examples of supplemental benefit plans, benefits that plans provide and how they improve patient outcomes, other supplemental benefits?

Ms. Bella. Sure, I think -- Chris, do you want to answer?

Mr. Wing. Well, again, if you take the FIDE SNP where we can provide these Medicaid type of benefits, you know, I mentioned I wrist card, solid flooring in the bathroom, solid flooring in the kitchen, guard rails in the toilet area and the shower that prevent the fall, a home- and community-based services, having a home health aide to help with bathing, cooking to prevent nursing home viable people being placed in custodial care. It is really being able for a Medicare Advantage plan to offer Medicaid-like benefits to prevent the reason for necessity for acute admission or even more importantly, going into long term custodial care where they are never going to come back from. These are really demonstrated long time demonstrated benefits that really curtail costs, but they radically improve the quality of life for beneficiaries.

Mrs. Brooks. Thank you. Thank you for those examples. I yield back.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady yield back. The chair recognizes the gentlelady from California, Ms. Matsui, 5 minutes for questions, please.

Ms. Matsui. Thank you, Mr. Chairman, and I want to thank the panelists here today. We are learning an awful lot and realize that there is so much more to learn here.

I have got to say that the future of special needs plans is so very important as we move forward because since their creation I guess in 2003, we have seen success in managing complex populations across Medicare and Medicaid, such s those dually eligible for programs and seniors with chronic conditions like diabetes and dementia and so forth.

But as we see the increase in population and look to see the quality of care that the individuals have gotten, I think it is important because sometimes it is not as successful and we really need to be very clear as we move towards full integration in Medicare and Medicaid options for the chronically ill and dual eligible beneficiaries. The protection of beneficiary rights and the quality of care that beneficiaries receive should be the first consideration when evaluating any policy change. To that end, I think one of the most important things that could impact a beneficiary's experience is a unified appeals and grievance process.

Now I know that for many individuals, it can be overwhelming to understand how to appeal, doubly-so if you are a person who happens to have both Medicare and Medicaid benefits.

All of our witnesses have highlighted the importance of a consistent and understandable appeals process for our beneficiaries, but I would like to dig a little deeper into this.

Mr. Wing, can you discuss how appeals and grievances work in the FIDE SNP, and how this is different from other types of SNPs?

Mr. Wing. Well, I will talk about one of the solutions is we do suffer from the different rules for Medicare and Medicaid. We have to deal with that. I think Melanie Bella has been talking about that for years. It is very complex. It is confusing for the members, for the family, for the doctors and that confusion leaves people to go, I am not going to join.

Ms. Matsui. Right.

Mr. Wing. At SCAN, we have what we call for our fully integrated D-SNPs, we have basically concierge care. We want these people to stay with us, but when they are having a problem with an appeal or a referral or anything, we want them to have a one-on-one relationship with somebody in our call center that is not a bank. So everyone of our fully integrated D-SNP members have what we call a PAL, personal assistant line, where they develop a unique relationship with someone at our call center. If they have got a problem with coordinating appeals and grievances we are there for them. If they have got a problem with the delivery system, we are there for them. If they have got a problem with how we deliver care or home health aide services at home, we are there for them. And that is mission essential. These people, they have got a lot of special needs, complex needs. They need the system to come alongside them as opposed to them coming along aside the system.

Ms. Matsui. Okay. Ms. Bella, can you talk about this issue from the perspective of your former role as Director of Medicare and Medicaid Coordination Office? What barriers did you encounter?

Ms. Bella. In the grievances and appeals specifically?

Ms. Matsui. Yes.

Ms. Bella. There are some legislative barriers and then there are some administrative barriers and so part of the -- the language that is in the House bill will go a long way toward fixing, so in the Medicare/Medicaid programs there are different requirements about time frames, for example, and what level you have to go to, for example.

And so in CMS, in the demonstrations, we were able to integrate some of those things, but we just couldn't go quite far enough and we were still doing it under demonstration authority. Again, the language that you are considering today makes a huge step forward and then there are some administrative pieces where we can continue to wrap around that. That would streamline it even better and make it both protective of the beneficiary, but also make it easier for all parties to operate under.

Ms. Matsui. Okay. Thank you. Dr. Atkins, even with your associations, why diversity in membership? It seems like this is an important recommendation that has been agreed upon. Can you discuss why unified appeals are so important from the beneficiary perspective?

Mr. Atkins. Well, certainly. I mean one of the more confusing aspects of the system is the different routes and different time frames and things that are involved in appeals and grievance under the different programs. So I think it is critical that we work toward getting a single set of uniform set of rules.

We would, of course, love to see a common architecture in the program, a common architecture for integrated plans that would address a lot of these kinds of issues.

