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DUAL ELIGIBLES: UNDERSTANDING THIS VULNERABLE POPULATION AND HOW TO IMPROVE THEIR CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JUNE 21, 2011

Serial No. 112–64

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DUAL ELIGIBLES: UNDERSTANDING THIS VULNERABLE POPULATION AND HOW TO IMPROVE THEIR CARE

TUESDAY, JUNE 21, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:04 p.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Whitfield, Shimkus, Latta, Lance, Cassidy, Guthrie, Upton (ex officio), Pallone, Christensen, Markey, and Waxman (ex officio).

Staff present: Howard Cohen, Chief Health Counsel; Andy Duberstein, Special Assistant to Chairman Upton; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Kirby Howard, Legislative Clerk; Debbee Keller, Press Secretary; Peter Kielty, Senior Legislative Analyst; Ryan Long, Chief Counsel, Health; Carly McWilliams, Legislative Clerk; Jeff Mortier, Professional Staff Member; Katie Novaria, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Press Assistant; Heidi Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator, Admin/Human Resources; Tom Wilbur, Staff Assistant; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Purvee Kempf, Democratic Senior Counsel; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Dual eligibles, those individuals who are eligible for both the Medicare and Medicaid programs, are one of our sickest, poorest, most costly and most vulnerable populations. If we are to simultaneously improve and lower the cost of their care, we must do a better job at integrating Medicare and Medicaid benefits and services.

Dual eligibles are unique. While more than half of dual eligibles live below the poverty line, only 8 percent of Medicare-only beneficiaries have incomes below the poverty line. Nineteen percent of

dual eligibles live in an institutional setting, while only 3 percent of Medicare-eligible-only individuals live in such a setting. They are also more likely to be hospitalized, to go to emergency rooms, and to require long-term care than other Medicare beneficiaries.

According to the Centers for Medicare and Medicaid Services, more than 9 million people fall into the dual-eligible category. Forty-three percent of them have at least one mental or cognitive impairment, while 60 percent have multiple chronic conditions.

According to the Kaiser Family Foundation, dual eligibles, who make up only 15 percent of Medicaid enrollment, consume 39 percent of total Medicaid spending. Additionally, in 2005, the Medicare and Medicaid programs spent an average of $20,000 per dual eligible, almost five times greater than the average amount spent on other Medicare beneficiaries.

These individuals, who have fewer resources and more complicated health care needs, face the added struggle of trying to navigate both Medicare and Medicaid. Medicare covers their basic acute health care services and prescription drugs, and Medicaid fills in the gaps. Medicaid generally pays the Medicare Part B premium and the cost sharing for Medicare services. For some, Medicaid also covers various benefits not covered by Medicare, including long-term care supports and services, dental care, eyeglasses, and other benefits.

Each State determines its own eligibility standards and which benefits will be provided to Medicaid beneficiaries. So, we are able to watch various States experiment with different models and designs to better align the care of dual eligibles. Currently, 15 states have been selected to receive funding, data and technical assistance from CMS to develop a more coordinated model of care for dual eligibles.

We can improve the quality of care that dual eligibles receive. We can make their care more efficient and easier for them to navigate. We can do all this while lowering costs to both the federal government and the beneficiary.

I look forward to hearing from our witnesses today about which models are being tried in the States and what we have learned so far.

[The prepared statement of Mr. Pitts follows:]

Opening Statement for Rep. Joe Pitts
Energy and Commerce Subcommittee on Health
Hearing on "Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care"
June 21, 2011
(Remarks Prepared for Delivery)

Dual eligibles, those individuals who are eligible for both the Medicare and Medicaid programs, are one of our sickest, poorest, most costly, and most vulnerable populations.

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Mr. PITTS. At this time I will yield the remaining time to the vice chairman, Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

In no other area is the lack of coordination at the federal level more apparent than when we deal with people who are dually eligible for Medicare and Medicaid. Studies of the population make it clear that Medicaid is actually 56 separate programs administered by the States and territories in the context of duals. It sometimes becomes a game of hot potato.

Data suggest that duals are sicker when they are hospitalized, that their costs are almost 10 percent greater, and they have more episodes of avoidable hospitalization. It is a symptom of no one being held accountable for their care. Certainly, better alignment of Medicare and Medicaid is needed.

Now, unfortunately, ACOs, accountable care organizations, that may have provided a model and a good place to start, it seems that once again the bureaucracy has killed any such hope for that happening. The rule that was produced on ACOs was virtually unintelligible and most large groups that thought themselves to be ACOs have now moved away from this.

You want to drive cost savings with better care. This is a problem that really we could solve. Fifteen percent of Medicaid enrollees are duals and they account for almost 40 percent of the program's spending. The old Willie Sutton law, you rob banks because that is where the money is, clearly it should apply here. And these patients are fully covered by Medicare and the entire Medicare benefits package and still they are five times costlier. These are patients that are defined. We know where they are. We know who they are. We know when they are accessing care and why they are accessing it, and yet for some reason we lack the fundamental amount of consistency for coordinating their benefits.

I rarely find myself agreeing with Ezra Klein and the Washington Post, but I did last week when he talked about the fact that this was an idea whose time has come. What I don't understand is why it takes an entirely new federal agency when CMS has had broad waiver authority and demonstration authority for years to take care of this problem.

I will yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

I really welcome today's hearing on a critical issue: the coordinating and improving of health care of those dually eligible for Medicare and Medicaid programs, otherwise known as dual eligibles, and I appreciate my colleagues for working with us in preparing this hearing and look forward to our discussion. This is an

area of our health care system that I think has potential for effective change.

The reality is that dual eligibles are a vulnerable population. Their care is both costly and frequently uncoordinated, which is resulting in poor outcomes in many cases. In total, there are 9.2 million Americans who rely on both Medicare and Medicaid. Meanwhile, they are significantly poorer and tend to have extensive health care needs. Overall, they are also more likely to suffer from chronic conditions such as heart disease, pulmonary disease, diabetes and Alzheimer's disease, and as such, their care is complicated and too often they are not receiving the patient-centered care they need and that they deserve.

In addition, dual eligibles represent less than 20 percent of the Medicare and Medicaid programs but bear the responsibility for a significant amount of the programs' expenses. In fact, in 2007, they comprised only 15 percent of enrollees but represented 39 percent of Medicaid spending and their medical costs were more than six times higher than non-disabled adults in Medicaid. Meanwhile, in Medicare, they represent 16 percent of enrollees and 27 percent of expenditures. Compared to all other Medicare enrollees, the health costs are nearly five times as great.

These are powerful numbers that demonstrate if we can improve care coordination and make life better for these individuals, there is also an opportunity for savings. That is why, in passing the Affordable Care Act, we created the Federal Coordinated Health Care Office at the Department of Health and Human Services, otherwise known as the Medicare-Medicaid Coordination Office. Its mission is to gain some much-needed efficiency within the system for this group of beneficiaries.

I must admit, the timing of the coordinated office, as well as today's hearing, couldn't be better. Congress and this committee are increasingly concerned about the rising cost of Medicare health care coverage for the 45 million elderly and disabled Americans and Medicaid's 55 million poor patients. So what better place to explore, understand and address than the sickest and most expensive populations to cover. But we mustn't set a price tag on their care nor should we shape policy with the goal of only saving money.

It is clear we have some real big challenges, yet some real big opportunities in providing care for dual eligibles. So I look forward to hearing from our expert panel today, and I would specifically like to welcome Ms. Melanie Bella, the head of the new coordinated office. I know that she has a long history of aiming to restructure the services of dual eligibles, so I look forward to hearing about her innovative work.

I also look forward to hearing about the successful efforts represented here today by the different panelists. I hope we can hear some new ways Congress can be helpful in addressing what has been a longstanding problem facing our health care system.

And I yield back, Mr. Chairman. Thank you.

[The prepared statement of Mr. Pallone follows:]

The Honorable Frank Pallone, Jr.
House Energy and Commerce Subcommittee on Health Hearing

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care"

Opening Statement

June 21, 2011

Thank you, M. Chairman. I really welcome today's hearing on a critical issue – the coordinating and improving of health care of those dually eligible for Medicare and Medicaid programs, otherwise known as "dual-eligibles." I appreciate my colleague for working with us in preparing this hearing and I look forward to our discussion. This is an area of our health care system that I think has potential for effective change.

The reality is that dual-eligibles are a vulnerable population. Their care is both costly and frequently uncoordinated, which is resulting in poor outcomes. In total, there are 9.2 million Americans who rely on both

Medicare and Medicaid. Meanwhile, they are significantly poorer and tend to have extensive health care needs. Overall, they are also more likely to suffer from chronic conditions such as heart disease, pulmonary disease, diabetes and Alzheimer' disease. As such, their care is complicated and too often they are not receiving the patient-centered care they need and deserve.

In addition, dual-eligibles represent less than 20-percent of the Medicare and Medicaid programs but bear the responsibility for a significant amount of the programs' expenses. In fact, in 2007, they comprised only 15-percent of enrollees but represented 39-percent of Medicaid spending and their medical costs were more than six times higher than non-disabled adults in Medicaid. Meanwhile, in Medicare they represented 16-percent of enrollees and 27-percent of expenditures. Compared to all other Medicare enrollees, the health costs are nearly five times as great.

These are powerful numbers that demonstrate if we can improve care coordination and make life better for these individuals, there is also an opportunity for savings. That is why, in passing the Affordable Care Act, we created the Federal Coordinated Health Care Office at the Department of Health and Human Services – otherwise known as the Medicare-Medicaid Coordination Office. Its mission is to gain some much-needed efficiency within the system for this group of beneficiaries.

So, I must admit, the timing of the Coordinated Office, as well as today's hearing couldn't be better. Congress and this Committee are increasingly concerned about the rising cost of Medicare health care coverage for the 45 million elderly and disabled Americans and Medicaid's 55 million poor patients. So what better place to explore, understand and address than the sickest and most expensive populations to cover. But we mustn't set a price tag on their care nor should we shape policy with the goal of only saving money.

It's clear we have some real big challenges, yet some real big opportunities in providing care to dual-eligibles. So, I look forward to hearing from our expert panel today. I'd specifically like to welcome Ms. Melanie Bella, the head of the new Coordinated Office. I know you have a long history of aiming to restructure the services of dual-eligibles, so I look forward to hearing about your innovative work.

I also look forward to hearing about the successful efforts represented here today. I hope that we will hear about some new ways Congress can be helpful in addressing what has been a long-standing problem facing our health care system

Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the full committee chairman, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman.

According to CMS, more than 9 million Americans qualify for both Medicare and Medicaid, including at least 257,000 in Michigan.

I want to thank our two panels this afternoon for agreeing to share their expertise in serving this vulnerable population, often referred to as dual eligibles. We look forward to hearing your perspective on the health care needs and the barriers that currently prevent them from properly navigating the health care system.

This hearing is important for two key reasons. First, we must better understand the distinctive behavioral and physical health care complexities associated with the dual-eligible population. And second, we need to better understand what is currently being done to help these individuals navigate the health care system. By the end of the hearing, we should be able to identify what initiatives exist to effectively integrate care for dual-eligible populations, what coordination models are working, what prevents these effective models from expanding, and building on the positive efforts already underway, we must also look for ways to modernize the current structure so these individuals are ensured access to quality health care with less red tape.

Most Americans have uniform coverage that guides them through the complex health care system, but for the dual eligible, that process is more complicated because they have to navigate the waters of two different entitlement programs that offer different benefits and cover different services and providers. Because of that segmented structure, we have come to learn that dual eligibles have difficulty identifying where to access good, quality care. Not surprisingly, they frequently end up in the ER, which is harmful to both patients and taxpayers, who end up with the costly bill for preventable hospitalizations.

Again, we welcome you, and I yield the balance of my time to Dr. Cassidy.

[The prepared statement of Mr. Upton follows:]

Chairman Fred Upton
Subcommittee on Health Hearing
"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."
Tuesday, June 21, 2011

According to the Centers for Medicare & Medicaid Services (CMS), more than 9 million Americans qualify for both Medicare and Medicaid-including at least 257,000 Michigan residents.

I want to thank our two panels this afternoon for agreeing to share their expertise in serving this vulnerable population often referred to as "dual-eligibles." We look forward to hearing your perspective on their health care needs and the barriers that currently prevent them from properly navigating the health care system.

I believe this hearing is important for two key reasons.

First, we must better understand the distinctive behavioral and physical health care complexities associated with the dual-eligible population.

According to CMS, 60 percent of dual-eligibles have multiple chronic conditions and 43 percent have at least one mental or cognitive impairment. Dual-eligibles are clearly unique in their health care needs and as we design a model to improve their care, we must remember their vulnerabilities.

Second, we need to better understand what is currently being done to help these individuals navigate the health care system. By the end of this hearing, we should be able to identify what initiatives exist to effectively integrate care for the dual-eligible population, what coordination models are working, and what prevents these effective models from expanding.

Building on the positive efforts already underway, we must also look for ways to modernize the current structure so these individuals are ensured access to quality health care with less red tape.

Most Americans have uniform coverage that guides them through the complex health care system. For the dual-eligible, that process is more complicated because they must navigate the waters of two entitlement programs that offer different benefits and cover different services and providers.

Because of this segmented structure, we have come to learn that dual-eligibles have difficulty identifying where to access care. Not surprisingly, they frequently end up in the emergency room, which is harmful to both the patient and taxpayers who end up with the costly bill for preventable hospitalizations.

I hope this hearing will provide every member the opportunity to learn more about this vulnerable population so that we can identify policy solutions that will improve their care while also reducing unnecessary costs.

OPENING STATEMENT OF HON. BILL CASSIDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. CASSIDY. Thank you, Chairman Pitts.

Medicare and Medicaid are important programs that are unfortunately unsustainable in their current form. Medicare, per the actuaries who run the program, is going bankrupt in 10 years hastened by $500 billion extracted from it by Obamacare. Medicaid is bankrupting States, and this was before the Obamacare mandates that usurp States' rights.

Now, as a doctor who teaches, who still teaches and treats the uninsured in a public hospital, though, my primary concern is patient welfare, and fortunately, there is an opportunity for improvement. As we know, dual eligibles oftentimes have poor outcomes. Now, Republican have proposed freeing States from the rigid Medicaid rules, which make it difficult to coordinate benefits between Medicaid and Medicare. We have also put forward a plan to save Medicare from bankruptcy, to preserve Medicare as it has been known for those who are on it, and to preserve it for those who will be on it. Now, saving Medicare from bankruptcy is important for all Americans, all senior citizens, but particularly for dual eligibles.

Now, unfortunately, under the current situation, Medicare provides incentives to treat patients in one way and it provides Medicare incentives to treat patients in another way, and these dueling incentives oftentimes lead to poor patient outcomes. This is the problem of large bureaucracies trying to dictate what happens to a patient in the patients' exam room. We can do better.

So despite the fact that Medicare and Medicaid spend disproportionate amounts upon dual-eligible patients, again, their outcomes are poor, and this is actually the most important issue. Now, we should note that we shouldn't take the policy of do nothing for short-term political gain and kick this issue of Medicare's fiscal solvency as an issue down the road. We have got to address it now.

I am very interested in the perspectives presented here today. I have had the pleasure to speak with Ms. Bella. She is knowledgeable. I just look forward to it. Similarly, the perspective of the PACE providers and the States. I will say the Office of Dual Eligibles, I kind of like that. It is the one provision of Obamacare I applaud. As we say in the South, even a blind hog finds an acorn every now and then.

I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

As observers of this hearing will note that by and large whether you are a Democrat or a Republican, we care about this issue and this is a hearing where we have collaborated in providing panels that will give us the best information on how we can address the problems that are unique to the people who are dual eligibles, or both on Medicare and Medicaid.

This has been a major issue facing both programs. By design, these individuals should have access to the best of these programs, the best that each one has to offer, but too often they struggle, fall between the cracks and cycle in and out of nursing homes, hospitals, specialty care without receiving the coordinated patient-focused care they deserve.

Dual eligibles are not a homogenous group but they can be considered as several subgroups. Some, such as Medicare beneficiaries who are eligible for Medicare by virtue of their age and for Medicaid because they have low income, can be in their mid 60s and may not differ significantly from other Medicare beneficiaries in their need for care. Others, however, such as adults under 65 with developmental disabilities such as cerebral palsy or intellectual disabilities, require significantly more care and resources to live their lives. Older Medicare beneficiaries with cognitive impairments such as Alzheimer's are another significant and very frail subgroup, a group we are going to hear about today.

Many of these individuals may require nursing home level of care or home-based support services allowing them to live outside of an institution. A disabled person under the age of 65 costs Medicare and Medicaid between $23,000 and $84,000 in 2005 depending on whether he or she needed nursing home stay. This is very expensive but not getting this care is worse, resulting in eroding health, trips to the emergency room, suffering for the patient and his or her family, and astronomical costs for the patient and the taxpayer. These costs present both a challenge and an opportunity to develop and implement reforms that over time will simultaneously improve care while reducing costs.

There is a Medicare Payment Advisory Commission and the Medicaid and the child health program have their commissions as well, and all these commissions have described how a lack of coordination between Medicare and Medicaid can create harmful and wasteful outcomes and misaligned incentives. For example, a nursing facility may find it profitable to transfer a complex patient to a hospital even if the facility is capable of managing that patient because of different payment rates and benefit rules in each program.

We have heard in this committee many times over the years about problems generated by pure fee-for-service medicine that provides no coordination of benefits. For dually eligible beneficiaries, those problems are multiplied because of their intensive care needs.

We face a lot of challenges in improving care for dual eligibles and reducing costs to the taxpayer but it is important to recognize that we shouldn't rush into new programs for purely a budgetary focus. We should not assign a price tag to this population and then design the policy around it.

As we will hear today, the best and most successful efforts to integrate care for the duals has been local and it has been focused on a small group of beneficiaries. These programs have been built around intensive interventions by nurses, physicians, social workers, therapists and others. But these interventions can be difficult to scale up to a large population, and I think we need to be wary about grand promises regarding this decades-old problem.

I want to mention that one of the results of the Affordable Care Act, which some people call Obamacare, was to extend the Medicare trust fund, and in fact, it was extended over 12 years. Another thing to recognize is that whatever cuts some of our colleagues objected to in the Affordable Care Act, they took all of those cuts and went way beyond it in their Medicare proposal, which they would transform into a whole different system.

We have opportunities to save money we are spending on dual eligibles by examining the drug rebates in Part D where we pay a higher price for the dual eligibles than we used to pay in the past. Providing better coordinated care and saving money are not mutually exclusive goals and for the dual eligibles, this may be the key to improved quality of care.

Thank you, Mr. Chairman, for calling this hearing.

[The prepared statement of Mr. Waxman follows:]

Statement of Rep. Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
Hearing on "Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care"
June 21, 2011

I thank Mr. Pitts for calling today's hearing, and for his collaboration in selecting witnesses to appear before us today. I look forward to our discussion of the very complex issues surrounding the health needs of people dually eligible for Medicare and Medicaid – the so-called "dual-eligibles".

Providing for the health needs of dual-eligibles has long been a major issue facing both programs. By design, these individuals should have access to the best both programs have to offer – but too often, they struggle, fall between the cracks, and cycle in and out of nursing homes, hospitals, and specialty care, without receiving the coordinated, patient-focused care they deserve.

Dual-eligibles are not a homogenous group, but can be considered as several sub-groups. Some, such as Medicare beneficiaries eligible for Medicare by virtue of age and for Medicaid by virtue of low-income can be in their mid 60s and may not differ significantly from other Medicare beneficiaries in their need for care.

Others, however, such as adults under 65 with developmental disabilities such as cerebral palsy or intellectual disabilities, require significantly more care and resources to live their lives. Older Medicare beneficiaries with cognitive impairments such as Alzheimers' are another significant, and very frail, subgroup – a group we are going to hear from today.

All of these individuals may require nursing home levels of care, or home-based support services allowing them to live outside of an institution.
A disabled person under the age of 65 cost Medicare and Medicaid between $23,000 and $84,000 in 2005, depending on whether he or she needed a nursing home stay.

This is very expensive, but not getting this care is worse, resulting in eroding health, trips to the emergency room, suffering for the patient and his family, and astronomical costs for the patient and the taxpayer. These costs present both a challenge and an opportunity to develop and implement reforms that over time will simultaneously improve care while reducing costs.

The Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission describe how a lack of coordination between Medicare and Medicaid can create harmful and wasteful outcomes, and misaligned incentives. For example, a nursing facility may find it profitable to transfer a complex patient to a hospital, even if the facility is capable of managing that patient, because of different payment rates and benefit rules in each program.

This Committee has heard many times of the problems generated by pure fee-for-service medicine that provides no coordination of benefits. For dually eligible beneficiaries, those problems are multiplied because of their intensive care needs.

We face a multitude of challenges in improving care for dual-eligibles and in reducing costs to the taxpayer. But it's important that we don't rush into new programs with a purely budgetary focus. We should not assign a price tag to this population and then design the policy around it.

As we'll hear today, the best and most successful efforts to integrate care for the duals has been local, and it has often focused on a small group of beneficiaries. These programs have been built around intensive interventions by nurses, physicians, social workers, therapists, and others.

But these interventions can be difficult to scale up to large populations. I hope that we hear today about how Congress and the Administration can help speed that process to scale-up, but we must remain wary about grand promises regarding this decades-old problem.

We also have important opportunities to save money we are spending on dual-eligibles by examining drug rebates in Part D. I certainly hope the Committee will give a high priority to examining that in the future as well.

Providing better coordinated care and saving money are not mutually exclusive goals, and for the dual-eligibles, this may be the key to improved quality of care.

Mr. PITTS. The chair thanks the gentleman.

We have two panels today, and I would like to ask panel one to take her seat at the witness table. I want to thank all the witnesses for agreeing to appear before the committee. On panel one, we welcome Melanie Bella, who is the Director of the Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. Your written testimony will be made part of the record. We would ask that you please summarize your opening statement in 5 minutes and then we will go to questions and answers. Welcome.

STATEMENT OF MELANIE BELLA, DIRECTOR, FEDERAL COORDINATED HEALTH CARE OFFICE, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. BELLA. Good afternoon, Chairman Pitts, Ranking Member Pallone, Chairman Upton, Ranking Member Waxman and members of the subcommittee. Thank you for the invitation to participate in this discussion today. My name is Melanie Bella, and I am the Director of the Federal Coordinated Health Care Office at the Centers for Medicare and Medicaid Services.

This office, which we are referring to as the Medicare and Medicaid Coordination Office, to better explain our mission, was created by the Affordable Care Act and our single focus is the topic of the hearing today.

Medicare and Medicaid enrollees, also referred to as dual eligibles, are a heterogeneous group. They include low-income seniors, individuals with disabilities as well as those with serious and persistent mental illness. Some individuals start on Medicaid and age into Medicare. Other individuals start on Medicare and have a functional or a financial decline that makes them Medicaid eligible. Either way, these individuals have very complex care needs. Three out of five have multiple chronic conditions and two out of five have at least one mental or cognitive impairment. Not surprisingly, given their higher-than-average health care needs, the cost of providing care for these individuals is significant. Together, Medicare and Medicaid spend roughly $300 billion a year to provide care to this population.

Our office is working across Medicare and Medicaid with States, providers and other stakeholders on a number of key initiatives to ensure better health, better care and lower costs through improvement for Medicare and Medicaid enrollees. Specifically, our efforts are focused in three main areas. The first is program alignment, the second is data and analytics, and the third is models and demonstrations. I will highlight a few of those efforts today starting with program alignment.

Better coordination begins with program alignment. Currently, Medicare and Medicaid enrollees must navigate two completely separate systems, Medicare for coverage of basic acute-care services and drugs, and Medicaid for coverage of supplemental benefits such as long-care care supports and services. Medicaid also provides help with Medicare premiums and cost sharing. Although both programs provide important benefits, they operate as separate systems with different administrative procedures, statutory provisions and payment policies. One of the first objectives of our office was to

catalog all of the places where Medicaid and Medicare literally bump up against each other. This creates barriers to effective care, and though internal and external consultation and outreach, we use that opportunity to identify places where we can improve alignment between the two programs. We have published a list of these alignment opportunities in the Federal Register, specifically to invite public comment. This alignment initiative will allow us both to identify barriers to high-quality cost-effective care as well as prioritize areas for improvement.

Another key objective of this new office is to engage our State partners. Improving quality and cost of care for Medicare and Medicaid enrollees relies on effective partnership with States because we share the responsibility to provide care and to finance that care for this population. Our office has recently announced two key initiatives that support our State partners in improving care coordination for Medicare and Medicaid enrollees. One of these initiatives was the establishment of a new process for States to access Medicare data for care coordination purposes. Lack of timely Medicare data, particularly Part D data, has been a key barrier for States in expanding care management efforts for their dual population. These data provide States with a powerful new tool to support their efforts to improve care for some of their most complex and costly beneficiaries.

The second initiative done in partnership with the Center for Medicaid and Medicare Innovation is the State demonstrations to integrate for dual-eligible individuals under which 15 States were competitively selected to design new approaches to better coordinate care for Medicare and Medicaid enrollees. Through these design contracts, CMS is providing funding to selected States to support their efforts to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services. The goal of this initiative is to identify and validate new care delivery and payment models that can be tested and then replicated in other States. Importantly, though, our office serves as a resource to all States and is available to provide technical assistance to any State interested in working to improve quality and reduce costs for its Medicare and Medicaid enrollees.

In closing, a high priority for our office is to significantly increase the number of Medicare and Medicaid enrollees that have access to seamless, coordinated care. We will get there by eliminating barriers to integration, partnering with States, providers and other stakeholders and developing new delivery system and payment models. We expect that improved care coordination and quality outcomes for this complex population will result in better care at reduced cost for both the Federal Government and States. Thank you very much.

[The prepared statement of Ms. Bella follows:]

STATEMENT OF

MELANIE BELLA

DIRECTOR OF THE MEDICARE-MEDICAID COORDINATION OFFICE
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON
DUAL-ELIGIBLES: UNDERSTANDING THIS VULNERABLE POPULATION AND HOW TO IMPROVE THEIR CARE

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMITTEE ON HEALTH

JUNE 21, 2011

U.S. House Committee on Energy & Commerce
Subcommittee on Health

Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care
June 21, 2011

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the invitation to discuss the Center for Medicare & Medicaid Services' (CMS) efforts to integrate care for individuals who are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). The Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, was established by Section 2602 of the Affordable Care Act to more effectively integrate the Medicare and Medicaid benefits and to improve the coordination between the Federal and State governments for individuals enrolled in both the Medicare and Medicaid programs. A Federal Register notice officially establishing the Medicare-Medicaid Coordination Office was published on December 30, 2010.

Background

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment. Over the past 40 years, the Medicare and Medicaid programs have remained separate systems despite a growing number of individuals who utilize both programs for their health care. Many individuals become eligible for Medicare first, and then qualify for Medicaid as a result of an income-changing event. Others qualify for Medicaid initially and then in turn qualify for Medicare because of their age or disability. As the number of individuals who rely on both programs for their coverage grows, there is an increasing need to align these programs so that they better serve enrollees.

Today, more than 9 million Americans are enrolled in both the Medicare and Medicaid programs; two-thirds are low-income elderly, and one-third are under 65 and are disabled.[1] Additionally, Medicare-Medicaid enrollees include higher proportions of female, African-American, and Hispanic individuals than in the Medicare-only population. Medicare-Medicaid enrollees must navigate two separate programs for their care—Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services. Medicaid also provides help with Medicare premiums and cost-sharing for those who need additional financial assistance. A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for Medicare-Medicaid enrollees and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees.

People enrolled in both Medicare and Medicaid tend to have the most complex, chronic illnesses, and therefore they are some of the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care is estimated at $300 billion annually across both programs. In the Medicaid program, these individuals represented 15 percent of enrollees and 39 percent of all Medicaid expenditures. In Medicare, they represented 16 percent of enrollees and 27 percent of program expenditures.[2],[3] Compared to all other Medicare enrollees, Medicare-Medicaid enrollees' health costs are nearly five times greater. Compared to all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly 6 times greater. They are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.[4] These statistics demonstrate the tremendous opportunities available to improve the individual care experience by raising quality, and to lower costs through improved health outcomes for this population.

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[1] Based on the Centers for Medicare &Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.
[2] The Medicare Payment Advisory Committee (MedPAC), A Data Book: Healthcare spending and the Medicare program, June 2010. Available at: http://www.medpac.gov/documents/Jun10_EntireReport.pdf .
[3] Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medieare and Medicaid. January 2011. Available at: http://www.kff.org/medicare/upload/8138.pdf
[4] Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. Available at: http://www.kff.org/medicaid/upload/8081.pdf

Too often, the care journey for these individuals is fragmented and uncoordinated. Therefore, this population could benefit the most from integrated systems of care that ensure all their needs – primary, acute, long-term care, behavioral and social – are met in a high quality, cost effective manner. Better alignment of the administrative, regulatory, statutory, and financing aspects of these two programs promises to improve the quality and cost of care for this complex population.

The Medicare-Medicaid Coordination Office's mission is to address and improve the beneficiaries' experiences, access to care, quality of care, and cost of benefits for individuals enrolled in both the Medicare and Medicaid programs. To that end, the Medicare-Medicaid Coordination Office is engaged in ongoing discussions with key internal and external stakeholders, including beneficiary advocates, provider organizations, MedPAC, MACPAC and State Medicaid agencies, to work together to advance high quality, seamless care for Medicare-Medicaid enrollees. The Office is also working to improve collaboration and communication between Medicare and Medicaid program offices within CMS and across other Federal agencies.

The Need for Coordinated Care

Partnerships with the States

The 9 million Medicare-Medicaid enrollees accounted for approximately $120 billion in combined Medicaid Federal and State spending in 2007 – almost twice as much as Medicaid spent on all 29 million children it covered in that year.[5] While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 26 States, more than half of such spending in 4 States (Connecticut, New Hampshire, North Dakota and Wisconsin) and not less than a quarter of total spending in any State.

States alone spent more than $50 billion in 2007 to support the health and long-term care costs of people enrolled in Medicare. The average Medicaid spending per beneficiary on Medicare-Medicaid enrollees was $15,459 in 2007, more than six times higher than the comparable cost of

[5] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm

a non-disabled adult covered by Medicaid ($2,541).[6] This spending mostly reflects the significant costs associated with a population with low income and high health care needs; however, there are opportunities for savings through improved care coordination, simplification, and alignment of some Medicare and Medicaid rules. In 2007, roughly 5 percent of Medicaid spending for Medicare-Medicaid enrollees went to acute care services. This is a relatively low figure, compared to the 70 percent of Medicaid spending for Medicare-Medicaid enrollees' long-term care services, which are mostly not covered by Medicare or private insurance.

Too often, the current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it. This is a complex problem and not something that CMS can fix on its own. We are relying on collaboration with our partners in the States to find real solutions that, through better care coordination, will improve the experience and quality of care for beneficiaries and reduce costs. The Medicare-Medicaid Coordination Office is working to facilitate innovation by nurturing these vital State-Federal relationships.

Better Care for People

The Medicare-Medicaid Coordination Office has been working to improve Medicare-Medicaid enrollees' satisfaction, program awareness, health, functional status, and well-being. Most individuals enrolled in both Medicare and Medicaid are not receiving coordinated care. Our goal is to assure that Medicare-Medicaid enrollees are receiving high quality and person-centered acute, behavioral, and long-term care services and supports.

To further this mission, our Office has worked in concert with the Center for Medicare and Medicaid Innovation, the Center for Medicaid, CHIP and Survey & Certification and the Center for Medicare within CMS to foster significant reforms across the health care delivery system that will improve the coordination of care for all patients, including low-income beneficiaries, many

[6] Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. http://www.kff.org/medicaid/7846.cfm

of whom are Medicare-Medicaid enrollees. One example of such an initiative is the Partnership for Patients, an investment of up to $1 billion in patient safety initiatives that are designed to improve coordination of care and reduce preventable hospital-acquired conditions. The Partnership for Patients hopes to take these safety efforts to scale, which could save tens of thousands of lives, avoid millions of preventable injuries, and save Medicare and Medicaid billions of dollars over time.

The Partnership for Patients, which aims to prevent hospital readmissions and hospital-acquired conditions will help drive better care for Medicare-Medicaid enrollees. In a recent CMS study, 27 percent of the Medicare-Medicaid enrollees were hospitalized at least once during the year, totaling almost 2.7 million hospitalizations.[7] More than a quarter of these hospital admissions may have been avoidable, either because the condition itself could have been prevented (e.g., a urinary tract infection), or the condition could have been treated in a less costly and more appropriate setting (e.g., adult asthma). The study projects that the total costs for potentially avoidable hospitalizations for Medicare-Medicaid enrollees will be between $7 and $8 billion for 2011.[7] Providing appropriate, coordinated and integrated care may be able to prevent unnecessary hospitalizations, which would allow these individuals to remain independently at home while saving scarce health care resources.

Benefits of Integrated Care

A real-life example of the significant benefits of integrated care for people enrolled in both Medicare and Medicaid is a 77 year old woman named Mattie. Mattie is a fiercely independent woman who lives alone but requires significant personal assistance to maintain independence. She has diabetes, depression, and hypertension, and over the years has suffered three strokes, resulting in left-side weakness and limited mobility. Before receiving integrated care, she fell frequently, had inadequate food intake, and had three potentially avoidable hospitalizations that resulted from poorly controlled diabetes. In addition, she faced difficulties making her medical appointments because of mobility limitations, challenges accessing and managing personal care

[7] Centers for Medicare & Medicaid Services, Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations, 2011. Available at: http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf.

attendant services, and problems obtaining mental health services. In order to receive routine medical care, Mattie had to navigate and manage three separate health care systems, with three different benefit structures and three different identification cards—one for Medicare, one for her prescription drug coverage, and one for Medicaid. She had multiple providers that rarely communicated with one another, and her health care decisions were rarely coordinated and were not made from a patient-centered perspective. As a result of all these challenges, her care was fragmented and she was considering nursing home care.

Fortunately, Mattie was able to enroll in a special program that integrates her Medicare and Medicaid covered services and which has at its core a multi-disciplinary care team that assumes full responsibility for all of her care needs. She now has access to the full range of services to meet her needs and keep her at home, including necessary nutrition support, mental health services, and durable medical equipment. In this program, Mattie only has to manage one set of benefits, and has a single insurance card. One year after enrolling in this program her health has improved, and her care costs have been reduced: she has had no falls, achieved diabetic control, improved her mobility, reduced her personal care attendant support needs, and has had no hospital or emergency department contacts since enrollment in the program. Coordinated care has meant that Mattie can maintain her independence and receive high quality care, while Medicare and Medicaid have avoided the high costs of preventable hospitalizations and nursing home care. These outcomes are the care we want to make available to everyone.

Initiatives to Date

The Medicare-Medicaid Coordination Office has already launched a variety of initiatives to meet its Congressional charge to improve access, coordination and cost of care for Medicare-Medicaid enrollees. Our work falls into the following broad areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

Program Alignment

On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. As stated previously, the lack of alignment between the programs too often leads to fragmented or episodic care for people enrolled in Medicare and Medicaid, which can reduce quality and raise costs. For example, Medicare and Medicaid have different coverage standards for those accessing durable medical equipment. These differences can lead to fragmented care and coverage gaps that could result in patients losing access to the treatments and equipment that help them live at home or in the community. Even temporary coverage gaps can be disruptive and potentially even life-threatening if patients no longer have coverage for wheelchairs or other medical care.

The Alignment Initiative is not simply an effort to catalogue the differences between Medicare and Medicaid, or to make the two programs identical. Rather, it is an effort to advance beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

The first step in the Alignment Initiative is to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a wide-ranging list of opportunities for legislative and regulatory alignment on areas identified through numerous stakeholder discussions. Those areas fall into the following broad categories: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment, and appeals. We published our list in the Federal Register on May 16, 2011 and are seeking public comment through July 11, 2011.

The Medicare-Medicaid Coordination Office will continue to engage with stakeholders on the Alignment Initiative through regional listening sessions, which are intended to supplement the Federal Register Notice by engaging stakeholders, including beneficiaries and providers, in an open discussion about how to improve care for these individuals. The first of these listening sessions was held for New York and New Jersey on June 1, and the second one took place

yesterday (June 20, 2011) for California, Arizona, Hawaii, Nevada, and several Territories. We are committed to being open and transparent in our efforts to better streamline these programs to ensure more efficient and effective care, and will continue to engage the States and the public as we move forward on this Initiative.

Data to Support Goals

On May 11, 2011, the Medicare-Medicaid Coordination Office also announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid. Access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for their highest cost beneficiaries. For example, a State that wants to expand its long-term care and behavioral health care management program to serve low-income seniors and people with disabilities needs data on its Medicare-covered hospital, physician, and prescription drug use. With Medicare data, States can identify high risk and high cost individuals, determine their primary health risks, and provide comprehensive individual client profiles to their care management contractors to tailor interventions. The ability to access the entire spectrum of information on clients enables States to better analyze, understand, and coordinate a person's experience within the Medicare and Medicaid programs.

The Medicare-Medicaid Coordination Office has been focused on understanding the utilization profiles and care experience of individuals eligible for Medicare and Medicaid. As a foundation for this goal, we will be preparing brief profiles of individuals eligible for Medicare and Medicaid in each State, including demographics, service utilization, and availability of benefits. Our Office also seeks to go beyond data and actually speak with beneficiaries to gain a better understanding of their experiences from their perspectives. To build on ongoing efforts to better understand the needs of Medicare beneficiaries under the age of 65, we are in the process of conducting focus groups across the country with individuals with disabilities enrolled in both Medicare and Medicaid to understand the impact of integrated care on beneficiary experience and health outcomes. Finally, the Medicare-Medicaid Coordination Office will monitor and report on issues from a national viewpoint, including annual total expenditures, health outcomes, and access to benefits for individuals enrolled in Medicare and Medicaid.

Models and Demonstrations

The Medicare-Medicaid Coordination Office is also supporting State efforts to coordinate and align Medicare and Medicaid acute and long-term care benefits. Partnering with the Center for Medicare and Medicaid Innovation (Innovation Center), the Medicare-Medicaid Coordination Office has awarded contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for Medicare-Medicaid enrollees.[8] The 15 States selected for the design contracts are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The overall goal of this contracting opportunity is to identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other States. CMS will work with the States to develop and design models and interventions that can be implemented in future phases. The primary "deliverable" of the initial design period will be a demonstration proposal that describes a State's methods for structuring, implementing, and evaluating a model aimed at improving the quality, coordination, and cost effectiveness of care for individuals enrolled in Medicare and Medicaid. Beyond these contracts, technical assistance will be available to all States through a State Resource Center, which will support our State partners as they develop models that better integrate care for Medicare-Medicaid enrollees.

It is important to note, however, that a CMS contract with a State to design a coordinated care model does not confer authority to implement, or endorsement of, the particular model. Only after a State has submitted a coordinated care model design that meets CMS' specifications and is consistent with its contract will the model receive further consideration by CMS for implementation. We will also take recommendations that the Medicare Payment Advisory Commission (MedPAC) has shared with us into consideration. These include testing capitated payment models, collecting consistent quality and cost data across demonstrations, assessing ways to increase enrollment, preserving beneficiary protections, and promoting the appropriate use of Federal funds. We will assess

[8] http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

State proposals with these concerns in mind to ensure models that are tested improve the quality of care while ensuring appropriate use of program funding.

Collaborative Efforts

The Medicare-Medicaid Coordination Office is also facilitating a collaborative effort across the Medicare and Medicaid programs, and with external partners, to evaluate and promote the development of quality measures to better assess beneficiary access to care to reflect the unique circumstances of individuals eligible for Medicare and Medicaid. CMS will engage partners to review the availability of appropriate quality and access measures, and assist in the development of measures which accurately reflect the quality of care received by individuals eligible for Medicare and Medicaid. Our partners will move forward in strategic development of such measures in a manner that streamlines quality measurement across Medicare and Medicaid for individuals receiving care under both programs.

As noted above, the Medicare-Medicaid Coordination Office is also working collaboratively with the Innovation Center to design unique opportunities for integrated care through payment and delivery system reform for individuals eligible for Medicare and Medicaid. These State and provider-based demonstrations will complement the work underway in the Innovation Center on Medicare Accountable Care Organizations and other payment and delivery system demonstrations (for example, Medicare care transitions or Medicaid health homes), which will improve coordination of care for a number of individuals eligible for Medicare and Medicaid.

Finally, the Medicare-Medicaid Coordination Office has consulted and coordinated with both the MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC), including presenting at the MACPAC public meeting in October 2010. The Medicare-Medicaid Coordination Office will continue to collaborate with staff and members of both Commissions on important issues related to data analysis, care model demonstrations, and policy alignment opportunities for Medicare-Medicaid enrollees.

Conclusion

CMS, through the Medicare-Medicaid Coordination Office, is working to ensure better health, better care, and lower costs through improvement for individuals that are enrolled in both Medicare and Medicaid. Over the years, a lack of coordination for this population has led to fragmented and episodic care, which can lead to lower quality and higher costs for this population. With the creation of the Office, we have a tremendous opportunity to better integrate the programs and better serve this population. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals who need it the most.

Mr. PITTS. Thank you. I want to thank you for your opening statement. I will now begin the questioning and recognize myself for 5 minutes for that purpose.

Director Bella, in a 2010 paper entitled "Options for Integrating Care for Dual-Eligible Beneficiaries," you wrote: "The goals should be clear: to provide beneficiaries with the right care at the right time in the right places and to give States and other stakeholders the flexibility they need to design and test accountable models of integrated care." Is it fair to say that you still believe the current system does not provide States the sufficient flexibility or incentives necessary to integrate care for duals?

Ms. BELLA. As I mentioned in my testimony, States are critical partners for us and so we have to recognize the variation in the States and understand where the States are in being able to develop models to improve care for this population. When I think of flexibility for this population, I don't think of it in the context of being able to cut benefits or services. I think about it in terms of we have a population with very complex needs and we have to be able to adapt to those needs, and by adapting to those needs, it allows us to provide more cost-effective care than might otherwise be available in the traditional Medicare and Medicaid systems when they are fragmented and not integrated. And so we see potential for integrated and coordinated systems to be able to take a holistic look at an individual, understand what that individual needs and make sure that we are getting those needs met in the most cost-effective way.

Mr. PITTS. What feedback have you received from States, in your current capacity, about their interest and willingness to further integrate care for duals?

Ms. BELLA. It is a great question. Everyone knows States are financially strapped right now, now more than ever before, and they recognize a tremendous opportunity to improve quality, and by improving quality, help control costs with this population. I have seen more motivation in States than ever before to really understand the needs of this population and to develop integrated and seamless systems of care. Again, that improved quality, and by improving quality will lead to reduced cost over time.

Mr. PITTS. As you know, there are various opinions on how dual eligibles should be enrolled in integrated care models or in coordinated care programs. Do you believe that mandatory enrollment with an opt-out policy would increase enrollment?

Ms. BELLA. Certainly, enrollment is a significant issue, and first and foremost I should say that the commitment of our office is really to establish beneficiary protections so that the programs we are creating are ones that are better than what are available to beneficiaries today.

In thinking about enrollment, enrollment is one of many issues where we have to be open to exploring options to understanding what is keeping people out of integrated systems today, and again, this is one of the issues on the list that we are committed to exploring with our State partners.

Mr. PITTS. Your office recently announced the availability of Medicare data on duals for States to access on a project basis. Why do believe the availability of this data was so important for States,

and what else can CMS do to improve the availability of real-time Medicare data for States and providers?

Ms. BELLA. Well, I have a personal interest in this. I am a former Medicaid director, and when Part D happened and Medicaid agencies lost access to pharmacy data, it was like tying their hand behind their back because a critical tool was taken away to understand how to provide better care to these beneficiaries. So by giving States these data, we support their efforts to identify high-risk individuals to provide the data to primary care providers and care managers who are developing care plans to understand opportunities to prevent hospitalizations, for example, or to reduce medication errors or medications that are going to have adverse effects with each other. We believe that putting the data out there for States that we have will get them exactly where they need to be. It is timely. It covers Medicare A, B and D, and it is done in a way that allows us to protect the important privacy and confidentiality safeguards yet still give this critical tool to States who are trying to design programs to improve quality.

Mr. PITTS. I think I have time for one more question. Realizing the Medicaid expansions in PPACA do not directly apply to dual eligibles, do you believe implementation of the expansions could have a woodworking effect on the overall system that could increase the number of woodworking dual eligibles?

Ms. BELLA. We have not done—the Office of the Actuary has not done as detailed estimates on this as in other populations but our early examination of the issue does not lead us to believe that there will be a woodwork effect for dual eligibles under the expansion.

Mr. PITTS. Thank you.

The chair recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I was going to ask unanimous consent for Ms. Christensen to sit in on today's hearing, Mr. Chairman.

Mr. PITTS. Without objection, so ordered.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to try to ask you three questions and try to get in three questions here, Ms. Bella. My first relates to budgetary concerns. As you heard in my opening statement, I am always concerned that decisions about dual eligibles are based on budget concerns. I am not suggesting that that is true for you but I always worry that that is a big factor or maybe disproportionate to what it actually should be. And as we said, you know, it is a very complicated group. There are patients like people with developmental disabilities who may be well under 65 but you also have duals who are people with cognitive impairments like Alzheimer's diseases at advanced stages, so because they are not the type of patients that insurance companies are rushing to sign up for, you know, that is another concern I have. It is a very expensive population. So I think we have to be creative and assertive in our attempts to improve care for duals but we also need to be realistic in our goals and understand that it may be costly and budgetary expedience should not drive our treatment of the sickest and the frailest of our citizens.

So my question is, first question, can you tell us about how you and your office are thinking about the dual eligibles as groups? Are you looking at them by what kinds of diseases that they might have or by the basis for eligibility for the programs, and of course, you know, my concern is that it is not budgetary driven.

Ms. BELLA. You are exactly right. It is a very diverse group. There are a few different ways that you can think about slicing and dicing the population, and I think that is one of the advantages to having this office is we are really going to drill down and look at subset analysis of the population. One of the ways we are looking is at the highest level over and under 65 to understand the different care needs of those groups and, for example, when the under-65 population with disabilities, the presence or absence of mental illness, I like to call it a game changer. It significantly changes the utilization, the picture. On the corollary, the over 65s, the same thing can be said for Alzheimer's and dementia, and you will hear more about that today. So we are looking at those levels and we are teasing out the subsets.

In addition, there is also ways of looking at the population, understanding if their needs are more acute-care driven so folks who have five, six, seven or eight physical comorbidities or if they are long-term care driven, so these are folks who have needs that are more supportive services and those types of needs and the long-term care, some of those individuals are in nursing homes and some of them are in the community, so that further distinguishes how we have to think about subsetting the population. Now, we tend not to think about it by conditions or by eligibility groups. We tend to look for care opportunities. So regardless of what the profile is in many ways what needs to happen for these patients is an assessment of their needs is the availability of a care team, supports to get them the most cost-effective services they need in whichever setting they need them.

So coming back to your question, those are examples of ways we are looking at subsetting the population, and then using that information to drive our decisions about what types of care models, what types of care needs, what types of payment and measurement systems we would have in place.

Mr. PALLONE. Now I am going to try to get two more things in. You mentioned the nursing home population. More than half of all nursing facility residents are dual eligibles. In 2007, more than 70 percent of Medicaid expenditures for dual eligibles were for long-term care. What can be done to improve the care and quality for people in nursing homes and what are States proposing that would help these individuals? Obviously I would prefer that they not be in nursing homes. Are there ways to improve care in nursing homes or get them out of nursing homes altogether so they don't have to stay in the nursing homes?

Ms. BELLA. The answer to that is yes, there are ways to improve the care, and there are several States, many States that are looking at rebalancing efforts. I think you will hear about some initiatives in North Carolina in particular to target those folks in nursing homes, but a couple of examples. We can really focus on avoidable hospitalizations of nursing home residents, and I will give you some examples. Urinary tract infection, pressure ulcers, dehydra-

tion, fall prevention, those are all things that are avoidable and they are preventable, and by targeting interventions and clinical resources on site, we can improve the quality of care, reduce hospital transfers and presumably help toward the cost-effectiveness change as well.

Mr. PALLONE. My third question is, I know that, you know, they worry about passing the buck, in other words, is the State—who is responsible for their care, the State, the plan, you know, their insurance plan, and a lot of times there is passing of the buck in terms of who takes care of them, who follows up, how to enforce their rights and fulfill their medical needs. Who is truly accountable at the end of the day for ensuring that the needs of duals are met and that quality care is provided? Is it the plan, the State, the Federal Government, and do you see it as part of your office's mission to clarify that to make the pathway easier? In other words, can you play a role in all this so that the buck doesn't get passed?

I know I am out of time, Mr. Chairman. Maybe she can be quick in her answer.

Ms. BELLA. I will be quick. States and feds are accountable. We share responsibility. Our office is absolutely accountable, and I think the reason that was created was to streamline care and to help make sure that we do keep the systems together and improve accountability for the program overall.

Mr. PALLONE. So you try to coordinate between these?

Ms. BELLA. Yes.

Mr. PALLONE. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the full committee chairman, Mr. Upton, for 5 minutes for questions.

Mr. UPTON. Thank you, Mr. Chairman.

I appreciate your testimony. In your testimony, of course, you said the total annual spending for their care is estimated at $300 billion annually, and that the 9 million Medicare/Medicaid enrollees accounted for approximately $120 billion in combined Medicaid, federal and State spending in 2007, almost twice as much as Medicaid spent on all 29 million children that it covered in that year. Now, in responding to Mr. Pallone, you talked about some savings you may see in terms of targeting certain innovations. What other ideas to eliminate barriers do you think we might be able to achieve to actually see some real savings in the program? What innovations should we think about here?

Ms. BELLA. Sure. I appreciate the question. Unfortunately, there is no silver bullet, and the savings tend to happen over time. However, if you think about—I think where we think holds the most promise is understanding how do we create systems that are accountable and coordinated for the 9 million dual eligibles. There are, by our count, around 100,000 people that are in fully integrated programs, and by fully integrated, I mean, there is an accountability for both Medicaid and Medicare. So the opportunity is large for the rest of the dual-eligible population, and absent that coordination and integration, we are not as aligned and efficient and effective as we could be. And so great opportunity exists to look at delivery system and payment reform models that understand how to create a way to take care of the totality of a bene-

ficiary's needs and how to ensure that the incentives are aligned for doing so.

Mr. UPTON. Well, can we actually come up with some nuts and bolts to see not only the innovations but then lead directly to some savings, and if so, what would the savings be either as a percentage or real dollars?

Ms. BELLA. So as was mentioned, one of the first things we did is to engage States in a partnership to work with us in an innovation center to design new fully integrated models. So we have 15 States. That is exactly what we are doing. We are working with them to design the nuts and bolts of what this would take. We are in the design phase so we don't have savings estimates for you at this point. Certainly we can expect that there are opportunities, as I mentioned, in some of the avoidable hospitalizations, but we also have seen in programs in the States that do have them oftentimes there is an increase before you see a decrease because there is a lot of pent-up demand, there is care management that is occurring, there is new services that are taking place in order to reduce other services now or down the road. So it needs to balance out, but what we will be working on getting some concrete estimates over time by working with our States on the models that they would like to do.

Mr. UPTON. So as you are looking at those 15 States, how long will it take for them to complete the work that they are doing and you can actually look at some accountability in terms of what they have done?

Ms. BELLA. The way we structured this demonstration initiative right now is that it is a 12-month design period. It doesn't mean that States that can't submit a proposal earlier.

Mr. UPTON. Which started when?

Ms. BELLA. April.

Mr. UPTON. April?

Ms. BELLA. It started in April. Several States are interested in putting something forward earlier, and as I mentioned, all States are able to put proposals together, we are just working with these 15 to receive funding, so States aren't—like I said, they can come in sooner with ideas. We designed this, because this isn't a typical CMS demonstration where we are prescriptive about what we want to see because that hasn't worked for us with the States so far, so we need to work with the States to design what is going to be most effective for each of them. However, this is a complex population and we have to do this in a way that makes sure that we are addressing significant issues around beneficiary safeguards, provider participation, financial incentives correctly, and that is why we have designed it in a design phase.

Mr. UPTON. Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman.

There is an interaction between the issues we are talking about today and the Medicare Advantage program is a complicated one. Some Medicare Advantage special needs plans have been around for a long time and built deep roots in their communities. Others

have less successful track records and of course the program has for a long time been supported by large subsidies provided by taxpayers and other beneficiaries. The Affordable Care Act pared back many of the extra payments to Medicare Advantage plans but not all of them and not immediately. I was surprised to find that some States are proposing to use Medicare Advantage benchmarks as the basis for their proposed payments in the duals integration demonstration. Ms. Bella, wouldn't the use of Medicare Advantage benchmarks increase costs to the federal taxpayer if they were adopted for duals integration demonstration?

Ms. BELLA. We certainly think that—as I mentioned, our goal is to get more beneficiaries served in integrated systems and so in integrated systems there is an opportunity to achieve savings. You are obviously pointing out what we all have seen in terms of the differential and the MA rates, and I would just come back to that the purpose of the innovation center is to develop and identify delivery system and payment reforms that improve quality and reduce cost, and so as we go forward with these demonstrations, that is going to be our overriding principle, so we will work with States to ensure that the proposals they are putting in place do both of those things, which would mean understanding how we would address the rate issue in a way that would support improving quality but not add cost to the system.

Mr. WAXMAN. Well, we want to highlight that issue to look at carefully in your design of these proposals. There are numerous cost savings with regard to the Medicaid program that shift costs from the Federal Government to the State governments instead of lowering cost. The intent of this hearing and the mission of the Medicare and Medicaid Coordination Office is to improve care for dual-eligible individuals, thereby lowering health care costs in Medicaid and Medicare, a better way of saving money than shifting responsibility.

I want to ask about some of these contracts you have been talking about in response to other questions. You recently awarded to 15 States to design coordination care models. One requirement you included was integrating care across primary, acute, behavioral health and long-term support services. Can you discuss the importance of integrating care across all these benefits, the barriers to integrating care across all these benefits and how prevalent such full integration is today?

Ms. BELLA. Sure. The importance is to get at exactly what you talked about, the opportunity to cost-shift, so we need to mitigate or eliminate those opportunities, for example, if we have acute care in one system and long-term care in another system. But more importantly, if we are going to put together systems of care that are better for real people that need them, we have to provide a seamless way of them interacting with the system rather than three different cards, three different doctor networks, three different grievances and appeals, and I say three because most of the duals are in separate Part D plans so they are navigating Medicaid, Medicare and pharmacy coverage. So that is the importance of putting everything together in a way that is seamless to them.

The challenges are many. There are certainly always—whenever you change a system, there are concerns. We have concerns with

capacity, with provider capacity, particularly in the long-term supports and services side. We have carve-outs in some States, particularly around behavioral health, so all those issues that we need to address, but the opportunity is great, and one of the reasons these States were selected was because they are committed to providing full integration. As I mentioned earlier in response to another question, we think only about 100,000, maybe 120,000 folks have fully integrated models. You will hear about one of those today with the PACE program. But again, our goal is to create those types of systems for significantly larger numbers of Medicare and Medicaid enrollees.

Mr. WAXMAN. As you move forward in developing these new systems for dual-eligible beneficiaries, I think it is critical that you hear from the individuals and their family caregivers and get their input into the process to ensure that any new approaches are simple enough for these individuals and their caregivers to navigate, protects the rights currently guaranteed to beneficiaries in Medicare and Medicaid while also meeting their health concerns. How will your office ensure that we get these voices heard from the patients and the caregivers?

Ms. BELLA. Well, first of all, we share your commitment and your interest in doing that. We are very vigilant with the States on the expectations in terms of stakeholder engagement. We have gotten wonderful input from different consumer advocacy organizations about how to ensure that is meaningful. We are doing focus groups of real dual-eligible beneficiaries around the country so hearing from the real people about what is working and what is not working, why did some choose integrated systems, why did others not, and so those types of conversations really will be informing and driving our efforts.

Mr. WAXMAN. Thank you very much. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the subcommittee vice chairman, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

In the section of the Affordable Care Act that you referenced that creates your office, there is paragraph E says the Secretary shall as part of the budget submit to Congress an annual reporting containing recommendations for legislation that would improve care coordination and benefits for dual-eligible individuals. When should we expect that report?

Ms. BELLA. So our office was officially created December 30th through the Federal Register and so we missed really the typical budget cycle. In February the Secretary submitted a letter outlining the progress of the office to date, committing to our priorities over the coming year, and now that we are established we will get caught up on the regular cycle and provide you that annual report as part of the annual budget process as the mandate requires.

Mr. BURGESS. So when should we expect to receive that report?

Ms. BELLA. Next year.

Mr. BURGESS. Next year, January, next year——

Ms. BELLA. Next year, February of 2012.

Mr. BURGESS. It is just interesting, in the law that was signed your office was created not later than March 1, 2010. It is always

interesting how something can be created 3 weeks before the bill got signed into law.

Let me ask you a question. In January, Dr. Berwick was at the Commonwealth Fund symposium that they put on every year, and of course, he articulated this problem, and I think he was a little more dramatic. He said 20 percent of the beneficiaries are costing 80 percent of the money including blind and disabled in that group as well. But that was a pretty startling figure that he related. Now, another Member of Congress who was there, and I can't take credit for this, it was actually a Democrat who complained that American health care was so complicated that he had to go out and hire a concierge physician to manage his care between the two coasts on which he lived, and so I asked Don Berwick, why wouldn't you have a concierge doctor for a dual eligible. It seems like it would make a lot more sense to pay a physician to manage these conditions. I have got some figures from 2005 where it is $26,000 a year that we spend on a Medicare/Medicaid dual-eligible patient unless they have five or more conditions in which case that cost doubles. It seems like there is some significant efficiencies that could be gained here through the integration of that care, whether you call it a retainer physician, whether you call it integrated primary care, but really putting the doctor and not the agency and not a home health aide, putting the doctor in charge of that patient and holding them accountable, of course, to perform its metrics that you outlined, the alignment, the data and the models and demonstrations. Why not do that?

Ms. BELLA. I don't think these things are mutually exclusive. I think there are opportunities depending on what is driving a beneficiary's needs. Some of them are less medical. They are non-medical and so in those cases it does make more sense to have a care manager, a behavioral health specialist or a home health aide.

Mr. BURGESS. But why not have a physician in charge of all of those facets of care?

Ms. BELLA. There are certainly models that do that, and you may hear a little bit about those on the second panel. There are a lot of medical-home initiatives underway right now which the primary purpose is to support the physician and provide infrastructure support so that the physician is managing the totality of the care and is accountable for the financing, so I think there is a lot of promise for many of those models and several States are exploring those very things.

Mr. BURGESS. Well, forgive me for seeming impatient. I think there is a lot more than a lot of promise. I think there is a deliverable that could be obtained really in a much shorter time frame than anything we have heard discussed here this afternoon, and we are talking about enormous amounts of money. We are talking about people's lives, people who are medically fragile, whose care is of utmost criticality to them and to their families, and I simply cannot understand why we wouldn't move with greater dispatch. We are going to have to wait another year for a report from your office. I mean, these are things that should have been in the works for some time.

Ms. BELLA. Certainly, developing new delivery system and payment models is first and foremost on what we are doing. We are

happy to come over and do briefings at any time, and we have done that repeatedly with several staffs. And the only other thing I would say is, again, it is not that we are not advancing physician-directed medical-home-type models but we are also looking at different types of care models, some of which are less expensive and perhaps better tied to a beneficiary's needs, which again would I think advance what you are charging us to today, which is control cost.

Mr. BURGESS. Well, you do get what you pay for. You know, the experience with the accountable care organization rules and regs that came down is just so disappointing. So many people had placed so much emphasis on this and so much importance, and then to find the reg was absolutely unworkable, that clinics who actually considered themselves accountable care organizations said we can't do this, and I worry about the same thing happening in this population where it is so critical that we get it right.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Welcome. We are glad to have you here. Realizing that the Medicaid expansions in the health care law do not in totality affect dual eligibles, do you believe that the expansion of Medicaid—and I know you mentioned this woodworking aspect—do you fear the woodworking aspect with the expansion of Medicaid under the health care law?

Ms. BELLA. We don't, no.

Mr. SHIMKUS. The latest MedPAC report included a chapter on dual eligibles. In its report, the commission noted that a single program design is not likely to be adopted in every State. They added, there is no clear evidence about which programs are most effective for every type of dual-eligible beneficiary. Do you agree that a one-size-fits-all strategy for improving the coordination and integration of care for duals is a bad strategy?

Ms. BELLA. We think it is very important that we recognize that there are different delivery system designs in the States, and if we are going to be effective, we have to work with States to understand what systems are going to work best for a given State, and honestly, for a population within that State.

Mr. SHIMKUS. And following up on that, do you believe that mandatory enrollment with an opt-out policy would increase enrollment?

Ms. BELLA. As we discussed a little bit ago, enrollment is obviously a significant issue. We don't have as many people in these types of systems as we would like to today so it is one that we are exploring to understand. It is one that we are learning from in the focus groups as well to understand what it is that is holding back enrollment, and that is one of the things that is part of this design process in our work with both States and stakeholders.

Mr. SHIMKUS. And part of the problem in obviously the Medicaid, the dual eligibles, the Medicaid and Medicare, is that the 50/50 share of Medicare and the ownership that the State has versus Medicare, which is the federal program, and, you know, the contention is or the fear that some States may not be motivated to help solve this based upon depriving them of the 50/50 share if Medicare

is assuming more of a role, or a role. Can you talk me through that and your experience in talking with States and whether this might lend itself to a sharing of Medicare as part of this debate of how you have inclusive care?

Ms. BELLA. Sure. Our work with States highlights that an area that creates challenges is the misalignment of incentives between the Federal Government and the States. The governors have said that. NGA has said that. MedPAC has said that. This Administration recognizes that. So that is part of our work with States is to understand if we are going to get this right, we have to look at how we align the incentives to create systems of care that are better than we have today.

Mr. SHIMKUS. And I will just end on this, and again, I appreciate your time and look forward to the second panel. Illinois in particular is a struggling State, as many States are, but we have a $12 billion debt. A lot of it is due to the expansion of Medicaid without comparable increase in revenue by the State and so it just was borrowed money and the like. Under the health care law, which leads back to the first question, it actually increased enrollment for Medicaid versus over the very lucrative program the State has. That is why I would argue that there should be a concern about more people coming out into the arena based upon the expanded benefits, and I would hope that you all would take a closer look at that because I do think that is going to be additional liabilities for us that we are not calculating in costs today.

Thank you, Mr. Chairman. I yield back.

Mr. BURGESS. Would the gentleman yield?

Mr. SHIMKUS. I would yield to Dr. Burgess.

Mr. BURGESS. Can I go back to the integrated care question that I was talking about just a moment ago? So what is being done right now as far as making families aware of the availability of integrated type of care?

Ms. BELLA. It depends on a given State and a given health plan so there are opportunities to inform beneficiaries and their caregivers of integrated care options either through State efforts or through health plan efforts.

Mr. BURGESS. Is anything being done to enroll people in integrated care programs?

Ms. BELLA. Certainly, but there are two different enrollment processes, one for the Medicaid half of the person and one for the Medicare half of the person.

Mr. BURGESS. But the estimates I have are less than 2 percent of all of the dual eligibles are in some type of integrated care program.

Ms. BELLA. Correct.

Mr. BURGESS. And yet the promise these types of programs hold is high. Maybe you can get back to me with some additional information on what is being done to foster that information.

Ms. BELLA. I would be happy to do so.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes for questions.

Mr. LATTA. Well, thanks very much, Director, for being with us this afternoon. I appreciate your time.

Just a little background because I didn't see, where were you director at?

Ms. BELLA. Indiana.

Mr. LATTA. And how long were you the director in Indiana?

Ms. BELLA. From 2001 through 2005.

Mr. LATTA. I always like to find out a little bit about a person's background because sometimes it is good to see things from the other side of the fence. I was in the State legislature in Ohio for 11 years, and during that time we had our go-arounds, especially with the cost of Medicaid going up, what it is costing the State budget today, and so I am glad you have that experience.

And not that I wasn't fascinated with all of your testimony but something struck me on page 4. In the second paragraph when you are talking about coordination of the offices, the one thing that really caught my attention was the seamless care, and I know that years ago when was in the legislature, I had been a county commissioner for 6 years prior to that, we had an individual in the county that we had a lot of problems trying to get to the right service, to the right place, and I was very proud of my home county in that we worked things out, and how we termed it was "seamless." And the reason I find that interesting is that how is it that it has taken this long for us to get to this point that after decades that we are finally starting to talk about seamless and then also in your testimony talking about the offices working to improve the collaboration and the communication out there. And again, I think that goes back that you have seen things from the other side of the fence that, you know, for decades States have been on the receiving end of things and the Federal Government is saying one thing and the State is saying, well, how are we going to get this done. So I will just ask you that.

Ms. BELLA. Well, a few thoughts. I mean, when these programs were created, I don't think it was ever envisioned there would be 9 million people eligible for both and so they work exactly as they were designed to work, which is completely separately, and we haven't had the resources to date committed and accountable for trying to put them together and create seamless systems, and you all fixed that by creating this office, and so I think it is a recognition. Oftentimes it seems to be the most difficult fiscal times that drive some good developments that could help real people and coordinate care, and that perhaps is what we are seeing today is one of the greatest advantages of having to realize where we need to focus is on this population and so we now have a group of people that is all we do, and so we are accountable for making that better and working with our State partners to do so.

Mr. LATTA. Let me ask this, if I may because, you know, I hate to say it this way, but we do have some established bureaucrats in this city that have been here for a while, and in listening to your testimony and answering the questions to other members with us today, you know, that you are talking about doing focus groups around the country, that you are going to be listening and that, you know, there is no one size that fits all because, again, like the State of Ohio is completely different than what is happening out in Idaho or you name it. But I think it is going to take the direction from you as someone that has seen it from the other side to really

impose upon these individuals down here that there is something that occurs outside this beltway. I have folks back home ask me, I don't care what it is about, they say don't they understand what is going on back here, and it is very difficult to always have to tell them no. And so we are going to be looking for your guidance to make sure that these folks down here that have been here for a while understand that they do have to take that direction from you, that you are going to be listening, that you are going to have these focus groups to find out what works best.

So with that, Mr. Chairman, I appreciate the time and I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Thank you, Ms. Bella. I appreciated our phone conversation a little while ago and I appreciate your testimony today.

Now, I have been trying to figure out, you mentioned the buckets of dual eligibles, and the partial duals versus the full duals, the full duals with the wraparound, and I gather the full duals may have custodial care paid for by Medicaid but medical services paid for by Medicare, and the partials will the deductible copay paid for by Medicaid. What percent of patients who are duals are in each bucket, and what percent of the expense of duals are in each bucket? Because clearly wherever—and then what are the medical outcomes of each bucket? Because clearly, if we have poor outcomes and higher expense for that more expense and poor outcomes in a bucket, that is where we should focus our attention, yet it seems as if it should take two different approaches.

Ms. BELLA. So the biggest bucket would be the full duals who are receiving all Medicaid services and Medicare services——

Mr. CASSIDY. Not to be rude, but just so I understand, so really, in the full duals, there is not that much that Medicaid is paying for for acute medical services, I gather; rather, they are paying for the custodial care. Is that correct?

Ms. BELLA. They are paying for largely the custodial care. They wrap around and provide some things like behavioral health services or home health, in cases where Medicare—it is wraparound acute. It is the wraparound for the cost share for the duals and then it is primarily the long-term care service and support.

Mr. CASSIDY. OK. So then if we can differentiate how much the Medicaid dollar is going for custodial versus those medical services which Medicare does not pay for, do you all have data on that? Because I am gathering that most of the expense is in custodial care which is relatively——

Ms. BELLA. I would broaden it to call it long-term care supports and services just because people tend to think of custodial as an institutional base. So 70 percent of costs are in the long-term care bucket, if you will, for those folks.

Mr. CASSIDY. For the full duals?

Ms. BELLA. Yes, but again, that is not just the custodial care.

Mr. CASSIDY. So then if you separate out—oK. Medicare and Medicaid together, the duals are a higher percent relative to a cohort, a non-disabled cohort?

Ms. BELLA. Yes.

Mr. CASSIDY. OK. So if you just look at the non-long-term-care costs for those duals, how does that relate compared to a cohort? Do you follow what I am saying?

Ms. BELLA. So on primarily their Medicare expenditures?

Mr. CASSIDY. Yes.

Ms. BELLA. Yes, they are still higher across the board.

Mr. CASSIDY. And is it as dramatic?

Ms. BELLA. It is fairly dramatic. I mean, if you think about they are qualifying people for both Medicaid and Medicare so they have not just the medical needs but they have a lot of psychosocial complexity.

Mr. CASSIDY. Now, let me ask you, we are going to hear about a PACE program, and I am very impressed with the concept of PACE but it is clearly not going to scale. I would like your perspective on why a program such as that is unable to go to scale.

Ms. BELLA. Well, PACE is designed for a very frail population, so a couple of things: One is, PACE is for people who are 55 or older and you need a nursing facility level of care, so again, that is a very, very frail population.

Mr. CASSIDY. But that must be your highest expense population?

Ms. BELLA. It is a high expense, although—yes, it is a high expense.

Mr. CASSIDY. And there must be a heck of a lot more than 20,000 people or 100,000 or whatever.

Ms. BELLA. There are opportunities that Shawn will discuss, and they have been thinking about to get something that is available to more people in more States. It tends to be resource-intensive to get some of the programs started but it has very fundamental concepts that we want to replicate.

Mr. CASSIDY. Well, I accept that, it has got great concepts, and say this not to diss but rather to say—that is disrespect—but rather just haven't gone to scale.

Ms. BELLA. Yes. He is going to get into a lot more, but I would be happy to have another conversation with you offline.

Mr. CASSIDY. The ACO rules which are just, I mean, place great faith in supercomputers to contact, to follow different patient interactions, physician interactions I almost see as counterproductive. Have you read the ACO rules and thought about how they are going to apply to dual eligibles?

Ms. BELLA. I have to be honest, I haven't read every single page. I have read a majority and have been thinking about how do you take that model for folks that have long-term care, not just acute-care needs, and that have different funding streams, both Medicare and Medicaid, and make sure that we are creating a system that again doesn't provide opportunities——

Mr. CASSIDY. I understand that is what your approach is but what I have just gathered from you, most of the Medicaid expense is actually on the long-term care aspect of it and the ACO is going to be principally on the acute medical services. In that way, the ACO still doesn't dictate or assign or anything else, it just follows. I think you answered the question. The following, it still seems like that is what we have now. You are just merely following and paying a lot of money for this coordinated care.

Ms. BELLA. We are excited about the opportunity to work with our States. Again, we are thinking about how do you adapt more of a managed fee-for-service approach that has an accountability like an ACO that brings in the long-term care side for this population.

Mr. CASSIDY. Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Kentucky, Mr. Whitfield, 5 minutes for questions.

Mr. WHITFIELD. Thank you, Mr. Chairman, and Ms. Bella, thanks for being with us today.

When the Affordable Care Act was passed, the method used in passing it created a lot of animosity, much of which is still out there, and I am assuming that you were not even working at CMS when it passed, but the method used, for example, when it was on the House Floor, this bill was 2,500 pages, whatever it was, we were not allowed to even offer one amendment. So I contrast that sort of process to deal with a complicated health care delivery system that has a lot of problems with what you are doing in your coordination office in which you are giving $1 million to 15 different States for the purpose of allowing them to explore, be innovative and see if they can come up with a system that works so it could be replicated in other States, which I think is commendable. But that same suggestion has been made for Medicaid regarding the grants to the States. A lot of controversy in the Republican budget was, we will have a capitated system for Medicaid.

My question would be, don't you think that there would be some merit in working out a system so that individual States on Medicaid could explore, be innovative? I know we are not talking about dual eligibles per se but the Medicaid program. Do you see any benefit by setting up a system that would work like that?

Ms. BELLA. We are really kind of singularly focused on setting up coordinated and accountable system for dual eligibles and making sure that there are beneficiary protections, access to care and funds sufficient to provide care in such a way that eventually helps with the cost conundrum.

Mr. WHITFIELD. But at least you all are doing that with 15 States, so I think that is a good idea.

I would like to yield the balance of my time to Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Whitfield.

If I could, let us just go back the fact that the spending per dual eligible in 2005, $26,000, unless they had five or more conditions in which case it doubled to $50,000. Obviously more medical conditions are going to cost more but it seems like that amount is greater in the dual-eligible realm than it is for the comparable Medicare patient with five or more chronic conditions. Is that a fair statement?

Ms. BELLA. Across the board, dual eligibles rate higher than Medicare-only beneficiaries, yes.

Mr. BURGESS. So is that increasing cost only because of the cost of long-term care or is there something else that is entering into that? What accounts for that cost differential?

Ms. BELLA. Well, this is a much more complex population and so the needs that they have and the way those needs translate into utilization of services is what drives cost. I mean, across the board,

again, this population is poorer, sicker, more impaired than any other population.

Mr. BURGESS. Correct, which is why my anxiety about not having a knowledgeable medical person in charge of orchestrating all aspects of that care, if you don't have that, then you are going to get what you have got, and the last thing we want is more of what you have got because we haven't got any more to give to pay for what you have got. Do you follow me? I mean, this is so critical that we have the knowledgeable medical person in charge and responsible for that patient's care. The elderly patient in the nursing home doesn't just get a urinary tract infection, they get urosepsis, and they come into the hospital and they die after five days of intensive therapy. The outcome is just absolutely dreadful and it costs a lot of money. Someone to be able to anticipate that and prevent that is literally worth their weight in gold in that situation. Is that not correct?

Ms. BELLA. We are trying to create systems where there is an accountable care team and an entity that is——

Mr. BURGESS. You don't need a team, you need a person. You need one person to be accountable. I am sorry, I am old school. I am a doctor. In the old days, there was one person in charge and accountable.

Mr. Chairman, against my better judgment, I am going to ask that this Ezra Klein article from the Washington Post from June 16th be entered into the record. Only about half of it is accurate but the part that is, is so accurate that I think it is worth sharing with our colleagues and the general public.

Mr. PITTS. Without objection, so ordered.

Mr. BURGESS. Thank you.

[The information follows:]

Better Medicaid coordination would cut costs, help the most seriously ill

By Ezra Klein, Published: June 16

White House officials strongly object to the notion that they're going to sign on to a deficit deal that makes its main cuts in Medicaid. But they don't deny, and in fact endorse the idea, that Medicaid will come in for some cuts. So I spent much of a day asking health-policy experts the same question: If you need to cut Medicaid, how would you do it?

One way is to simply cut spending on the program. That's the approach you see in the Republican budget. Currently, the federal government contributes to Medicaid based on need. That means spending goes up if there's, say, a massive financial crisis that knocks millions out of work. But Republicans want the federal government to tie those contributions to a formula that's unrelated to need and, in fact, grows more slowly than health-care costs. And that would work. You can spend less by spending less. But it'd mean the program either needs to cut benefits for children, the very poor and the very old and disabled, or kick some of those people off Medicaid entirely. That is to say, it shifts costs rather than controlling them. And we need a better solution to Medicaid than simply "less of it."

Indeed, one of Medicaid's problems is that it is, if anything, too cheap. It pays doctors much less than private insurance or Medicare. The result? Doctors don't like to take Medicaid patients. The New York Times reported Thursday on a study in which researchers called doctor's offices to schedule appointments for children with conditions like "diabetes, seizures, uncontrolled asthma, a broken bone or severe depression." When the researchers said the children were covered by private insurance, all but 11 percent got an appointment. When they said the children were covered by Medicaid, two-thirds didn't get an appointment.

"In some cases," says Len Nichols, director of the health-care policy program at George Mason University, "we would do better if Medicaid paid more. If we could get more doctors to treat the expectant mothers on the program and give them better care, that'd reduce the really expensive stuff from the neonatal intensive-care units. And when you look at that study in the Times, notice that the kids were waiting for specialists. That's a disaster. If the primary care doctor has sent you to a specialist, that means you've got a problem they can't solve. And if you have to wait, it festers."

You don't need to be a deficit hawk to worry when an 11-year-old's seizures go untreated. But if you are a deficit hawk, you should be particularly worried. Continually sending the paramedics out is really, really expensive. Worse, it's wasted money: A dollar spent keeping a kid healthy and learning is worth a lot more to our economy than a dollar spent stabilizing kids after they become unnecessarily sick.

Though sometimes better care costs more, at least upfront, sometimes it costs less. And the various experts I consulted believed there was one big opportunity for saving money in both Medicare and Medicaid: the "dual eligibles."

These are the people who are so sick and so poor that they qualify for Medicare and Medicaid. Typically, Medicare might cover their hospital costs, but Medicaid will cover their long-term care. And they are really, seriously, no-joke expensive. They account for 40 percent of Medicaid's spending even though they make up only 15 percent of its members, and if you add in Medicare's spending, you're looking at more than $200 billion a year for this group alone.

But expensive care isn't necessarily good care. These people are often disabled and in no real shape to navigate multiple government and medical bureaucracies. There's little coordination among their various doctors and hospitals and nursing homes. If their cases were managed better, they'd cost a lot less and the people would be a lot healthier.

The problem is that although coordinating their care could save us many billions over time, it's hard to do. You can't just tell the Congressional Budget Office you're going to try really hard and expect it to score your efforts as reducing the deficit by $40 billion. Worse — at least from the perspective of budget negotiators looking for new savings — a lot of the best ideas were in the Affordable Care Act. The law even set up the Federal Coordinated Health Care Office to oversee the effort. That office, says Edwin Park, a Medicaid expert at the Center on Budget and Policy Priorities, "is now sending out grants to states to test new delivery system models for the dual eligibles." So how soon can we expect to see some savings? Park doesn't sugarcoat it. "This will take a number of years before we know exactly what models work."

There are, of course, other places where we could plausibly eke out a few billion here or there. The administration says its budget proposal would save $100 billion over 10 years, and the costs would fall on drugmakers and providers rather than the disabled and the very poor. There was some skepticism among the experts I consulted as to the administration's ability to achieve those savings, but in the long-run, whether they'd really get $60 billion or $100 billion is almost irrelevant.

Nothing that anyone has proposed will be sustainable if we can't figure out a way to care for Medicaid and Medicare's sickest patients in a most cost-effective way. Shifting costs won't work because we're too decent a nation to let these people die in the streets. Taxing providers or further lowering reimbursement rates might buy you some time, but the savings will either be eaten up by cost growth or, if you cut too deep, be turned into cost shifting, as we're already seeing with the kids who can't get an appointment. In the end, it's really all about the tough, uncertain work of improving care, even if that work is hard for the CBO to score or the budget negotiators to tout. A serious commitment from both parties to work continuously and cooperatively on the dual-eligibles problem would be worth a lot more than the cuts and trims we're likely to see.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlelady from the Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and I thank you and the ranking member for allowing me to sit in on this important hearing, and I am particularly interested in being here because in the dual-eligible population, somewhere around 40 percent of that population are minorities, and so I hope, Director, that you are also working with the new Office of Minority Health to look at that subpopulation as you plan this coordination.

So the dual-eligible population disproportionately suffers from racial, ethnic as well as geographic disparities, and these are particularly pronounced in the end-stage renal disease population. There has been a successful, I think, completion of a 5-year coordinated care demonstration for end-stage renal disease patients, and what are your thoughts about expanding this demonstration to the dual-eligible population? Is this something that your office can work with others to implement?

Ms. BELLA. Well, we are certainly interested in looking at all demonstration opportunities that could be tailored to the dual-eligible population for different subsets of the population so it is certainly something that we can go back and discuss further with our colleagues.

Mrs. CHRISTENSEN. I think it might prove helpful, especially since end-stage renal disease, I am sure, accounts for a lot of the cost that Medicare puts out.

Also as a provider, like Dr. Burgess, and having worked with AmeriHealth Mercy family of companies, which is one of our country's largest Medicaid managed care plans to help understand some of the challenges, I understand that under current regulations, services provided to Medicaid health plan enrollees by institutions are not counted in determining payments to providers and this results in fragmented care because states often choose not to enroll these populations into Medicaid health plans or they carve out provider services from the plan's benefit coverage. Are you familiar with this problem and barrier to enrollment or expanding enrollment and are there any plans to address this?

Ms. BELLA. It is certainly something that we have heard from some States and some plans, and again, kind of taking that list of everything we have to begin to understand and figure out how we are going to address greater opportunities to promote alignment. That would be part of what we have on that list.

Mrs. CHRISTENSEN. Just one more question. Ms. Hewson from Community Care of North Carolina in her testimony, one of the things she notes is that programs targeting at-risk pre-duals may, you know, be something to really start looking at, not only for the care of those patients, better care of those patients, but also for the larger budget impact. Is this something that the office is working on?

Ms. BELLA. Absolutely. There is a huge opportunity with the pre-duals, particularly preventing their decline or their spend-down of resources and being smart about how we can make an investment on the front end and prevent migration into dual status. So yes, it is something that we are looking at.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady.

Mr. PALLONE. Mr. Chairman, could I ask unanimous consent that Mr. Markey be allowed to participate in the subcommittee today?

Mr. PITTS. Without objection, so ordered. Do you want to ask questions of this panel?

Mr. MARKEY. If you don't mind, Mr. Chairman.

Mr. PITTS. All right. The chair recognizes the gentleman for 5 minutes for questions.

Mr. MARKEY. I thank you, Chairman Pitts and Ranking Member Pallone, for holding this hearing, and I would like to thank Melanie Bella for helping to lead the charge at CMS to improve care for 9 million patients who by definition are the sickest, poorest, costliest individuals covered by either Medicaid or Medicare. The landmark health care law included language that I authored to create a pilot program called Independence at Home to address the unique needs of Medicare patients who have multiple conditions including Alzheimer's, Parkinson's, et cetera. Caring for these patients is disproportionately expensive yet this population often receives substandard and uncoordinated care that products conflicting diagnoses and confusing courses of treatment. Further, many of these individuals wish to remain at home rather than nursing homes or hospitals and they could do so if they were given some help. The Independence at Home program gets at the root of the problem by creating teams of health care providers who will work together to coordinate care for these patients and provide primary care services at the patient's own home. If they succeed in lowering costs beyond 5 percent, the providers will share in the additional savings, so there is a stake in lowering costs to the system.

It seems to me that Independence at Home could also help us improve care for the patients who are eligible for both Medicare and Medicaid by integrating health care services provided by Medicare with long-term supports and services provided by Medicaid. For years we have seen the success of Independence at Home-style programs at more than 250 VA locations and elsewhere throughout the country. The VA programs have reduced nursing home care by 88 percent and reduced overall costs by 24 percent on the highest cost, chronically ill patients all while achieving record-high patient satisfaction rates. ElderPAC, which has been operating this style of program for the dual population, shows savings to the Medicaid program of 23 percent over the past decade.

So let me as you this, Ms. Bella. In light of the fact that the Independence at Home model has proven successful in lowering costs and improving outcomes among some of the most challenging Medicare patients. Don't you agree that your office should look at expanding this model of patients that are eligible for both Medicare and Medicaid?

Ms. BELLA. Well, first of all, we thank you for your leadership and support on this issue. We are very committed to models that allow dual-eligible beneficiaries to stay at home with supports. We are in discussion with our colleagues about the Independence at Home demonstration. As you know, it is still in development. It will be available the first of 2012 and we are looking for opportuni-

ties to make sure that it is in the mix of models that could be considered for dual eligibles.

Mr. MARKEY. Is there in your experience a reason to believe that this is a good way of looking at how we keep these Alzheimer's and other patients at home longer and save the system money because they don't have to go to nursing homes?

Ms. BELLA. Certainly we are very interested in models that allow individuals to stay in care preferences of their choice and that are also cost-effective and so we do believe a model like this holds promise. Again, we look forward to understanding how we can adapt that in our work with States and others as we develop new delivery system models.

Mr. MARKEY. And do you think that it makes some sense to incentivize the health care providers that they make money if they can figure out ways of saving money by keeping patients at home? Do you think that that will incentivize them to think anew about how to take care of these patients?

Ms. BELLA. Well, we always want to make sure that there is appropriate beneficiary safeguards in place and that people are getting the services that they need, but opportunities where we know that there are opportunities to align incentives, it certainly is a direction that the agency has been heading in terms of being able to do some performance-based outcomes payments.

Mr. MARKEY. You know, I did that bill in conjunction with the Alzheimer's Association. As you know, there are 5 million Americans right now with Alzheimer's and 15 million baby boomers are going to have Alzheimer's, so it is obviously important that there be a plan that coordinates with families, you know, who are the principal caregivers so that they can have the maximum amount of help at home, because once they go to a nursing home, it is $60,000, $70,000 a year on Medicaid, you know, for those families, so this is just a program that obviously meant to help keep them at home, save the system money, make the families happier and the patient as well in a setting where they would feel more comfortable, so we thank you, and I would like to continue to work with you on developing that program.

Ms. BELLA. I would be happy to do so.

Mr. PITTS. The chair thanks the gentleman. That completes round one of questions. We have one follow-up. Dr. Cassidy.

Mr. CASSIDY. Ms. Bella, I should know this and I don't, and I apologize, but you mentioned a couple times that mental health issues are going to—you know, it is an independent variable, it sounds like. You do a retrogression analysis and it comes out mental health is a big issue. So a couple questions. Is this related to addictive disorders or is it related to, if you will, classical mental health issues, number one, you know, paranoid schizophrenia, for example. Is the issue that they are noncompliant with medical services and are going in and out with poorly controlled comorbidities or is the issue that they are going in and out with mental health admissions? And clearly, it seems as if that would be something that a wraparound managed care organization could theoretically improve outcomes and strengthen stability of the programs' finances. What is the track record of such programs?

Ms. BELLA. Let me try to take your questions in order. So the first, I mean, when we think about the folks that have behavioral health issues, it is mental illness, it is also substance use. There tends, as you know from treating patients, there is a higher prevalence of substance use in folks who——

Mr. CASSIDY. So that is a third category, if you will, combined?

Ms. BELLA. But you have the serious mental illness, schizophrenia, bipolar, and then you have folks that have depression and other symptoms. Clearly the utilization is different for those populations. What drives part of the trouble is there tends to be a disconnect in the physical and behavioral health systems, as you know, and a real lack of information sharing so that one half doesn't know what the other half is doing with regard to this patient, and again, as a practicing physician, you can understand why that would be so detrimental because the effects of——

Mr. CASSIDY. And again, that is why it just seems like managed care would be custom made, that this is where it would integrate and bring things together.

Ms. BELLA. Certainly. I mean, there's been different—States have tried different approaches. Some have given responsibility for everything to a health plan. Some have carved out behavioral health services to a health plan while physical health services have stayed in fee-for-service or sometimes physical health services have gone to yet another health plan. So there tends to be different mechanisms States have tried. There also have been a couple of really great pilots, one in Pennsylvania, that it was within a fee-for-service system but what they focused on was sharing information and aligning incentives between the physical health and the behavioral health world, and that made a huge difference.

Mr. CASSIDY. That was not managed care, that was just—there must have been some integration between the practice groups.