Ms. Matsui. Right, right. I think it is really important as we talked about the unification of -- and I think it is very, very difficult, as we know, in Medicaid and Medicare. But there is aspects here that I think I could see having some sort of unifying aspect of it where people aren't as confused as to what to do as we move forward. I see my time is gone. I yield back the balance.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. The chair observes that the chair has actually his time for questions to the end. We also have been joined by Mr. Costello who is not on the subcommittee, but I believe the gentleman would like to seek time for questions. Is that correct?

Mr. Costello. Yes, thank you, Mr. Chairman.

Mr. Burgess. I will recognize the gentleman for 5 minutes for his questions.

Mr. Costello. As a follow-up, to a line of inquiry that Mrs. Brooks had to you, Mr. Wing, could you share with me the certain types of specialty providers, be they medical or non-medical, that you see most likely to begin or most likely to have the capacity to offer telehealth services?

Mr. Wing. I thought you were going to go a different direction. I appreciate the question.

Mr. Costello. You can take another direction.

Mr. Wing. I thought you were going to ask me what is the specialty or type of provider that is going to make the most profound difference in the future.

Mr. Costello. That was going to be my next piece of it.

Mr. Wing. I like that question. I think it is going to be community health navigators. These people are $14 or $15 an hour, but going into the people's home, assessing what is going on with the social determinants. This is a low cost, high impact intervention. We would like to flood the market, especially for those who are nursing home certifiable, and make sure we are identifying the social determinants of health quickly, make sure the doctor knows. But I see no greater innovation. I don't think this is a medical problem that requires medical intervention. This is a social problem that requires a social solution and I think having an army, if you will, covering fully-integrated D-SNPs or seniors who have Chronic Special Needs Plans, I think is going to be one of the most pronounced interventions, the most impactful interventions to improving quality and reducing costs that we are going to see over the next 5 to 10 years.

Mr. Costello. Thank you. Ms. Bella, your testimony comments on how there are things that CMS and states can do to improve the coordination of benefits and delivery of services for dual eligibles, including those with disabilities. You know that state Medicaid manual should move toward capitation of their LTSS and behavioral health benefits.

You also said though that they need assurance that if they go down this path, the future of D-SNPs is not uncertain. So to confirm, you are effectively saying that a longer extension would allow more planning and investment in infrastructure and policies that would better serve individuals with disabilities? Is that correct and could you expound upon that a little bit?

Ms. Bella. Sure. I am actually saying that permanency would go the furthest because these have been sort of in limbo since 2003, meaning every few years people are wondering do we have to come back and argue for their case. And so Pennsylvania is a great example. Your state just spent several years putting together a managed LTSS program. They put in their Community HealthChoices Program. They have required all those participants to be D-SNPs. Tremendous amount of work. Tremendous amount of progress. And we want them to keep investing in that with already limited resources. They can't feel like it is at risk of going away. So if we want to get states to continue to building these programs, they need the assurance of knowing that this program is permanent and stable.

Mr. Costello. Thank you.

Mr. Atkins. Could I add one thing to that which is that the MMP program, which is the demonstration program, has a time limit on it and we have a lot of people enrolled very successfully in MMP programs. It would be helpful for those people to know where they go when that demonstration ends.

Mr. Costello. Thank you for your thoughts and thank you, Mr. Chairman.

Mr. Burgess. Does the gentleman yield back?

Mr. Costello. I do.

Mr. Burgess. The chair thanks the gentleman. The chair recognizes himself for the balance of the time. Just checking to see if you are paying attention. Ms. Matsui apparently not.

First off, thank you all for the very intriguing discussion this morning.

Mr. Wing, let me just start with you mentioned right at the end here of this something that I have thought for a long time which is, you even used the term concierge medicine. Yes, navigators are important. Yes, the home health aides are important, but you can have all the fingers in the world, but if you don't have a palm, it doesn't do you any good.

So I remember having this discussion with Dr. Berwick when he was CMS Director, many, many years ago, that when I voiced some of the same frustration that the gentleman from Georgia voiced this morning about not understanding why we have these programs that are sometimes difficult to comprehend and navigate, why there wasn't just one place and that, to me, would have been that position of the concierge or direct primary care or whatever you want to call the model.

So I was grateful to hear you mention that this morning. I do think that that is a direction that this subcommittee should explore. I have felt that for a long time.

And Ms. Bella, even the agency that you used to head up when we look at the enabling language in the Affordable Care Act, the establishment of a federal coordinated healthcare office, that was the goal. And when I talked to Dr. Berwick and I said why don't we do a concierge doctor for these poor folks and actually take care of them, his answer was we are going to set up a new federal agency. I wasn't thrilled when he told me that. I probably had a reaction much like Buddy Carter voiced this morning, but at the same time I will also say that as your former office has matured over time, it does seem to be providing a valuable service to patients.