Ms. BELLA. There was management on the behavioral health side and it was fee-for-service with PMPM overlay on the physical health side but no structural or organizational integration, if you will, and it all got down to really understanding, making sure all people involved in that care had a clear picture of what the beneficiary was getting on both sides.

Mr. CASSIDY. Now, they couldn't have been doing that with Medicaid rates. They must have been paying Medicare rates to providers, correct? Because that would be time-intensive to transfer that.

Ms. BELLA. It was time-intensive. They had some outside support during the pilot phase but also they got smarter about how they delivered care. They used other types of practitioners. They did a lot with peer support specialists, and the cost dynamic is different when you——

Mr. CASSIDY. Do you have an analysis of that you could share with us? Because I think it is very intriguing.

Ms. BELLA. I am not sure that any final sort of journal-ready analysis has been published but I would be happy to share with you what has been done to date and certainly some descriptive analysis and the metrics that they are using.

Mr. CASSIDY. Sounds great. And my second question, which was, since we went to the third, is the increased expense due to multiple

admissions for mental illnesses, for the paranoid schizophrenic, for example, or is it noncompliance with medical illnesses so it is bouncing in and out because their diabetes is poorly controlled, for example?

Ms. BELLA. It is hard to generalize. I mean, both, but clearly two things that both could be improved with integrated, coordinated and accountable systems.

Mr. CASSIDY. Do you have any idea of the—that will be a follow-up question at a later time, but I would be interested, again, I trying to understand which of this is compressible, long-term care is not as compressible, whereas perhaps this would be. What percent of the increased expense is related to this subgroup of populations, those with mental health and physical health issues simultaneously?

Ms. BELLA. We will call that our bucket analysis and we will work on getting you some analysis in those different categories across the board for the committee's consideration.

Mr. CASSIDY. Thank you.

Mr. PITTS. The chair thanks the gentleman. We have a follow-up questions from Dr. Christensen.

Mrs. CHRISTENSEN. Just a very brief question. As you know, the territories with Medicaid cap and not all of the help for Medicare either really have struggled to provide services for our dual eligibles so I just wanted to know if this process of coordination, if your office also looks at this issue in the U.S. territories.

Ms. BELLA. Our office is intended to be a resource for the States and the territories who are interested in improving care, so yes, we are available to work with the territories, absolutely.

Mr. PITTS. The chair thanks the gentlelady. That concludes panel one. The chair thanks the Director for her excellent testimony and yields to the ranking member for a unanimous consent request.

Mr. PALLONE. Thank you, Mr. Chairman. I would ask for unanimous consent to submit for the record the first report that Ms. Bella's office submitted to Congress as required by the ACA that one member, I think Dr. Burgess, was asking about.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

March 1, 2011

The Honorable John Boehner
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

I welcome this opportunity to provide you with an initial update on the early accomplishments of the Federal Coordinated Health Care Office, which was established by section 2602 of the Patient Protection and Affordable Care Act (Affordable Care Act). Pursuant to section 2602(e) of the Affordable Care Act, this letter reports on the steps that the Federal Coordinated Health Care Office has taken, and will take, to achieve the goals and responsibilities set forth in the Affordable Care Act. Although the Federal Coordinated Health Care Office is not currently making recommendations for legislation, it is anticipated that it will do so in next year's report.

The Affordable Care Act charges the Federal Coordinated Health Care Office with more effectively integrating Medicare and Medicaid benefits, and with improving the coordination between the federal and state governments for individuals eligible for both Medicare and Medicaid benefits (dual eligibles). While Medicare and Medicaid generally cover different populations, there are a significant number of individuals eligible for both programs. Since dual eligible beneficiaries must navigate the two programs separately, this can lead to the less than optimally efficient and effective provision of care for these beneficiaries. In 2008, 9.2 million beneficiaries were dually eligible for Medicare and Medicaid.[1] These dual eligible beneficiaries are among the most chronically ill and costly segments of both the Medicare and Medicaid populations, with many having multiple severe chronic conditions and/or long-term care needs. Sixty percent of dual eligibles have multiple chronic conditions.[2] Nineteen percent of dual eligibles live in institutional settings compared to only three percent of non-dual eligible Medicare beneficiaries.[3] Furthermore, dual eligibles account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs. Sixteen percent of Medicare enrollees are dual eligibles, but account for 27 percent of Medicare spending in 2006.[3] Fifteen percent of Medicaid enrollees are dual eligibles; however, these enrollees represented 40 percent of Medicaid spending in 2007.[2] Under the Affordable Care Act, Congress created the Federal Coordinated Health Care Office to – among other goals – improve the quality of, and access to, care for all dual eligible individuals. The Department of Health and Human Services (HHS) is committed to assuring these goals are met.

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[1] Data based on Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office of Research, Development and Information, July 2010.

[2] Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured. Kaiser Family Foundation, July 2010.

[3] Report to the Congress: Aligning Incentives in Medicare. MedPAC, June 2010.

In September 2010, the Administrator of the Centers for Medicare & Medicaid Services appointed a Director of the Federal Coordinated Health Care Office, Melanie Bella, who reports directly to the Administrator. A *Federal Register* notice establishing this office was published on December 30, 2010, and is enclosed for your reference. Ms. Bella is building a team with significant experience with this population, both within and outside of federal and state government.

Progress on Meeting Goals and Responsibilities

Under the direction of Ms. Bella, the Federal Coordinated Health Care Office has begun working to improve access, coordination, and cost of care for all individuals eligible for both Medicaid and Medicare through system transformation, innovation, and alignment of the administration, care delivery, financing, and quality measurement within and across the two programs.

Section 2602(c) of the Affordable Care Act delineated specific goals of the Federal Coordinated Health Care Office. Through all of its efforts, the Federal Coordinated Health Care Office is working to exceed these goals, including by addressing and improving beneficiary experience, access to care, quality of care, and cost of benefits for individuals with both Medicare and Medicaid coverage.

Pursuant to sections 2602(c)(5) and 2602(c)(7) of the Affordable Care Act, the Federal Coordinated Health Care Office is focused on eliminating regulatory conflicts and cost-shifting between Medicare and Medicaid and among states and the federal government. Sections 2602(c)(1)-(4) of the Affordable Care Act further charge the Office with addressing issues relating to quality of care and beneficiary understanding, satisfaction, and access under Medicare and Medicaid. The Federal Coordinated Health Care Office has been engaged in ongoing discussions with key internal and external stakeholders, including beneficiary advocates and provider organizations, as well as state Medicaid agencies. The Office has used input from these and other discussions to develop a comprehensive list of areas in which the Medicare and Medicaid programs have differing policy, regulatory, or statutory requirements or incentives which may prevent dual eligible individuals from receiving seamless, coordinated care. It has also begun to prioritize a list of opportunities to potentially align certain of these differences, so that we may begin to work on improving those that impact beneficiaries the most. It is committed to an open and transparent process, including: releasing a list of such alignment opportunities in early 2011; inviting feedback on additional items for inclusion and prioritization; and providing continual updates on its efforts.

The Federal Coordinated Health Care Office is also facilitating a collaborative effort across Medicaid, Medicare, and external partners to evaluate and promote the development of quality measures to better assess beneficiary access to care to reflect the unique circumstances of dual eligible individuals. The Centers for Medicare & Medicaid Services will engage partners in moving forward to review the availability of appropriate quality and access measures, and to assist in the development of measures which accurately reflect the quality of care received by dual eligible individuals. The partners will move forward in strategic development of such

measures in a manner that streamlines quality measurement across Medicare and Medicaid for individuals receiving care under both programs.

Section 2602(d) of the Affordable Care Act designated the specific responsibilities of the Federal Coordinated Health Care Office. In order to meet these responsibilities, the Federal Coordinated Health Care Office is working to provide states, payers, providers, beneficiaries, and caregivers with tools necessary for developing programs that align Medicare and Medicaid benefits for dual eligibles.

The first initiative in this area is the effort to provide timely Medicare Parts A, B, and D data to state Medicaid agencies for their dual eligible populations by spring, 2011. The Office would do so in a manner that comports with all applicable privacy laws and regulations and other statutory and regulatory constraints on releasing data. States have sought such data for years to better coordinate care for dual eligible individuals. The Federal Coordinated Health Care Office is also working to provide business intelligence tools for states that want access to analysis of Medicare data, but that do not have the capacity to integrate and process the Medicare raw claims or event data themselves.

The Federal Coordinated Health Care Office is supporting state efforts to coordinate and align Medicaid and Medicare acute and long-term care benefits. Partnering with the Center for Medicare and Medicaid Innovation ("Innovation Center"), the Federal Coordinated Health Care Office will award design contracts of up to $1 million each to up to 15 states working on providing seamless Medicare and Medicaid benefits to dual eligibles. The overall goal of this contracting opportunity is to identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other states. The primary outcome of the initial design period will be a demonstration proposal that describes the state's methods for structuring, implementing, and evaluating a model aimed at improving the quality, coordination, and cost effectiveness of care for dual eligible individuals. State responses were due February 1, 2011. The Centers for Medicare & Medicaid Services will award contracts based upon a number of factors, including overall approach to integrating care, state capacity and infrastructure, analytic capacity, stakeholder engagement, timeframe, and budget.

The Federal Coordinated Health Care Office is also working collaboratively with the Innovation Center to design unique opportunities for integrated care through payment and delivery system reform for dual eligible individuals. These provider-based demonstrations will complement the work underway in the Innovation Center on Medicare Accountable Care Organizations and other Medicare payment and delivery system demonstrations, which will improve coordination of care for a number of dual eligible individuals.

The Federal Coordinated Health Care Office has been focused on understanding the experience of dual eligibles in integrated care, coordinated care models, and other delivery systems. As a foundation for this goal, it has been preparing brief profiles of dual eligibles in each state, including demographics, service utilization, and availability of benefits.

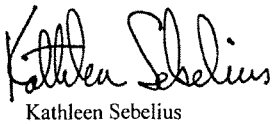
The Federal Coordinated Health Care Office will monitor and report on issues from a national level, including annual total expenditures, health outcomes, and access to benefits for dual eligibles, including subsets of the dual eligible population. It will also seek to go beyond the data and to go to beneficiaries themselves in order to better understand the dual eligible beneficiaries' experiences from their own perspectives. For example, in the spring of 2011, it will conduct focus groups with individuals with disabilities among the dual eligible population, to understand the impact of integrated care on beneficiary experience and outcomes. The state profiles and targeted focus groups are part of the Federal Coordinated Health Care Office's broader effort to equip federal and state officials, advocates, plans, providers, and other stakeholders with the data necessary to inform policy discussions on better serving dual eligible individuals.

Pursuant to section 2602(d)(4) of the Affordable Care Act, the Federal Coordinated Health Care Office has also consulted and coordinated with both the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, including presenting at the Medicaid and CHIP Payment and Access Commission public meeting in October 2010. The Federal Coordinated Health Care Office will continue to collaborate with staff and members of both Commissions on issues related to data analysis, care model demonstrations, and policy alignment opportunities.

The Federal Coordinated Health Care Office will use early experience and the work already underway to inform next year's report, which, pursuant to section 2602(e) of the Affordable Care Act, will include any recommendations that the office may have for legislation that would help improve care coordination and benefits for dual eligible beneficiaries. Please accept this letter as HHS's fulfillment of the requirement to report to Congress. I am also sending a copy of this letter to the President of the Senate.

The Federal Coordinated Health Care Office is committed to working with Congress, states, providers, payers, and, above all, beneficiaries and their caregivers to assure that individuals eligible for both Medicare and Medicaid receive seamless, effective, appropriate, and person-centered care. I look forward to keeping you apprised of its progress.

Sincerely,



Kathleen Sebelius

Enclosure

likely than other children to be irritable or to have mild, temporary diarrhea or vomiting. This happens within the first week after getting a dose of the vaccine.

Serious Problems: Some studies have shown a small increase in cases of intussusception during the week after the first dose. Intussusception is a type of bowel blockage that is treated in a hospital. In some cases surgery might be required. The estimated risk is 1 case per 100,000 infants.

What if my child has a severe reaction?

What should I look for?

Any unusual condition, such as a high fever or behavior changes. Signs of a severe allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?

Call a doctor, or get the person to a doctor right away.

Tell the doctor what happened, the date and time it happened, and when the vaccination was given.

Ask your doctor to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS Web site at *http://www.vaers.hhs.gov*, or by calling 1–800–822–7967. *VAERS does not provide medical advice.*

The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

People who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1–800–338–2382, or visiting the VICP Web site at *http://www.hrsa.gov/vaccinecompensation.*

For More Information

- Ask your doctor. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):

—Call 1–800–232–4636 (1–800–CDC–INFO) or

—Visit CDC's Web site at *http://www.cdc.gov/vaccines.*

Department of Health and Human Services

Centers for Disease Control and Prevention

Vaccine Information Statement

(00/00/0000) (Proposed)

42 U.S.C. 300aa–26

Dated: December 21, 2010.

Tanja Popovic,

Deputy Associate Director for Science, Centers for Disease Control and Prevention (CDC).

[FR Doc. 2010–32965 Filed 12–29–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Statement of Organization, Functions, and Delegations of Authority

Part F of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), (last amended at 75 FR 14176–14178, dated March 24, 2010) is amended to change the title of the Office of Executive Operations and Regulatory Affairs to the Office of Strategic Operations and Regulatory Affairs, to reflect the establishment of a new Federal Coordinated Health Care Office and to update the organization for CMS, as follows:

(1) Under Part F, CMS, FC. 10 Organizations, change the title of the Office of Executive Operations and Regulatory Affairs (FCF) to the Office of Strategic Operations and Regulatory Affairs (FCF).

(2) Under Part F, CMS, FC. 10 Organizations, insert the following new Office after the Center for Medicare and Medicaid Innovation (FCP): "Federal Coordinated Health Care Office (FCQ)."

(3) Under Part F, CMS, FC. 20 Functions, change the title of the Office of Executive Operations and Regulatory Affairs (FCF) to the Office of Strategic Operations and Regulatory Affairs (FCF).

(4) Under Part F, CMS, FC. 20 Functions, insert the following after the description of the Center for Medicare and Medicaid Innovation (FCP):

Federal Coordinated Health Care Office (FCQ)

- Manages the implementation and operation of the Federal Coordinated Health Care Office mandated in section 2602 of the Affordable Care Act, ensuring more effective integration of benefits under Medicare and Medicaid for individuals eligible for both programs and improving coordination between the Federal Government and States in the delivery of benefits for such individuals.
- Monitors and reports on annual total expenditures, health outcomes and access to benefits for all dual eligible individuals, including subsets of the population.
- Coordinates with the Center for Medicare and Medicaid Innovation to provide technical assistance and programmatic guidance related to the testing of various delivery system, payment, service and/or technology models to improve care coordination, reduce costs, and improve the beneficiary experience for individuals dually eligible for Medicare and Medicaid.
- Performs policy and program analysis of Federal and State statutes, policies, rules and regulations impacting the dual eligible population.
- Makes recommendations on eliminating administrative and regulatory barriers between the Medicare and Medicaid programs.
- Develops tools, resources and educational materials to increase dual eligibles' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
- Provides technical assistance to States, health plans, physicians and other relevant entities of individuals with education and tools necessary for developing integrated programs for dual eligible beneficiaries.
- Consults with the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment Advisory Commission with respect to policies relating to the enrollment in and provision of benefits to dual eligible beneficiaries under Medicare and Medicaid.
- Studies the provision of drug coverage for new full benefit dual eligible individuals.
- Develops policy and program recommendations to eliminate cost shifting between the Medicare and Medicaid program and among related health care providers.
- Develops annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

Authority: 44 U.S.C. 3101.

Dated: December 7, 2010.

Kathleen Sebelius,

Secretary.

[FR Doc. 2010–32957 Filed 12–27–10; 4:15 pm]

BILLING CODE 4120–01–P

Mr. PALLONE. And then I would ask unanimous consent to enter the statement of Mary Kay Henry, who is the president of SEIU, and I think you have both of these.

Mr. PITTS. Without objection, so ordered.

Mr. PALLONE. Thank you.

[The information follows:]

Statement of Mary Kay Henry

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to the

Subcommittee on Health

Committee on Energy and Commerce

Hearing on

Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care

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On behalf of the more than 2.1 million members of the Service Employees International Union, I am pleased to submit the following written testimony to be included in the public record for the House Energy and Commerce Committee hearing on "Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

The health care system in the US is highly fragmented. Lack of care coordination is a challenge for all clients, but may be most significant for individuals covered by both Medicare and Medicaid (typically referred to as "dual eligibles"). Most often, it is dual eligibles that have the most significant health needs of all Medicare beneficiaries.

Problems caused by the lack of coordination between Medicare and Medicaid services for the dual eligibles are well documented.[i] Medicare and Medicaid are run as two entirely separate programs with two distinct and separate payment systems—especially under fee-for-service arrangements, but also under many managed care frameworks. For dual eligibles, this results in "treatment silos," with Medicare covering primary and acute care, and Medicaid covering most long-term care services, some medication, medical devices and paying for Medicare premiums and co-pays.[ii]

Moreover, there is often little care coordination inside either Medicare or Medicaid—each provider acts in isolation, so that one client can receive care from several doctors operating under separate care plans. All too often, the fragmentation arising from the separate payment and delivery systems results in unnecessary, duplicative, or missed services and avoidable exacerbations of illness leading to expensive hospitalizations and institutional stays, as well as cost-shifting among payors.[iii]

There has been some innovation through PACE programs and some managed care arrangements that blend Medicare and Medicaid services and funding, but nationally only 1.5% of all dual eligible individuals are enrolled in any kind of integrated care program that includes long term and acute and primary care services.[iv] For dual eligibles, integrating long term care into care coordination programs is crucial because of their heavy reliance on these services.

The Untapped Potential of Home Care Workers

Within the existing long term care system, Home care workers deliver a vital and cost effective service for many populations, including dual eligibles. The core service that home care workers provide is assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).[v] Home care workers provide these services in clients' homes, thus enabling people who would otherwise need costly institutional care to remain at home and maintain more independent lives.

Dual eligibles have a demonstrated need for ADL assistance. Fifty-two percent of dual eligibles need assistance with one or more ADLs—23% need assistance with 1-2 ADLs, and 29% need assistance with 3-6 ADLs.[vi] When such services are provided by home care workers, these home care workers have regular contact with a large universe of dual eligible individuals.

Often, home care workers are the health care workers who spend the most time with clients, and they do so in an ongoing rather than episodic manner. This ongoing relationship means that Home care workers build trust with their clients (and often with clients' families). Home care workers are also likely to notice slight changes in a client's health and social well-being—changes that, if not addressed properly, may lead to emergent care, in-patient hospitalization, or longer-term institutionalization in a nursing home.

Despite this strategic positioning, home care workers are not trained, expected, or afforded the opportunity to provide additional services or to leverage their detailed and up-to-the-minute understanding of a client's health and social well-being into better care from other parts of the service delivery system.

The Concept: Integrating Home Care Workers into Care Coordination and Improved Service Delivery for Dual Eligibles

Much of the recent discussion of care coordination considers systems encompassing only primary care and acute care. Because dual eligibles have such significant long-term care needs, care coordination for duals will not be effective unless it includes long term care services. A fully integrated care coordination model that includes long-term care would improve on primary/acute care models by capitalizing on the position of home care workers in providing some of the most essential long-term care services and coordinating client care on a frequent and face-to-face basis.

For background, we assume that in any care coordination model there is a multi-disciplinary care team and a process for participant-centered care planning, where this care team and the care plan encompass primary care, acute care, and long-term care.

In addition to providing assistance with ADLs and IADLs as they do in existing programs, in an enhanced care coordination model the HCW would fill two additional essential roles:

1. Regularly communicating with care managers; and
2. Providing an expanded range of services (in addition to ADLs and IADLs).

First, because of regular and extensive client contact, the home care worker has a unique role to play in the development and execution of the individual's care plan. Home care workers and clients spend significant portions of their days together, performing intimate tasks such as bathing and dressing. For example, Home care workers in Massachusetts typically spend 20-30 hours per week delivering direct care in the homes of clients.[vii] This regular and intensive contact means that a home care worker is likely to notice subtle changes in condition that another caregiver—say, a doctor, in the course of a brief office visit—perhaps would not notice. This extensive contact also likely means that a home care worker builds a unique relationship of trust with the dual eligible individual. This heightened trust in turn means that the dual eligible individual may be more likely to—and better able to—speak candidly with her home care worker about pain or other symptoms.

As a result, home care workers can serve as a conduit of information in two directions. The HCW can share information with the care manager(s) that is crucial for health-related decision-making—information that would likely not otherwise come to the attention of the care manager or other provider. Similarly, the home care worker can take emergent issues identified by care managers into account in delivering care. This can prevent health and social issues from worsening to the point of requiring otherwise unnecessary services, and is likely to result in better health and social outcomes and lower expenditures.

Second, when a home care worker is in regular communication with a care manager overseeing a multi-disciplinary care team, and is helping the care manager identify health issues that need treatment in order to avoid institutional care, the quickest and most simple way to address those health issues may often be for the home care worker herself to provide treatment in the course of her regular contact with the client, rather than to schedule a separate visit from an RN or an office visit with the client's primary care provider. This care coordination approach would expand home care worker roles beyond assistance with ADLs and IADLs to tasks that are traditionally the province of registered nurses or other health professionals. Such tasks might include medication administration, assistance with physical therapy, wound care, administration of feeding tubes, and glucose monitoring. [viii] Home care workers can also play a role in preventative care by educating and supporting the client in proper nutrition, exercise/mobility assistance, smoking cessation, and safe household maintenance -- for example, ensuring presence of functioning smoke detectors.

A care coordination model along these lines has significant promise for helping to prevent avoidable care—especially avoidable hospitalizations and nursing home stays—and therefore has significant promise to bend the medical cost curve, as well as improve health outcomes for clients.

Supporting Evidence for the Potential of Leveraging Home care workers

As previously discussed, there are two components to the enhanced role of home care workers under this care integration concept—regular communication as part of the care coordination team and an expansion of the range of services home care workers deliver. Care coordination models that formally utilize home care workers in these ways do not exist on a significant scale in any part of the US to date, so there is little direct evidence of the efficacy of such potential programs. However, there are related programs, such as transition, nurse delegation, and certain care integration programs, that contain elements of this concept, and provide positive evidence in support of these elements.

Care Transitions, PACE, and Avoidable Hospitalizations—Supporting HCWs as members of the care team

The Program of All-Inclusive Care for the Elderly (PACE) is one example of a program in which HCWs serve as part of a multi-disciplinary care team. PACE is a capitated, care coordination program that integrates Medicare and Medicaid services for individuals 55+ who are eligible for nursing home care. Under PACE, services are provided by a team composed of at least the following members: a primary care physician, an RN, a social worker, a physical therapist, a pharmacist, an occupational therapist, a recreational therapist, a dietician, a PACE centers manager, a home-care coordinator, personal-care attendants, and drivers. Each member of the team performs an initial assessment of each patient, and

then the group works together to create a single care plan. The team holds weekly care-planning meetings during which the care plans are reassessed.

An evaluation of the PACE demonstration program found that enrollment was associated with higher patient satisfaction, improved health status and physical functioning, an increased number of days in the community, improved quality of life, and lower mortality. The benefits of PACE were even greater for the frailest older adults, whose enrollment was associated with lower rates of service utilization in hospitals and nursing homes and higher rates of ambulatory care services.

Benefits of Care Coordination in Post Acute Settings - A 2006 study of coordinated care given to elderly patients across various care settings following their discharge from an acute care hospital found significantly decreased rates of re-hospitalization. Nurses and social workers were trained as transition coaches, who then educated patients and their family caregivers on asserting a more active role during care transitions and fostering care coordination and continuity across settings, through four pillars of care. The four pillars included (1) assistance with medication self-management, (2) a patient-centered record owned and maintained by the patient to facilitate cross-site information transfer, (3) timely follow-up with primary or specialty care, and (4) a list of "red flags" indicative of a worsening condition and instructions on how to respond to them. Researchers estimated that for every 350 patients who received follow up coordinated care, hospital costs to Medicare/Medicaid were reduced by approximately $300,000.

This study illustrates the importance having home-based support to provide continuing care in the client's home after a hospital discharge, and its success demonstrates the potential of engaging front-line direct caregivers in coordinating care during a particularly important episode of care. Homecare workers could be of great value in such a model. They could assist with front line care coordination, especially where clients have no family caregivers, and could reduce the need for multiple nurse visitations as they are already in the client's home.

Potentially Avoidable Hospitalizations – The Center for Medicare and Medicaid Services Office of Policy commissioned a study on avoidable hospitalizations among 1.6 million dual eligibles receiving services in nursing facilities or through HCBS waiver programs. The study found that dually eligible beneficiaries in Medicaid HCBS waiver programs had very high rates of potentially avoidable hospitalizations. The potentially avoidable hospitalization rates were 408 per 1,000 person years for enrollees in Medicaid HCBS waiver programs using a full condition list, and 250 per 1,000 person years using a more restricted list of conditions.

One of the study's conclusions is that there is a clear unmet need in chronic disease management and early identification of acute exacerbations that might result in hospitalization. The study suggests that targeted interventions and educational initiatives to improve the recognition, assessment and early management of these conditions could reduce these hospitalizations. The information and conclusions in this study indicate the potential for HCW's to fulfill an important role in reducing costly hospitalizations by identifying and reporting conditions to other care team members so the client may be treated accordingly to prevent acute medical exacerbations.

Nursing delegation and enhanced responsibilities under consumer direction: Support for expanding the services HCWs deliver

Both Washington and New Jersey have innovative nursing delegation programs. Washington permits home care workers to take on expanded tasks beyond traditional ADLs/IADLs, and does so in two ways. First, the state permits extensive delegation by RNs to HCWs in any HCBS setting, and is not limited to specific tasks. Second, Washington allows individuals with disabilities to hire independent provider HCWs, and the client is permitted to delegate to the HCW any task whatsoever, so long as the consumer has the ability to self-direct. Studies of these programs have established that consumers value their ability to age at home and feel delegation and self-direction programs support this outcome. Both consumers and case managers believed the self-direction program in particular has saved the state money by preventing utilization of more expensive services such as nursing homes and emergency rooms.

New Jersey is currently in the middle of a three year nurse delegation pilot project. Although there is not yet any data available, it is important to note the purposes and drivers of the program. Acknowledgement that home care workers were performing skilled tasks without nursing oversight or supervision as well as a feeling that the state was not making full use of the "skills, knowledge and talent" of both nursing and home care aide staff were precipitating factors in setting up the program, and the state undertook several years of work with stakeholders prior to the implementation of the project. The nurse delegation pilot project serves around 200 individuals, who receive personal care services from 22 home care agencies within the state. Nurses at these agencies receive referrals and review existing caseloads to determine which clients would benefit from receiving delegated services. Nurses then train and assist aides to administer these services. While formal studies of the effectiveness and outcomes of the program have yet to be performed, long term goals of the pilot program include increasing the number of individuals able to remain at home or in the community, making a better use of the skill set of many home care providers, and a potential change of the state's nursing regulation to support broader delegation.

Senior Care Options Care Integration Model: An informal example of HCWs in care coordination

The Senior Care Options program provides integrated care to dual eligible seniors in Massachusetts. HCWs, in this case Personal Care Attendants (PCAs), deliver consumer-directed personal care services to many dual eligibles enrolled in this program, and care is coordinated through a Senior Care Organization (SCO). The Commonwealth Care Alliance (CCA) is a SCO with multiple primary care sites and promotes the use of PCAs to provide personal care support.

The Massachusetts' PCA program allows PCAs to assist clients with tasks they would otherwise do for themselves, under the direction and training of the client; these tasks often go well beyond assistance with ADLs/IADLs. Some examples of tasks that clients train PCAs to do include taking blood pressure, monitoring insulin levels and general medication assistance. At the request of the client, CCA will send a nurse to assist with training the PCA as to how to perform enhanced tasks. If a client requests closer collaboration between the PCA and the primary care team, this can be accommodated and can contribute to better care coordination and service delivery. At the request of the client, CCA can send a nurse to provide training to the HCW as to how to perform enhanced tasks. Through the client, the PCA may be an "extender" of the primary care team, in communication about the care plan, and sudden changes in the participant's health. It is important to note, however, that none of this is a requirement for SCOs and is not necessarily part of CCAs formal operational protocols; PCA communication with primary care team members is always is at the discretion of the client and can vary from person to person.

The evidence of the current informal PCA role is anecdotal, but administrators and clinicians at CCA recognize the important roles that PCAs play in delivering care, and have expressed interest in integrating the client and PCAs into the care team more formally as well as offer the opportunity for additional skill development for PCAs, if this is of interest to the client, in areas such as behavioral health, potential medication conflicts, assistance with physical therapy or exercise regimens, etc.

Conclusion

Home care workers are in direct contact with duals in their homes, and have the potential to serve as a crucial point of contact in a person-centered coordinated care model. As part of the care management team, a home care worker can readily identify changes in a client's condition or circumstances, allowing the team to take appropriate preventative action to avoid costly and disruptive health issues. Such a model has supportive anecdotal evidence, as well as additional supportive evidence from nurse delegation and care coordination transition studies. The home care workforce should not be overlooked as an integral part of fully coordinated care. States and private providers should be encouraged to incorporate enhanced roles for home care workers into emerging care coordination models as a practical and cost effective way to fully coordinate care and thereby improve health outcomes, enhance individual client experience, and help bring down healthcare costs.

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[i] See Board of Health Care Services, "Retooling for An Aging America Chapter 3: New Models of Care," Institute of Medicine Report, Committee on the Future Health Care Workforce for Older Americans, April, 2008. http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx.; Lewin Group, "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities, November 2008, http://www.hcbs.org/files/149/7433/Dual_eligibles_cost_savings.pdf; Lindsay Palmer Barnett, Center for Health Care Strategies, Technical Assistance Brief "Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles," July 2010, http://www.chcs.org/usr_doc/Integrating_Medicare_and_Medicaid_Data_for_Duals.pdf ; John E. Wennberg, Shannon Brownlee, Elliott S. Fisher, Jonathan S. Skinner and James N. Weinstein, Dartmouth Atlas White Paper: "An Agenda for Change. Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration," December 2008, http://www.dartmouthatlas.org/downloads/reports/agenda_for_change.pdf.

[ii] Sara Rosenbaum, Jane Hyatt Thorpe, and Sara Schroth, George Washington University, Center for Health Care Strategies, Inc., "Policy Brief: Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options, November 2009, http://www.chcs.org/usr_doc/Supporting_Alternative_Integrated_Models_for_Dual_Eligibles.pdf.

[iii] For a more thorough discussion see: The Lewin Group. "Increasing Use of the Capitated Model for Dual Eligibles"; Lindsay Palmer Barnette, "Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles."

[iv] A further challenge to effective care coordination—not addressed in this paper—is that there has been little incentive for providers and states to coordinate care because the savings of coordination between the two programs is not shared, and may accrue primarily to Medicare. For discussion of this issue, see Sara Rosenbaum, Jane Hyatt Thorpe, and Sara Schroth, Policy Brief.

[v] Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) describe a person's level of functioning in performing everyday tasks. There are six basic categories of ADLs: Hygiene (bathing, grooming, shaving and oral care); Continence ; Dressing; Eating (the ability to feed oneself); Toileting (the ability to use a restroom); Transferring (actions such as going from a seated to standing position and getting in and out of bed). IADLs are generally more complex and can include the following: Finding and utilizing resources (looking up phone numbers, using a telephone, making and keeping doctor's appointments) ; Driving or arranging travel (either by public transportation, such as Paratransit, or private car); Preparing meals (opening containers, using kitchen equipment); Shopping (getting to stores and purchasing necessities like food or clothing); Doing housework (doing laundry, cleaning up spills and maintaining a clean living space); Managing medication (taking prescribed dosages at correct times and keeping track of medications); Managing finances (basic budgeting, paying bills and writing checks).

[vi] Medicare Payment Advisory Commission, Data Book, June 2010, "Chapter 3 Dual Eligible Beneficiaries," (http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf.

[vii] 1199 SEIU UHE Internal analysis of 2009 Massachusetts statewide payroll data provided by state contracted Fiscal Intermediaries.

[vii] Permitting Home care workers to perform these tasks would likely require changes in the laws of various states – such as changes that would authorize RNs to delegate and supervise Home care workers in the performance of these tasks, or (following Washington State's example – see below) that would permit disabled individuals to directly delegate such tasks to a HCW. This is discussed in more detail later in this document.

Mr. PITTS. Thank you.

At this time I will ask the second panel to come forward, and I will introduce them in the order of testimony. Robert Egge is the Alzheimer's Association's Vice President of Public Policy and Advocacy. Billy Millwee is the Associate Commissioner for Medicaid and Children's Health Insurance Program at the Texas Health and Human Services Commission. Denise Levis Hewson is the Director of Clinical Programs and Quality Improvement at Community Care of North Carolina. And Shawn Bloom is the President and CEO of the National PACE Association. Your written statements will be made part of the record and we ask you to summarize each of your opening statements in 5 minutes before the question-and-answer period.

At this point the chair recognizes Robert Egge.

STATEMENTS OF ROBERT EGGE, VICE PRESIDENT OF PUBLIC POLICY, ALZHEIMER'S ASSOCIATION; BILLY MILLWEE, ASSOCIATE COMMISSIONER FOR MEDICAID/CHIP, TEXAS HEALTH AND HUMAN SERVICES COMMISSION; DENISE LEVIS HEWSON, DIRECTOR OF CLINICAL PROGRAMS AND QUALITY IMPROVEMENT, COMMUNITY CARE OF NORTH CAROLINA; AND SHAWN BLOOM, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL PACE ASSOCIATION

STATEMENT OF ROBERT EGGE

Mr. EGGE. Good afternoon, Chairman Pitts, Ranking Member Pallone and distinguished members of the subcommittee. I am Robert Egge, Vice President of Public Policy of the Alzheimer's Association, and I thank you for the opportunity to appear here today.

I want to begin by telling you about John and his wife Emma. John and Emma are an elderly, low-income couple who depend on both Medicare and Medicaid. John has Alzheimer's disease and diabetes. John's physician has been consistently attentive to his diabetes but not to his Alzheimer's. He has given John good diabetes treatment plan, but because of John's impairments due to his Alzheimer's, John has been increasingly unable to comprehend or follow those instructions. So despite his physician's efforts, John's diabetes and his overall health has steadily deteriorated. For her part, Emma has been ill-equipped to help John manage the demands of his dementia and his diabetes because of her own health and the lack of caregiver training and support that has been offered to her. Because of all of this, John and Emma began taking frequent trips to the hospital ER where John was regarded as a noncompliant, difficult diabetic.

Most of the hospital staff did not seem to recognize John's dementia and that his noncompliance with diabetes treatments wasn't about John being obstinate or unmotivated but was due to his inability to self-manage his care. Those that did recognize the presence and the implications of his dementia were at a loss for what to do about it. So John continued to show up at the emergency room for diabetes-related conditions at ever more frequent intervals. Each time he was sent home with discharge orders often explained to him without Emma even present that he had no hope of following. These ER episodes were disconnected from his physi-

cian's care. John's hospitalizations increased, his health deteriorated, claims to Medicare and Medicaid mounted. Reluctantly, John and Emma decided he could no longer live in his home but had to enter a Medicaid-funded nursing home much sooner than either of them had hoped or expected.

As reported in the Alzheimer's Association's 2011 Alzheimer's disease facts and figures, there are an estimated 5.4 million Americans like John with Alzheimer's, currently a terminal disease with no known means to prevent, stop or slow its progression, and there are almost 15 million unpaid caregivers, many like Emma, who help care for them. Those millions of Americans with Alzheimer's form a disproportionate share of the dual-eligible population. Sixty-one percent of dual-eligible individuals are cognitively or mentally impaired. Nearly one in every six dual eligibles has Alzheimer's disease or other dementia. Alzheimer's and other dementias are also extremely prevalent among dual eligibles in nursing homes where 59 percent of residents live with these conditions. Similarly, at any point in time, about one-quarter of all hospital patients age 65 and older have Alzheimer's or other dementias.

So this population of duals with Alzheimer's is large in scale and it is also very large in cost. Medicare payments for beneficiaries with Alzheimer's and other dementias are three times greater than for comparable beneficiaries without these conditions, and Medicaid payments are nine times higher. These facts lead to the first of two points I want to conclude with today.

Individuals with Alzheimer's that depend on Medicare and Medicaid make up such a large, vulnerable and cost-intensive share of the dual-eligible population that policymakers should focus on these beneficiaries in pilots, demonstrations and broader system reform efforts. Recognizing this group is offering a leading opportunity to improve care while controlling cost.

The other major point I wanted to close with is that focusing on improving care for dual-eligible individuals with Alzheimer's won't only deliver benefits for these millions of Americans but will also have health benefits more generally. Over the years, our growing awareness of the significance of manageable chronic conditions like diabetes has led to an important emphasis on prevention, self-management and patient-centered care. Today, in a similar way, our growing awareness of the widespread impact of cognitive impairments due to Alzheimer's and other causes should draw much-needed attention to themes such as reducing program complexity, the detection, diagnosis and documentation of medical conditions like Alzheimer's, and to putting in place care plans that recognize not only an individual's cognitive abilities but fully recognize and support the critical role of the unpaid family caregiver.

The foundation of effective care is in diagnosis, care planning and medical record documentation, principles contained in Mr. Markey's bill, the Hope for Alzheimer's Act, which the association strongly supports. Moreover, the insights underpinning this bill apply across the dual-eligible and Medicare populations.

So again, thank you. The Alzheimer's Association greatly appreciates the opportunity to address these issues, and we look forward to our continuing work with the subcommittee.

[The prepared statement of Mr. Egge follows:]

United States House of Representatives
Energy and Commerce Subcommittee on Health

Testimony of Robert Egge
Vice President of Public Policy
Alzheimer's Association

June 21, 2010

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Good afternoon Chairman Pitts, Ranking Member Pallone and distinguished members of the Subcommittee.

I am Robert Egge, Vice President of Public Policy at the Alzheimer's Association. Thank you for the opportunity to discuss the unique perspective of the millions of Americans living with Alzheimer's disease and other dementias who rely on both Medicare and Medicaid, as well as the Association's ongoing efforts to improve their care and quality of life.

I have two major points to make today. The first of these points is that it is important to examine those dual-eligible individuals with Alzheimer's and other dementias simply because they are such a large, vulnerable and costly portion of the overall dual-eligible population. Even if there were no broader benefit, better understanding and addressing the needs of this group are likely to yield much better care at lower cost, because there is such room for improvement.

The second major point is that improving care for dual-eligibles with Alzheimer's and other dementias will bring additional benefits for dual-eligibles in general, and almost certainly for those many more beneficiaries in Medicare and in Medicaid programs more broadly. Over the past decade, our growing awareness of the significance of manageable chronic conditions like

diabetes led to an important emphasis on themes like prevention, self-management, and patient-centered care. Today, in a similar way, our growing awareness of the widespread impact of cognitive impairments due to Alzheimer's and other causes should introduce much needed attention to themes such as program simplification and supporting the unpaid caregiver.

Alzheimer's impact on America, and on the dual-eligible population specifically

Today, there are 5.4 million Americans living with Alzheimer's and almost 15 million unpaid caregivers. If left unchecked, by 2050 this devastating disease will affect as many as 16 million Americans. Alzheimer's disease is the sixth leading cause of death in the United States; the fifth leading cause of death for those over the age of 65; and the only one of the top ten causes of death in the United States without a means to prevent, cure or slow its progression. From 2000 to 2008, deaths from Alzheimer's disease increased by 66 percent, while deaths from heart disease, breast cancer, prostate cancer and stroke declined.

Turning specifically to the matter of today's hearing, we know Alzheimer's disease is highly prevalent among dual-eligible individuals. According to a Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File (2006), 61 percent of dual-eligible individuals are cognitively or mentally impaired. Nearly one in every six dual-eligibles in America today has Alzheimer's disease or other dementia.

And 22 percent of older people with Alzheimer's disease and other dementias are dual-eligibles. Alzheimer's disease is also extremely prevalent among dual-eligibles in nursing homes, where 59 percent of residents live with the disease.

Alzheimer's beneficiaries are among the costliest of dual-eligibles. Medicare and Medicaid pay over 70 percent of the total cost of caring for people with the disease. Absent a cure or effective treatment options, total care costs for those with Alzheimer's and other dementias will rise from $183 billion today to $1.1 trillion in 2050, and Medicare and Medicaid's share of these costs will rise from $130 billion to over $800 billion in 2050 in today's dollars.

In addition, costs for individuals with Alzheimer's are significantly higher than their counterparts. In 2004, average per person Medicaid payments for Medicare beneficiaries aged 65 and older with Alzheimer's and other dementias were more than nine times as great as average per person Medicaid payments for Medicare beneficiaries without Alzheimer's and other dementias.

The reasons for these increased costs become apparent when examined along different dimensions, such as care setting. For instance, hospital stays are a major component of Medicare expenditures. As reported in the Alzheimer's Association's *2011 Alzheimer's Disease Facts and Figures*: "In 2004, there were 828 hospital stays per 1,000 Medicare beneficiaries aged 65 and older with Alzheimer's or other dementia compared with 266 hospital stays per 1,000 Medicare beneficiaries without these conditions. At any point in time, about one-quarter of all hospital patients aged 65 and older are people with Alzheimer's and other dementias."

Due to the sheer scale of the population of dual-eligibles with Alzheimer's and other dementias, and the disproportionate costs that they bring to the Medicare and Medicaid systems, they merit

an in-depth investigation to determine innovative ways to deliver better care to these beneficiaries as effectively as possible. Even if cost saving is not the driving motivation for such efforts, unmanaged dementia is so inefficient in terms of poorly managed coexisting medical conditions, increased hospitalization and readmissions, earlier placement in institutional care and the like, that cost savings are almost sure to follow in tandem with better outcomes. We urge that the dual-eligible population with Alzheimer's and other dementias be a particular focus for innovation in pilots, demonstrations, and broader system reform efforts.

The challenges faced by dual-eligibles with Alzheimer's and other dementias

Who are these dual-eligible Americans with Alzheimer's and why is care for them so inefficient today? The Alzheimer's Association has a strong understanding of the challenges faced by dual eligible individuals with Alzheimer's and other dementias. It is an understanding developed and refined by delivering programs and services through more than 300 points of care across the country, and through handling more than a quarter of million calls each year through our 24 hour a day, 365 day per year nationwide toll-free helpline. While every case is unique, the recent experiences of an individual I'll call John are typical, and illustrate how important it is to view the issues before us today through the perspective of this population.

John and his wife, Emma, are an elderly, low-income couple and are eligible for both Medicaid and Medicare. John has Alzheimer's disease and diabetes. John's physician is very attentive to his diabetes but not to his Alzheimer's. He has given John a good diabetes treatment plan, self-

management guidelines and nutritional education. Yet, because of his impairments due to Alzheimer's disease, John cannot remember or fully comprehend his physician's instructions. So, despite his physician's efforts, John's diabetes is poorly managed and his blood glucose levels are out of control. Emma is ill-equipped to help him manage the demands of his dementia or his diabetes – let alone the interplay between the two – because of her own health issues and the lack of caregiver training and support provided to her.

Instead of effectively managing his health and avoiding unneeded expenses through proactive care, John and Emma take frequent trips to the hospital where John is perceived as a "non-compliant, difficult diabetic" by hospital staff. The staff does not recognize John's dementia and that his non-compliance with diabetes treatments is due to his inability to self-manage his care. So, John continues to show up at the emergency room for diabetes-related conditions at ever more frequent intervals. Each time he is sent home with discharge orders – explained to him often without Emma present – that he has no hope of following. These ER episodes are disconnected from his physician's care. John's hospitalizations increase; his health deteriorates; claims to Medicare and Medicaid mount. Reluctantly, John and Emma decide he can no longer live in his home but must enter a Medicaid-funded nursing home instead much sooner than either of them had hoped or expected.

The Alzheimer's Association can, unfortunately, attest that John's story is all too typical, and is but one of many that exemplify the need to plan and coordinate services to improve care – and to delay nursing home placement for as long as possible – for this vulnerable population.

Lessons from cases like John and Emma's for dual-eligible programs in general

As I mentioned at the outset of this testimony, tracing the experiences of cognitively impaired, dual-eligible individuals like John highlights the challenges before us this afternoon – challenges that extend far beyond just this population, as large as it is. Specifically, this population casts into stark relief challenges – and opportunities – related to **access**, **coordination**, **innovation** and **alignment**.

Access: improving the beneficiary's experience by reducing complexity. Financial barriers to care have received considerable attention in recent years, as they should. But dual-eligibles with cognitive impairment illustrate that barriers are not only financial – they are often due to the complexity of and fragmentation of the systems these beneficiaries must contend with. As we know from calls we receive to our nationwide toll-free helpline each and every day, many Americans are at a loss for how to gain access to available services and are often overcome with frustration. From the vantage point of a cognitively impaired person, navigating through the Medicare and Medicaid systems is extremely daunting. The Medicaid application process can be cumbersome and laden with requirements that are particularly challenging for individuals with memory loss and impaired executive function. Separate applications are often required to access each of the services and benefits needed. For example, in John's case, though he has been deemed eligible for Medicaid services, he would need to apply separately for adult day care, or in-home care, or a respite program.

Peggy, from Montana, cares for her husband with Alzheimer's. Her challenges are also typical of what we hear regularly from families around the country: "When my husband was diagnosed

with Alzheimer's in March 2005, I never dreamed that I wouldn't be the one to take care of him the rest of his life. I did meet his needs for several years, but at some point, I realized I couldn't do it alone. I learned about the PACE program, but I found out it would cost approximately $3500 per month unless we chose to put Jim on Medicaid to pick up the cost. There was no way we would be able to pay for it without this support. It was a very long process and a lot of paperwork of to apply for Medicaid that required the services of an attorney, delaying our access to support. All this has left me with a very insecure future, but I do not know how I could have possibly managed his illness without this help."

As part of any dual-eligible system redesign, the Alzheimer's Association encourages particular attention to what is all too often an afterthought – designing processes to be as simple as possible from the beneficiary's perspective. For instance, a seamless Medicaid application process for Medicare beneficiaries, where the systems are fully integrated, service and benefit needs are assessed at the point of application, and eligibility for those services is determined at the outset, could alleviate administrative barriers to service access that many dual-eligibles experience. Further, the prevalence of Alzheimer's and other cognitive impairments underscores how important it is for these processes to accommodate the assistance of the unpaid caregiver or surrogate representative as well.

Coordination: Improving the beneficiary's experience through better diagnosis and documentation. John's case illustrates that many dual-eligible beneficiaries, particularly those with Alzheimer's disease and other dementias, face a fragmented system that often results in reduced quality of care and increased costs.

Many discussions of how to address these challenges understandably look to care coordination for improvement. However, it is essential to remember that care coordination in turn depends on having fundamental preconditions in place such as an accurate understanding of the individual's health challenges. In the case of Alzheimer's and other dementias, some of the largest challenges are related to detection and diagnosis, and then ensuring that these conditions are recognized and taken into account by the beneficiary's full care team across care settings and transitions.

Studies indicate that half of people with Alzheimer's and other dementias have never received a formal and documented diagnosis, and some studies suggest it could be as high as 80 percent. As we saw in the case of John, a documented diagnosis that follows him across care settings is critical to ensuring that care providers treating coexisting medical conditions, such as diabetes and heart disease, can devise appropriate courses of treatment.

The current system relies heavily on self-management, which can be challenging or inappropriate for the majority of dual-eligible individuals who, as previously noted, have a cognitive or mental impairment. Successful chronic disease management requires educating patients on how to self-manage their diseases. While this care model works well for some people living with certain chronic conditions, self-management is extremely difficult and requires special considerations when patients are cognitively impaired. Current self-management models fail to take into account the needs of the cognitively impaired population, often resulting in repeat visits to their health care provider or the hospital. The Alzheimer's Association has been working with the nation's largest chronic disease self-management program to understand what

happens when individuals with dementia are participants in such programs. Such programs may, when properly tailored, provide some benefit to some individuals with the disease and their caregivers. But, this much is clear: While we can treat people living with Alzheimer's and dementia for other diseases – we simply cannot do it in the same way as we do for a person who does not have cognitive impairment.

In keeping with the Alzheimer's Association's commitment to improving the quality of care that beneficiaries with Alzheimer's receive, we are pleased to support efforts, such as the Health Outcomes, Planning and Education (HOPE) for Alzheimer's Act, which will improve care and outcomes for Medicare beneficiaries with Alzheimer's disease, and we look forward to working with the Subcommittee on initiatives that will improve care for all individuals living with Alzheimer's.

Innovation: Improving the beneficiary experience through innovations such as caregiver assessments and counseling. Innovation is certainly needed to improve the experience of dual-eligible beneficiaries. Perhaps the leading areas ripe for innovation stem from widespread cognitive or mental impairment among this population. However, the Alzheimer's Association's experiences advocating on behalf of those with dementia suggests that this reality was not front of mind when these programs were developed.

Among the leading areas of focus for innovation must be empowering unpaid caregivers in their often heroic and too often thankless role of caring for and advocating on behalf of individuals with cognitive impairment, and making additional accommodations through surrogates when

such unpaid caregivers are not present. For instance, as suggested above in the discussion of the HOPE for Alzheimer's Act, when an individual is diagnosed with Alzheimer's or another dementia, this should trigger development of a care plan. This care plan should include an assessment of the needs and capabilities of the individuals and their caregivers – for example, does the individual have support from unpaid caregivers that can be integrated into the care process and what needs do the caregivers have to improve their effectiveness? Strong evidence indicates that well supported caregivers can lead to better outcomes for beneficiaries while reducing program costs through effects such as delayed nursing home placement.

If individuals do not have unpaid caregivers who can adequately advocate on their behalf, they should have the opportunity to work with a surrogate representative. As the disease progresses, individuals living with Alzheimer's have difficulty expressing their thoughts or wishes. Without a caregiver able to do so on their behalf, individuals are often unable to convey the difficulties they are experiencing or to comply with medication and other elements of care plans created for them.

Alignment: Improving the beneficiary's experience through improved Medicare and Medicaid alignment. The need for alignment between Medicare and Medicaid is most apparent for dual-eligibles with Alzheimer's disease who are in a nursing home setting. Nursing home care is often required for individuals at some point during the progression of Alzheimer's. Once an individual has successfully qualified for Medicaid and is seeking nursing home care, they are likely to find a shortage of available Medicaid beds, resulting in placement on a waiting list and/or placement in a facility many miles away from their communities and families. They are

also likely to find multiple points of fragmentation within the systems which affects their ability to access appropriate care. For example, some individuals are admitted to a nursing facility prematurely because their family could not access the needed home and community based services and supports to allow them to keep their loved one at home. Nursing home placement can present other difficult issues for dual-eligibles such as repeated hospitalization, a lack of high level nursing care, and a lack of communication and coordination between care settings.

According to a 2007 MedPAC report, almost 18 percent of Medicare beneficiaries who were discharged from the hospital were readmitted within 30 days. The report also found that Medicare spending on potentially preventable readmissions is substantial: $12 billion for cases readmitted within 30 days. Hospital readmissions are particularly challenging for people with Alzheimer's disease because they may experience increases in cognitive impairment levels and have difficulty managing the transitions and changes in environment.

With 59 percent of dual-eligibles in nursing homes living with Alzheimer's or dementia, dementia training is critical. Our national training program, part of the Alzheimer's Association Campaign for Quality Residential Care, provides care professionals with specialized skills and hands-on practices based on the latest research and expert evidence in the dementia care field. Studies show that staff trained specifically in dementia care are able to provide a better quality of life for residents and have increased confidence, productivity and job satisfaction.

Another way to address these challenges is to encourage continuity during transitions between care settings. The MedPAC report suggest a variety of models that have seen success in hospitals

around the nation. These models include employing a "transition coach," connecting patients and nurses after discharge to manage their discharge plan, and scheduled calls to report vital data. The Alzheimer's Association supports proposed new models of care that could be effective for dual-eligibles with Alzheimer's disease because of the need to decrease incidents of rehospitalization, monitor the effects of the transition between settings, and provide education and support about the disease progression and management of any other coexisting medical conditions. Such coordinated models advance the overarching goal of providing a seamless integration of benefits and coverage, allowing the focus to be on effective care for the beneficiary.

Mr. Chairman, without improved access, coordination, innovation and alignment, dual-eligible individuals, particularly those with Alzheimer's disease and other dementias, will continue to face inefficient health care leading to worse health outcomes and will cost Medicare and Medicaid unnecessary additional dollars. As we continue to make investments in research to find a therapy that will slow, stop, or prevent Alzheimer's, we must ensure that individuals have access to the available services that can improve their quality of life today. The Alzheimer's Association greatly appreciates the opportunity to address these issues and looks forward to working with the Subcommittee.

U.S. House of Representatives, Energy and Commerce Subcommittee on Health

Summary of Testimony of Robert Egge

Vice President of Public Policy, Alzheimer's Association

June 21, 2010

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

It is important to examine those dual eligible individuals with Alzheimer's and other dementias simply because they are such a large, vulnerable and costly portion of the overall dua eligible population. As reported in the Alzheimer's Association's *2011 Alzheimer's Disease Facts and Figures* there are 5.4 million Americans living with Alzheimer's and nearly one in every six dual-eligibles in America today has Alzheimer's disease or other dementia.

In addition, improving care for dual eligibles with Alzheimer's and other dementias will bring additional benefits for dual eligibles in general, and almost certainly for those many more beneficiaries in Medicare and in Medicaid programs more broadly. Specifically, this population casts into stark relief challenges – and opportunities – related to **access**, **coordination**, **innovation** and **alignment**. Opportunities include:

- Access: improving the beneficiary's experience by reducing complexity
- Coordination: Improving the beneficiary's experience through better diagnosis and documentation.
- Innovation: Improving the beneficiary experience through innovations such as caregiver assessments and counseling.
- Alignment: Improving the beneficiary's experience through improved Medicare and Medicaid alignment.

alzheimer's association

factsheet

Alzheimer's Disease Treatments = Savings for Medicare and Medicaid

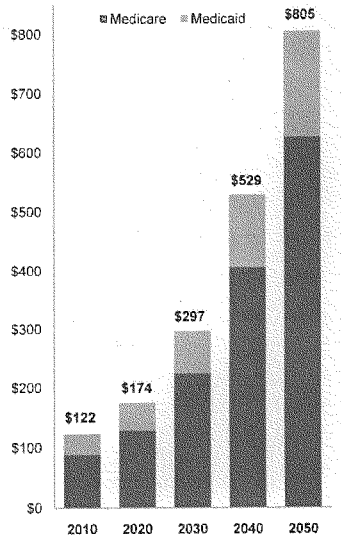
Caring for people with Alzheimer's disease will cost all payers – Medicare, Medicaid, individuals, private insurance and HMOs – $20 trillion (in today's dollars) over the next 40 years. The overwhelming majority of that will be spending by Medicare and Medicaid.

- Medicare and Medicaid will spend an estimated $130 billion in 2011 on people with Alzheimer's and other dementias.
- That figure is projected to increase to $805 billion in 2050 (before inflation).

While there are currently no known treatments to prevent or delay the progression of Alzheimer's disease, such treatments could have a dramatic impact on Medicare and Medicaid spending.

- The ultimate goal is a treatment that completely prevented or cured Alzheimer's.
- However, even more modest and, perhaps, more easily attainable treatments could prove extremely beneficial.

Medicare and Medicaid Costs of Caring for People with Alzheimer's
Current Trajectory in Billions

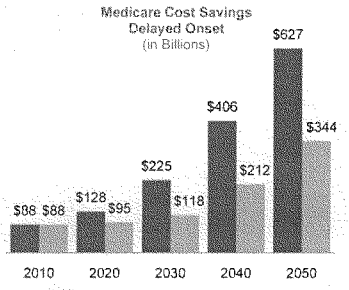


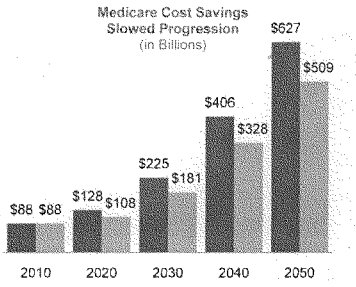
If a treatment became available in 2015 that *delayed the onset* of Alzheimer's disease for five years (a treatment similar to the effect of anti-cholesterol drugs on preventing heart disease) –

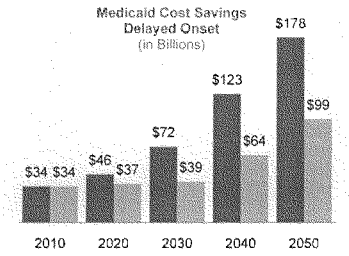
- Savings would be seen almost immediately: in 2020, Medicare and Medicaid spending would be $42 billion *less*.
- In 2050, Medicare *savings* would be $283 billion and Medicaid *savings* would be $79 billion. This would be 45 percent less than what would be spent on people with Alzheimer's if there were no such treatment.

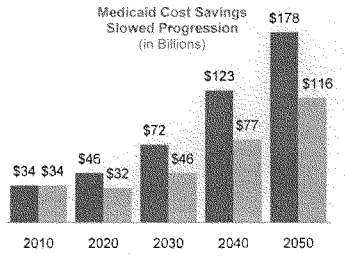
If a treatment became available in 2015 that *slowed the progression* of Alzheimer's by keeping individuals in both the mild and moderate stages of the disease five times longer (similar to what has happened with HIV/AIDS and some cancers) –

- $34 billion would be *saved* by Medicare and Medicaid in 2020.
- In 2050, the government health care programs would *save* $180 billion – $118 billion in Medicare and $62 billion in Medicaid.









Current Trajectory Hypothetical Treatment Outcome

Alzheimer's Disease and Related Disorders Association, Inc.
SCHEDULE OF FEDERAL/SUBCONTRACTOR AWARDS RECEIVED
July 1, 2008 thru May 31, 2011

Federal Grantor/Subcontractor Grantor/Program Title	7/1/10 - 05/31/11	Y/E 6/30/10	Y/E 6/30/09
U.S. Department of Health and Human Services			
Administration on Aging - Special Programs for the Aging - Title IV and Title II - Discretionary Projects Alzheimer's National Call Center	$ 987,000	$ 963,500	$ 963,500
Centers for Disease Control and Prevention - Investigations and Technical Assistance - To Partner and Implement Public Health Strategies	584,993	822,438	542,079
National Institute of Health			
Int'l Conference on Alzheimer's Disease & Related Disorders			50,000
U.S. Department of Justice			
Office of Juvenile Justice and Delinquency Prevention - Missing Children's Assistance - National Alzheimer's Patient Alert Program: Wandering & Safety Response Initiative	65,556	59,262	
Office of Juvenile Justice and Delinquency Prevention - Missing Children's Assistance - National Alzheimer's Patient Alert Program: Safe Return		229,285	610,715
U.S. Department of Transportation			
National Highway Traffic Safety Administration Older Driver Resources on Caregivers & Dementia	6,765		
RTI International			
Alzheimer's Disease Demonstration Grants to States Program	6,045	57,654	179,227
Alzheimer's Disease Supportive Services Program	192,064	145,085	
Total revenues/subcontracted awards received	$ 1,842,423	$ 2,277,224	$ 2,345,521
Annual/YTD Revenues	$ 82,054,000	$ 87,888,000	$ 91,600,000
% of federal/subcontracted awards as a % of annual revenues	2.25%	2.59%	2.56%

Mr. PITTS. The chair thanks the gentleman and recognizes Mr. Millwee for 5 minutes.

STATEMENT OF BILLY MILLWEE

Mr. MILLWEE. Thank you, Mr. Chairman, members of the committee. I would like to spend a few minutes speaking to you about the STAR+PLUS program. The STAR+PLUS program is a capitated managed care model that integrates acute and community-based care services for the aged, blind and disabled population in Texas. This includes the dual-eligible members.

A little bit about the Texas Medicaid population. There are about 3.2 million people on Medicaid in Texas today. Of that number, about 700,000 are classified as aged, blind and disabled, and of that number, about 400,000 are duals. ABDs represent about 25 percent of the Medicaid population but approximately 58 percent of the total Medicaid cost.

Where does STAR+PLUS originate? STAR+PLUS originated in 1998 as a pilot in Harris County in Houston. It was created largely to address concerns about cost, quality and access to services for the aged, blind and disabled population, also the subset we refer to as duals, and to address how we could better integrate acute and long-term care for that population. The program was started with about 58,000 people in 1998. Today, STAR+PLUS now serves 42 Texas counties and 257,000 people. By March 2012, the program will be expanded to serve another 370,000 people in Texas in 80 counties.

And here is how the program works at a very high level. It is an integrated care delivery model in a capitated managed care environment so we take acute care services and long-term care services and bundle those together, deliver them to the HMO. Central to that model is a primary care provider and a service coordinator who really work with that patient to get them the services that they need, whether those services are acute care or long-term care. The service coordinator is responsible for assessing that person's need and ensuring that the needs are met, and by doing that, it provides that early intervention so we keep people out of the hospital, out of the emergency room and out of the nursing institutions.

Several studies to date by our external quality review organization have shown the model is effective. We have decreased inpatient services, hospitalizations about 22 percent, reduced ED visits by 15 percent, and, more importantly, people who are involved in the program report a high degree of satisfaction with the program. We are excited about the opportunity now to work with CMS on how we can better coordinate care and I look forward to working with Melanie Bella in her program that she just started.

[The prepared statement of Mr. Millwee follows:]

Testimony of Billy Millwee

Associate Commissioner, Medicaid and CHIP

Texas Health and Human Services Commission

before the

House Energy and Commerce Committee, Health Subcommittee

June 21, 2011

Introduction

I am pleased to be with you today to offer testimony regarding the challenges and opportunities of providing comprehensive Medicaid health care services to the aged and persons with disabilities that are dually eligible for Medicaid and Medicare through the STAR+PLUS program.

The Texas Health and Human Services Commission (HHSC) is the state agency responsible for administering the state's Medicaid and Children's Health Insurance Programs.

Texas, like many other states, has experienced considerable growth in our Medicaid program in recent years. The Texas Medicaid program now serves more than 3 million people out of a total population of about 25 million.

The aged and persons with disabilities comprise about 25 percent of Medicaid recipients in the State of Texas and about 58 percent of the state's Medicaid costs.

These clients often have complex medical conditions and frequently need both acute care—hospitalization, outpatient services, laboratory—and long term services provided in the home or community, such as assistance with daily living, skilled nursing, and therapy services.

STAR+PLUS

In the mid-1990s, Texas began to see that the costs of care for the aged and persons with disabilities in Medicaid was rising in part because there was no comprehensive approach to treatment. In response, the state developed the STAR+PLUS program in Harris County Texas in 1998 serving 58,000 clients, half of whom were dual eligibles.

STAR+PLUS now serves 42 counties and over 257,000 persons. By March 2012, STAR+PLUS will serve over 386,000 people in 80 urban counties in Texas. Both Medicaid and Medicare cover more than half of these people, referred to as "dual eligibles." Dual eligibles confront a care system in which Medicare provides their acute care services, with most of their long-term services and supports provided by Medicaid. This bifurcation makes it difficult for either state or federal programs to assess the needs of these clients and address their health care and long-term care requirements comprehensively.

STAR+PLUS addresses this problem by integrating the delivery of acute and long-term services and supports for aged, blind and disabled Medicaid recipients. By increasing appropriate preventive and supportive care in the community, a corresponding reduction of acute care costs is possible. Presently, Texas is able to determine this for the Medicaid only population, as it has all the available data for this population. However, Texas believes that this same savings is achieved for the acute care services provided to the persons in STAR+PLUS that have both Medicare and Medicaid.

A central feature of STAR+PLUS is service coordination. Each STAR+PLUS member, including dual eligibles, has access to a Service Coordinator who is responsible for assessing that person's Medicaid and long-term care needs and ensuring that those needs are met. A Service Coordinator is a clinician or other knowledgeable person that can respond to a person needs to develop an individual plan of care for the person. While not responsible for the provision of Medicare services, the Service Coordinator is able to assist a person to locate a Medicare physician, ensure the physician is aware of the person's needs and services provided by Medicaid.

By providing early intervention or rapidly responding to a person's condition change, STAR+PLUS helps reduce inappropriate and unnecessary emergency room visits, hospitalizations, or placement in a nursing facility.

Cost

In STAR+PLUS, managed care organizations (MCOs) provide all acute and long-term care services through a "full-risk" capitated model. This model combines the responsibility for both the financing and service delivery under one entity and drives a patient-centered management approach to addressing multiple and complex health care needs. MCOs have incentives to coordinate care and services that reduce the costs of inpatient care, over-utilization of prescription drugs, and other expensive categories of health care services. The state balances cost and quality objectives through a system that puts part of the payments to the MCO "at-risk" of payback to the State if certain access to care and health outcome standards are not met.

Studies have shown that STAR+PLUS has improved access to services, reduced duplication, and created a more effective delivery of health care services. STAR+PLUS has stemmed the costs for this population, and established greater accountability for the services delivered to individuals under Medicaid. A recent analysis estimates STAR+PLUS may save up to:

- 22% for in-patient care;
- 15% for acute out-patient care, including emergency room care;
- 15% for non-physician services, ambulatory care, home health, and behavioral health; and
- 10% for long-term services and supports (LTSS).

Quality/Satisfaction

In addition to the cost advantages of the model, the comprehensive approach to care creates opportunities to deliver high quality services to clients and savings several ways. A review of 22 Medicaid managed care studies conducted by the Lewin Group determined that these mechanisms include:

- Improving access to preventive and primary health care by requiring providers to meet standards for hours of operation, availability of services, and acceptance of new patients;
- Investing in outreach and education that promote preventive services and healthy behaviors;
- Providing a "medical home" to an individual as opposed to relying on the patient's ability to self-refer appropriately;
- Providing case management and disease management services;
- Using lower-cost services and products where such services and products are available and clinically appropriate; and
- Enhancing provider accountability for quality and cost-effectiveness.

Access

A key integration feature of STAR+PLUS is improved access to long-term services and supports and the reduction of interest lists for community-based long-term care services in lieu of nursing facility placement. Upon entering STAR+PLUS, any person that is eligible for Supplemental Security Insurance and identified as having the need for long term services is immediately evaluated and a plan of care tailored to that person's needs

is developed. This access is not available in the traditional Medicaid Community-based Alternatives program.

Summary

The STAR+PLUS program has resulted in cost savings to the State and improved access and quality of care for clients. Since 1998 the STAR+PLUS program has demonstrated positive outcomes with regards to access to health care services, quality of care, client satisfaction and cost effectiveness. The STAR+PLUS program has demonstrated the ability to support aged and disabled persons in their communities and produce cost savings for a population that accounts for a disproportionate share of Medicaid costs.

Again, STAR+PLUS:

- Integrates acute care and long-term services and supports.
- Provides eligible persons that qualify for long-term services and supports access to these services without being placed on an interest list.
- Allows flexibility in benefits (can provide non-Medicaid covered services as service substitutions).
- Transfers risk for the cost of health care services from the state to the MCO.
- Facilitates the use of preventive health care and community support services.

Mr. PITTS. The chair thanks the gentleman and recognizes Ms. Hewson for 5 minutes.

STATEMENT OF DENISE LEVIS HEWSON

Ms. HEWSON. Good afternoon, Chairman Pitts and Ranking Member Pallone and the other distinguished members of the subcommittee. I am Denise Levis Hewson. I direct the clinical and quality programs for Community Care of North Carolina, and I appreciate the opportunity to tell you about our program. It is a collaborative organization of regional networks of health care providers, physicians, hospitals, health departments, social service agencies and other community organizations. Each network is a nonprofit organization and I work for the central office that helps coordinate and provides supports to all of the 14 networks.

We create medical homes matching each patient with a primary care provider who leads an interdisciplinary team, professionals who coordinate seamless medical services aimed at producing better outcomes. Our challenge is not only to improve the quality of care but to cut costs without changing benefits and fees. As you start looking at changing the benefit package and fee structures, oftentimes you are pushing the patient into other delivery areas like the emergency room. You need engaged providers to do this program and engaged patients to be successful.

Sustainable savings come only from learning to deliver care in a smarter and more coordinated way. We have been doing this for 10 years. We started as a pilot in 1998 and we have been adapting and refining this model, most recently really targeting the highest costs and highest risk.

What is different about program is that it is led by physicians who are charged with changing the face of health care at the local community level. It is a bottom-up governance. It is key to getting buy-in at the practice level. We have begun to make some significant changes in local delivery systems. It is built on a model where each patient has a medical home. We have 1,400 medical homes across North Carolina in our 14 networks that provide the infrastructure to provide wraparound support to the medical homes. We have about 600 care managers. We have 30 medical directors, 14 network directors, 18 clinical pharmacists and 10 local psychiatrists. These are local people managing local patients and driving improvements in their systems. The physicians are engaged because they are part of the solution. They lead the local teams. They decide how to collaborate best to get the best results.

Efforts to improve care and save money are owned by those who directly provide that care. Our care managers know their patients. They know the community and the resources and that varies greatly in some of our rural communities. Care managers are the boots on the ground. They connect the dots between the patient, the physician, the specialist, the hospital, home health and other community resources. We believe that all health care is local and that community support for individuals with multiple chronic conditions can significantly improve health outcomes.

One of the challenges in this program is defining the impactable population. You have to have the information and data to go after

those patients and manage them and provide the right support so that they can have better outcomes.

We serve over a million Medicaid recipients. We started as a Medicaid program. Now we have about 80,000 duals that are enrolled with our program. In addition, about 180,000 of those are aged, blind, disabled so those represent fairly large, significant high-cost patients. We get hospital data. Hospitals and community providers are partners in this organization. To manage these individuals, you have to follow them across different providers and delivery systems.

We hope that this committee will look hard at better aligning Medicare and Medicaid services at the patient and community level, allow for shared savings in per-member, per-month management fees that provide patient management without capitation or risk models. We are a fee-for-service system. The delivery system must be patient centered. The important thing to remember is that patients need changes over time so a system must follow their needs across settings and providers. Our community-based medical home and network infrastructure focuses on population management strategies, and we aim to achieve the triple aims that we hear a lot in the literature, which is not only about improving quality, access and reliability but reducing the cost of that care. We have learned some key lessons in North Carolina with the dual population, and you have heard it by several of the other testimonies today that they have multiple comorbidities. They use the system more than a lot of other populations. They take a lot of medicines. And so they truly do benefit from a wraparound support at the community level. Our total annual budget for Community Care is about 1 percent of the total Medicaid costs in North Carolina.

Our commitment to quality doesn't just mean better care, it also leads to significant program savings. We asked the analytics company, Trio Solutions, to help us estimate savings, and they have done that and you have got more information of that in some of the handouts. Our trend data is fairly significant in terms of costs and savings.

Mr. Chairman, I would like to thank you and the members of your subcommittee for the opportunity to be here today and discuss these issues, and we hope we can be a resource to you as you move ahead.

[The prepared statement of Ms. Hewson follows:]

United States House of Representatives
Energy and Commerce Subcommittee on Health

Testimony of Denise Levis Hewson
Director of Clinical Programs and Quality Improvement
Community Care of North Carolina

June 21, 2011

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Good afternoon Chairman Pitts, Ranking Member Pallone and distinguished members of the Subcommittee. I am Denise Levis Hewson, Director of Clinical Programs and Quality Improvement Community Care of North Carolina. Thank you for the opportunity to discuss our work with citizens dually eligible for Medicare and Medicaid in North Carolina enrolled in the Community Care Program.

What is Community Care of North Carolina (CCNC)?

Community Care is a collaborative organization comprised of regional networks of health care providers, physicians, hospitals, health departments, social service agencies and other community organizations. Each network is a nonprofit organization and CCNC is a separate nonprofit that serves as a "central office" coordinating efforts statewide and providing economies of scale for mutually-beneficial efforts like building robust data systems and supporting clinical and quality program implementation .

We create medical homes, matching each patient with a primary care provider who leads an interdisciplinary care team — professionals who coordinate seamless medical services aimed at producing better outcomes.

Our challenge is to cut costs without slashing fees or benefits – as limiting access to preventive and primary care can often have the opposite effect on cost as what is intended. We have found that you simply don't save money by moving more people's care into the ER setting.

Sustainable savings come only from learning to deliver care in a smarter, more coordinated way. In the last ten years, we have learned how to do that in North Carolina. We're always adapting and refining our model, but we've had some success in changing how care is delivered for the highest risk and cost patients.

What is different about CCNC?

CCNC is led by the physicians who are charged with changing the face of health care. This bottom-up governance is key to getting buy-in at the practice level. With this buy-in, we have begun to make significant changes in how the community-based health care delivery system functions.

CCNC is built on a model in which every patient has a "medical home." This approach identifies a primary care physician who assumes responsibility for an enrolled patient population over the long term. We have built more than 1,400 medical homes across North Carolina.

In our 14 networks across the state, we wrap support around the primary care physicians / medical homes with: approximately 600 care managers, 30 medical directors, 14 network directors, 18 clinical pharmacists and 10 local psychiatrists. These are local people managing local patients – and driving improvements in the system. The physicians are engaged and participate in creating standardized expectations around implementing evidence based best practices – they lead the local

teams deciding how to collaborate to get the best results. CCNC's partners are accountable and empowered.

Efforts to improve care and save money are owned by those who directly care for patients. CCNC Care managers know their patients, the community and the resources that are available locally. Care managers "on the ground" connect the dots between patient, physician, specialist, hospital, home health, and other community resources. We believe that all health care is local and that community support for individuals with multiple, chronic conditions can significantly improve health outcomes.

The state and CCNC identify clinical priorities based on incidence, cost and amenability to specific health interventions. CCNC's informatics Center provides quality and care management data to networks and practices. Physicians get regular performance feedback that helps drive improvement in the care they deliver. They are held accountable for improving care and containing costs. We believe it is critically important to stratify your population to focus on patient who will benefit the most from your population management interventions.

Who works together for CCNC enrollees?

Serving CCNC's over 1 Million Medicaid and NC Health Choice enrollees — some of our state's most vulnerable citizens – is a big job. This population includes citizens from all 100 North Carolina counties. This includes about 80,000 dual-eligible beneficiaries and about 180,000 beneficiaries in the Aged, Blind and Disabled (ABD) category.

Hospitals provide data and collaborate in patient management. Health departments, departments of social services, local hospitals, mental health organizations and area health educations centers

are also key partners. For dually-eligible patients, our networks and practices are also connecting with long-term care support providers.

We hope this committee will look hard at better aligning Medicare and Medicaid services at the patient and community level. Allowing for shared savings and/or per-member, per-month management fees that would provide better patient management without capitation, risk models, new provider organizations or additional silos. The delivery system must be patient centered. The important thing to remember is that patients' needs change over time so a system must follow the patient across settings and providers and engage patients early in their chronic disease process. Our community based medical home and network infrastructure can focus on population management strategies and achieve the "triple aims" – of improving the health care of the dual population; improving the quality, access and reliability of care; and reducing the costs of care.

Financial impact

The total annual budget for Community Care and its 14 networks is just one percent of total Medicaid costs in North Carolina, yet CCNC's performance metrics have met or exceeded HEDIS measures attained by managed care organizations managing other state Medicaid populations.

Our commitment to quality doesn't just mean better care. It has also lead to significant program savings. We asked an analytics company Treo Solutions to help us estimate CCNC's impact on cost. Looking at data from just 2007 through 2009, Treo estimated CCNC to have saved nearly 1.5 billion dollars in health care costs in North Carolina. When we have all of the data for 2010, we think this number will rise considerably.

Our trend data is also significant. What we're seeing is that when figures are adjusted for risk, actual costs for CCNC enrollees are consistently below expectations. Conversely, costs for the un-enrolled Medicaid population are significant *higher* than expected – comparable to the cost creep most states are seeing.

For example, on a per-member, per-month (PMPM) basis, costs for CCNC enrollees dropped from $397 to $391 between 2007 and 2009. Costs for non-enrolled Medicaid patients were 15 and 16 percent higher in than expected in 2008 and 2009, respectively.

Private sector interest grows

Seeing what we've done in North Carolina with Medicaid, other payers have gotten interested in utilizing CCNC's approach. This includes Medicare, through the 646 demonstration project in 22 NC counties and a Beacon community, for all payers, in three counties. There is a separate multi-payer demonstration through the CMS Innovations Program in 7 rural counties in our state. Finally, we are about to launch a new initiative with private sector employers and insurers in the Triangle area (Raleigh-Durham-Chapel Hill area around the capital).

Mr. Chairman, I would like to thank you and the members of your Subcommittee for the opportunity to be here today to discuss these important issues. I hope that Community Care can be a resource to this Subcommittee as you move forward.

U.S. House of Representatives, Energy and Commerce Subcommittee on Health

Summary of Testimony Denise Levis Hewson
Director of Clinical Programs and Quality Improvement
Community Care of North Carolina
June 21, 2010

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."

Community Care is a collaborative organization of nonprofit regional networks of primary care physicians, hospitals, health departments, other community organizations.

There is no corporate headquarters or government bureaucracy telling physicians how to practice – just committed, local teams that are accountable for results.

Our system is built on 1400 "medical homes," each lead by a primary care physician who takes responsibility for the managing the health of enrolled beneficiaries.

Physicians get support from 14 CCNC networks, including approximately 600 care managers, 30 medical directors, clinical pharmacists and 10 local psychiatrists.

Cost savings under this model have been significant – estimated at 1.5 billion dollars for the three years from 2007 through 2009.

CCNC's success with the Medicaid population has lead to growing interest from other payers, including Medicare, North Carolina employers, the State Health Plan and private-sector insurers.

Community Care of North Carolina

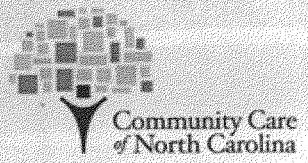
Testimony to the Subcommittee on Health

"Dual-Eligibles: Understanding this Vulnerable Population and How to Improve their Care"

June 21st, 2011

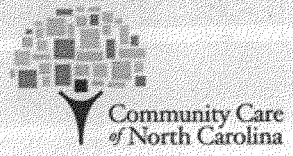
Denise Levis Hewson, RN, BSN, MSPH
Director of Clinical Programs and Quality Improvement

Medicaid & Medicare Challenges



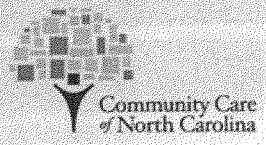
- Lowering reimbursement reduces access and increases ER usage/costs
- Reducing eligibility or benefits limited by federal "maintenance of effort"; raises burden of uninsured on community and providers
- The highest cost patients are also the hardest to manage (disabled, mentally ill, etc.) — CCNC has proven ability to address this challenge
- Utilization control and clinical management only successful strategy to reining in costs overall

Community Care Provides NC with:

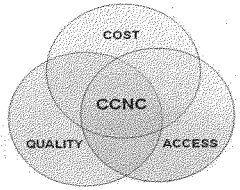


- Statewide medical home & population management system (care & disease management, acute and preventive care, etc) in place to address quality, utilization and cost
- 100 percent of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

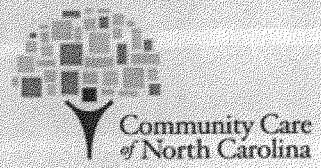
Key Tenets of Community Care



- Public-private partnership
- "Managed not regulated"
- CCNC is a clinical partnership, not just a financing mechanism
- Community-based, physician-led medical homes
- Cut costs primarily by greater quality, efficiency
- Providers who are expected to improve care must have ownership of the improvement process

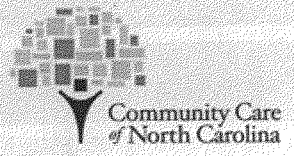


Primary Goals of Community Care



- Improve the care of the enrolled population while controlling costs
- A “medical home” for patients, emphasizing primary care
- Community networks capable of managing recipient care
- Local systems that improve management of chronic illness in both rural and urban settings

Community Care: "How it works"



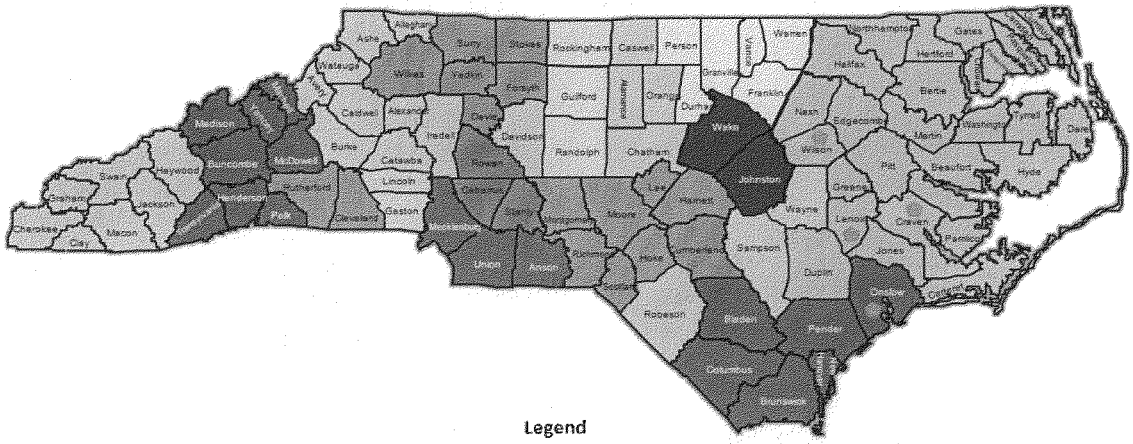
- Primary care medical home available to 1.1 million individuals in all 100 counties (Currently over 80,000 duals are enrolled).
- Provides 4,500 local primary care physicians with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery

How it works

- The state identifies priorities and provides financial support through an enhanced PMPM payment to community networks
- Networks pilot potential solutions and monitor implementation (physician led)
- Networks voluntarily share best practice solutions and best practices are spread to other networks
- The state provides the networks access to data
- Cost savings/ effectiveness are evaluated by the state and third-party consultants (Mercer, Treo Solutions).

Community Care Networks

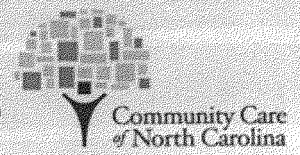
Community Care of North Carolina



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Community Care Networks



- Are non-profit organizations that receive a per member per month (PMPM) payment from the state
- Primary care providers also receive a PMPM payment
- Provides resources needed to manage enrolled population, reducing costs
- Central office of CCNC is also a nonprofit 501(c)(3)
- Seek to incorporate all providers, including safety net providers
- Have Medical Management Committee oversight
- Hire care management staff

Each network has:

- Clinical Director
  - A physician who is well known in the community
  - Works with network physicians to build compliance with care improvement objectives
  - Provides oversight for quality improvement in practices
  - Serves on the Sate Clinical Directors Committee
- Network Director who manages daily operations
- Care Managers to help coordinate services for enrollees/practices
- PharmD to assist with Med Mgt. of high cost patients
- Psychiatrist to assist in mental health integration

Current State-wide Disease and Care Management Initiatives

- **Asthma** (1998 – 1st Initiative)
- **Diabetes** (began in 2000)
- **Dental Screening and Fluoride Varnish** (piloted for the state in 2000)
- **Pharmacy Management**
  - Prescription Advantage List (PAL) - 2003
  - Nursing Home Poly-pharmacy (piloted for the state 2002 - 2003)
  - Pharmacy Home (2007)
  - E-prescribing (2008)
  - Medication Reconciliation (July 2009)
- **Emergency Department Utilization Management** (began with Pediatrics 2004 / Adults 2006)
- **Case Management of High Cost-High Risk** (2004 in concert with rollout of initiatives)
- **Congestive Heart Failure** (pilot 2005; roll-out 2007)
- **Chronic Care Program – including Aged, Blind and Disabled**
  - Pilot in 9 networks 2005 – 2007
  - Began statewide implementation 2008 - 2009
- **Behavioral Health Integration** (began fall 2010)
- **Palliative Care** (began fall 2010)
- **Pregnancy Medical Home** (began spring 2011)

Chronic Care Process
Community Care of North Carolina
Patient-centered Care Management
Care Management Plan
Care Management Team
Care Management Plan
Care Management Team
Care Management Plan
Care Management Team

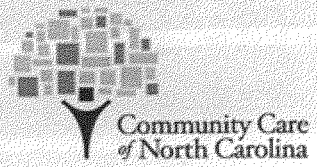
Chronic Care Program Components

- Enrollment/Outreach
- Screening/Assessment/Care Plan
- Risk Stratification/ Identify Target Population
- Patient Centered Medical Home
- Transitional Support
- Pharmacy Home – Medication Reconciliation, Polypharmacy & PolyPrescribing
- Care Management
- Mental Health Integration
- Informatics Center
- Self Management of Chronic Disease

Key Lessons re: Managing the Duals

- Have the highest cost and utilization of health care services
- Have multiple co-morbidities and seek specialty care – managing care across providers and delivery settings
- Greater than 50% have co-morbid mental health conditions – behavioral health integration is important
- Supporting self-management of chronic conditions needs to be a part of the delivery system in the community
- Take multiple medications – poly-pharmacy and poly-prescriber efforts
- Transitional support is paramount – medication reconciliation, participate in hospital discharge planning, coordinate with hospitalists, etc.
- Linkage to a patient centered medical home supported by community-based care managers is a key to our success
- Community based efforts are most effective as solutions to care issues are local

Community Care's Informatics Center



Informatics Center – Medicaid claims data

- Utilization (ED, Hospitalizations)
- Providers (Primary Care, Mental Health, Specialists)
- Diagnoses – Medications – Labs
- Costs
- Individual and Population Level Care Alerts

Real-time data

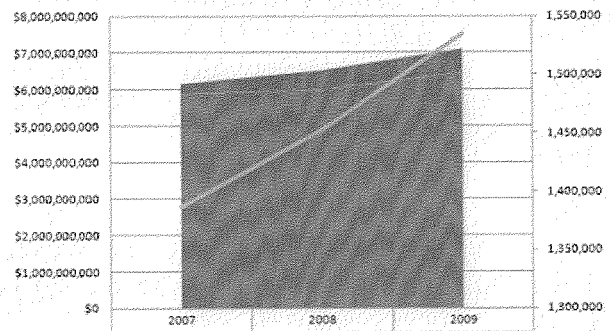
- Hospitalizations, ED visits, provider referrals

Community Care's Informatics Center

- Care Management Information System (CMIS)
- Pharmacy Home
- Quality Measurement and Feedback Chart Review System
- Informatics Center Reports on prevalence, high-opportunity patients, ED use, performance indicators
- Provider Portal

Financial results

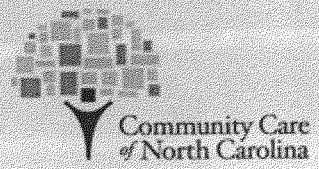
$1.5 Billion Savings Attributable to CCNC 2007-2009



	2007	2008	2009
Cost Avoided with CCNC	$273,494,489	$530,025,813	$653,783,841
Total Actual Paid	$5,883,757,653	$5,995,955,476	$6,463,531,761
Total Distinct Medicaid Recipients	1,387,170	1,451,987	1,534,971

Using the unenrolled fee-for-service population, risk adjustments were made by creating a total cost of care (PMPM) set of weights by Clinical Risk Group (CRG), with age and gender adjustments. This weight set was then applied to the entire NC Medicaid Population. Using the FFS weight set and base PMPM, expected costs were calculated. This FFS expected amount was compared to the actual Medicaid spend for 2007, 2008, 2009. The difference between actual and expected spend was considered savings attributable to CCNC. Treo Solutions, Inc., June 2011.