The reports that you generate at the end of every fiscal year and I guess the most recent one I have is for Fiscal Year 2015 and you were probably involved in the generation of that report, were you not, Ms. Bella? So it is helpful. It is not just a recitation of things that were done. It actually has some meaningful insights and perhaps legislative direction that the legislative branch could pursue, so I think that is a good and positive development.

But again, Mr. Wing, when you mentioned the word concierge medicine, yes, I think that is right. When Don Berwick would complain, I got 20 percent of my folks spending 80 percent of my bucks and I need to do better with that. It seemed to lend itself in that direction. So I would be happy to hear your thoughts on that because this is the first time in all of these years of having these hearings that I have heard anyone actually mention that.

Mr. Wing. Well, we believe the center of the universe really should be the doctor.

Mr. Burgess. That is the right answer. Thank you.

Mr. Wing. Well, it should be, but often again doesn't know what is going on in the community, so our people in the community are integrating via a laptop into the EMR with the doctor and we are trying to do the same thing through or provider integration efforts so that any encounter that we have with our PALS unit gets right back with the primary care physician. Primary care physicians armed with complete data will make complete decisions. Without complete decisions, they won't. And we need to arm them to do a better job.

Mr. Burgess. And are you utilizing, of course, the day the Affordable Care Act was written the smartphone was in its infancy. The ability now that people have to connect even absent a navigator in the home, the fact that their smartphone can electronically transmit a daily weight, a blood pressure, a blood sugar, to some central facility.

Mr. Wing. We are piloting -- actually, some of our medical groups on their own are piloting, having a smartphone, but really, it is not really doing telemetry of health outcomes or bioreadings, but if you have a problem, here is a number to call.

So they have a smartphone. Just call here. If you think you need to go to the ER, if you are uncertain, call us.

However, we spend a lot of time on the fully duals and these people have a lot of cognitive impairment. Oftentimes, they are socially isolated. Oftentimes they have multiple ADLs and multiple chronic conditions. Smart anything, I don't think this is going to solely a technology answer. It is going to have to be a high touch. We need to have people there to come alongside to help them.

Mr. Burgess. I don't disagree, but even as the gentlelady from California mentioned taking care of her parents when I was in a similar situation, the ability to get that information to someone to help you make a decision.

Mr. Wing. We are very supportive of that. We are very supportive of that.

Mr. Burgess. Let me, again, fascinating panel, and I really appreciate all of you being here this morning. I am sorry Ms. Eshoo has already left. I am obligated to answer some of the charges that she made, so I have some stuff for the record, and I want to offer for the record an op-ed from February 7, 1997. The op-ed is almost old enough to vote itself. An op-ed from February 7, 1997 from the New York Times, Making the Budget Bearable. This was back in the Clinton administration. Part of the op-ed says the President offers an important reform of

Medicaid, proposing to control future spending by placing a cap on the amount of federal spending per enrollee and allowing states to place enrollees in managed care without going through the frustrating process of begging for Washington's approval, the New York Times recommending the per capita cap. That was an idea of a Democratic Administration back in the 1990s.

Further evidence, Senator Murray from Washington State, Senator Murray speaking to -- on the Congressional Record December 22, 1995, Mr. President, I hold in my hand today a letter to President Clinton that is signed by all 46 members of the Democratic Caucus. This letter urges him to hold firm in our commitment to basic health care for children, pregnant women, and the elderly, and the disabled. This letter supports a per capita cap approach to finding savings in the Medicaid program. This was a problem 22 years ago. It is no less a problem today.

As Margaret Thatcher once aptly observed that you can eventually run out of other people's money. And that is a concern that although this is an authorizing committee, not an appropriations committee, it is a concern that we should have as well. And I think one of the things that this panel helps us with today is understanding we need to be spending dollars wisely. It is not that we are not going to spend dollars, but we need to spend them wisely.

This is not a new concept of what is being debated in this committee this year and over in the Senate even as we speak, not a new concept, one that was embraced by a Democratic Administration 21 years ago, Democratic Senators 22 years ago, the New York Times, 20 years ago. So it has been an interesting panel this morning. I want to thank you for being here.

Seeing that there are no further members wishing to ask questions, I again want to thank our witnesses. We have received outside feedback from a number of organizations on these bills, so I would like to submit statements from the following for the record: Molina Health Care, Avalere, the Health Care Leadership Council, the National Association of Medicaid Directors, AHIP, the Association for Community Affiliated Plans, Bipartisan Policy Center, UPMC, and a letter from 12 advocacy groups on Special Needs Plans.

Additionally, I want to submit the New York Times editorial from 1997 and the Congressional Record statement from 1995. Without objection, so ordered.

[The information follows:]

*********COMMITTEE INSERT 4*********

Pursuant to committee rules, I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days upon receipt of the questions. Without objection, this Subcommittee is adjourned.

[Whereupon, at 11:59 a.m., the Subcommittee was adjourned.]