Financial results

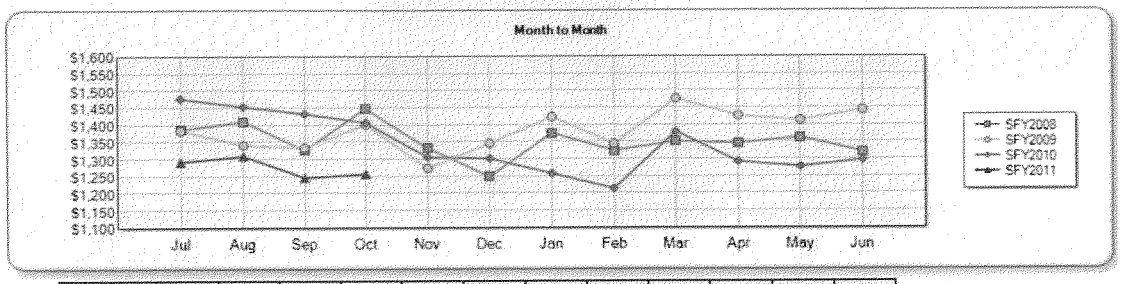


- **Earlier studies by Mercer, Inc. estimated CCNC savings as:**

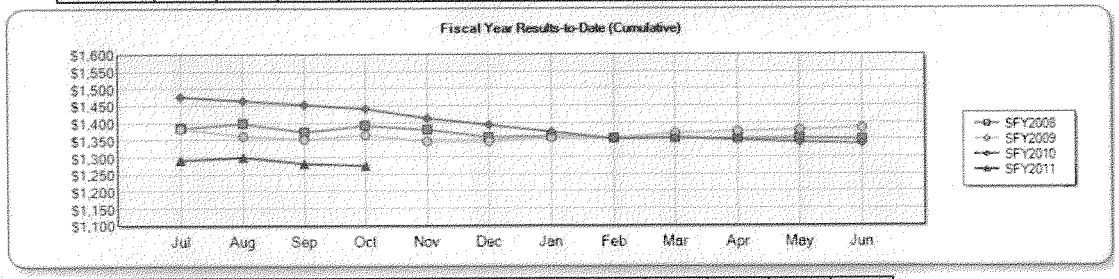
State Fiscal Year	Estimated Savings
2005	$77 - $81M
2006	$154 - $170M
2007	$135 - $149M
2008	$156 - $164M
2009	$186 - $194M

DHHS Performance Measures for CCNC

Enrolled Non-Dual ABD Cost PMPM



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,410	$1,325	$1,447	$1,331	$1,248	$1,375	$1,324	$1,351	$1,345	$1,362	$1,321
SFY2009	$1,383	$1,340	$1,333	$1,400	$1,273	$1,345	$1,422	$1,344	$1,476	$1,426	$1,412	$1,443
SFY2010	$1,476	$1,453	$1,432	$1,406	$1,305	$1,301	$1,257	$1,213	$1,379	$1,291	$1,277	$1,297
SFY2011	$1,291	$1,308	$1,246	$1,256	-	-	-	-	-	-	-	-



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY2008	$1,385	$1,398	$1,373	$1,392	$1,379	$1,357	$1,360	$1,355	$1,355	$1,354	$1,355	$1,352
SFY2009	$1,383	$1,361	$1,352	$1,364	$1,345	$1,345	$1,356	$1,355	$1,369	$1,375	$1,379	$1,385
SFY2010	$1,476	$1,464	$1,453	$1,441	$1,413	$1,394	$1,374	$1,353	$1,356	$1,350	$1,343	$1,339
SFY2011	$1,291	$1,300	$1,281	$1,274	-	-	-	-	-	-	-	-

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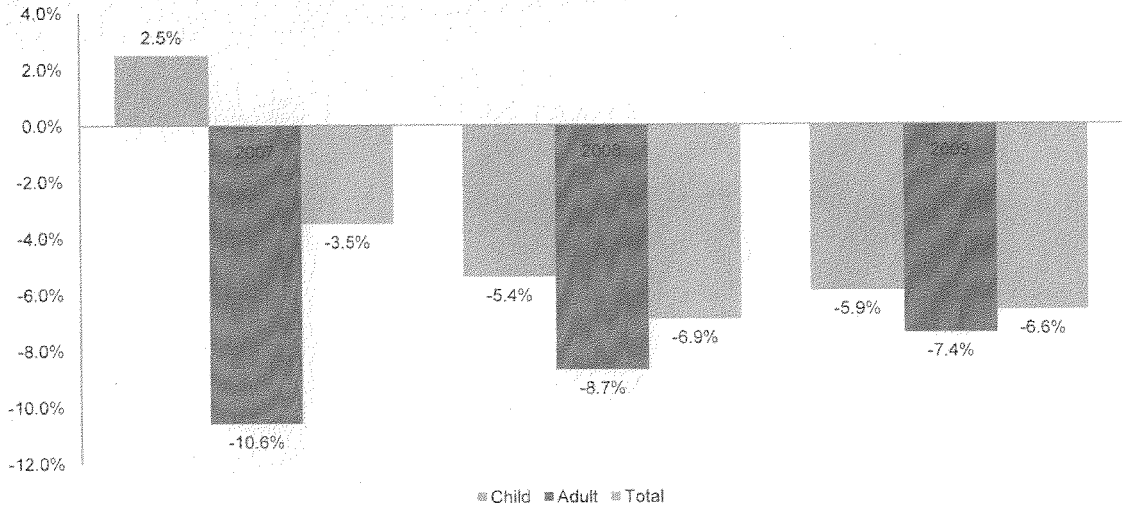


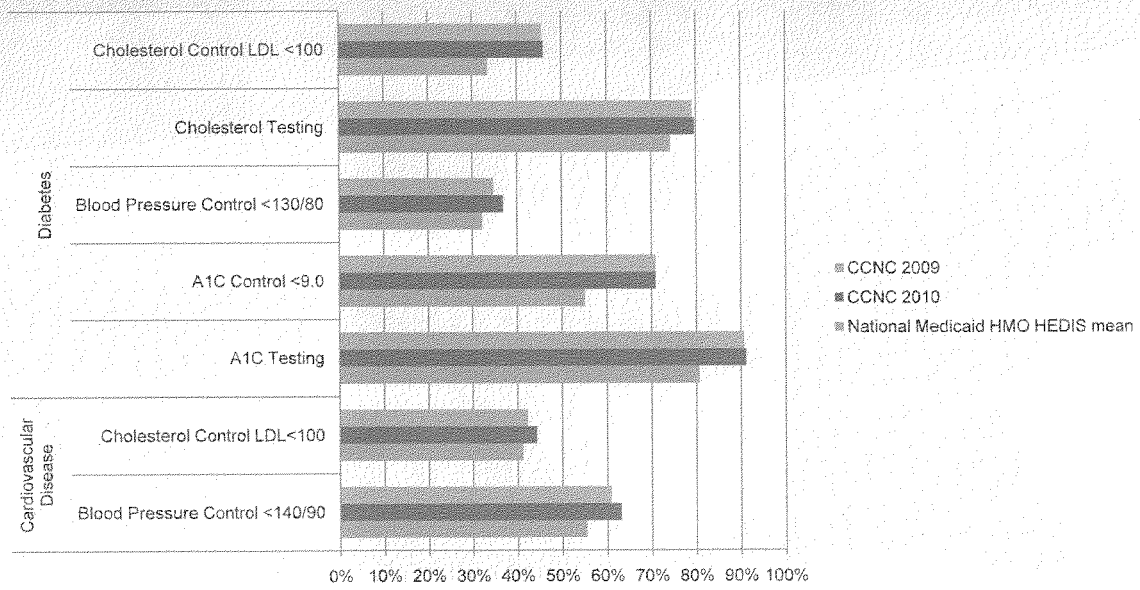
Variance from Expected Spending

Adjusting for the severity of illness of the population, total spending for CCNC enrollees has been lower than expected each of the past 3 years.

Quality results

- Community Care is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care.
- More than $700 million in state Medicaid savings since 2006.
- Adjusting for severity, costs are 7 % lower than expected. Costs for non-Community Care patients are higher than expected by 15 percent in 2008 and 16 percent in 2009.
- For the first three months of FY 2011, per member per month costs are running 6 percent below FY 2009 figures.
- For FY 2011, Medicaid expenditures are running below forecast and below prior year (over $500 million).

Quality HEDIS Measures



Building on Success

Other payers and major employers are interested in benefit's of CCNC's approach

- Medicare 646 demo (22 counties) caring for Medicare patients (including duals)
- Beacon Community (3 counties), all payers
- Multi-payer primary care demo (7 rural counties) Medicare, Medicaid, Blue Cross and Blue Shield of North Carolina, State Employees Health Plan
- New major employer initiative (40,000 patients)

Improving Care for Duals- NC

- Aligning Medicare and Medicaid is important
- Additional pmpm payments needed to support services needed to improve care
- Local flexibility and collaborative partnerships necessary to work both in rural and urban areas
- Programs targeting at risk "pre-duals" may have biggest budget impact
- Data needed to manage population

Mr. PITTS. The chair thanks the gentlelady and recognizes Mr. Bloom for 5 minutes.

STATEMENT OF SHAWN BLOOM

Mr. BLOOM. Thank you very much, Chairman Pitts, Ranking Member Pallone and distinguished members of the subcommittee. I am Shawn Bloom, CEO of the National PACE Association. On behalf of NPA and its members, I am honored to testify today, and I appreciate the time that you have allotted us.

I would like to kind of focus on three things, very briefly describe PACE to you and then offer some suggestions regarding ideas with respect to overcoming barriers that we have identified in expanding PACE, and three, identify some voluntary demonstration programs that we have generated in which we could expand the availability of PACE to additional eligible categories of dually eligible.

First and foremost, PACE is a fully integrated model of care that exclusively serves the frailest, oldest and sickest subset of the duals, that is, the nursing home-eligible seniors. We do so in a manner that is really focused in the community in the sense that we are community based. Our goal in PACE is to allow individuals to remain living in their homes in the community. We do that through reducing nursing home use, reducing hospitalization, and we do that in a comprehensive fashion through integrated use of Medicare and Medicaid bundled payment, and the heartbeat within PACE is the interdisciplinary team, or the concierge team, if you want to call it that, in the sense that they are a fully employed staff that on a daily basis are involved in the care, delivery and management of the care of the individuals that we serve. And the third key feature of PACE is, we are accountable. We are accountable in the sense that we are accountable to government for the payment provided to PACE, 90 percent of which comes from Medicare and Medicaid, and we are accountable to the families and the frail that we serve. And I think those three things taken together have very effectively aligned incentives for PACE. We are fully accountable for the cost and quality of care that we directly provide. So to the extent that we do a good job, those that we serve are able to stay out of the hospital, in their homes and achieve good health care.

I think recognizing the effectiveness of PACE, a recent June 15th MedPAC report states: "Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services." Authorized by the Balanced Budget Act of 1997, we have been around for 20 years. We are a tested model of care, and we are very interested in finding ways to kind of growth.

I think as has been mentioned earlier, and I think Melanie mentioned it, there have been significant obstacles to PACE growth, and we would like to kind of talk just a minute about those now. One, some of the regulatory requirements certainly focus on the required process of care rather than the outcomes of care, and those particular regulatory requirements have so far hindered growth, innovation and efficiency and how we deliver care. Two, fairly significant capital startup costs and long lead times for programs that accept full financial risk for a population that on average is about

300 people, that is a significant undertaking, and our eligibility for PACE is very narrow. We serve, as I mentioned earlier, a very small subset of the duals 55 years of age or older, and you have to be nursing home eligible. We believe there are opportunities to expand the availability of PACE.

So to overcome these barriers, we recommend the following modifications to the PACE statute and regulation, and this is based on a decade of operational experience under the current regulation. One, allow us to more appropriately use contract community-based physicians rather than full employed physicians; two, take full advantage of the State license capability of nurse practitioners and physician assistants to practice up to their level of standards within the State practice acts; and then without compromising PACE participants' receipt of comprehensive care and assessment, allow more flexibility to personalize and individualize the use of interdisciplinary teams based on the individuals' needs, not using a one-size-fits-all approach. And lastly, allow States, and this is something of great interest to PACE providers right now, really begin to look at States and encourage them to see PACE as a means by which to pull people out of nursing homes. Some of our PACE programs throughout the States without great State support have had the ability to do that.

With respect to voluntary demonstrations, we have five ideas with the goal of kind of expanding PACE and finding additional regulatory modifications. One, we would like to expand the availability of PACE to individuals under the age of 55 that are nursing home eligible. These are typically the physically disabled individuals that we believe would benefit from PACE. Two, allow at-risk or what we call high-need, high-risk, high-cost beneficiaries to have access to PACE, many of which are not currently nursing home eligible but we believe would benefit from PACE services. Three, reduce PACE organizations' reliance on the PACE center, which is really the focal point for the organization of services but not necessarily the need to kind of do it all there. Fourth, the ability to kind of implement alternative approaches to providing Part D drugs. Right now, we have to implement Part D in the context of a very small program whose benefit was designed for large health plans. And lastly, a demonstration with the objective of increasing Medicare-only beneficiaries' enrollment in PACE. Currently, about 90 percent of all beneficiaries in PACE are duals but we believe it is a model of care that should be applicable to others.

If I had more time, I could give you a great story about the actual benefits of PACE to a consumer but unfortunately I have run out of time, but we appreciate the opportunity to testify before the care, and as mentioned before, PACE is a tangible, proven model of care and we look forward to working with the committee to find ways to expand its reach. Thank you very much.

[The prepared statement of Mr. Bloom follows:]

Testimony of Shawn Bloom
President & Chief Executive Officer
National PACE Association

Before the Committee on Energy and Commerce
Subcommittee on Health

"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care"

Tuesday, June 21, 2011

801 N. Fairfax St., Suite 309
Alexandria, VA 22314

INTRODUCTION

Chairman Pitts, Ranking Member Pallone, distinguished members of the Subcommittee, my name is Shawn Bloom. I am the President and Chief Executive Officer of the National PACE Association (NPA). On behalf of the 76 PACE organizations that are members of the NPA and more than 30 additional members actively working to develop PACE programs across the country, I am honored to appear before the Subcommittee today.

There are nearly 9 million individuals "dually" eligible for both Medicare and Medicaid. Dual-eligible Medicare and Medicaid beneficiaries often have multiple, complex health conditions. As a cohort, they are in poorer health and have lower incomes relative to other Medicare beneficiaries. They also happen to be one of the most expensive categories of beneficiaries served by federal health care programs. According to a June 2010 report by the Medicare Payment Advisory Commission (MedPAC), on average, annual fee-for-service spending on dual-eligible beneficiaries is 2.2 times higher than annual fee-for-service spending on beneficiaries who are not dually-eligible beneficiaries; $15,384 for duals versus $6,992 for non-duals.

We understand the dual-eligible population well. Almost 90 percent of PACE participants are dual-eligibles. PACE exclusively serves the frailest subset of the duals, older adults requiring nursing home level of care. Such frail older dual-eligible beneficiaries served by PACE are precisely those who have the most complex treatment needs, have the highest health care expenses, and have illnesses and needs that place the greatest demand on family caregivers. The vast majority of individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of

daily living, such as eating, bathing, transferring, toileting and dressing. About half of our program enrollees have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older, averaging 81 years of age, 30 percent of which are age 85 or older.

My testimony will focus on three main areas. First, I want to briefly discuss the history of the Program of All-inclusive Care for the Elderly (PACE) and outline the PACE model of care, focusing on those elements that have made the program so successful in providing high-value, person-centered care to the oldest and frailest of the duals. Second, based on our experience, I will identify several barriers to PACE growth and expansion since PACE was established as a nationwide, permanent Medicare provider and state Medicaid option in 1997. Finally, I will propose several program enhancements and potential voluntary demonstration programs that could help expand the PACE program to a greater number of dual-eligibles and others who would benefit from receiving PACE services and benefits.

PACE HISTORY AND EXPANSION

PACE was developed and first implemented in 1983 by On Lok Senior Health Services in San Francisco, California. On Lok originated in response to the local Chinese-American community's desire to provide comprehensive medical care and social services for its elders without placing them in nursing homes.

The success of PACE would not have been possible without the longstanding bipartisan support of Congress, including several members currently serving on the Energy and Commerce Committee. The PACE community-centered approach pioneered by On Lok proved so successful in enabling older adults to remain in their homes that the federal government extended

the program to additional sites across the country through a demonstration program beginning in 1986. Based on the demonstration's success, in the Balanced Budget Act of 1997, Congress authorized PACE as a permanent Medicare provider and Medicaid state option. In the Deficit Reduction Act (DRA) of 2005, Congress established a program to expand PACE to rural areas of the country.

With the support of Congress, the number of PACE organizations has doubled in the last five years to 76. Today, PACE providers serve 22,000 enrollees in 30 states. Since its inception, on any given day, PACE enables over 90 percent of its participants to remain living in their homes, rather than permanently residing in a nursing home. There also has been more diversity among the types of interested sponsors during the past few years. For example, several hospice organizations now sponsor PACE programs and several others are developing PACE. Additionally, 13 rural PACE programs have been developed in the last four years operated by a range of different types of health care providers such as Area Agencies on Aging and community-health clinics. States' interest in PACE also is growing, driven in large part by policymakers' desire to find better solutions to address dual-eligible beneficiaries' health care needs and, at the same time, to provide more predictability and control of their Medicaid payments to PACE.

For example, Oklahoma is exploring a statewide expansion of PACE as a potential strategy to improve care for the state's dually-eligible population. There are 10 programs under development in North Carolina and in the next two years almost all eligible frail elderly will have access to a PACE program in New Jersey and Pennsylvania. Lastly, Texas just passed legislation intended to support the growth of PACE.

We also understand that the need and desire for PACE likely will increase as the population ages and increasingly understands the benefits of integrated care.

KEY FEATURES OF THE PACE PROGRAM

The PACE program has three fundamental characteristics: (1) it is a community-based care provider, not a health plan; (2) it provides comprehensive, fully-integrated care; and (3) it is fully-accountable and responsible to its enrollees, their families and the government for the quality and cost of care it provides.

PACE is a community-based provider of care. Since its beginning as a demonstration program more than 25 years ago, PACE has provided innovative person-centered care for frail older adults that allows them to stay in their homes in the community, an option many families do not think is even possible. Without PACE, many of these frail adults would be in a nursing home. PACE is the recognized gold standard for older adult care and a model for how others looking to improve the system could succeed.

PACE provides comprehensive and fully integrated care. The PACE financing model bundles fixed payments from Medicare and Medicaid or private sources into one flat-rate payment to provide the entire range of health care services a person needs – including paying for hospital and nursing home care, when necessary. While a number of ideas are circulating about possible ways to coordinate care, PACE is a "real" program that has a long history of combining care into one seamless delivery package. Our programs are not large insurers primarily involved in approving and paying medical claims. Rather, they are the primary caregivers for the beneficiaries they serve. At the heart of the PACE delivery model is an interdisciplinary team (IDT) comprised of doctors, nurses, therapists, social workers, dieticians, personal care aides, transportation drivers, and others who meet daily to discuss the needs of PACE participants. Through PACE's unified financing system, older adults receive individualized care that revolves around their unique needs and at a fixed payment amount.

PACE is accountable to its enrollees, their families and government, accepting full responsibility for the cost AND quality of care it provides. The result is better health outcomes, controlled costs and better value. PACE participants utilize, on average, about three days of hospital care annually. A 2009 interim report to Congress from the Department of Health and Human Services (DHHS) examined the quality and cost of providing PACE program services and found that PACE generates higher quality of care and better outcomes among PACE enrollees than the comparison group. PACE enrollees reported better health status, better preventive care, fewer unmet needs, less pain, less likelihood of depression and

better management of health care. PACE participants also reported high satisfaction with their quality of life and the quality of care they received.

The bottom line is that PACE providers accept 100 percent responsibility for the cost and quality of care they deliver. The focus on prevention and wellness means avoiding unnecessary care and the escalating costs that go along with it. Through PACE's integration of all services, not just financing, costs are controlled and health care outcomes are high.

Perhaps the best way for the members of this Subcommittee, and the American public, to understand what PACE does and what it means to the participants and families that it serves, is to share the experience of one of our enrollees.

George is a 69 year-old who lives in the Southern Bay Area of Northern California. He has severe lung problems, heart failure and kidney disease. He lives alone in a single room occupancy hotel. He walks with a cane and has had several falls. He has short-term memory problems, needs help with bathing, meal preparation, housekeeping and shopping. By his own admission he "isn't good with taking his meds."

In the year prior to his enrollment in PACE, he had been admitted to the hospital four times. During the five-week period prior to enrolling in PACE, he had made three trips to the emergency room—usually complaining of shortness of breath or chest pain. He is on Medicare and Medicaid. He rarely makes it to doctors, primarily because he lacks access to reliable transportation. During his last emergency room visit, the physician who treated George discussed his concerns over George's progressive kidney disease and said George would "likely" need dialysis treatments. Nevertheless, George did not keep his follow-up appointment with the

kidney specialist. The hospital case manager made an entry into his record to "pursue nursing home placement with his next admission."

George was referred by a community social worker to the PACE program in the area. With the integrated payments of Medicare and Medicaid that are core to this program model, he now has access to a full team of on-site primary care physicians, clinic nurses, therapists, and social workers. The PACE program provides transportation to and from the center, as well as to outside specialists. His medications are directly managed by the clinic and home care team. He attends the center three times a week and on the other days a home care worker goes to his apartment to help with meals, medication and hygiene. He eats meals in the center and has meals delivered at home by the PACE program and his nutritional needs are directly overseen by a registered dietician.

Six months after enrollment, he has not been to the emergency room or to the hospital. His kidneys are functioning much better and there is no longer the concern of imminent dialysis. His blood pressure is also better controlled. He has had dental care and his ability to eat is also improved.

Each emergency room visit, with ambulance, costs an estimated $2,500 and each hospital admission was close to $10,000. Based on just his six month stay, PACE saved Medicare at least $30,000. That does not even take into consideration the additional costs of dialysis that were likely avoided. A nursing home placement was avoided and the emergency room was no longer impacted by his frequent visits. Most importantly, George is more engaged with his own care, is more socially connected with other peers in the PACE program, and his quality of life has improved immeasurably.

As George's story shows, the existing PACE statutory and regulatory framework has allowed PACE organizations, together with CMS and states, to implement an effective model of care for dual-eligible individuals, over age 55, experiencing both major chronic diseases, and significant functional and/or cognitive impairments. We know this program works. It has a long track record of success and a nearly 15 year history as a permanent national program.

Just last week, in fact, the Medicare Payment Advisory Committee (MedPAC) released a report to Congress entitled *Medicare and the Health Care Delivery System* which stated that: "Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services."

BARRIERS TO PACE GROWTH

The challenge facing policymakers now is to overcome barriers to PACE growth without compromising PACE beneficiaries' experience, quality of care, and PACE organizations' success at managing the full range of Medicare and Medicaid covered services and their associated costs.

In our view, there are four primary barriers to PACE growth:

1. Certain specific regulatory requirements, focused largely on required processes of care, have hindered growth and innovations to improve efficiency, program growth and meet the changing needs of PACE enrollees.
2. High capital costs and long lead times associated with program start-up and expansion.
3. Requirement that new PACE organizations assume full financial risk for all Medicare and Medicaid covered services on day one of program operations. In contrast to large Medicare Advantage organizations that are insurance entities, PACE organizations are small provider-based programs with less opportunity to distribute risk across their

enrolled population. This is particularly true during the initial years of PACE program operations when the total number of program participants is relatively small.

4. Enrollment in PACE is limited to individuals who are a minimum of 55 years of age and meet states' eligibility criteria for nursing home level of care. From states' perspective, this enrollment limitation prevents PACE from being a more comprehensive solution to addressing the needs of a broader population of high-need, high-cost individuals.

PROPOSED SOLUTIONS TO OVERCOMING PACE BARRIERS

To overcome these barriers, we recommend the following modifications to the PACE statute and regulation:

1. Allow PACE organizations more flexibility in contracting with community-based primary care physicians.

   Currently, PACE participants generally receive their primary care from physicians employed by PACE organizations. As a consequence, PACE growth is limited by PACE organizations' ability to hire additional primary care physicians who are often in short supply and PACE participants' choice of primary care physicians is limited.

2. Permit nurse practitioners (NPs) and physician assistants (PAs) to conduct certain activities that are currently assigned to PACE primary care physicians, in particular to perform participant assessments and engage in care plan development, consistent with state law and regulation governing their scope of practice.

   This change, which would not alter state scope of practice laws in any way, would allow PACE organizations' access to an expanded pool of qualified primary care practitioners to help conduct certain activities.

3. Without compromising PACE participants' receipt of comprehensive assessment and care planning, allow for more flexibility in the composition and processes of the PACE Interdisciplinary Team (IDT).

   We believe a smaller core team made up of the primary care practitioner, nurse and social worker, with requirements to add additional team members as determined necessary on the basis of participants' individual health care needs, would enhance program efficiency without compromising quality of care.

4. Encourage states to utilize PACE as a means for transitioning Medicaid eligible beneficiaries residing in nursing homes back to the community.

   This could be accomplished, for example, under the Money Follows the Person demonstration by (1) allowing an enhanced federal match to apply to the PACE Medicaid capitation payment for PACE program participants who are nursing home residents at

enrollment and who, with the support of the PACE organization, transition to community residence; and (2) requiring states to make an enhanced payment to PACE organizations for these individuals.

DEMONSTRATIONS MAY BE AN IMPORTANT WAY TO EXPAND PACE AVAILABILITY

NPA and its members are in the process of developing several demonstration proposals we will share with CMS and hope they will implement. These voluntary demonstrations will allow PACE organizations and their states to test significant modifications to current PACE requirements and evaluate their implications for participant and program outcomes. This series of voluntary demonstrations is designed with two goals in mind: (1) to foster PACE expansion without compromising quality, outcomes and accountability and (2) to identify specific opportunities for future, additional regulatory changes that will encourage many more prospective providers and states to pursue PACE. Following are the ideas that we are developing and plan to submit to CMS in the near future.

1. A demonstration allowing PACE organizations to enroll individuals under the age of 55 who meet their states' eligibility criteria for nursing home level of care.

   Under this demonstration, PACE organizations would be required to provide comprehensive, coordinated, accountable care but would have substantial flexibility to implement modifications to current PACE regulatory requirements in order to best meet the needs of this younger population.

2. A demonstration to allow PACE organizations to enroll high-need, high-cost beneficiaries, as defined by states, who may not yet meet their eligibility criteria for nursing home level of care and currently are not well served.

3. A demonstration to reduce PACE organizations' reliance on the PACE Center as the primary location for the delivery of service and expanding PACE organizations' use of alternative care settings and contracted community-based providers.

   A demonstration to test expanded use of alternative care settings and expanded use of contract providers would allow CMS, states and PACE organizations to evaluate the impact of these significant changes on a variety of participant outcomes, including quality of care and overall program viability.

4. A demonstration that would allow interested PACE organizations to implement alternative approaches to providing Part D drugs to their PACE participants.

   The administrative requirements associated with Part D have been extensive, particularly in light of PACE organizations' size and core competencies as provider entities.

5. A demonstration with the objective of increasing Medicare-only beneficiaries' enrollment in PACE.

   Currently, the vast majority of PACE participants are eligible for both Medicare and Medicaid benefits. The small number of Medicare-only participants enrolled in PACE pay a monthly premium equivalent to the Medicaid capitation amount and a Part D premium. We would like to test alternative approaches to PACE program design, use of community-based physicians, and premium-setting with the objective of encouraging Medicare-only beneficiaries' enrollment in PACE.

CONCLUSION

In closing, we once again appreciate the opportunity to testify before the Subcommittee. As mentioned, PACE is a tangible program with a proven track record of providing high quality care to the frailest segment of the dual-eligible population. While not all dual-eligible beneficiaries require the intensive services provided by PACE, for the individuals who do, PACE is a good alternative to permanent nursing home placement. PACE is community-based, comprehensive, and fully accountable for all risk. The PACE community would like to contribute to state and federal governments' efforts to improve health care for more dual-eligible individuals, and we look forward to working with you on these activities.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
KEY RESEARCH FINDINGS: QUALITY CARE, IMPROVED HEALTH, COST-EFFECTIVE

Since its first program began 30 years ago, PACE has been the subject of over a hundred health care articles. In many of these, researchers have examined a range of factors to determine whether the community-based, comprehensive and accountable care offered by PACE providers delivers quality care, improved health, and value for the health care system. This chart summarizes key research findings demonstrating PACE effectiveness in delivering gold-standard care for older adults, and ways its approach can be a model for others looking to improve the health care system.

QUALITY CARE PACE treats the whole person, not just a combination of their medical conditions.	
Key Findings	**Supporting Research**
PACE is effective and efficient in treating individuals with multiple and complex health care needs	PACE was one of three chronic care models identified that include processes that improve the effectiveness and efficiency of complex primary care. Four processes present in the most successful models of primary care for community-based older adults who have multiple chronic conditions, including PACE, are: 1) development of a comprehensive patient assessment that includes a complete review of all medical, psychosocial, lifestyle and values issues; 2) creation and implementation of an evidence-based plan of care that addresses all of the patient's health needs; 3) communication and coordination with all who provide care for the patient; and 4) promotion of the patient's (and their family caregiver's) engagement in their own health care. *Boult, C. & Wieland, G.D. (2010). Comprehensive primary care for older patients with multiple chronic conditions: "Nobody rushes you through." JAMA, Vol. 304, No. 17, pp. 1937-1943.*
Caregivers and participants rate PACE high in satisfaction	The findings document a comparatively low annual rate of disenrollment from PACE (7%), suggesting that enrollees are quite satisfied with the care they receive. There is no increase in disenrollment risk by age, functional or cognitive impairment, Medicaid eligibility, or diagnoses. *Temkin-Greener, H.; Bajorska, A.; & Mukamel, D.B. (2006). Disenrollment from an acute/long-term managed care program (PACE). Medical Care, Vol. 44, No. 1, pp. 31-38.* PACE participant satisfaction levels and family member/caregiver satisfaction levels are high (96.9% - 100%) among enrollees of PACE organizations in Tennessee. *Damons, J. (2001). Program of All-Inclusive Care for the Elderly (PACE) Year 2 Overview. Long Term Care, Bureau of TennCare, Tennessee.*
IMPROVED HEALTH PACE emphasizes timely preventive primary care over specialty and institutional care.	
Key Findings	**Supporting Research**
PACE participants report they are healthier, happier and more independent than counterparts in other care settings	A U.S. Department of Health and Human Services study found higher quality of care and better outcomes among PACE participants compared to home and community-based service (HCBS) clients. PACE participants reported: 1) better self-rated health status; 2) better preventive care, with respect to hearing and vision screenings, flu shots and pneumococcal vaccines; 3) fewer unmet needs, such as getting around and dressing; 4) less pain interfering with normal daily functioning; 5) less likelihood of depression; 6) and better management of health care. Both PACE participants and HCBS clients reported high satisfaction with their quality of life and the quality of care they received. *Leavitt, M., Secretary of Health and Human Services. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.* [1]

PACE participants live longer than enrollees in a home- and community-based waiver program	This South Carolina specific study examined long-term survival rates of participants in PACE and an aged and disabled waiver program over a five-year period. Despite being older and more cognitively and functionally impaired than those in an aged and disabled waiver program, PACE participants had a lower long-term mortality rate. When stratifying for mortality risk, "PACE participants had a substantial long-term survival advantage compared with aged and disabled waiver clients into the fifth year of follow-up." The benefit was most apparent in the moderate- to high-risk admissions, highlighting the importance of an integrated, team-managed medical home for older, more disabled participants, such as those in a PACE program. *Wieland, D., Boland, R., Baskins, J., and Kinosian, B. (2010). Five-year survival in a Program of All-Inclusive Care for the Elderly compared with alternative institutional and home- and community-based care. J Gerontol A Biol Sci Med Sci. July: 65(7), pp. 721-726.*
COST-EFFECTIVE The focus on prevention and wellness means avoiding unnecessary care and the costs that go along with it.	
Key Findings	**Supporting Research**
PACE reduces the need for costly, long-term nursing home care	The study found that, "Despite the fact that 100% of the PACE participants were nursing home certifiable, the risk of being admitted to a nursing home long term following enrollment from the community is low." The risk of admission to nursing homes for 30 days or longer was 14.9% within 3 years. Based on this study of 12 PACE sites, fewer than 20% of participants who died spent 30 days or more in a nursing home prior to death. *Friedman, S.; Steinwachs, D.; Rathouz, P.; Burton. L.; & Mukamel, D. (2005). Characteristics Predicting nursing home admission in the program of all-inclusive care for elderly people. The Gerontologist, Vol. 45, No. 2, pp. 157-166.*
PACE prevents and/or significantly reduces preventable hospitalizations	In this Texas specific study, the analysis concluded that despite the number and severity of participant medical conditions, PACE saves Texas about 14% compared to statewide costs of regular nursing home and medical care for the frail elderly. While PACE cares for a more frail population than Medicare in general, PACE enrollees had fewer hospital admissions and shorter hospital stays, thus successfully preventing avoidable conditions that could require or lengthen hospitalization. *Rylander, C. (2000). Recommendation of the Texas Comptroller: Chapter 8: Health and Human Services, "Expand the Use of an Effective Long-term Care Program." Texas Comptroller of Public Accounts, Austin, Texas.* PACE provides a 17% cost savings relative to the TennCare managed care organization/behavioral health organization nursing facility system. Inpatient hospitalization rates are low, averaging 1140 days per 1000 and a 3.1 day average length of stay; an average of 8% of participants received care in a nursing home. *Damons, J. (2001). Program of All-Inclusive Care for the Elderly (PACE) Year 2 Overview. Long Term Care, Bureau of TennCare, Tennessee.* PACE enrollees had fewer hospital admissions, preventable hospital admissions, hospital days, emergency room visits, and preventable emergency room visits than a comparable population enrolled in the Wisconsin Partnership Program. *Kane, R. L.; Homyak, P.; Bershadsky, B; & Flood, S. (2006). Variations on a theme called PACE. Journal of Gerontology Series A, Vol., 61, No. 7, pp. 689-693.* The Massachusetts Division of Health Care Finance and Policy (DHCFP) evaluated the effectiveness of the PACE program in keeping its enrollees well and out of a hospital. PACE was compared to a group of older adults who, like PACE program participants, were nursing home eligible, but receiving care in a home or community rather than institutional setting, and a sample of nursing home residents. The analysis found that PACE inpatient days, average length of stay, and outpatient emergency department visit rates were lower than the nursing home group. PACE also showed lower rates of inpatient discharges, days, and emergency department visits than the waiver group. *Division of Health Care Finance and Policy, Executive Office of Elder Affairs. (2005). PACE Evaluation Summary. Accessed on May 25, 2011 at: http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/05/pace_eval.pdf.* A New York City specific study compared hospital and skilled nursing facility utilization between PACE and a Medicaid-sponsored, managed long-term care plan. PACE participants had fewer

	hospitalizations than the Medicaid plan enrollees. Medicaid plan members were more likely to be admitted to a hospital and experienced longer stays. *Nadash, P. (2004). Two models of managed long-term care: comparing PACE with a Medicaid-only plan. Gerontologist, 44(5), pp. 644-654.*
PACE produces Medicare savings	Total Medicare and Medicaid capitation payments are generally comparable to estimates of projected Medicare and Medicaid fee-for-service (FFS) expenditures for PACE enrollees in the year following enrollment. For this period, the study estimates Medicare capitation rates are 42-46% lower than estimates of fee-for-service expenditures, while Medicaid capitation rates are higher than estimated fee-for-service costs. The analysis, however, does not provide an overall assessment of the cost effectiveness of PACE to States. This would require the cost experience of comparable population followed for a longer time period; at a minimum several years' post enrollment. *White, A., Abel, Y. & Kidder, D. (2000). Evaluation of the Program of All-Inclusive Care for the Elderly Demonstration: A comparison of the PACE capitation rates to projected costs in the first year of enrollment. Abt Associates. Contract No. 5001.* Medicare costs for PACE and a comparative group were analyzed for a 60-month study period and found to be similar, suggesting Medicare capitation rates for PACE were set appropriately. For Medicaid, PACE and the comparison group costs were followed for only two years, and the Secretary of Health and Human Services acknowledged that the abbreviated study period did not include expenditures of institutional and end of life care normally incurred by Medicaid later in a person's care trajectory. *Leavitt, M., Secretary of Health and Human Services. (2009). Interim report to Congress. The quality and cost of the Program of All-Inclusive Care for the Elderly.* [1]

[1] *This is the most recent government-sponsored study to objectively evaluate the quality and cost of PACE. A complete and current PACE study that examines savings to Medicaid and compares costs over a longer time period is needed.*

For additional information, please contact Brenda Sulick at brendas@npaonline.org or (703) 535-1521 or Chris van Reenen at chrisvr@npaonline.org or (703) 535-1568.

The National PACE Association works to advance the efforts of Programs of All-inclusive Care for the Elderly (PACE) to support, maintain, safeguard and promote the provision of quality, comprehensive and cost-effective health care services for frail older adults. More information on NPA and PACE is available at www.npaonline.org.

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Chad Boult; G. Darryl Wieland

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Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

"Nobody Rushes You Through"

Chad Boult, MD, MPH, MBA
G. Darryl Wieland, PhD, MPH

Older patients with multiple chronic health conditions and complex health care needs often receive care that is fragmented, incomplete, inefficient, and ineffective. This article describes the case of an older woman whose case cannot be managed effectively through the customary approach of simply diagnosing and treating her individual diseases. Based on expert consensus about the available evidence, this article identifies 4 proactive, continuous processes that can substantially improve the primary care of community-dwelling older patients who have multiple chronic conditions: comprehensive assessment, evidence-based care planning and monitoring, promotion of patients' and (family caregivers') active engagement in care, and coordination of professionals in care of the patient—all tailored to the patient's goals and preferences. Three models of chronic care that include these processes and that appear to improve some aspects of the effectiveness and the efficiency of complex primary care—the Geriatric Resources for Assessment and Care of Elders (GRACE) model, Guided Care, and the Program of All-inclusive Care for the Elderly (PACE)—are described briefly, and steps toward their implementation are discussed.

JAMA. 2010;304(17):1936-1943 www.jama.com

PATIENT'S STORY

In late 2004, Ms N was a 77-year-old retiree. She had completed high school and worked for many years as a nursing assistant and a factory worker. Ms N lived alone in a modest senior housing apartment in a middle-class urban neighborhood. She received income from Social Security and support from her only child, a daughter who lived nearby. Her health insurance consisted of coverage by Medicare Parts A and B and her state's Medicaid program.

She had a history of hypertension with left ventricular hypertrophy, peripheral vascular disease with a left below-knee amputation, chronic obstructive pulmonary disease (COPD), glaucoma, keratitis, osteoarthritis with chronic right shoulder pain, and degenerative intervertebral disk disease. In conversation, she was alert, conversant, and oriented to time, place, and person. Physical examination did not detect abnormality of her heart, lungs, abdomen, nervous system, or skin. She had a well-healed left lower tibial stump and nonpalpable right dorsalis pedis and posterior tibial pulses. Her seated brachial blood pressure was 100/78 mm Hg; her intraocular pressures were 28 mm Hg (right eye) and 21 mm Hg (left eye). Her routine red and white blood cell counts, platelets, serum electrolytes, liver function studies, creatinine, and blood urea nitrogen values were normal.

Despite having a lower-leg prosthesis, she was nonambulatory and unable to shop, do housekeeping or laundry, drive, or use public transportation. She required assistance with food preparation, medication management, bathing, and transferring in and out of her wheelchair and bed. Her score on the Folstein Mini-Mental State Examination was 23 (out of a possible 30).

See also p 1948.

CME available online at www.jamaarchivescme.com and questions on p 1963.

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Ms N's prescribed medications included amlodipine, furosemide, potassium chloride, theophylline, albuterol, clopidogrel, enteric-coated aspirin, gabapentin, and quinine sulfate. She saw a primary care physician and an ophthalmologist regularly. She used a pill box to organize her medications, but she missed some doses nonetheless. She no longer smoked or used alcohol. She did not restrict her diet or engage in regular exercise or physical activity.

During 2002-2003, Ms N had been admitted to several hospitals and skilled nursing facilities for treatment of a ruptured lumbar intervertebral disk, *Clostridium difficile* colitis, an exacerbation of her COPD, and an ischemic foot ulcer that had become gangrenous. She had undergone a lumbar laminectomy, a left femoral-popliteal bypass procedure, a below-the-knee amputation, and prosthetic rehabilitation. She had received annual influenza vaccinations, but no screening tests. Her multiple chronic issues caused her daughter to refer her for eligibility evaluation to a local Program of All-Inclusive Care of the Elderly (PACE), where she was enrolled.

Ms N and her PACE primary care physician, Dr R, were interviewed by a Care of the Aging Patient editor in December 2009.

THE PATIENT'S NEEDS IN PERSPECTIVE

Ms N: *I had* [in 2004] *poor circulation, an amputation, emphysema, and arthritis in my right shoulder. I had a prosthesis, but it just wasn't working. It made my stump not sore but tender. I kept it off most of the time. I would only put it on if I had to go out.*

Dr R: *Her main thing was that she had severe peripheral vascular disease and a left below-knee amputation. Her stump was repeatedly breaking down, and she had very poor circulation in her right leg. Plus, she had several other chronic diseases, and she took 9 prescribed medications.*

Ms N is typical of the 10 million US residents who are older, living with 4 or more chronic health conditions, and in noninstitutional residences. Their lives (and sometimes their family caregivers' lives) are dominated by disease-related symptoms, disabilities, tests, treatments, and visits to health care clinicians. Their care is very costly, accounting for 80% of the Medicare program's annual expenditures.[1]

Good primary care physicians are often overwhelmed by the many needs for basic care in this population.[2] Medical school and residency training typically address provision of preventive services, care for acute illnesses and injuries, and diagnosis and treatment of 1 chronic disease at a time. However, many primary care physicians have not been trained to provide comprehensive care for patients with complex needs who have multiple chronic conditions, prescription medications, functional limitations, and a variety of health care professionals providing their care.[3]

Primary care physicians therefore face a perplexing dilemma—a steadily increasing number of chronically ill patients, but little opportunity to collaborate with the nurses, social workers, pharmacists, and rehabilitation therapists who could help meet the complex care needs of these patients. Underlying and exacerbating this crisis are 4 infrastructure deficiencies: (1) most primary care physicians and many other health professionals have not been trained to work in teams to provide complex chronic care; (2) sophisticated health information technologies, such as interoperative electronic health records, telemonitoring devices, and patient portals that could facilitate the essential processes of chronic care are not widely installed; (3) most current public and private health insurers' payment policies, which are based on fee-for-service payments, do not support the supplemental services provided by the newer models for providing complex chronic care; and (4) the payment for and the provision of medical and social services are separate and not integrated.

As a result, many primary care physicians cannot facilitate the essential components of high-quality, cost-effective, complex care for their chronically ill patients. Simply trying harder and working smarter cannot overcome these fundamental obstacles.

The consensus of experts, based on currently available evidence, indicates that high-quality, cost-effective health care for older patients with multiple chronic conditions is often associated with 4 concurrent, interacting processes that transcend and support the diagnosis and treatment of individual diseases.

- Comprehensive assessment of all of the patient's diseases, disabilities, cognitive abilities, medications, health-related devices, other treatments, self-care behaviors, health-related lifestyle habits, psychological conditions, environmental risks, family (or friend) supports, and other resources—plus the patient's relevant values and preferences for care.[4,5]
- Creation, implementation, and monitoring of a comprehensive, evidence-based plan of care that addresses all of the patient's health-related needs in the context of the patient's preferences.[5,6]
- Communication and coordination with all who provide care for the patient, including specialist physicians, hospital and emergency staff, rehabilitation therapists, mental health professionals, home care providers, social workers, and community-based agencies (eg, adult day health care facilities, exercise programs, and support groups)—especially during transitions between hospitals and other sites of care.[7]
- Promotion of the patient's (and caregiver's) active engagement in his or her health care—through self-management classes (when available) and ongoing encouragement, direction, and reinforcement.[8-11]

Unfortunately, mainstream primary care in the United States in 2010 rarely includes these 4 processes; therefore, patients with complex needs like Ms N often receive care that is noncomprehensive, nonevidence-based, frag-

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mented, and inefficient.[12] Care is often further undermined by poor patient adherence[13,14] and limited assistance from families and friends.[15]

METHODS

The Evidence: The Effects of New Models of Primary Care

We searched MEDLINE for English-language articles published between September 1, 1999 and August 30, 2010, that reported the results of studies about the effects of US models of comprehensive primary care for older patients with multiple chronic conditions. We used the search terms: *primary health care, comprehensive health care, patient care team, care coordination, frail older adults, health services,* and *outcome assessment* (health care). From the articles identified, we selected those for which the abstract indicated that the reported analysis compared an intervention group with an equivalent concurrent control group to evaluate the effect of the intervention on quality of health care, quality of life or functional status, and the use or cost of health services. We excluded articles that reported the use of weak study designs (eg, historical controls), inadequate numbers of older participants with multiple chronic conditions, the use of unvalidated or unreliable measures, or inappropriate statistical analyses. We also searched the Web site of Mathematica Policy Research,[16] which contracted with the Centers for Medicare & Medicaid Services to evaluate the effect of PACE on the quality of care.

RESULTS OF EVIDENCE REVIEW

Complete results of the studies meeting the inclusion criteria are shown in the eTable (available at http://www.jama.com). A 12-month randomized controlled trial (RCT) measured the effects of home-based primary care among participants (N=1966) who were terminally ill and those who were not.[17] No effects on functional status (as measured by the Barthel Index or the Short Form-36 [SF-36]) were seen in either group. The nonterminally ill group had significantly better satisfaction with care on a number of parameters and better caregiver-rated SF-36 scores, compared with the control group. Caregivers in both groups reported significantly higher satisfaction with care. Total health care costs for participants who received home-based primary care were significantly higher than total costs for those who received usual care.

The Geriatric Resources for Assessment and Care of Elders (GRACE) model was evaluated in an RCT conducted over 2 years (N=951).[18] During the first year, participants receiving the GRACE intervention were significantly more likely than control participants to receive a flu shot (74% vs 67%), newly identify a primary care physician (81% vs 63%), have a follow-up primary care visit within 6 weeks of a hospital discharge (83% vs 54%), newly receive a medication list (58% vs 38%), and newly report having a health care representative or a living will (44% vs 17%).[19] Those receiving the GRACE intervention were also more likely to report the identification of, referral for, and receipt of information about geriatric conditions including difficulty walking or falls, urinary incontinence, depression, and hearing impairment (audiology or ear, nose, and throat clinic visits among individuals with baseline impairment).

After 2 years, there were no differences between the groups' performance of activies of daily living or instrumental activities of daily living, SF-36 Physical Component Summary scores, days spent in bed at home, or satisfaction with care, although the GRACE group's mean SF-36 Mental Component Summary score was significantly better (treatment effect [SE]=2.4 [10.5]).[20] Visits to emergency departments were reduced by 17% ($P=.03$), but the groups' admissions to hospitals and total health care costs were similar. In a preplanned analysis of a subgroup of participants at high risk of hospitalization (probability of repeated admission [PRA] score ≥0.4), the GRACE group had fewer hospital admissions in year 2, less cost related to hospitalization, more cost related to chronic and preventive care, no difference in total costs at 1 and 2 years, and lower total costs during year 3, at 1 year postintervention.[21]

Several effects of Guided Care were assessed in a cluster RCT (N=904). Boyd et al[22] used the Patient Assessment of Chronic Illness Care (PACIC) scale to measure care quality as experienced and reported by participants. After 18 months, participants were more likely to give high-quality ratings to Guided Care than to usual care (adjusted odds ratio [OR], 2.13; 95% confidence interval [CI], 1.30-3.50). In the same study, participants' family caregivers (N=196) also completed the PACIC in rating the quality of care provided to their care recipients.[23] Again, Guided Care was rated more highly on aggregate quality and most of the PACIC subscales; caregiver strain and depression did not differ between the groups. Using insurance claims from the first 8 months of this same cluster RCT (N=835), Leff et al[24] found trends toward reduced utilization and costs of health care by Guided Care patients, but the differences were not statistically significant. Marsteller et al[25] studied the effects of Guided Care on primary care physicians (N=49 physicians) during the first year of this same cluster RCT. This study found higher physician satisfaction with patient and family communication and better physician knowledge of patients' clinical characteristics, but no significant difference in physicians' ratings of other aspects of care.

PACE was evaluated in 1 cross-sectional time series and 3 cohort studies, each of which compared participants in the PACE group with control participants who were receiving different packages of medical and supportive services in their local communities. In the cross-sectional time series (N=1285; 20 107 person-months, comparisons unadjusted for any confounding),[26] PACE had significantly fewer hospital admissions and preventable hospital admissions per

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thousand patients per month (35.7 vs 52.8, and 8.6 vs 13.3, respectively), as well as fewer total and preventable emergency department visits, compared with a community-based analog of PACE in which medical care was provided by independent primary care physicians (eTable). Differences in the groups' hospital days and average length of hospital stay were not statistically significant.

A 6-year cohort study (N=1215) compared PACE participants with similarly disabled Medicaid enrollees who were receiving community-based supportive services.[27] The final survey (2½-6 years after enrollment) indicated that PACE participants had less pain and fewer unmet needs for assistance in bathing, dressing, and getting around; the 2 groups did not differ significantly in self-rated health, difficulty performing activities of daily living, recent falls, weight loss, unmet needs for help with toileting and getting out of bed, and most behavioral problems (reported by proxies) and depressive symptoms. Satisfaction with personal assistance and the overall quality of medical care was similar. During the year before the survey, PACE participants were less likely to have been hospitalized and were more likely to have had a hearing screening, a vision screening, an influenza vaccination, and an advanced directive. PACE participants were more likely to have had a nursing home stay—probably reflecting PACE's use of nursing homes for subacute, postacute, and respite care.

A 12-month cohort study compared the use of hospital and nursing home services by participants in PACE and those in a Medicaid-sponsored, managed long-term care plan (N=2679).[28] PACE enrollees had fewer hospitalizations, more nursing home stays, and shorter median lengths of stay than participants receiving nurse-provided case management in the managed care plan. Finally, a 5-year cohort study (N=2040) found longer median survival among individuals enrolled in PACE than in those who received case management and community services. The difference was statistically significant among patients with high mortality risk at baseline.[29]

Studies of other US models of comprehensive primary care for complex older patients reported isolated promising findings, but they did not evaluate the outcomes required for inclusion in this review.[30-32] Modest findings were also identified from studies of related models in 3 countries with global health budgets: Canada,[33] Great Britain,[34] and the Netherlands.[35] These studies did not offer additional insights of value to the US health care system.

ALTERNATIVE MODELS OF CARE

Based on the literature review, 3 comprehensive primary care models appear to have the greatest potential to improve quality of care and quality of life for older patients with complex health care needs, while reducing or at least not increasing the costs of their health care: the GRACE model, Guided Care, and PACE. Each represents a different approach to enacting the 4 primary care processes described previously, and each incorporates several of the structural elements of the chronic care model for improving health-related outcomes for patients with multiple chronic conditions.[36,37]

How the Alternative Models Work

All 3 models are based on care by teams of professionals–including primary care physicians, registered nurses, and other health professionals–that are based in primary care settings. Teams in all 3 models provide many of the same services to older patients with complex health care needs including

- Comprehensive assessment
- Development of a comprehensive care plan that incorporates evidence-based protocols
- Implementation of the plan over time
- Proactive monitoring of the patient's clinical status and adherence to the care plan
- Coordination of primary care, specialty care, hospitals, emergency departments, skilled nursing facilities, other medical institutions, and community agencies
- Facilitation of the patient's transitions from hospitals to postacute settings
- Facilitation of the patient's access to community resources, such as meals programs, handicapped-accessible transportation, adult day care centers, support groups, and exercise programs

These models differ significantly, however, in other aspects of their structures and operations.

How the Alternative Models Differ

GRACE. In the GRACE model, primary care physicians and on-site support teams provide comprehensive primary care for low-income older patients receiving care through community health centers (TABLE). The support teams meet with off-site geriatrics interdisciplinary teams to review each patient's clinical status at least quarterly.[38] Most of the services provided by the support team and the geriatrics interdisciplinary team (average cost ≈ $105/patient per month) are not covered by fee-for-service Medicare, Medicaid, or private health insurance. Thus, primary care physicians' opportunities to use the GRACE model are currently limited to geographic areas[39] where practices participating in regional pilot tests or demonstrations of the "medical home" or "advanced primary care" concepts might incorporate GRACE resources to improve their care. Most of these programs are being conducted and funded by Medicare Advantage plans, large employers, the Veterans Health Administration, or private payers.

Guided Care. In the Guided Care model (Table), 2 to 5 primary care physicians partner with a registered nurse practicing at the same site, to provide comprehensive primary care to 55 to 60 older patients who are at high risk for using extensive health services during the following year. This risk is estimated by computing each patient's hierarchical con-

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Table. Models of Comprehensive Primary Care for Older Patients With Multiple Chronic Conditions

	GRACE	Guided Care	PACE
Year program began	2002	2006	1990
Primary care clinician	Established primary care physician	Established primary care physician	PACE staff physician[a]
Other team members	On-site advanced practice nurse and social worker; off-site geriatrician, physical therapist, mental health social worker, pharmacist, community liaison	Registered nurse	Registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, pharmacist, dietitian, home care coordinator, personal care aide, driver, site manager
Service base	Community-based health center	Primary care office	Day health center
Patient eligibility	Low-income	Hierarchical condition category score in highest quartile[b]	Certified as requiring long-term care
Frequency of contact	Monthly	Monthly	1-5 days per week
Services covered by			
Medicare	No[c]	No	Yes
Medicaid	No	No	Yes

Abbreviations: GRACE, Geriatric Resources for Assessment and Care of Elders; PACE, Program of All-Inclusive Care for the Elderly.
[a] At some sites, PACE contracts with community-based physicians.
[b] Indicates risk of using extensive health services during the following year.
[c] Only home visits by advanced practice nurses are covered.

dition category (HCC) score from the diagnoses on all health insurance claims generated by the patient during the past year.[40]

Each Guided Care nurse completes a 40-hour online course, earns the Certificate in Guided Care Nursing from the American Nurses Credentialing Center, and is employed by the practice. The nurse encourages patients to engage in productive health-related behaviors by helping them to create personal action plans, referring them to 6-session chronic disease self-management courses,[41] and using motivational interviewing[42] during their monthly contacts with the patients. The nurse also assesses family caregivers and provides them with educational material, suggestions, referral to community agencies, and emotional support.[43] Details about the Guided Care model are available in print[44] and on the Internet.[45]

The services of Guided Care nurses (average cost ≈ $150/patient per month) are not reimbursable under the fee-for-service Medicare program, state Medicaid programs, or most private insurance plans. Thus, as with the GRACE model, primary care physicians' opportunities to adopt Guided Care are now limited to geographic areas where regional pilot tests or demonstrations of the medical home or advanced primary care concepts are being conducted.[39] Technical assistance for primary care practices, including an implementation manual, a patient education booklet, and online courses for nurses, practice leaders, and primary care physicians, is now available.[44,46]

PACE. PACE provides many of the same care processes as the GRACE and Guided Care models, although it differs in terms of patient population, scope of services, organization, and financing. Each PACE site serves local patients who are aged 55 years or older and state certified as eligible for nursing home care, but able (with PACE services) to continue living safely in the community. Like Ms N, most patients (89%) are medically complex, low-income, and enrolled in both Medicare and Medicaid (ie, "dual eligibles"); unlike Ms N, however, most have disabilities that are irreversible. Approximately half have dementia, and more than half are dependent on others to help them with at least 3 basic activities of daily living.[47]

Each PACE site provides to its patients, either directly or by contract, a comprehensive set of services: primary, specialty, emergency, hospital, home, palliative, and institutional long-term care; case management, prescription drugs, dentistry, laboratory tests, radiology, adult day care, transportation, prosthetics, durable medical equipment, meals; and for family caregivers, respite, education and support. PACE participants are transported by PACE vans from their homes to the PACE day health center several times each week for health care, education, and social activities. PACE clinicians provide care in the PACE day health center and in patients' homes, assisted living facilities, and nursing homes. The PACE interdisciplinary team, which is based in the PACE day health center, includes a wide range of health professionals (Table). The largest PACE organization currently serves nearly 2400 patients, but most serve fewer than 300.[48-50]

Each PACE site operates as a managed care plan that receives capitated payments from Medicare and Medicaid and uses these funds to pay for all of the health-related services required by its patients. Since 1997, PACE has been recognized as a "provider" (as in physicians and hospitals) by the Medicare program, and all state Medicaid programs have had the option to recognize and contract with PACE organizations to provide care for eligible individuals enrolled in both Medicare and Medicaid. Despite PACE's attractive features, operational challenges have limited its geographic reach (recognition by 29 states) and aggregate size (21 000 patients).[51-53] In contrast, 600 000 similarly complex, dis-

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abled persons receive supportive care at home through Medicaid "aged and disabled" service programs,[34] and 875 000 reside in nursing homes.[35,36]

THE PATIENT'S STORY, CONTINUED

Ms N met all of the local PACE program's requirements. She joined the local PACE in December 2004 and has received all of her care there for the past 6 years.

Ms N [in 2009]: *We are picked up from our homes. The drivers are patient and good with the seniors. The center has nice hot lunches, coffee, tea, and snacks. The doctors are patient. They have the time, and they give you the care you need. Nobody rushes you through. We also have music, brain words, drawing, sculpting, singing, exercise, and meditation. We are blessed to have all this.*

Dr R: *Ever since Ms N came to PACE in 2004, our physical therapist and I have paid close attention to her prosthesis; we've worked closely with a prosthetist. Now I forget that she has a prosthetic leg because she walks on it so well. We have also worked with her on her lipids, her emphysema, and her arthritis.*

The Process of Chronic Care

For the past 6 years, PACE has provided Ms N with all 4 of the concurrent, interacting processes needed to supplement the prevention and treatment of individual diseases to produce high-quality, cost-effective chronic care.

Comprehensive Assessment. Upon enrolling in PACE, Ms N underwent a multidisciplinary assessment by the PACE team: the medical director, a nurse practitioner, a nurse, a social worker, a pharmacist, a physical therapist, an occupational therapist, a dietician, and a nurse's aide. Besides clarifying her medical diagnoses, this assessment revealed previously undiagnosed depression, a poorly-fitting leg prosthesis, inadequately treated pain, suboptimal medication adherence, lack of exercise and social interaction, and excessive intake of dietary sodium and fat.

Evidence-Based Care Planning and Implementation. Beginning with published evidence-based guidelines, the PACE team collaborated in drafting a plan, consistent with Ms N's goals for care, for optimizing each of her conditions and health-related behaviors. Through the next several months, the team consulted a prosthetist for revision of her leg prosthesis and worked with Ms N and her daughter to rehabilitate the skin of her stump, begin physical therapy for her shoulder and back pain, reduce her intake of hydrocodone, improve her sleep, obtain a multidose medication box to organize her daily doses, recognize and treat the early signs of bacterial respiratory infection, begin a mild daily exercise routine, begin gradual reduction of sodium and fat in her diet, and join several ongoing social activities with other patients at the PACE day health center.

Coordination With Other Providers. Building on PACE's long-standing relationships with community providers, members of the PACE team collaborated with her ophthalmologist and her prosthetist in providing Ms N's ongoing care.

Patient and Family Engagement in Self-care. The PACE nurse helped Ms N to begin exercising, modifying her diet, and taking her medications consistently. The program nurse also provided Ms N's daughter with information about Ms N's health conditions and encouraged her to help her mother fulfill her crucial role in managing her health at home, eg, with proper diet, exercise, medication adherence, blood pressure checks, and early treatment of respiratory infections.

Ms N's Results

Ms N [in 2009]: *They got my prosthesis to fit so it's comfortable. It's no problem now. Most people don't even know I wear a prosthesis. I only take it off when I'm ready to go to bed. I love coming here. The nurses, the doctor, the physical therapists, everybody who works here, we are just one big family.*

Dr R: *I've been carefully treating her lipids to minimize progression of her peripheral vascular disease; it's been very stable since I met her 6 years ago. Her emphysema and shoulder arthritis have been well controlled, too. She's had zero hospitalizations since I've known her. At the first sign of trouble with her COPD or skin breakdown, we see her in clinic and start treatment right away.*

Six years after enrolling in PACE, Ms N continues to live independently, exercising 3 times each week, limiting the salt in her diet, and taking all of her doses of medication as prescribed.

The skin on her left leg stump and her right lower extremity is intact. Her blood pressure, serum lipid levels, and intraocular pressures are within the target ranges. The arthritic pain in her spine and right shoulder is well controlled, and her keratitis has resolved. She walks without assistance, performs most of her activities of daily living independently or with assistive devices, and receives assistance only with shopping, transportation, heavy chores, and bathing. She volunteers at the PACE center as a greeter for other patients.

During the 2 years before she enrolled in PACE, Ms N was admitted to hospitals several times for respiratory infections and 3 major nonelective surgical procedures, after which she spent many months receiving postacute wound care and prosthetic rehabilitation in skilled nursing facilities. During the 6 years after she enrolled in PACE, she has visited the hospital only once for an elective outpatient excision of a lipoma. Ms N's case is anecdotal but illustrates the ways in which the components of the PACE program addressed her multitude of issues in a systematic way—improving her independence and helping prevent hospital and nursing home admissions.

CHRONIC CARE IN PRIMARY CARE PRACTICE

Primary care physicians without access to GRACE and Guided Care options for their patients have a few alternatives. One is to refer eligible patients to a PACE site, if avail-

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able,[37] but referred patients must usually transfer their medical care from their primary care physicians to PACE physicians. Another possible action for clinicians in states where PACE is a Medicaid-covered option is to support local coalitions that seek to establish local PACE sites. Those in other regions can urge their state Medicaid programs to designate PACE as a covered option.

Primary care physicians without these options can refer their chronically ill patients who need supportive services to local resources such as Area Agencies on Aging, state-sponsored home and community-based services (for Medicaid recipients), and other community-based voluntary and philanthropic service organizations. Unfortunately, such referrals seldom establish the bidirectional interactions between health care professions who provide medical and social services that are characteristic of GRACE, Guided Care, and PACE.[38]

Finally, some primary care clinicians may wish to transform their practices into medical homes, advanced primary care practices, or accountable care organizations that can provide cost-effective complex services to their chronically ill patients. However, such a transformation usually requires hiring new staff, acquiring health information technology, supplemental training of physicians and office staff, revamping workflows, and transient reductions in productivity. These costly changes generally are feasible only in the context of pilot programs or demonstrations that provide sufficient technical assistance and supplemental revenue to offset the costs of transformation and the practice's subsequent expanded clinical services. Many such pilot programs and demonstrations are in various stages of development or operation.[39]

As the United States implements new models of chronic care, such as the 3 described here, more research is needed to define the optimal methods for identifying the patients who will benefit most, for providing the essential clinical processes, for disseminating and expanding the reach of these models, and for paying for excellent chronic care. Also necessary will be significant advances in the education of health care professionals and the managerial infrastructure that underlies new models of care.[59,60]

As progress is made, in part through initiatives launched by the Patient Protection and Affordable Care Act of 2010, a growing cadre of US primary care providers will have new opportunities to care for their chronically ill patients more effectively and efficiently. They will more nearly meet the goals of maximizing patients' independence and function and reducing the need for admission to hospitals and nursing homes.

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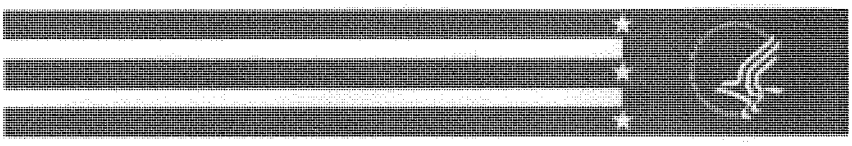
CENTERS FOR MEDICARE & MEDICAID SERVICES



Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)

What are Programs of All-inclusive Care for the Elderly (PACE)?

PACE is a Medicare program for older adults and people over age 55 living with disabilities. This program provides community-based care and services to people who otherwise need nursing home level of care. PACE was created as a way to provide you, your family, caregivers, and professional health care providers flexibility to meet your health care needs and to help you continue living in the community.

An interdisciplinary team of professionals will give you the coordinated care you need. These professionals are also experts in working with older people. They will work together with you and your family (if appropriate) to develop your most effective plan of care.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor care, transportation, home care, check ups, hospital visits, and even nursing home stays whenever necessary. With PACE, your ability to pay will never keep you from getting the care you need.

Who can join a PACE Plan?

You can join PACE if you meet the following conditions:

- You are 55 years old or older.
- You live in the service area of a PACE organization.
- You are certified by the state in which you live as meeting the need for the nursing home level of care.
- You are able to live safely in the community when you join with the help of PACE services.

Note: You can leave a PACE program at any time.

★

PACE services include but aren't limited to the following:

- Primary Care (including doctor and nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Nursing Home Care
- Emergency Services
- Home Care
- Physical therapy
- Occupational therapy
- Adult Day Care
- Recreational therapy
- Meals
- Dentistry
- Nutritional Counseling
- Social Services
- Laboratory / X-ray Services
- Social Work Counseling
- Transportation

PACE also includes all other services determined necessary by your team of health care professionals to improve and maintain your overall health.

You should know this about PACE:

PACE Provides Comprehensive Care

PACE uses Medicare and Medicaid funds to cover all of your medically-necessary care and services. You can have either Medicare or Medicaid or both to join PACE.

The Focus is on You

You have a team of health care professionals to help you make health care decisions. Your team is experienced in caring for people like you. They usually care for a small number of people. That way, they get to know you, what kind of living situation you are in, and what your preferences are. You and your family participate as the team develops and updates your plan of care and your goals in the program.

PACE Covers Prescription Drugs

PACE organizations offer Medicare Part D prescription drug coverage. If you join a PACE program, you'll get your Part D-covered drugs and all other necessary medication from the PACE program.

Note: If you are in a PACE program, you don't need to join a separate Medicare drug plan. If you do, you will lose your PACE health and prescription drug benefits.

You should know this about PACE: (continued)

PACE Supports Family Caregivers

PACE organizations support your family members and other caregivers with caregiving training, support groups, and respite care to help families keep their loved ones in the community.

PACE Provides Services in the Community

PACE organizations provide care and services in the home, the community, and the PACE center. They have contracts with many specialists and other providers in the community to make sure that you get the care you need. Many PACE participants get most of their care from staff employed by the PACE organization in the PACE center. PACE centers meet state and Federal safety requirements and include adult day programs, medical clinics, activities, and occupational and physical therapy facilities.

PACE is Sponsored by the Health Care Professionals Who Treat You

PACE programs are provider sponsored health plans. This means your PACE doctor and other care providers are also the people who work with you to make decisions about your care. No higher authorities will overrule what you, your doctor, and other care providers agree is best for you. If you disagree with the interdisciplinary team about your care plan, you have the right to file an appeal.

Preventive Care is Covered and Encouraged

The focus of every PACE organization is to help you live in the community for as long as possible. To meet this goal, PACE organizations focus on preventive care. Although all people enrolled in PACE are eligible for nursing home care, only 7% live in nursing homes.

PACE Provides Medical Transportation

PACE organizations provide all medically-necessary transportation to the PACE center for activities or medical appointments. You can also get transportation to appointments in the community.

You should know this about PACE: (continued)

What You Pay for PACE Depends on Your Financial Situation

If you qualify for Medicare, all Medicare-covered services are paid for by Medicare. If you also qualify for your State's Medicaid program, you will either have a small monthly payment or pay nothing for the long-term care portion of the PACE benefit. If you don't qualify for Medicaid you will be charged a monthly premium to cover the long-term care portion the PACE benefit and a premium for Medicare Part D drugs. However, in PACE there is never a deductible or copayment for any drug, service, or care approved by the PACE team.

For more information about PACE do the following:

- Visit www.npaonline.org on the web. This website is sponsored by the National PACE Association.
- Visit www.medicare.gov/Nursing/Alternatives/PACE.asp on the web.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

PACE Organizations Across the Country

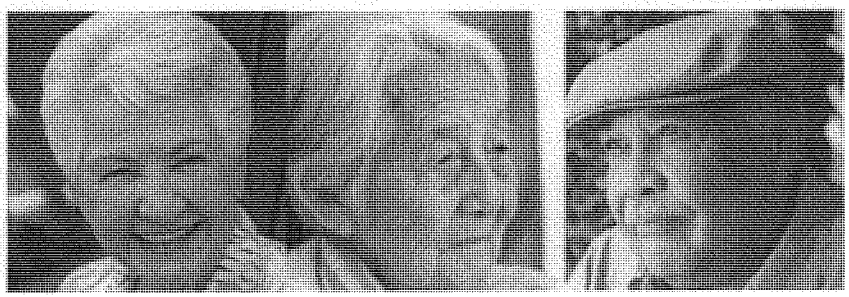
Current as of June 1, 2011

	PACE Organization	City
AR	Total Life Healthcare	Jonesboro
CA	Altamed Senior BuenaCare	Los Angeles
	Center for Elders' Independence	Oakland
	On Lok Lifeways	San Francisco
	St. Paul's PACE	San Diego
	Sutter SeniorCare PACE	Sacramento
CO	Rocky Mountain PACE	Colorado Springs
	Senior CommUnity Care	Montrose
	Total Longterm Care	Denver
FL	Florida PACE Centers	Miami
	Hope HealthCare Services	Fort Myers
	Neighborly Care Network	Clearwater
IA	Siouxland PACE	Sioux City
KS	Midland Care PACE	Topeka
	Via Christi HOPE	Wichita
LA	PACE Baton Rouge	Baton Rouge
	PACE Greater New Orleans	New Orleans
MD	Hopkins ElderPlus	Baltimore
MA	Elder Service Plan of Harbor Health Services	Mattapan
	Elder Service Plan of the Cambridge Health Alliance	Cambridge
	Elder Service Plan of the East Boston Neighborhood Health Center	East Boston
	Elder Service Plan of the North Shore	Lynn
	Summit ElderCare	Worcester
	Upham's Elder Service Plan	Boston
MI	Care Resources	Grand Rapids
	Center for Senior Independence	Detroit
	CentraCare	Battle Creek
	Life Circles	Muskegon
MO	Alexian Brothers Community Services	St. Louis
MT	Billings Clinic PACE	Billings
NJ	LIFE at Lourdes	Pennsauken
	LIFE St. Francis	Trenton
	Lutheran Senior LIFE	Burlington
NM	Total Community Care	Albuquerque
NY	ArchCare Senior Life	New York
	Catholic Health – LIFE	Buffalo

	PACE Organization	City
	Comprehensive Care Management	Bronx
	Eddy SeniorCare	Schenectady
	Independent Living for Seniors	Rochester
	PACE CNY	North Syracuse
	Total Senior Care	Olean
NC	Elderhaus	Wilmington
	PACE of the Triad	Greensboro
	Piedmont Health SeniorCare	Burlington
	St. Joseph of the Pines	Fayetteville
ND	Northland PACE	Bismarck
OH	McGregor PACE	Cleveland Heights
	TriHealth SeniorLink	Cincinnati
OK	Cherokee Elder Care	Tahlequah
OR	Providence ElderPlace	Portland
PA	Community LIFE	Pittsburgh
	everyday LIFE	Bethlehem
	LIFE – University of Pennsylvania School of Nursing	Philadelphia
	Life at Home	Kennett Square
	LIFE Geisinger	Danville
	LIFE Lutheran Services	Chambersburg
	LIFE Pittsburgh	Pittsburgh
	LIFE St. Mary	Feasterville Trevose
	Lutheran SeniorLife	Cranberry Twp
	Mercy LIFE	Philadelphia
	NewCourtland LIFE	Philadelphia
	SeniorLIFE	Johnstown
RI	PACE Organization of Rhode Island	Providence
SC	Palmetto SeniorCare	Columbia
	The Oaks PACE	Orangeburg
TN	Alexian Brothers Community Services	Chattanooga
TX	Bienvivir Senior Health Services	El Paso
	La Paloma	Lubbock
	The Basics at Jan Werner	Amarillo
VT	PACE Vermont	Colchester
VA	AllCARE for Seniors	Cedar Bluff
	Centra PACE	Lynchburg
	Mountain Empire PACE	Big Stone Gap
	Riverside PACE	Newport News
	Sentara Senior Community Care	Norfolk
WA	Providence ElderPlace	Seattle
WI	Community Care	Milwaukee

PACE Policy Summit

SUMMARY AND RECOMMENDATIONS



National PACE Association

PACE Policy Summit
SUMMARY AND RECOMMENDATIONS

On December 6, 2010, the National PACE Association (NPA) convened a policy summit in Washington, D.C. Summit participants were health policy experts including federal and state policymakers, health services researchers, and consumer and provider representatives. The summit aimed to address three primary questions:

1. How can the Program of All-inclusive Care for the Elderly (PACE) evolve and expand, building on its track record of providing comprehensive, integrated, high quality care to high-cost, high-need individuals?
2. What methods and measures can be used to evaluate PACE and compare it to alternative care models focused on comparable populations?
3. What are the opportunities for PACE as payers, providers, and leaders to pursue innovations designed to improve the effectiveness of care, manage costs, expand community-based alternatives to institutional care, and promote other positive changes to the health care delivery system through implementation of the Affordable Care Act (ACA)?

Ideas and recommendations of summit participants are presented in this summary. The format follows the summit agenda, which began with a brief description of PACE and discussion of the model's current strengths and challenges. The remainder of the summit focused on identifying opportunities for PACE to lead, advance, and evolve in the future.

PACE—An Innovation with a Successful Track Record

PACE is a comprehensive, fully integrated health care delivery system for frail, older adults. PACE was initially developed by On Lok, a community-based organization in San Francisco, CA, to address the shortcomings of an often fragmented health care delivery system for older adults with complex medical and long-term supports and services (LTSS) needs. Based on comprehensive assessment of program participants' needs, PACE organizations provide and manage a full spectrum of services, including preventative, primary, acute, and LTSS, regardless of the type or location. PACE organizations are fully accountable for the quality and cost of all services provided, either directly by PACE organization staff or by contracted providers. To be eligible for PACE, individuals must be 55 or older; certified by the state as requiring nursing home level of care; reside in a PACE service area; and be able to live in the community safely with the assistance of PACE at the point of enrollment. PACE organizations are sponsored by a variety of different types of organizations, primarily non-profits, including health systems, free standing community agencies, hospices, community health centers, LTSS providers, and hospitals.

"It's a place where geriatric care is the norm and it's the gold standard."

—PACE Policy Summit Participant

PACE Strengths

Summit participants identified many strengths of the PACE model, noting that it originated as an innovation in response to a specific need. In 1983, at the time of PACE's origins, the health care system was not equipped to support frail, older adults who wanted to remain at home and in their communities—nursing home placement was often the only long-term option. To address this need, On Lok, the first PACE program in San Francisco, developed the model and its key components for which PACE is now recognized and valued. Because PACE's core competencies have proven successful in providing high quality care over time, other programs targeting frail individuals may benefit from including components of PACE into their care coordination models. These include:

- ***Comprehensive, Coordinated, and Continuous Care.*** PACE organizations provide person-centered, comprehensive, integrated care using an interdisciplinary team (IDT) approach to needs assessment and care planning. The IDT integrates care provided by multiple, individual providers into a single, comprehensive, individualized care plan that takes into account program participants' need for care 24 hours a day, 7 days a week, 365 days a year. PACE IDT members—physicians, nurses, therapists, social workers, pharmacists, health care aides and others—deliver much of the participants' health care directly, enabling

them to monitor changes in participants' health status and respond in a timely manner. The PACE team also is responsible for managing services delivered by contract providers, such as hospital and nursing home care, and medical specialty services.

- ***Integrated, Capitated Financing.*** PACE integrates financing for people who are eligible for Medicare and Medicaid, receiving fixed, monthly payments for individuals enrolled in the program. These payments are pooled at the program level, providing PACE organizations flexibility to comprehensively address the needs of program participants. As a result, PACE providers consider all care options, are not restricted by fee-for-service reimbursement requirements, and have strong incentives to proactively address each individual's person-specific needs to improve health and reduce the need for acute care and long-term institutionalization.
- ***Accountability.*** PACE organizations are fully accountable for the quality and cost of all care provided both directly and through contracted providers, as well as the consequences of not providing needed services.
- ***A "Gold Standard of Geriatric Care."*** PACE has focused on geriatric care, resulting in a model with expertise in the assessment, treatment, and care of older adults. As one summit participant stated, "It's a place where geriatric care is the norm and it's the gold standard." In PACE, primary care providers, working closely with other key members of the PACE interdisciplinary team, have a crucial role in the delivery of medical care. PACE providers are knowledgeable in geriatrics and able to respond to their patients' multiple medical conditions, health care goals and preferences, and follow their patients over time and across settings. The concept of the medical home is an integral part of the PACE model.
- ***Prevention and Timely Intervention.*** PACE participants match the profile of some of the costliest beneficiaries in both the Medicare and Medicaid programs. PACE organizations improve upon the care these individuals receive in the fee-for-service system by emphasizing preventive, primary and community-based care over avoidable high-cost specialty and institutional care. PACE organizations develop comprehensive systems of care as an alternative to the fragmented, poorly coordinated non-systems in which PACE-eligible individuals often find themselves. The result is greater independence and improved functioning in the community, and far less need for hospital, emergency room, and long-term institutional care.
- ***Transportation.*** Transportation for PACE participants is another covered benefit and key way in which PACE supports participants and their caregivers. Transportation is provided to and from the PACE Center, as well as to other appointments. Providing transportation also places a driver, who has been trained to observe cues, in the home of the PACE participant. Drivers can then report cues that may signal a change in health status or other changes that should be monitored.
- ***Family Caregivers.*** PACE organizations support family members and other caregivers with caregiving training, support groups, and respite care to help families keep their loved ones in the community.

Over the post 25 years, as PACE has exponded to new communities under the sponsorship of new organizations, these components hove established a track record of proven results. PACE is recognized by policymakers, health care professionals, and researchers as a model of care that achieves excellence for frail, older adults who wish to live at home, in their communities. Currently, there are 75 PACE organizations serving over 23,000 people in diverse communities across 29 states, in both urban and rural areas. PACE also is working with the Veterans Administration to offer older veterans care ot up to twelve pilot sites across the country.

PACE Challenges

As PACE expanded, initially as a demonstration and then as a permanent Medicare and Medicaid provider, assuring its effectiveness relied on implementing the key components originated by On Lok, which were eventually incorporated into federal and state regulatory requirements. Several of these requirements, in addition to obstacles directly related to PACE operations, were identified as having contributed to PACE's limited growth, and include:

"PACE is viewed as a boutique model that can't be scaled up."

—PACE Policy Summit Participant

- ***Start-up Costs and Prescriptive Regulations.*** High start-up costs for PACE, which are a consequence of: 1) the required establishment af o PACE center, 2) the length of time necessary to obtain regulatory approvals, and 3) the requirement to provide many PACE services directly rather than through contracts with community providers and physicians.
- ***Marketing.*** Marketing challenges include a general lack of cansumer awareness, the inaccurote perception that PACE requires attendance at the PACE center, and the requirement that individuals often must give up their community physicians.
- ***Financial Risk.*** Many capable community-based organizations that could sponsor PACE are concerned about the financial risk inherent in PACE's fully capitated financing model.
- ***Cost Effectiveness.*** The absence of a comprehensive evaluation of PACE cost-effectiveness, particularly Medicaid cost-effectiveness, that enables state and federal policymakers to fully understand the positive fiscal impact af the program has hindered PACE expansion.
- ***Expansion of PACE Beyond the Dual Eligible Population.*** PACE has focused its enrollment on low-income individuals who are typically dually eligible for both Medicare and Medicaid with minimal success serving individuals with higher incomes. PACE could propose payment alternatives that make PACE more attractive to beneficiaries from various income levels.
- ***Standardized Outcome Measures.*** PACE programs lack a standardized system to measure outcomes, making it difficult for PACE to compare outcomes across PACE programs and with other LTSS providers. PACE should work with CMS and other stakeholders to develop and implement the use of standard outcome measures.

PACE is seen as a successful, if not widespread, model of care by policymakers and researchers. But, despite the program's recent growth, summit participants noted that PACE serves a limited number of older adults. The challenge for PACE is to renew the creativity and energy that characterized its initial development and to expand to meet the needs of growing numbers of PACE eligible individuals as well as other high-cost, high-need populations. In meeting this challenge, PACE can draw on the core strengths of its care delivery model, the expertise of its leadership, and the high esteem of those seeking to reform the broader health care system.

Opportunities in Health Care Reform for PACE

Health care reform seeks to address many of the weaknesses in the current system that the PACE model was originally designed to resolve: fragmented, often duplicative delivery of services; lack of coordination and continuity of care for persons with multiple chronic conditions and functional impairment; misaligned financial incentives; poor access to geriatric primary care; and a reliance on institutional rather than community-based care. PACE is well-positioned to capitalize on the new opportunities provided by the ACA through: increasing access to the existing PACE model, expanding the PACE model to serve new populations, and acting as a resource to emerging care coordination programs that would like to incorporate components of PACE into their models.

"PACE is exceptional because all the pieces are there."

—PACE Policy Summit Participant

Increasing Access to the Existing PACE Model

For the frail, low-income, older adults that PACE primarily serves, increasing the number and size of PACE organizations would provide greater access to the type of fully integrated, effective model of care intended by health care reform. Health reform and policy initiatives already underway can support this growth through:

- ***Regulatory Reform.*** Assuring that state and federal regulations allow existing and developing PACE programs greater flexibility to try new operational and care delivery approaches that would improve care, increase efficiency, and enhance consumer appeal. For example, expediting the regulatory approval process for new PACE programs would reduce start-up costs and increase speed to market.
- ***Access to New Funding and Programs.*** Ensuring that PACE has access to new funding and/or programs could enhance PACE services. Examples include the Money Follows the Person program, designed to help individuals residing in nursing homes return to the community; medical/health homes, designed to promote integrated primary care; the Community Living Assistance Supports and Services (CLASS) Plan designed to help individuals receive the LTSS they need; and Community First Choice, designed to cover home and community-based attendant services as a Medicaid state option.

- ***Consumer Education and Choice.*** Advising older adults, their caregivers, and their physicions of their eligibility for PACE services upon determination that they require a nursing home level of core would enable more consumers to determine if PACE is right for them. Informing older adults of PACE os an option could be required of Medicare ond Medicaid health plons, and incorporated into transitional care programs being developed to improve outcomes for people who transition from one care setting to onother, e.g., from a hospitol to a nursing home. Additionally, hospitols could provide information about PACE upon dischorge. Finally, older adults can be informed of PACE as a care option through Aging and Disability Resource Centers (ADRC) and organizations funded under the Older Americans Act, including area agencies on oging and senior centers.
- ***Housing Integration.*** Locating PACE services in or near senior assisted/public housing would improve residents' access to services that would help them remain in their homes and communities, and avoid permanent nursing home institutionalization.

Expanding the PACE Model to Serve New Populations

Because of PACE's history in serving individuals with complex health care needs, expansion of PACE to new populations could be beneficial. The PACE community and policymakers should consider expanding PACE to enable additional populations to participate, such as:

- ***Complex Care Individuals.*** PACE strengths could be applied to high-risk, high-cost populations beyond older adults. Services for people with complex care needs, such as those with severe physical disabilities, mental illness, and intellectual disabilities, who require nursing home level of care, could benefit from PACE services. These individuals use significant amounts of emergency care and inpatient care, and PACE provides an excellent opportunity for both improved outcomes and cost reductions.
- ***Medicare-only Beneficiaries.*** Currently, PACE can serve individuals with Medicare benefits who are not eligible for Medicaid benefits. However, to date, these individuals make up a very small proportion of PACE enrollment. Developing payment arrangements that make it affordable and attractive for Medicare-only beneficiaries to participate in PACE would result in greater access to the program for this population.
- ***At-Risk Individuals.*** A subset of PACE services could be made available to people wha are "at-risk" for nursing home placement due to the presence of multiple, chronic conditions, functional disabilities, and/or cognitive impairments. PACE's coordinated care model could intervene to prevent avoidable complications and improve health status. Adaptations to the PACE model may be necessary for at-risk individuals who do not require the full intensity of services generally provided by PACE.

Incorporating Key Components of PACE into Emerging Care Models

PACE organizations can help providers adapt PACE components as well as aspects of its operations to enhance the effectiveness af emerging care models and delivery systems included in health care reform. Summit participants identified the following health reform initiatives as ones that could benefit from incorporating components of the PACE model:

- ***Health Reform Initiatives.*** New ACA models and initiatives attempting to reform health care through delivery and payment systems could include PACE programs or specific PACE components. Examples of these reforms are accountable care organizations (ACO), bundling of related services, shared savings, medical/health homes, Independence at Home, care transition payments, and additional pilots being developed by the Center for Medicare and Medicaid Innovation, and the Federal Coordinated Health Care Office. PACE organizations could provide technical assistance regarding components such as coordinated care, service integration, or polypharmacy management for at-risk patients.
- ***State Demonstrations to Integrate Care for Dual Eligible Individuals.*** PACE organizations may want to pursue their own demonstrations or work with states that receive federal grants to develop and test integrated care systems for people who are eligible for both Medicare and Medicaid. PACE is experienced with this population, as over 90 percent of its participants are dually eligible for Medicare and Medicaid.
- ***Workforce.*** PACE provides an optimal setting for training of a full range of interdisciplinary professionals in effective geriatric care. There is a critical need for more competency and training in the treatment of frail, older adults, providing PACE with an opportunity to share its experience with other organizations interested in geriatric care training.
- ***Preventing Elder Abuse.*** PACE can work with the Department of Health and Human Services Coordinating Council and Advisory Board created by the Elder Justice Act to identify and disseminate effective strategies for preventing elder abuse. In particular, other coordinated care models could benefit from PACE's experience in conducting background checks of staff.

Recommendations: Using Health Care Reform Opportunities to Advance and Evolve PACE

Based on the health reform-related opportunities for PACE identified above, summit participants recommended several ways to advance and expand the program. These include new PACE demonstrations, state and federal policies, payment alternatives, PACE operations and communication, and research.

"PACE is the epitome of the medical home."

—PACE Policy Summit Participant

1. Demonstrations

PACE programs should work with the CMS Center for Medicare and Medicaid Innovation and CMS Federal Coordinated Health Care Office to develop and implement demonstrations that would improve eligible individuals' access to PACE as well as expand PACE to new populations. Demonstration areas for consideration include:

- Payment alternatives could be explored, particularly for pricing PACE services for Medicare beneficiaries who are not financially eligible for Medicaid.

- PACE programs and/or services could be developed for other populations that would benefit from comprehensive, highly coordinated care. One example is to expand the PACE model to people with severe mental illness, as previously suggested. However, the PACE model would require a greater focus on services for people with mental illness, staff competency development, and development of an appropriate payment methodology. Because many people with mental illness may require the comprehensive care coordination offered by PACE before they are 55 years old, lowering the eligibility age for people with mental illness would be an important consideration.
- PACE programs could operate as a health home for a broader population including those with complex chronic illnesses and those at risk of needing nursing home level of care. This would require adjusting the clinical eligibility criteria for PACE and developing payment systems appropriate for those who are at lower levels of acuity, and operational changes to the model.
- Medicare and Medicaid could work together to develop a reimbursement methodology that allows for the total savings achieved by PACE to be shared across both programs. Considering the comprehensive costs and savings, relative to other care delivery systems, would provide an incentive to states to expand PACE services to the extent that these services demonstrated their ability to reduce costs for both the Medicare and Medicaid programs.

2. State and Federal Policies

- State and federal regulations to allow PACE greater flexibility to try new operational and care delivery approaches that would improve care, increase efficiency, and enhance consumer appeal.
- State policymakers should develop approaches to promote the availability of PACE statewide. This can be achieved through partnerships with providers willing to sponsor PACE programs and a planned approach to determining the service areas that will be supported by each program. States such as Pennsylvania, Virginia, and North Carolina can serve as models for promoting statewide access to PACE services.
- State Medicaid budgets can promote PACE as a cost effective care option through comprehensive, multi-year budget allocations for LTSS, rather than single year allocations targeted to specific provider types, e.g., nursing homes, day care, home care.
- States should consider PACE as a health home option. PACE organizations, working with community-based networks of primary care physicians, could serve as health homes to better manage care for a chronically ill population. Through this support, PACE could expand coverage to those who are at risk of needing a nursing home level of care, including persons under age 55. This expansion of services would require a change in the current requirement that PACE serve only those over age 55 and the nursing home eligible requirement for PACE participants, as well as expedited enrollment processes. North Carolina has tested a similar approach that could serve as a model.

3. Payment

- State and federal grant programs for PACE start-up costs would expedite PACE development and expansion, providing greater access to PACE services.
- In some cases, states' confidence in the cost-effectiveness of PACE might be enhanced by risk adjusted payment systems for Medicaid beneficiaries. Such systems would link prospective payment rates to the health status and specific needs of individual enrollees.
- PACE could propose payment alternatives that make PACE more attractive for beneficiaries from various income levels.

4. PACE Operations and Communications

- If PACE organizations choose to expand and serve different populations, they would need to assure staff competencies related to the core of these individuals, such as those with intellectual disabilities or mental health needs. PACE organizations also would want to establish effective partnerships with community organizations, such as residential care facilities and vocational rehabilitation programs, and health professionals with expertise in caring for these populations. Existing PACE organizations should pursue linkages with community service providers that can support their current capacity to maintain people in the community. These may include senior centers, transportation providers, meals on wheels, and exercise programs.
- PACE organizations should explore the application of home health monitoring and care delivery technology to increase the quality of care and cost effectiveness of PACE services. PACE programs also need advanced electronic health records to gather data needed for monitoring program performance and demonstrating outcomes.
- PACE organizations could encourage their sponsoring entities to include key components of the PACE model in their broader health care delivery systems and emerging care coordination programs, e.g., accountable care organizations.

5. Research

- Research is needed to identify the relative importance of key elements of the PACE model, such as the composition and role of the interdisciplinary team and the use of PACE center services, on outcomes and overall effectiveness. This research would inform the development and implementation of variations on the PACE model.
- Research is needed to identify reliable and appropriate outcome measures for PACE that can be used to compare PACE organizations' performance over time and to one another, as well as to compare PACE performance with alternative care options. This will support policy and payment actions related to PACE expansion.
- Research is needed to examine the cost effectiveness of PACE organizations relative to other care options, particularly capturing the longitudinal costs of care for the population PACE

serves and the comprehensive costs of that care, across all payers and service settings. Cost effectiveness research will need to incorporate accurate comparisons of PACE costs to different service delivery program options.

- Research is needed to understand how PACE could support older adults living in low-income housing. These data would be used to develop appropriate co-location strategies, outreach, and services for this population.

Renewing an Innovation

Health care reform presents a unique opportunity for PACE to renew itself through innovation and lead other organizations interested in developing care coordination models. PACE can build on its origins as an innovative model and its subsequent track record of achieving outstanding results for the people in its care. **As one summit participant noted, "PACE is tangible, real and not theoretical . . . and it can be for all populations."** Policymakers and stakeholders should look to PACE and its core competencies as they seek to promote care coordination and integration across the entire health system.

PACE Policy Summit Participants

Judith Baskins, Director, Clinical Integration, Palmetto SeniorCare; Robert Berenson, Fellow, Urban Institute; Shawn Bloom, President/CEO, National PACE Association; Greg Case, Director, Office of HCBS, U.S. Administration on Aging; Jennie Chin Hansen, CEO, American Geriatrics Society; Sharon Donovan, Director, Division of Program Alignment, CMS Federal Coordinated Health Care Office; Judy Feder, Professor and Former Dean, Georgetown Public Policy Institute; Peter Fitzgerald, SVP, Integrated Care Strategies, Volunteers of America, Inc.; Marsha Fretwell, Medical Director, Elderhaus, Inc.; Vicki Gottlich, Senior Policy Attorney, Center for Medicare Advocacy, Inc.; Enid Kassner, Director, Independent Living/LTC, AARP Public Policy Institute; Robert Master, President/CEO, Commonwealth Care Alliance; Kathryn McGuire, SVP of LTC & Senior Services, Rochester General Health System; Anne Montgomery, Senior Policy Advisor, U.S. Senate Special Committee on Aging; Carol O'Shaughnessy*, Principal Policy Analyst, National Health Policy Forum; James Pezzuti, Principal, Sellers Dorsey; Paul Saucier, Director, Thomson Reuters; Kirsten Sloan, Vice President, National Partnership for Women and Families; and Robyn Stone, Executive Director, Institute for the Future of Aging Services.

*Ex-officio

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The National PACE Association works to advance the efforts of Programs of All-inclusive Care for the Elderly (PACE) to support, maintain, safeguard and promote the provision of quality, comprehensive and cost-effective health care services for frail older adults. More information on NPA and PACE is available at www.npaonline.org.

Summary of Testimony – Shawn Bloom, President and CEO, National PACE Association

Committee on Energy and Commerce Subcommittee on Health
"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care"
Tuesday, June 21, 2011

Introduction. There are nearly nine million individuals "dually"- eligible for both Medicare and Medicaid. Dual-eligible Medicare and Medicaid beneficiaries often have multiple, complex health conditions. As a cohort, they are in poorer health and have lower incomes relative to other Medicare beneficiaries. PACE organizations understand the dual-eligible population well. Almost 90 percent of PACE participants are dual-eligibles. PACE exclusively serves the frailest subset of the duals: older adults requiring nursing home level of care.

The National PACE Association (NPA) represents 76 PACE organizations in 29 states, serving over 22,000 frail, older adults across the country. The vast majority of individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of daily living, such as eating, bathing and dressing. About half of PACE participants have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older, averaging 81 years of age, and 30 percent are 85 years of age or older.

My testimony will focus on three main areas: (1) PACE history and model of care, (2) barriers to PACE growth and expansion, and (3) program enhancements and potential voluntary demonstration programs that could help expand the PACE program and beneficiary access to PACE.

(1) PACE History and Model of Care. On Lok Senior Health Services in San Francisco, California developed and first implemented PACE in 1983 in response to the local Chinese-American community's desire to provide comprehensive medical care and social services for its elders without placing them in nursing homes. The federal government extended the program in 1986 to additional sites across the country through a demonstration program. In the Balanced Budget Act of 1997, Congress authorized PACE as a permanent Medicare provider and Medicaid state option. The Deficit Reduction Act of 2005 established a program to expand PACE to rural areas of the country.

The PACE program has three fundamental characteristics: (1) it is a community-based provider of care, focused on supporting the ability of the frail elderly it serves to remain living in their homes and their communities; (2) it provides comprehensive, fully-integrated care; and (3) it is fully-accountable and responsible to its enrollees, their families and the government for the quality and cost of care it provides.

(2) Barriers to PACE Growth and Expansion. Certain specific regulatory requirements, focused largely on required processes of care rather than outcomes, have hindered growth and innovations to improve efficiency, program growth and meet the changing needs of PACE enrollees. These include:

- High capital costs and long lead times associated with program start-up and expansion;
- Requirements that new PACE organizations assume full financial risk for all Medicare and Medicaid covered services on day one of program operations. In contrast to large Medicare Advantage organizations that are insurance entities, PACE organizations are small provider-based programs with less opportunity to distribute risk across their enrolled population; and
- Enrollment in PACE is limited to individuals who are a minimum of 55 years of age and meet states' eligibility criteria for nursing home level of care.

(3) Program enhancements and potential voluntary demonstration programs that could help expand PACE and beneficiary access to PACE. To overcome these barriers, we recommend the following modifications to the PACE statute and regulation:

Program Enhancements

- Allow PACE organizations more flexibility in contracting with community-based primary care physicians.
- Permit nurse practitioners (NPs) and physician assistants (PAs) to conduct certain activities that are currently assigned to PACE primary care physicians, in particular to perform participant assessments and engage in care plan development, consistent with state law and regulation governing their scope of practice.
- Without compromising PACE participants' receipt of comprehensive assessment and care planning, allow for more flexibility in the composition and processes of the PACE Interdisciplinary Team (IDT).
- Encourage states to utilize PACE as a means for transitioning Medicaid-eligible beneficiaries residing in nursing homes back to the community.

Voluntary PACE Demonstrations

NPA and its members are in the process of developing several demonstrations. The following voluntary demonstrations will allow PACE organizations and their states to test significant modifications to current PACE requirements and evaluate their implications for participant and program outcomes.

- A demonstration allowing PACE organizations to enroll individuals under the age of 55, who meet their states' eligibility criteria for nursing home level of care.
- A demonstration allowing PACE organizations to enroll high-need, high-cost beneficiaries, as defined by states, who may not yet meet state eligibility criteria for nursing home level of care and currently are not well served.
- A demonstration to reduce PACE organizations' reliance on the PACE Center as the primary location for the delivery of service and expanding PACE organizations' use of alternative care settings and contracted community-based providers.
- A demonstration that would allow interested PACE organizations to implement alternative approaches to providing Part D drugs to their PACE participants.
- A demonstration with the objective of increasing Medicare-only beneficiaries' enrollment in PACE.

Conclusion. PACE is a tangible program with a proven track record of providing high quality care to the frailest segment of the dual-eligible population, and is a good alternative to permanent nursing home placement. In its June 2011 report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated: "Fully integrated managed care plans and PACE providers offer the best opportunity to improve care coordination for dual-eligible beneficiaries across Medicare and Medicaid services." The PACE community would like to contribute to state and federal governments' efforts to improve health care for more dual-eligible individuals, and we look forward to working with you on these activities.

For additional information, please contact Shawn Bloom at shawnb@npaonline.org, (703) 535-1567; Brenda Sulick at brendas@npaonline.org, (703) 535-1521; and Chris van Reenen at chrisvr@npaonline.org, (703) 535-1568.

Mr. PITTS. The chair thanks the gentleman and thanks the panel for your opening statements, and we will now do a round of questioning and the chair recognizes himself for 5 minutes for that purpose.

Mr. Millwee, as you know, States are generally not informed about hospitalizations or prescription drug information for dual eligibles. How important is Medicare data to States in coordinating care and reducing costs associated with dual eligibles?

Mr. MILLWEE. Well, you are certainly correct. Without that data, we can't know the health condition of the dual-eligible member, and I think it is going to be critical as the Centers for Medicare and Medicaid coordination forms to provide States with that data so that we can implement the disease management programs that can be more cost effective if we were to have that data.

Mr. PITTS. How does Texas share in the savings generated through the STAR+PLUS program with the Federal Government? How important is it for States to be able to share in the savings generated by integrated care programs for duals?

Mr. MILLWEE. Well, today we don't share in that savings. The program was put in place to serve the population absent the need to share in that savings, and it has been recent that CMS was open again to discussions with the State about potential gain-sharing arrangements. So as we get that Medicare data, we believe that we can take to CMS a proposal that will demonstrate that STAR+PLUS has created savings not only for the State on the Medicaid side but also for the Federal Government on the Medicare side, so we will be developing a proposal to take to CMS.

Mr. PITTS. Thank you.

Mr. Bloom, you wanted to talk about the benefits of PACE to consumers. Please explain in more detail your idea to modernize the PACE program to include alternative settings of care. And why is the facility requirement a burden on the program today?

Mr. BLOOM. Yes, you know, I think historically the PACE program, if you drive by PACE program you will see what appears to be a very large day center within which there is space for a medical clinic, rehab, social services, personal care and possibly a kitchen. It has been a very convenient kind of focal point of care organization and deliver but what we have discovered over time is that the ability of PACE to grow is somewhat geographically constrained by the center. To the extent that we can begin contracting out, for example, for day center services using existing infrastructure down the street by an existing daycare provider would allow us to grow the program without undertaking significant capital costs and setting up a new center every time we want to expand our geographic market. That is but one example, and I could certainly offer you more.

Mr. PITTS. Thank you.

Ms. Hewson, you note in your testimony that the CCNC could have saved the State of North Carolina approximately $1.5 billion between 2007 and 2009, and that 100 percent of all Medicaid savings remain in the State. How are those savings shared with your organization?

Ms. HEWSON. At this point they are not shared. It goes back into the Medicaid budget. But we have been able to maintain provider

fees at 95 percent of Medicare. So in a way, that is a way to provide the infrastructure building and sustainability, but the money goes back into keeping the Medicaid program and dealing with the State budget issues.

Mr. PITTS. Do you have more information on what portion of those savings are associated with the 80,000 dual eligibles you serve?

Ms. HEWSON. I don't have it on hand but we could certainly get that information for you. We are missing some of the Medicare data to be able to tell a complete story on the duals at this point.

Mr. PITTS. How are the duals enrolled in your program? Is that mandatory enrollment?

Ms. HEWSON. It is voluntary. They typically choose—they are going to a provider that is participating with us, and oftentimes it is the provider that encourages them to enroll because they can then provide the wraparound support service of the care coordinators.

Mr. PITTS. Are the other 220,000 duals in North Carolina mostly served through fee-for-service or are there other coordinated care programs in the State to serve those duals?

Ms. HEWSON. We have, I think, two PACE programs and several in application and then there is the Medicare Advantage program, a few of those, but primarily the rest are in fee-for-service.

Mr. PITTS. Thank you.

Mr. Egge, in your testimony you note several beneficiary examples where the complexity and fragmentation of the system prevent frail duals from gaining access to available services. You note that fully integrated system could alleviate administrative barriers. Do you believe such a system is a one-size-fits-all or do you believe there could be a variation of models that could be used to help improve beneficiary access to care?

Mr. EGGE. First of all, there is great variety in the experience of people with Alzheimer's and other dementias. Our suspicion is that there could be very some important common elements that we can use and design any kind of system, but at this point, innovation and looking at different kinds of approaches and how they work is very appropriate as we learn what is going to work best.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I wanted to ask initial questions of Ms. Hewson and also Mr. Bloom. In Medicare, we have always maintained the principle that enrollment in managed care plans is voluntary for all Medicare beneficiaries. So let me start with Ms. Hewson.

As I understand it, your program of coordinated care, although not a managed care plan, is voluntary for Medicare beneficiaries. Is that correct, and how does that impact the program, that it is voluntary?

Ms. HEWSON. Well, it is correct. I think by being voluntary, there is probably less enrollment than if it was an opt-out program, but typically they are enrolling because they want to have assured access to a primary care physician that they go to, and that physician is encouraging them so that they can use the resources of the network that supports the physician in leading their care.

Mr. PALLONE. And then similarly, Mr. Bloom, I know that the PACE association has long believed that it is important to have beneficiaries buy in through voluntary enrollment rather than requiring dual eligibles into PACE. Do you want to comment on that too?

Mr. BLOOM. Yes. Dually eligible beneficiaries have the opportunity to opt in and out of PACE, and that has been the longstanding track record within the PACE program since its inception. Having said that, we have very, very low levels of disenrollment which I think certainly aligns the incentives for us to keep our eye on the quality and the satisfaction to the beneficiary.

Mr. PALLONE. And I note that in MedPAC's chapter on dual eligibles released last week, they said that many of the groups they interviewed raised concerns about access to care for beneficiaries, particularly individuals with disabilities who have established relationships with doctors already, and I just want you to know, I support efforts to get duals into better care relationships but we need to be careful not to take away Medicare protections for the lowest income Medicare beneficiaries because they are trying to access help though Medicaid as well.

Let me go back to Mr. Bloom. We recognize that PACE is a specialized program focused on the very medically needy and the fragile population so it not intended to nor would it be appropriate to serve all 9 million dual eligibles but currently PACE organizations have an enrollment of about 22,000 people nationwide, and while we don't know exactly how many people could theoretically be eligible, we know it is not 9 million but it is obvious that there are a lot more people that you could serve. You described the desire of PACE organizations to expand enrollment, can you just tell me a little bit about what Congress could do to help PACE grow and the cautions you have about growing too fast. You know that PACE has long been supported by bipartisan members of the committee but we want to make expansions that would work and help improve care for people and not create problems.

Mr. BLOOM. Very good question, very good question. First off, I think as Melanie testified earlier, it is very important to note that the duals are a very diverse population. This ranges from the young disabled to the elderly that are simply low income to the elderly that are frail to older individuals with intellectual disabilities. It is a very diverse population. And I think based on our experience and experience working with other integrated-type providers, there are different approaches for different populations that we need to look at. In the context of PACE, PACE is very well designed for a very high-need, very frail, very functionally impaired population. The examples I gave earlier with respect to barriers to growth were really focused on the federal side.

I would argue that there are an equal number, if not a greater number, of barriers that exist on the State side, one of which, and I will just throw it out, in this era that we live in today, you can get into a nursing home within a day typically. It often takes you 4 to 6 weeks to get into a community-based service program like PACE. That is because of the eligibility determination process in most States as well as some other administrative and other obsta-

cles that exist. That is a significant barrier for growth in addition to some other kind of State-specific examples.

Mr. PALLONE. What is your sense of how many additional people could be helped, you know, could go into PACE if we made the improvements, you know, if we managed to do things that you are suggesting to make it more accessible?

Mr. BLOOM. Good question as well. You know, it is probably to note, we are not a health plan. At the heart of PACE is the provider. We fully employ all—I mean, I think 90 percent of all care is provided directly by PACE employees, physicians, nurses and the like, so we are not going to be able scale each individual program on par with the United Health Plan or other large commercial health plans. Having said that, we do have programs that are as large as 2,600 people. We have programs in Appalachia as small as 40. So this is a program that can move large and small, so I do think each individual program is capable of serving several thousand people but I think you need multiple programs on the ground.

Mr. PALLONE. So theoretically, if you had a lot of them you could handle a lot more people?

Mr. BLOOM. Correct.

Mr. PALLONE. But they are going to have to be relatively small?

Mr. BLOOM. The solution to PACE growth is not to scale upon 76 that are on the ground today but to replicate the availability of the model throughout the country. The other witness testified, the State of North Carolina has two on the ground. They are filling the entire State with PACE. They will have 10 in development within 2 years. The State of Pennsylvania is another State where almost the entire State is full. The State of New Jersey within 2 years will probably have PACE available to every senior in the State. It takes a lot of leadership on the State. It takes a long-term vision, and I think it takes a strategic kind of approach to budgeting for Medicaid long-term care costs, which looks beyond the next 6 to 9 months, and that is difficult in this current era, admittedly. But I think it is possible and you are seeing examples of that across the States today.

Mr. PALLONE. All right. Thank you.

Mr. BURGESS [presiding]. The gentleman's time is expired.

Let me just ask each of you, what we have heard from this panel in various forms is the fact that an integrated-type model is possible and it does work seemingly every time it is tried. Is that something that I understand? Although the programs may be different that we have heard about, they all basically involved an integrated model of care with someone being responsible for the patient. I will start with Mr. Millwee from Texas.

Mr. MILLWEE. Well, I think you are right. There are integrated care models out there, and what strikes me is none of these are mutually exclusive. There is no best answer. We have the STAR+PLUS program because it works for us. We also have PACE. STAR+PLUS and PACE can coexist, or they work well together. I am familiar with the North Carolina model and it could work very well for Texas in a rural area where we have STAR+PLUS in urban areas. So I think the answers are out there. I think States have done a lot of work, a lot of innovative work on this very important issue for us because of the Medicaid expenditure and also

Medicare is going to benefit from that too. So the models are out there.

Mr. BURGESS. Yes, Mr. Bloom.

Mr. BLOOM. Yes, I think that is exactly the answer. I couldn't agree more. The only thing I would add is that if you look at commercial health plans which typically are the approach to integrating care for the duals, they do receive integrating financing. They attempt through their contract network to integrate care but do they do a wonderful job I think at improving the coordination of care for the most part but they often will carve-out long-term care risk from their payment and that is the population we serve so I think as Mr. Millwee mentioned, these are programs that work very complementary, albeit for very distinct populations and segments of the duals. So if done right, I think Texas is a good example, they have a very good vision for how they want this to roll out. It provides great hope, great opportunity and also provides the rights to service product for the right population based on their unique needs at a particular point in time. But I do think this is the direction to go.

Mr. BURGESS. Mr. Egge, obviously the Independence at Home is a little bit difference but still it is care coordination. Is that not correct?

Mr. EGGE. That is right. With Independence at Home and other models, our aim is not to create a certain silo just for those with Alzheimer's and dementia but to make sure that every system like Independence at Home is fully dementia capable. Many people with Alzheimer's, for example, have greatly appreciated PACE programs and their enrollment there, so we just want to make sure that whatever systems are there, we fully recognize the importance of dealing with cognitive impairment and the caregiver.

Mr. BURGESS. I just have to say, your story about the gentleman with Alzheimer's who also had diabetes who accessed care the best that he could, that is a tough thing to listen to as a physician, that someone could be exposed to that many gaps in their care in seemingly a caring and competent environment of a major hospital emergency room. That is just tough to hear.

Ms. Hewson?

Ms. HEWSON. I agree with the other panelists, other than I don't think just having integrated care assures that you are doing the right thing. I think you have to have a delivery system that does the right thing, and integrated care just is a way to align the incentives and the reimbursement strategies, and in North Carolina, we are not yet aligned in the reimbursement strategy although we are one of the 15 States that will be working with the coordinated office to develop a plan along that line, but we also have a very strong bias towards the medical home and keeping folks in the community, you know, delivered primarily through primary care providers is probably a model that has worked really well for us.

Mr. BURGESS. But primarily you do have to have—someone has to be responsible for that patient's care, and in my limited view of the world, that is obviously a physician, a single physician, but nevertheless, somebody has to be accountable for that patient's care on an ongoing basis.

Well, what do you make of the fact that the MedPAC report from this year, the current one, says less than 2 percent of all duals are enrolled in some type of integrated care program? Are they just not counting accurately because they are missing all of you out there or is that truly that we are only capturing a very, very small percentage of the dual eligibles?

Ms. HEWSON. I think MedPAC is counting when Medicaid and Medicare are putting funding together as an integrated approach which the PACE model is an example where both Medicare and Medicaid are funding the care of that individual. Our program, which serves over one million, is still a fee-for-service system so none of our individuals are counted in the MedPAC report. So the delivery system is integrated; the financing is not.

Mr. BURGESS. And what are the barriers to, or is there a problem with it being a fee-for-service system? Does that work well for you?

Ms. HEWSON. Well, I think you have to align the incentives. There are still silos and there is cost shifting that occurs so I think aligning the financial strategies and having, you know, Medicare and Medicaid sharing in those responsibilities, taking care of, in this instance, the duals is really important. So I think that is why we wanted to be one of those 15 States to develop that integrated model which aligns the integration with financing in addition to delivery.

Mr. BURGESS. Well, do you think more federal control is necessary? I mean, could you do your job better with a bigger and more powerful——

Ms. HEWSON. Well, I think you have heard ours is very local.

Mr. BURGESS. Yes, I think so too.

OK. My time is expired. I will recognize Dr. Cassidy for 5 minutes.

Mr. CASSIDY. The STAR+PLUS program, now, I am just trying to understand it. Ms. Bella said that 70 percent of the costs of dual eligibles in Medicaid is related to the long-term care aspect of it and most of the Medicaid acute medical expense, is the wraparound for that which Medicare does not cover. It seems like your savings are quite substantial if the—and I am not challenging, I am just trying to learn—that the provider or the Medicare managed care organization with which you are contracting, the only place they can lower cost is in the Medicaid component of the acute care. Is that correct?

Mr. MILLWEE. That is not the only place that have to manage cost and achieve effectively better utilization. I think it is through a number of mechanisms on the acute and long-term care support side. Remember, we are talking in STAR+PLUS about the entire aged, blind and disabled population. It is not just a model for dual eligibles. So about 40, 50 percent are dual eligibles.

Mr. CASSIDY. I see.

Mr. MILLWEE. So you have an acute care model of care that is integrated with the long-term care and what the HMO will likely do, particularly for the Medicaid that is aged, blind and disabled, is leverage those less expensive community-based services to keep them out of the more expensive acute care services, which is what we both want to do. We want to keep people out of nursing facili-

ties and out of hospitals and sometimes a personal attendant will do that for you relatively inexpensively.

Mr. CASSIDY. So just for a specific example, if you can use your Medicare dollar to get a personal attendant for a patient who is pre-nursing home, if you will, then that can save money on the Medicaid side, which would be a much greater expense, by using the Medicare dollar to pay for a service that would not be available under Medicaid. Is that a good example?

Mr. MILLWEE. That is correct. In fact, you might use a Medicaid cost to save Medicare money on the acute care side, and that is what we need to work through with CMS to talk about how we can leverage that to talk about some gain-sharing opportunities.

Mr. CASSIDY. Now, Mr. Bloom, although you said that you are not a health plan, you really do appear to be a staff model HMO. I mean, you are at risk, and you are using your own people. If you will, you are the Kaiser Permanente of the frail and fragile. Is that a fair statement?

Mr. BLOOM. That is an absolutely fair statement, absolutely, and I think we feel that burden every day in some of the requirements that we have to shoulder with respect——

Mr. CASSIDY. Let me ask you, I mean, because I only have a couple minutes, I don't mean to be rude. So when you speak of going beyond the duals into the Medicare only, again, effectively, you are becoming a staff model HMO for Medicare patients?

Mr. BLOOM. Correct. I would argue, however, that what we are suggesting is not all Medicare patients but those that we believe are high need, high risk and need kind of a medical home.

Mr. CASSIDY. Now, next, I have been fascinated since Dr. Nelson came from Baton Rouge to speak to her, and of course, we know each other personally and I have read about your program, but I have spoken to folks who criticize it and saying that really the cost savings are not there. In your testimony, you gave an anecdote which spoke of an individual but that when you actually kind of run the numbers with a big spreadsheet, that PACE has not been shown to save money. Is that a fair or unfair criticism?

Mr. BLOOM. I think it is an unfair criticism. There have been definitive government studies, two of which actually that looked at the Medicare cost in PACE and found that at worst we were budget neutral. On the Medicaid side, there has never been a definitive longitudinal study of PACE cost. Having said that, we continue to see States added to the list of PACE states. I think that what we have told States from day one is to the extent you set your rates appropriately, all of which are significantly below nursing home costs, then you in the longitudinal measurement will save money.

Mr. CASSIDY. Now, but again, maybe the criticism was that by keeping people out of the nursing home but still getting nursing home per diems, that again there are Medicaid savings that are not realized. Now, again, I am channeling right now.

Mr. BLOOM. I think what you are suggesting yes, our PACE rate includes a component of costs that reflect the full risk that we are assuming for long-term placement, and there are, you know, roughly on any given day 7 to 8 percent of the people we serve are permanently placed in a nursing home at cost to us, not to the State. So again, the true benefits of the——

Mr. CASSIDY. So it is a cohort savings, if you will?

Mr. BLOOM. It is a cohort savings, so the State is literally in many ways similar to——

Mr. CASSIDY. I am about of time. Sorry. Can you send those two articles that you have?

Mr. BLOOM. Yes.

Mr. CASSIDY. Now, Ms. Hewson, the savings that you have, you actually have your pediatric population in your CCN and you have your duals in the CCN. You savings you describe are global. What percentage of those are attributable to the dual eligibles? And that is my last question.

Ms. HEWSON. Well, I would say a greater percentage are due to the aged, blind and disabled, which include the dual eligibles, so we have over 100,000 straight Medicaid aged, blind, disabled so when we look at savings we are looking primarily at the aged, blind and disabled that are straight Medicaid because we don't have all the data on the Medicare so we are missing some of the hospital data in Part D and Part B data.

Mr. CASSIDY. You have done a good job of analyzing your data. Could you forward the more complete report on that?

Ms. HEWSON. Yes.

Mr. CASSIDY. Thank you. I yield back.

Mr. BURGESS. The gentleman's time is expired. The chair recognizes the gentlelady from the Virgin Islands, Dr. Christensen, 5 minutes for the purposes of questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

I guess I have a pretty broad question that anyone can answer. I probably would address is mainly to Mr. Millwee and Mr. Bloom and Ms. Hewson. I know that minorities figure very disproportionately in Alzheimer's cases as well, but some of the sickest individuals in Medicare and Medicaid of course are racial and ethnic minorities, so can each of you tell me what percentage of your population are people of color of those that you serve? Are the referrals proportional to the need? Is more outreach needed and are you experiencing the same positive outcomes and cost savings in the racial and ethnic minority population compared to the others?

Mr. MILLWEE. I don't have those numbers with me today. I do know that there is an equal benefit but I just don't have those numbers with me today but we would be glad to get those for you.

Mr. BLOOM. Yes, I can't cite specific statistics but I am fairly confident that the majority of people served by PACE are minorities. I anecdotally note many programs where it is literally nearly 100 percent minority based on the neighborhood within which they exist and the like, but I would be happy to get you the specific figures. But yes, it is a program that is focused on that segment of the population.

Ms. HEWSON. We serve all the minority Medicaid population in the State. We have all the safety-net providers participating in our program, and in the medical home models when you actually look at some of the quality performance metrics have been able to really show improvement in disparities because if you are providing best care for diabetes, you are doing it across the board for all your patients and so that has been a very rewarding quality metric that

we have been tracking. I will be glad to send you more information if you would like.

Mrs. CHRISTENSEN. Thanks. I know that they are there. We just weren't hearing about them, and I would expect that the models that you are talking about would be improving the care across the board.

Mr. Bloom, have you had occasion to look at or been asked to look at the PACE model in any of the territories, and if you know, do you foresee any barriers that would prevent you from setting up one of the PACE programs in one of the offshore areas?

Mr. BLOOM. We did have some initial and very preliminary discussions with Puerto Rico a number of years ago. They didn't progress on anything constructive after that, however. Having said that, we are always open, and I am not aware of any barriers to expanding PACE into any of the territories and actually would argue what little I know about the Medicaid program for the territories that I think it would be very mutually beneficial, so I would be happy to talk to you about that.

Mrs. CHRISTENSEN. Everybody has talked about, you know, the need for your programs and the fact that your programs are really community based. One of the amendments that I was involved in in the Affordable Care Act had to do with grants for community health workers, and I was just curious as to whether you utilize them in your programs. Mr. Egge, do you think that the community health worker would be a program that would be of assistance in care giving, even as the alternate caregiver in the Alzheimer's situation?

Mr. EGGE. Yes, we certainly found that is the case, that services that are provided in the community by social workers and by others can be tremendously important, especially at the early stages of Alzheimer's and other dementias while people are still able to live quite successfully in the community if they have that kind of support. We have found that is extremely important to well being for both the individual, and if they are living with somebody else, for their caregivers as well.

Mrs. CHRISTENSEN. Everybody uses community health workers?

Ms. HEWSON. In North Carolina——

Mrs. CHRISTENSEN. Promotores?

Ms. HEWSON. Promotores, and with the self-management of chronic disease, we engage lay community health advisors that actually live in the community that they are doing the chronic self-management programs so they have been very, very beneficial.

Mrs. CHRISTENSEN. Thank you. I am always concerned that the issue of quality of health care is often pitted against whether health care costs—if you are bundling and trying to bring these programs together, do you see any problems in moving forward to ensure that the dual-eligible health care quality and access in the health outcomes are not pitted against or held hostage to the health care cost containment issues?

Mr. MILLWEE. Well, in STAR+PLUS, we believe that critical to that is the external quality review organization where we aren't dependent upon just the State's data, we aren't dependent upon the HMO data but have an independent source to verify and look at the data that can measure, sure, the program is cost-effective but

is it providing high-quality service or access to services where they should be. So we believe that is critical, and as we learn more about quality and its importance on the program to change the program to respond to those concerns.

Mrs. CHRISTENSEN. Anyone else?

Mr. BLOOM. I would simply say that in PACE, we are, as I mentioned, we operate at full financial risk for all Medicare, Medicaid and medically necessary services with no carve-out, no copay, no deductible, no benefit limitations. We are immensely motivated and incentivized to provide good health outcomes. As the provider of care and the bearer of risk at the end of the day we are accountable, and it is truly in our best interest to get out in front of individuals' care needs and so that is what perfectly aligns the incentives within PACE.

Mr. BURGESS. The gentlelady's time is expired. The chair now recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes for the purposes of questions, please.

Mr. LANCE. Thank you, Mr. Chairman, and I yield my time to you, Mr. Chairman.

Mr. BURGESS. That is very kind of you.

Let me just ask you, Mr. Millwee, since we have a little additional time, you have talked in your testimony about the service coordinators, but some people look at that and say well, you are adding personnel so you are going to be adding cost. How does that work? How do you justify that?

Mr. MILLWEE. Well, some might speculate that would increase cost but actually that service coordinator, remember, that service coordinator is a clinical person who is working with that client so that clinical service coordinator is actually a dollar saver in many ways because they are identifying what that patient needs and how to get that for them so that we can have those early interventions so we don't have the hospitalizations or the nursing facility admits or the emergency department visits. So they literally pay for themselves time and again by having that intervention to make sure that the people who need those services, whether they are Medicaid or Medicare, that they are getting those things.

Mr. BURGESS. So you have demonstrable savings that you can point to in your program in Texas?

Mr. MILLWEE. Absolutely.

Mr. BURGESS. And do you think that works in Texas, do you think it would transition or translate to work on a national scale?

Mr. MILLWEE. Well, I think it could work in other States. I think the model is transferable. I don't think that people who are sick in Texas are any different that much really than people in Washington or California but I think that they could—the model is completely transferable to other States.

Mr. BURGESS. Do you have, can you share data with the committee, not necessarily right now, but is there data that you can share with us as to the actual dollar figures that have been saved?

Mr. MILLWEE. We certainly can. We can provide the committee with that information.

Mr. BURGESS. And how do you get around HIPAA?

Mr. MILLWEE. Well, we wouldn't provide you with client-specific data. We would provide you with deidentified aggregate information that would——

Mr. BURGESS. But more generally, how do the service coordinators themselves, how do they navigate the system under the constraints of HIPAA?

Mr. MILLWEE. Well, they are working with the client as an agent of the client, so they can——

Mr. BURGESS. So they are fully integrated into it?

Mr. MILLWEE. They are fully integrated into it, so they are not really burdened by HIPAA.

Mr. BURGESS. Generally, how do they monitor the day-to-day health of a patient? Is it telephonic, or how do they do that?

Mr. MILLWEE. It is not high tech, it is high touch. It is people talking to people, picking up the phone and talking to that person, finding out how they are doing. We do use electronic health records. A lot of the HMOs are moving to that. But it really comes down to relationships and somebody caring about another person, picking up the phone and calling them and seeing what they need.

Mr. BURGESS. That is what is so crucial, somebody caring about someone else. And Mr. Egge's story that still haunts me, you know, somebody caring about someone else, that wouldn't be happening.

Mr. MILLWEE. Right.

Mr. BURGESS. I am going to yield back the balance of my time and recognize the gentleman from Massachusetts for 5 minutes for the purpose of questions.

Mr. MARKEY. Thank you, Chairman Burgess, very much.

Mr. Egge, you did a good job in highlighting the important place for Alzheimer's patients in this discussion. More than 22 percent of seniors with Alzheimer's disease qualify for both Medicare and Medicaid coverage. Often these seniors rely on Medicaid to pay for expensive nursing home services. Since Alzheimer's patients can require constant attention, nursing home care for patients and Alzheimer's can ultimately wind up being three times as expensive as nursing home care for those without it. As a result of those costly nursing home stays, in 2004 the average Medicaid payment for a Medicare beneficiary over 65 with Alzheimer's was nine times larger than the average Medicaid payment for other beneficiaries in the same group. As such, seniors with Alzheimer's represent an extremely vulnerable portion of the dually eligible population.

I also have a particular interest in Alzheimer's since my mother passed away from it, which is why I created the Alzheimer's Caucus with Congressman Smith from New Jersey 13 years ago. I have seen it firsthand and I know the incredible commitment that our family had to make to keep my mother at home during that entire period of time.

One ongoing problem is the disconnect between those in the medical office seeing patients and those in the home caring for them. In your testimony, Mr. Egge, you mentioned the bill that Dr. Burgess and I have introduced, the Hope for Alzheimer's Act, which would encourage doctors to diagnose Alzheimer's patients earlier. After an Alzheimer's diagnosis is made, the bill that allows caregivers to be included in a conversation between doctors and patients to help plan for the disease and treatments. That conversa-

tion would give caregivers and doctors a reason to be working together because it will be the caregiver who will help the patient remember their diabetes medication and avoid ending up in a hospital.

In your testimony, you talked about John, who suffered from diabetes but because of his Alzheimer's disease found it difficult to follow his doctor's instructions. As a result, he ended up in the emergency room, and the doctors there were unaware of the Alzheimer's disease which created a struggle to provide further care. Can you, Mr. Egge, explain how a formal and documented diagnosis of Alzheimer's will help to improve care amongst different providers and settings?

Mr. EGGE. Yes, we found from our experience that the documentation of Alzheimer's or other forms of dementia is critical care and it is critical to coordinated care. So the reason it matters is because you cannot provide appropriate care if you don't know dementia exists, and we talked about how that pertains of course to how you handle instructions for compliance, for instance, whether that can be directed to the individual or provided to a caregiver if available or perhaps to a surrogate when not, so in that sense it is fundamental. It is also fundamental when we think about documentation of the condition, the medical record, follows that person with a well-functioning system from setting to setting. We know that care transitions are one of the most risky moments for those with Alzheimer's and other dementias because of all the problems that can happen, especially in a hospital setting and others as they transition in and out. So it is critical to this committee that there is that documentation, diagnosis and then documentation.

Mr. MARKEY. So this is an amazing number, but just one disease, Alzheimer's, last year cost the Federal Government $130 billion out of Medicare and Medicaid. It is just an astounding number. You know, it is about a quarter of the entire defense budget, and that is just one disease, Alzheimer's. How with the Hope Act support caregivers and help provide them access to the resources they need to care for their loved ones, to keep them at home and as a results keep down the costs to the program?

Mr. EGGE. That is a great question, and one element of the Hope Act in particular is groundbreaking in that it provides for the first time for the health care provider to have consultations with the caregiver, whether or not the individual with Alzheimer's or other dementia is present, which is extremely important because sometimes it is most appropriate for the conversation to happen in number of different ways, so we applaud that and it is built on the recognition of how important a caregiver is for these individuals.

Mr. MARKEY. Thank you, Mr. Egge. You know, it is $130 billion now. By the time all the baby boomers have it, 15 billion, the bill for Alzheimer's will equal the defense budget. It will be about $500 billion or $600 billion a year. So I think it is also calling upon us to increase the NIH research budget so that we can find a cure because ultimately we can't balance the budget if we have a problem like this that is on the horizon.

Thank you, Mr. Chairman, so much.

Mr. BURGESS. The gentleman's time is expired, and actually that concludes today's hearing. I remind members they have 10 busi-

ness days to submit questions for the record, and I ask that the witnesses all agreed to respond promptly to these questions.

The committee is now adjourned.

[Whereupon, at 4:27 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of the Honorable Joe Barton
Chairman Emeritus, Committee on Energy and Commerce
Sub Committee on Health
"Dual-Eligibles: Understanding this Vulnerable Population and How to Improve their Care "
June 21, 2011

Thank you, Mr. Chairman for holding this important hearing to discuss dual eligible Medicare and Medicaid beneficiaries. As a growing number of individuals rely on both of these programs for their coverage, we must find ways to improve coordination between federal and state governments to increase the quality and reduce the cost of providing healthcare services.

People enrolled in both Medicare and Medicaid tend to have the most complex, chronic illnesses and more difficulty navigating the health care system. As a result, their healthcare often suffers which leads to unnecessary and more costly treatment.

An improved Medicare-Medicaid system will present a significant opportunity for cost savings to the state and federal governments. This can be achieved by improving care coordination and simplifying programs rules.

Congress should give states flexibility to develop innovative state-based solutions to their healthcare needs. These coordinated plans must be incentivized to allow states to share in the cost savings.

As I have expressed before, I am deeply concerned about the massive Medicaid expansion under Obamacare, and the affect that it will have on state budgets. Medicaid is

unsustainable on both a federal and state level, and this overreaching legislation only accelerates that fact.

I look forward to hearing from our witnesses today so that we can get a better idea how to address the inadequacies of these programs going forward.

Thank you, I yield back.

Rep. Lance

E&C - Health Subcommittee - Dual-Eligibles Hearing - Opening Statement - 06.21.2011

Thank you Mr. Chairman.
According to the Centers for Medicare and Medicaid Services (CMS), there are more than 9 million Americans who are eligible for both the Medicare and Medicaid programs, including more than 200,000 in New Jersey alone. These so-called, "dual-eligibles" are the sickest, most chronically ill individuals among all Medicare and Medicaid beneficiaries.

While dual-eligibles represent less than 20 percent of the enrollment of the Medicaid and Medicare programs, they account for a significant amount of the programs' expenses. Because dual eligibles have significant medical needs they have a much higher per capita cost than other beneficiaries. For example In New Jersey dual-eligibles represent 21 percent of its total Medicaid population but constitute 49 percent of the expenditures.

Because dual-eligibles have greater health care needs they also have the most difficulty in navigating the health care system than other Medicare and Medicaid beneficiaries. As a result, their health often suffers and their treatment patterns become more costly.

According to CMS data, nearly 30 percent of the dual-eligible population is hospitalized during the year, totaling almost 2.7 million hospitalizations. Of these hospitalizations, approximately 26 percent could have been avoided providing a potential savings of $5.6 billion.

Looking forward, this committee is faced with many challenges as we seek to improve the integration and coordination of care for dual-eligibles while reducing costs to the Federal and state governments and assuring beneficiary safeguards that will ultimately strengthen both the Medicare and Medicaid programs in the years ahead.

I look forward to hearing the testimony today on how we can address these challenges.

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
Subcommittee on Health
"Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care."
June 21, 2011

Thank you Mr. Chairman for holding today's hearing focusing on individuals dually eligible for Medicare and Medicaid. These nine million Americans represent some of our most vulnerable in society – low-income, young and elderly, disabled or with multiple chronic conditions. Given the often complex and chronic illnesses of this diverse population, they also tend to represent the highest cost individuals in both Medicare and Medicaid.

In my home state of Michigan, the care for 204,000 dual eligibles costs roughly $7.7 billion. According to Melanie Bella, Director of the Federal Coordinated Health Care Office, total spending for dual eligibles care is estimated at $300 billion annually across both programs. This is a tremendous cost for our states and for our Medicare and Medicaid programs. It is clear that as we begin looking at ways to improve the quality of care we are providing beneficiaries in the Medicare and Medicaid programs, that we must also look to address inefficiencies in caring for dual eligibles.

The Affordable Care Act took some initial steps to begin to improve care for dual eligibles through the development of the Federal Coordinated Health Care Office to improve integration between Medicare and Medicaid, as well as establishing the Center for Medicare and Medicaid Innovation to test pilot projects to reform care delivery for these groups. My home state of Michigan is one of 15 states receiving funding for such a pilot. The Center for Medicare and Medicaid Innovation is also undertaking the "Alignment Initiative", which will invite stakeholders to help to identify and address any conflicting requirements between Medicare and Medicaid.

I commend the Administration for taking these initial steps to address the needs of this unique population and I look forward to working with my colleagues on both sides of the aisle to find ways that we can help to improve and coordinate the care dual eligibles receive today. While we explore innovative approaches to caring for dual eligibles – whether through medical homes, PACE organizations or integrated care management - we must ensure that any reform moving forward protects the rights of these dual eligibles, while also helping them to navigate the health care system in order to receive the care they need.

Melanie Bella's
Additional Written Questions for the Record
"Dual Eligibles"
Energy & Commerce Health Subcommittee

June 21, 2011

The Honorable Michael C. Burgess
54% of duals have cognitive/mental impairment; (2.3 times higher than other Medicare patients). Combined Medicare/Medicaid spending on duals with dementia is, at a *minimum*, 30% higher than similar patients without dementia, but those costs rise up to 90% higher than those without, depending on medical conditions.

1. **What impact do you believe this has on the costs of these patients?**

Answer: People enrolled in both Medicare and Medicaid tend to have complex, chronic illnesses, and are often some of the highest cost individuals within the Medicare and Medicaid programs. Because Medicare-Medicaid enrollees must navigate two programs, they often receive fragmented and uncoordinated care which may lead to poor health outcomes and more costly care. Coordination between the two programs can improve the quality of care received and the overall health of the Medicare-Medicaid enrollees.

2. **What programs are available through Medicaid and Medicare to help treat mental illnesses, and thus improve overall medical treatment and costs?**

Answer: The Centers for Medicare & Medicaid Services (CMS) has many programs to help treat mental illness and improve overall treatment and costs. Behavioral health homes and medical homes are two programs within the Medicaid programs that treat mental illness and improve overall treatment. Additionally, programs such as the Substance Abuse and Mental Health Services Administration's Assertive Community Treatment (ACT) are designed to provide comprehensive community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. In addition to these programs, CMS offers other programs through Medicaid State Plan Amendments and section 1915 (c) waivers.

I have cosponsored legislation with Mr. Markey to ensure that Medicare pays for confereneing with family members about the many care options available and how to access them. Informed families often are more comfortable keeping a dual family member at home, thus keeping families together longer, and reducing the cost of hospitalization.

3. **Would this help alleviate fears and help in training families to care for their loved ones themselves?**

Answer: The Medicare-Medicaid Coordination Office is focused on the beneficiary and committed to working with Medicare-Medicaid enrollees to improve the overall care experience

by improving the communication and awareness of available programs and services. While the Administration has not taken a formal position on this proposed legislation, we support efforts aimed at strengthening communication and information sharing with beneficiaries and their families.

4. What is the cooperative relationship between Medicare and Medicaid that can coordinate the care/hospitalization of these patients so that they get better follow-up on their conditions, thus preventing such unnecessary medical emergencies?

Answer: The Medicare-Medicaid Coordination Office was created by the Affordable Care Act to improve coordination and more effectively integrate benefits across Medicare and Medicaid for Medicare-Medicaid enrollees. Our office facilitates collaboration across CMS and States to help improve States' and providers' coordination of the care/hospitalizations of Medicare-Medicaid enrollees in order to achieve high quality care.

The Medicare-Medicaid Coordination Office is focused on coordination across the full spectrum of services, working to promote Medicare-Medicaid enrollees' receipt of high quality, person centered primary, acute, behavioral, and long-term services and supports. Important aspects of this integration of services include: following up with patients; making sure they are not unnecessarily placed in hospitals; working with patients to communicate and raise awareness; taking preventive steps, and ensuring they receive the proper care in the proper setting.

To that end, CMS recently launched the Partnership for Patients, a department-wide patient safety effort designed to improve coordination of care and reduce preventable hospital-acquired conditions and readmissions. These efforts will help drive better care for Medicare-Medicaid enrollees.

5. How are families being taught to care for their dual-eligible loved ones so that they can monitor their medical conditions?

Answer: Our office understands that family members are often the primary decision makers for Medicare-Medicaid enrollees or involved in their care and recognizes both the value and importance of focused efforts to better communicate with caregivers and families. Pursuant to section 2602(c) of the Affordable Care Act, our office is focused on increasing Medicare-Medicaid enrollees' understanding of and satisfaction with coverage under the Medicare and Medicaid programs. Increasing the understanding and satisfaction of Medicare-Medicaid enrollees also means working together with families and caregivers to foster the knowledge and awareness needed to improve the quality of care received by their loved ones. To help meet this goal, we are conducting focus groups around the country to learn more about the needs and concerns of this population as well as new channels of communication to improve the care they receive. This is the first of many steps in improving communications with Medicare-Medicaid enrollees and their families.

6. Could better follow-up care improve these statistics?

Answer: Medicare-Medicaid enrollees are a high cost population with complex care needs. As a result, it is critical that we make informed and well thought out decisions regarding this population, balancing both the beneficiary's care needs and the State and Federal government responsibility to manage resources effectively.

Through our demonstration programs we hope to identify and outline delivery system and payment coordination models that can be tested and replicated in other States. Patient follow-up, transitions, and other patient-centered models are among the many different care components being tested. As our demonstrations identify follow-up practices and tactics to improve care, our office will work to replicate those efforts in other States.

I noticed in your written comments that you state, "The Medicare-Medicaid Coordination Office's mission is to address and improve the beneficiaries' experiences, access to care, quality of care, and cost of benefits for individuals enrolled in both the Medicare and Medicaid programs."

In Fiscal Year 2010, CMS implemented the Disproportionate Share Hospital Audit Rule. In the Texas border region, this rule has had an impact of over $40 Million annually. This result occurred when hospitals were forced to flow over Medicare payments for dual eligible patients in their Medicaid DSH Hospital payment formulary, despite the fact that Medicaid made no payment.

While this led to payment reductions for some, unfortunately, it did not translate into savings for the program. The money was simply redistributed to communities with more affluent populations whose Medicare beneficiaries have commercial insurance as a supplement or no supplement at all.

7. Can you provide your thoughts on this action?

Section 1923(g)(1)(A) of the Social Security Act states that these hospital-specific DSH limits should be calculated based on payment for individuals who are eligible for medical assistance under the State plan. As you may know, CMS has provided guidance on how costs and revenues associated with Medicare-Medicaid enrollees (or dual eligibles) must be treated when calculating Medicaid hospital-specific Disproportionate Share Hospital (DSH) limits. In the Medicaid DSH audit and reporting final rule, published on December 19, 2008, and in guidance released since, CMS has instructed States that costs and revenues associated with individuals dually eligible for Medicare and Medicaid, including Medicare payment revenue received by the hospital on behalf of the patient, must be included in the calculation of the hospital-specific DSH limit.

Prior to CMS clarifying our policy on this issue, some States and hospitals were excluding cost and revenues, or simply revenues, associated with Medicare-Medicaid enrollees when calculating hospital-specific DSH limits. This practice led to artificial inflation of hospital-specific DSH limits and permitted some hospitals to be paid twice based on the same costs.

We recognize that this policy has had an impact on some States and hospitals. While we continue to examine the policy, we believe that this policy promotes the integrity of the Medicaid DSH program by ensuring that hospitals receive Medicaid DSH payments only up to the uncompensated costs incurred in providing inpatient and outpatient hospital services to individuals eligible for Medicaid or individuals with other source of coverage.

8. Do you believe it will translate to reduced access for dual eligible patients since facilities only have to flow over Medicare payments for dual eligible patients, while Medicare patients with private supplemental insurance remain unchanged?

We do not believe that our policy will reduce access for Medicare-Medicaid enrollees because the hospital is receiving compensation for services to these individuals. The policy recognizes that Medicaid DSH payments are limited to uncompensated costs. In this circumstance, the compensation received by hospitals from Medicare or other payers in treating Medicaid-eligible individuals must be taken into account in determining the extent of uncompensated costs in serving Medicaid patients.

When calculating hospital-specific DSH limits, we interpret the statute to require determination of uncompensated costs of providing inpatient and outpatient hospital services to Medicaid-eligible individuals by comparing the cost of services with associated revenues for those services.

9. Does this not disincentive hospitals to treat dual eligible patients?

We do not believe that hospitals have a disincentive to treat Medicare-Medicaid enrollees because the hospital is receiving compensation for services provided to these individuals. This policy recognizes DSH payments are limited to uncompensated costs in serving Medicaid and uninsured patients. In this circumstance, the compensation received by hospitals from Medicare or other payers in treating Medicaid-eligible individuals must be taken into account in determining the extent of uncompensated costs in serving Medicaid patients.

When calculating hospital-specific DSH limits, we interpret the statute to require determination of uncompensated costs of providing inpatient and outpatient hospital services by comparing the cost of services with associated revenues for those services.

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RESPONSE OF MR. ROBERT EGGE TO
QUESTIONS SUBMITTED BY THE HONORABLE JOHN D. DINGELL
SUBCOMMITTEE ON HEALTH
"DUAL-ELIGIBLES: UNDERSTANDING THIS VULNERABLE POPULATION AND HOW TO IMPROVE THEIR CARE"

I first want to start with Mr. Egge. During the first panel I asked Ms. Bella about how best to help beneficiaries access the care they need. In your testimony, you use the example of John and Emma. John has been relying on his wife to serve as a care giver, however, Emma has been ill-equipped to help him due to her own health issues.

1. Now Mr. Egge, the Alzheimer's Association has unique experience dealing with the cognitively impaired. Given the challenges these individuals face in accessing care and navigating the system, what guidance would you provide to the Administration to help engage this population and their caregivers in the design and implementation of any new care model?

The Alzheimer's Association commends members of Congress and the Administration for their commitment to developing new care models that better meet the needs of people living with a cognitive impairment who are also dually eligible for both Medicare and Medicaid.

A crucial component of that development is the engagement of those with the disease and their caregivers. Increasingly, people in the early and middle stages of Alzheimer's disease are speaking out about their care needs. The Association engages these individuals and their caregivers on an on-going basis through platforms such as our Early Stage Advisory Group, Board of Directors, annual Advocacy Forum, national 24-hour telephone Helpline, national chapter network, and support groups.

The Association also convenes special workgroups and other platforms from time to time to ensure the voices of individuals living with Alzheimer's are heard. Several years ago, the Association sponsored town hall meetings for individuals and their caregivers where they spoke on many different issues, including access to necessary care and treatment as well as navigating the complex health care, long-term care and home- and community-based service systems in this country.

Currently, the Alzheimer's Association is hosting input sessions throughout the country regarding the creation of the first National Alzheimer's Plan, required by Congress in the National Alzheimer's Project Act (P.L. 111-375). At these input sessions, we are soliciting individuals' firsthand experiences with this devastating disease. The Association will compile and analyze these responses, in addition to responses received online, and will share that feedback with the Administration and members of Congress. Through these means, the Administration and Congress will gain a broad understanding of the impact of Alzheimer's disease on the families who live with it daily, and that will in turn help inform and strengthen the National Alzheimer's Plan.

As I mentioned in my written testimony, the success of any new care model being considered is reliant upon having fundamental preconditions in place such as an accurate understanding of the individual's health challenges. In the case of Alzheimer's and other dementias, one of our most significant challenges is related to

detection and diagnosis. Although Alzheimer's disease is diagnosed correctly up to 90 percent of the time by physicians with specialized training, as many as half of individuals meeting specific diagnostic for dementia never receive a diagnosis - and some evidence suggests it could be as high as 80 percent.

We encourage the Administration to look at a proposed model included in H.R. 1386 / S. 738, the HOPE for Alzheimer's Act, which the Alzheimer's Association strongly supports. The HOPE for Alzheimer's Act will improve diagnosis of Alzheimer's disease and increase access to information, care and support for newly diagnosed individuals and their families - providing essential support for those facing this devastating, debilitating disease.

After ensuring that detection and diagnosis has taken place to define the population and their caregivers, there are several principles we urge the Administration to consider. To best inform the design and implementation of new care models for dual eligibles living with a cognitive impairment, we recommend that the Administration follow an engagement approach similar to the Association's; that is, adopt a transparent process utilizing a variety of methods to gather information. This process should include direct outreach to people with Alzheimer's disease and their caregivers and should employ various points of contact, including town hall meetings, small group input sessions, online data gathering and telephonic outreach. This process should be used to assess:

- current availability of services, including services for caregivers;
- care models currently available and of those, which adequately meet the needs of the target population;
- gaps in services and care;
- the need for additional chronic disease care; and
- environmental challenges that may exist for residents in rural settings such as lack of transportation options or proximity to caregiver(s).

Direct information gathering and assessment methods were used to develop a number of innovative models of care that have been effective in randomized clinical trials for people with Alzheimer's disease and other dementias. Examples include the PREVENT[i] and ACCESS models of care.[ii] Findings have not yet been reported from a random clinical trial of another model, Partners in Dementia Care, but preliminary results are impressive. These models of care were effective because they first included a careful assessment of the needs of the person with Alzheimer's or other dementia and the person's family caregivers, followed by the development and implementation of plans of care based specifically on those needs.

In short, we believe that new care models will only succeed if the designers of the models listen to the beneficiary and caregiver, assess their respective needs, develop a plan of care to meet those needs and provide services in accordance with a care plan.

2. I also believe strongly that any new care model for dual-eligibles must ensure the rights and protections beneficiaries currently provided under Medicare and Medicaid are retained. What consumer protections do you believe are needed to protect those with dementia or Alzheimer's in any new care model?

The Alzheimer's Association agrees that any new care model must retain the protections beneficiaries currently possess under both Medicare and Medicaid. But, because of cognitive impairment, individuals with Alzheimer's disease and other dementias need additional protections.

As new models of care are developed to integrate Medicare and Medicaid, the Alzheimer's Association believes that the following consumer protections are particularly important for people with Alzheimer's:

- Following diagnosis, a caregiver should be identified to participate in discussions about treatment and care, as appropriate, but especially when an individual becomes cognitively incapable of understanding treatment options.
- Caregivers' or legal representatives' names and contact information should be in the medical record to receive coverage notices and appeal rights to guarantee that the rights of the impaired individuals are protected.
- Adequate provider networks should be available and should include dementia-trained providers. Individuals with dementia should have the ability to seek exceptions to network requirements.
- Beneficiaries should have enrollment rights that maintain their freedom of choice and provide opportunities to make enrollment changes as necessary.
- Where Medicare and Medicaid provide two different coverage standards for providing the same benefit, the integration effort should ensure beneficiaries access under the more favorable standard.
- Where due process, notice and appeal rights diverge between Medicare and Medicaid, the integration effort should provide beneficiaries access to the most favorable standard. It is important for individuals to receive clear notice of the reason for denial of care and an explanation of the right to appeal.
- Clear standards for care coordination and assessments are needed to ensure that new models actually deliver these important benefits.
- Transition protections are necessary to ensure access to providers and treatments as beneficiaries enroll and disenroll from integration and coordination models.
- Linguistically and culturally appropriate information and care should be provided.

Finally, we would encourage Congress and the Administration to look at a proposed model included in H.R.1386 / S.738, the Health Outcomes, Planning, and Education (HOPE) for Alzheimer's Act, which the Alzheimer's Association strongly supports. While this legislation is targeted at early diagnosis of Alzheimer's disease for all individuals on Medicare, not just those who are dually eligible, the consumer model it creates is broadly applicable: in order to achieve better care, individuals and their caregivers must be consulted, care must be planned, and the diagnosis must be documented in the patient's medical record.

---

[i] Callahan CM, et al. "Effectiveness of collaborative care for older adults with Alzheimer disease in primary care: A randomized controlled trial." *Journal of the American Medical Association* 2006; 295(18):2148-2157.

[ii] Vickery BG, Mittman BS, Connor KI, et al. "The effect of a disease management intervention on quality and outcomes of dementia care: A randomized, controlled trial." *Annals of Internal Medicine* 2006; 145:713-726.

Community Care of North Carolina

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August 4, 2011

Mr. Joe Pitts
Chairman, Subcommittee of Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pitts:

It was my pleasure to present before the Subcommittee on Health on Tuesday, June 21st, 2011 to testify at the hearing entitled "Dual-Eligibles: Understanding this Vulnerable Population and How to Improve Their Care". I am responding to the additional questions sent as a follow-up to that testimony.

1) *Recent studies by the New England Journal of Medicine and the Center for Health Care Research and Transformation at the University of Michigan have documented that it is very difficult for Medicaid recipients to get appointments with specialist they need. Does the North Carolina model allow specialists to be the patient-centered medical home or is it entirely based on primary care?*

   Most of our medical homes are primary care providers, but specialists are able to sign up as medical home providers if they are willing to meet the expectations of a medical home. There are more specialists participating as medical homes in rural communities or in large multi-specialty practices. For some individuals whose primary disease is cardiovascular, they view their cardiologist as their "medical home". Some of the types of expectations that the specialists must agree to meet include but are not limited to the following:
   - Ensure their enrolled patients receive regular screenings and health prevention (e.g. Flu shots)
   - Treat or arrange for handling acute episodic health events, such as the flu, sprains, etc. (other than the emergency department)
   - Provide 24/7 coverage (process for after hours calls from patients)
   - Participate in the quality improvement initiatives – implementing evidence-based best practices for chronic illness care
   - Coordinate and communicate with other members of the patient's health care team

2) *As a follow-up, what studies have been done on patient access to specialist care in the North Carolina model and how do access issues compare to the population not covered under this model.*

   To date, North Carolina has not had an access problem with having enough medical homes to serve the enrolled Medicaid and dually-eligible population. Almost all of our primary care physicians are participating in the Community Care program. The medical homes have developed relationships with specialty providers for their patient population. I am not an expert on medical manpower shortage areas, but we do have areas of the state that have difficulty finding dentists and behavioral health providers to serve our population. Since we only began targeting dually-eligible beneficiaries to

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join Community Care in the past couple of years, we have not conducted any access studies. Currently, over 1/3 of the dually eligible beneficiaries are enrolled in our program.

I have attached a report that was published by the North Carolina Institute of Medicine in June 2007 entitled: "*Providers on Demand: North Carolina's Primary Care and Specialty Supply*", than may have some relevance.

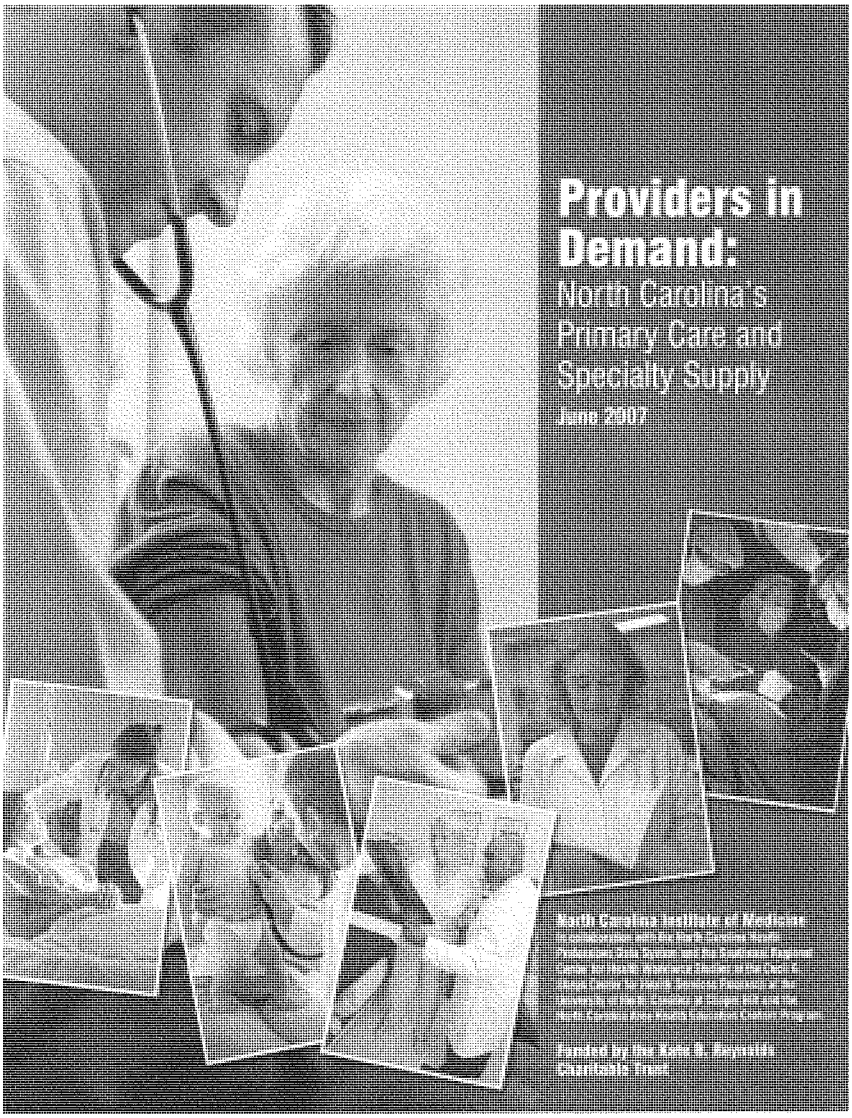
3) *How visible is this system to patients? In other words, are patients required to select a primary care physician and stay with that physician for all their primary care and for any referrals to a specialist (like and HMO)? If not, how are patients attributed to the primary care practices that get the care management fee?*

Yes, patients are asked so select from a list of participating practices in their area (as mentioned in the response to #1, most are primary care providers but there are also specialty practices if they have signed a participation agreement). Once they have chosen a "medical home", and if they have need for specialty care the primary care provider will coordinate that care and ensure appropriate follow-up and communication occur between the primary care provider and specialty providers. The patient can choose the specialist they want to see as long as they are enrolled as a Medicaid provider. It is not unusual for a dually eligible enrollee to regularly see their primary care provider, but to also have regular visits with their cardiologist, pulmonologist, etc. to meet their health care needs. Our program aims to improve the coordination of care amongst providers and ensure that the right information follows the patient across provider and delivery settings.

Please let me know if I can be of any further assistance and thank you for your interest in our program.

Sincerely,

Denise Levis Hewson, RN, BSN, MSPH
Director of Clinical Programs and Quality Improvement


Providers in Demand:
North Carolina's Primary Care and Specialty Supply
June 2007
North Carolina Institute of Medicine
Funded by the Kate B. Reynolds Charitable Trust

health policy
North Carolina Institute of Medicine

The North Carolina Institute of Medicine serves as a nonpolitical source of analysis and advice on issues of relevance to the health and healthcare of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health and healthcare issues, and a source of advice regarding available options and approaches for problem solutions.

The full text of this report is available online at:
http://www.nciom.org/projects/supply/primary_specialty.html

One complimentary copy of this report will be made available to requesting agencies and programs in North Carolina while supplies last. All requests must be submitted on official letterhead. There will be a $20 charge for each additional copy.

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Providers in Demand:

North Carolina's Primary Care and Specialty Supply

June 2007

North Carolina Institute of Medicine

In collaboration with the North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill and the North Carolina Area Health Education Centers Program

Funded by the Kate B. Reynolds Charitable Trust

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Acknowledgements

The Task Force was a collaborative effort between the North Carolina Institute of Medicine (NC IOM), the North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the North Carolina Area Health Education Centers Program. The work of the Task Force was funded through a generous grant from the Kate B. Reynolds Charitable Trust.

The NC IOM extends special recognition to the Task Force Chair, E. Harvey Estes, Jr., MD, Chairman Emeritus, NC IOM Board of Directors, Professor Emeritus, Department of Community and Family Medicine, Duke University, who helped direct the work of the Task Force. The Task Force's work and clarity of vision would not have been possible without his leadership. The NC IOM also wants to thank the 34 members of the Task Force and Steering Committee (listed below) who gave freely of their time and expertise for more than a year to try to address the impending shortage of physicians, nurse practitioners, physician assistants, and certified nurse midwives.

In addition to Task Force members, the NC IOM would like to extend special appreciation to our partners at the North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies at the Cecil G. Sheps Center for Health Services Research. The North Carolina Health Professions Data System is the oldest and most comprehensive state-level health professions data system in the country. Thomas C. Ricketts, III, PhD, MPH, Deputy Director, Cecil G. Sheps Center for Health Services Research; Erin Fraher, MPP, Director, North Carolina Health Professions Data System; Katie Gaul, MA, Research Associate; and Jennifer King, Research Associate, were invaluable to this Task Force. Much of the Task Force's analyses would have been impossible without their help. They provided background information about the trends in provider supply, distribution of providers across the state, racial and ethnic composition of practitioners, and number of North Carolina providers who completed their medical training or residency in state. The NC IOM also wants to extend special thanks to our other partner, the North Carolina Area Health Education Centers Program. Thomas J. Bacon, DrPH, Executive Associate Dean and Director, North Carolina Area Health Education Centers Program, University of North Carolina at Chapel Hill School of Medicine, also has extensive knowledge about provider supply issues. He and his staff helped provide information about health professions training programs, graduate medical education, and educational pipeline programs. Torlen Wade, MPH, Director, North Carolina Office of Rural Health and Community Care, North Carolina Department of Health and Human Services; Andrea Radford, DrPH, MHA, Research Associate, North Carolina Office of Rural Health and Community Care; Pamela P. Highsmith, MEd, Associate Executive Director, North Carolina Medical Society Foundation; Cathy Wright, Former Associate Director, Community Practitioner Program, North Carolina Medical Society Foundation; and Jeff Spade, CHE, Executive Director, North Carolina Rural

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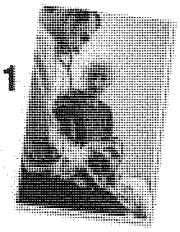
North Carolina's Healthcare Needs and Provider Supply Trends

Chapter 1



Growth in the provider supply has not kept pace with growth in the overall population or the increased demand for health services in North Carolina. The state is likely to face a severe shortage of physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) over the next 20 years, absent major changes in the healthcare delivery system or significant increases in the number of providers.

The North Carolina Institute of Medicine (NC IOM) convened a Task Force to analyze current and projected trends in provider supply and to examine whether the existing production of physicians, NPs, PAs, and CNMs will address the state's growing healthcare needs. The Task Force was a collaborative effort with the North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill and the North Carolina Area Health Education Centers Program. The Task Force was chaired by E. Harvey Estes, Jr, MD, Chairman Emeritus of the NC IOM Board of Directors and Professor Emeritus, Department of Community and Family Medicine, Duke University. The 34 other Task Force and Steering Committee members were drawn from across the state and included representatives of professional associations (representing allopathic and osteopathic physicians, NPs, PAs, and CNMs), provider specialties, academic health centers, other health professions training programs, residency directors, hospitals, and the North Carolina Office of Rural Health and Community Care.

The state is likely to face a severe shortage of physicians, nurse practitioners, physician assistants, and certified nurse midwives over the next 20 years.

The Task Force examined trends in provider supply including: (1) types of providers (by specialty) likely to be needed to address future healthcare needs; (2) areas of the state that experience persistent shortages; and (3) underrepresentation of certain ethnic and racial minorities in specified health professions. The goal of the Task Force's work was to develop public and private policy options to ensure North Carolinians have access to the providers they need. In short, the goal was to ensure that North Carolina has the right combination of providers in the right places.

The Task Force met for over a year and developed a set of preliminary recommendations that were presented to a larger group of stakeholders at a summit in December 2006. The summit included more than 100 invited guests, including a broader array of healthcare professionals, hospitals, state and local policy makers, and insurers. Recommendations of the summit participants were considered and incorporated into the report. The work of the Task Force was supported by a generous grant from the Kate B. Reynolds Charitable Trust.

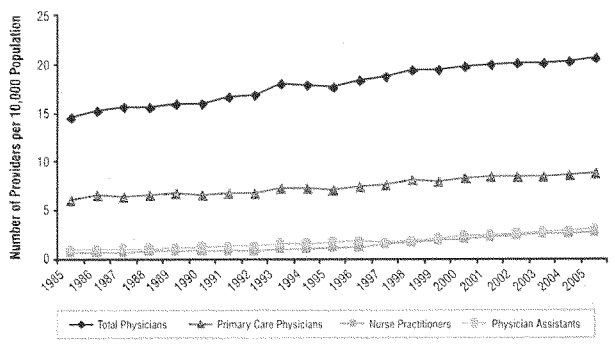
Provider Supply and Population Health

Physicians, NPs, PAs, and CNMs (referred to collectively as "providers") are indispensable practitioners in the state's healthcare system. Having access to these providers contributes to the overall well-being of the population. While the exact relationship of overall provider supply to population health measures is disputed,[1]

the specific contribution of physicians and other nonphysician clinicians to individual health is not in doubt. The consequences of not being able to see healthcare providers when needed are clear. Studies have shown people with less access to medical care live shorter lives with more disability and lower productivity.[2] Physicians, with their extensive education and training, provide the leadership and expertise to manage complex health conditions. NPs, PAs, and CNMs also help address the healthcare needs of North Carolinians.

For most of the last 20 years, North Carolina has seen a steady increase in the ratio of providers-to-population as the number of licensed providers has grown faster than the population. (See Chart 1.1.) Although there has been growth in the ratio of providers-to-population over the last 20 years, over the last five years the rate of growth has slowed. Between 1985 and 2000, the physician-to-population ratio increased by approximately 2.1% annually. However, starting in 2000, the annual growth rate slowed to 0.9%.

Chart 1.1
Providers per 10,000 Population, North Carolina, 1985-2005

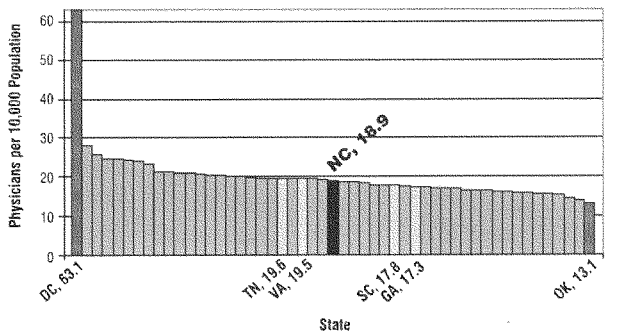


Note: Providers are active, in-state, non-Federal, non-resident-in-training providers licensed in North Carolina. Primary care physicians are those with a primary specialty of family practice, general practice, internal medicine, obstetrics /gynocology, or pediatrics.
Source: North Carolina Health Professions Data System and NC State Demographer.

While evidence suggests that more providers do not inevitably lead to better health outcomes,[3] other data suggest that too few providers, especially in underserved areas, can adversely affect health status.[4,5] No one currently knows the optimal number or type of providers needed to maximize population health. Yet, by most measures, North Carolina has neither too many nor too few physicians. Using data that allow state-to-state comparisons, North Carolina had 18.9 physicians to every 10,000 people in 2005, which is about average when compared to all states. (See Chart 1.2.) Note that these estimates come from American Medical Association (AMA) data. Caution should be used when comparing these data to data shown elsewhere in the report because of differences in the data collection efforts at the

AMA; the AMA master file relies on survey data and is updated throughout the year while the North Carolina data are collected in October of every year.

Chart 1.2
Physician Supply per 10,000 Population by State, 2005



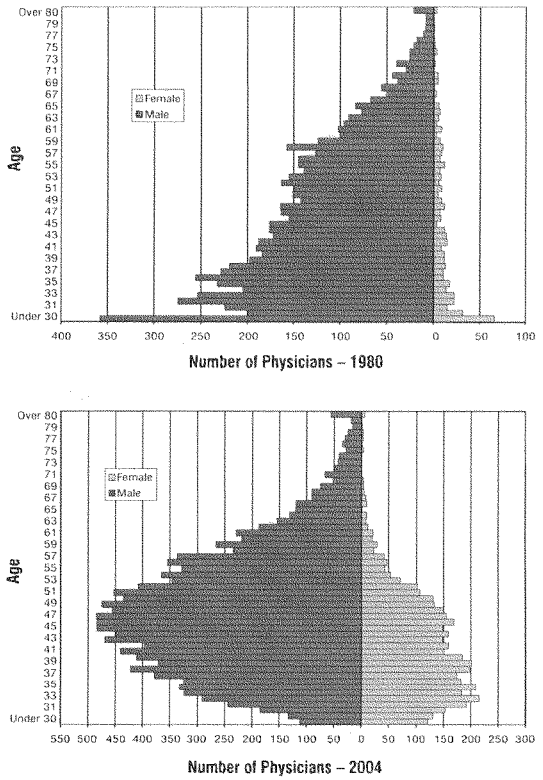
Source: American Medical Association Physician Masterfile. 2005.

The Potential Provider Shortage

While North Carolina's current overall supply may be adequate, state population growth, aging of both population and providers, and increase in the prevalence of chronic diseases may lead to a future workforce shortage. The growing population and aging of the provider workforce are two of the factors that contribute to decline in the provider-to-population ratio. The population is expected to grow 25.4% in North Carolina between July 2004 and July 2020. At the same time, provider supply is expected to increase only 23%. The physician workforce is aging, and a sizable portion of physicians are approaching traditional retirement age. In 1980, a large proportion of the physician workforce was in their 30s. (See Chart 1.3.) This cohort of physicians has remained the largest age group among North Carolina's practicing physicians, and so nearly 25 years later, this group of physicians is in their late 40s to early 50s. In fact, in 2004, 68% of North Carolina physicians were age 40 or older compared to 58% in 1980. Assuming the average retirement age of physicians (66) does not change significantly in the future, a large percentage of the current physician workforce is likely to retire in the next 20 years. NPs are similar as a group: 68% of NPs are age 40 or older. PAs are somewhat younger: 51% of PAs are age 40 or older.

In addition to state population growth and aging of the provider workforce, other factors affect provider supply. There is some evidence to suggest newer providers want to work fewer hours. This preference may be an effort to balance home and professional careers. Likewise, gender plays a role in physician supply. Female physicians are somewhat more likely to temporarily exit the profession during child raising years. Of the 173 physicians who were active in 2004 but became inactive in

Chart 1.3
Age Distribution of Physicians, 1980 and 2004



Note: There were three physicains with missing age.

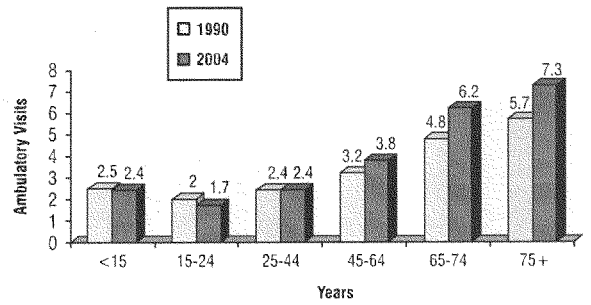
2005, 36 (21 percent) were women younger than 45.[6] This group constitutes 16% of all physicians, so women in this age group are slightly—1.3% versus 0.9%—more likely to become inactive than other physicians. Furthermore, on average women work slightly fewer hours per week than men.[a] As the percentage of physicians

a For example, in 2005 the average number of work hours per week reported by female physicians was about 91% of the average hours reported by males. NC Health Professions Data System. Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. 2006. It is important to note this difference will have a larger effect in specialties that have more females.

who are female increases, these factors will combine to slightly reduce provider supply for a given number of trained physicians located in the state.

The need for healthcare services is likely to increase at the same time the supply of providers begins to slow. As people age, they use more health services. Between April 2000 and July 2003, North Carolina had the fourth largest growth in number of older adults of any state in the nation.[7] Further, the population of older adults (65 or older) is expected to grow 59% between July 2004 and July 2020.[8] Approximately 12% of North Carolinians were age 65 or over in 2004; this number is projected to increase to 15% by 2020. On average, people make approximately three visits per year to a physician's office or clinic. However, utilization varies by age: 25-34 year olds made 2.3 annual visits to a physician's office or clinic (2003), while 75-84 year olds had more than 7.3 visits. (See Chart 1.4.) Moreover, the average number of visits for people over age 45 has increased in the last 20 years.

Chart 1.4
Average Number of Ambulatory Visits by Age of Patient, 1990 and 2004



Source: National Center for Health Statistics. *National Ambulatory Medical Care Survey (NAMCS)*. Number, percent distribution, and annual rate of office visits with corresponding standard errors, by patient characteristics: United States, 2004. Hyattsville, MD: National Center for Health Statistics. Advance Data No. 374; Table 3. Available online at: http://www.cdc.gov/nchs/data/ad/ad374.pdf. Accessed August 24, 2006. National Center for Health Statistics. *National Ambulatory Medical Care Survey (NAMCS)*. Number, percent distribution, and annual rate of office visits by patient's age, sex, race and geographic region: United States. Hyattsville, MD: National Center for Health Statistics. Advance Data No. 213; Table 1. Available online at: http://www.cdc.gov/nchs/data/ad/ad213.pdf. Accessed September 15, 2006.

In addition to aging of the population, growth in the number of people with chronic illnesses also affects demand for services. As a general rule, healthier individuals use fewer health services, and less healthy individuals use more. Between 1987 and 2002, there was a significant increase in the treated disease prevalence of certain chronic diseases such as cerebrovascular diseases (161% increase) with strokes being most common; kidney problems (99% increase); pulmonary conditions (90% increase); diabetes (64% increase); presence of abnormal or elevated lipids (fatty molecules) in the blood (437% increase) with cholesterol being most common; and certain back problems (78%).[9] An increase in the prevalence of obesity explains part of the increase in demand for treatment. For example, in 2001, 24% of the adult population was considered obese, an

increase of 10 percentage points since 1987.[10] People who are obese use more health services, and this group accounted for 27% of the growth in real per capita spending on healthcare during this same time period.

There are other factors aside from aging and increased prevalence of chronic illnesses that can drive demand for health services. Growth in the economy has historically led to greater demand for services.[b,11] Advances in medicine have the potential to decrease the use of some health services but can lead to greater use of other health services. Efforts to weed out unnecessary or marginally beneficial services can help reduce the need for health services.

It is impossible to predict fully the demand for and supply of provider services 20 years into the future. There are a number of different factors that must be considered in projecting provider supply and increased demand for health services. Some of these factors include anticipated growth in the supply of new physicians, NPs, PAs, and CNMs; anticipated exodus from the profession (due to death, retirement, moving out of state, or other factors); growth in the overall state population; aging of the population (which affects demand for services); and overall prevalence of chronic illness. The combined effect of three primary drivers of demand—growth of the population, aging of the population, and increase in the prevalence of chronic illnesses—is expected to increase the demand for services in North Carolina (measured in annual visits) by 34% between 2004 and 2020.

The NC IOM Primary Care and Specialty Supply Task Force developed a set of different workforce projections based on different assumptions. These included "best case" and "worst case" scenarios. The "best case" scenarios are based on the current growth of physicians and the higher than average rate of growth of nonphysician clinicians experienced in the last five years. These projections weigh nonphysician clinicians at 0.75 full-time equivalent (FTE) of a physician.[12] The "worst case" scenarios are based on current growth of physicians and average rate of growth of nonphysician clinicians over the last 25 years. These projections weigh nonphysician clinicians at 0.50 FTE of a physician (as used by federal workforce projections). In addition, there are separate estimates for provider-to-population

Table 1.1
Projected Change in Provider-to-Population Ratios, North Carolina, 2020 and 2030

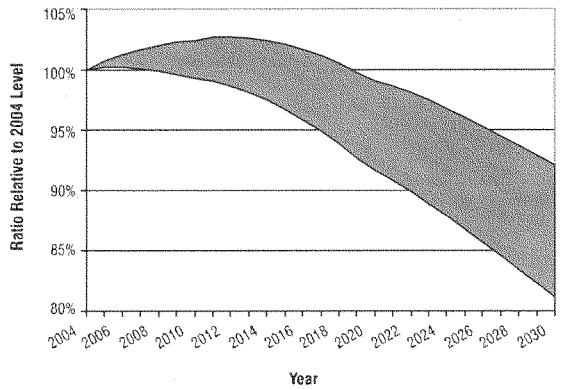
	Projected Change in Provider-to-Population Ratios		Projected Change in Provider-to-Adjusted Population Ratios	
	2020	2030	2020	2030
Physicians only	-8%	-21%	-12%	-26%
All providers				
Best Case	4%	-2%	-1%	-8%
Worst Case	-4%	-13%	-8%	-19%

Source: NC IOM and the NC Health Professions Data System. See Appendix A for details.

b There is a positive correlation between aggregate community wealth, measured by Gross Domestic Product (GDP) or personal income, and the demand for physician services. A longitudinal study of 14 Organisation for Economic Co-operation and Development (OECD) countries, including the US, found growth in physician supply corresponded to increases in GDP.

only and provider-to-adjusted population (based on increased demand due to aging of the population). These projections do not include the additional demand that would be anticipated from growth in the number of people with chronic illnesses. (See Table 1.1.) By 2030, under almost any realistic scenario, North Carolina is likely to experience significant provider shortages. Chart 1.5 presents the best and worst case projections for age-adjusted populations.

Chart 1.5
Range of Projected Provider-to-Population Ratios



Source: NC IOM and the NC Health Professions Data System. See Appendix A for details.

The state is likely to face a serious provider shortage over the next 20 years given growth in the population, aging of the population, and increase in chronic diseases. There are two fundamentally different approaches the state can take to address this problem: (1) restructure the healthcare delivery and finance system to create new and more efficient systems of care (particularly for people with chronic illnesses) or (2) increase provider supply. These options are not mutually exclusive. The state can redesign the healthcare delivery system and at the same time expand the overall supply of providers. North Carolina could maintain its current provider-to-population ratio (adjusted for demand changes) over the next 25 years by:

1) increasing yearly educational production of physicians by 20%, or
2) increasing production of nonphysician clinicians by over 30%, or
3) increasing in-migration of physicians by 15%, or
4) increasing the capacity of the health system to effectively manage the health of North Carolinians or improving the health of North Carolinians to reduce the need for health services by 15%.

Naturally, using multiple strategies would enable smaller percentage changes to satisfy the increasing demand. However, the longer the state waits to address

impending shortages, the greater percentage change that will be needed in future years. Options to expand the workforce or redesign the healthcare system to create new and more efficient models of care are discussed more fully in Chapter 2.

In addition to the projected overall provider supply shortage, the state is currently facing a significant maldistribution problem. North Carolina is a largely rural state and access to healthcare in rural areas has historically been a challenge. Some urban communities also face serious access barriers. North Carolina made significant headway in addressing provider maldistribution problems in the 1980s and 1990s; however, improvements have stagnated, and now maldistribution problems appear to be getting worse. There were 11 whole-county and 40 part-county health professional shortage areas in 2005.[c] Of these, 38 counties are considered persistent health professional shortage areas because they have failed to meet the minimum primary care provider-to-population ratio for six of the last seven years. Strategies to address the maldistribution issue are discussed more fully in Chapter 3.

In addition to an overall maldistribution problem, there are significant maldistribution issues among certain health professional specialties. Between 2000 and 2005:

- 27 counties experienced a decrease in primary care provider-to-population ratios;
- 53 counties experienced a loss in general surgeons relative to population, and five counties lost all general surgeons;
- 32 counties experienced a decline in the proportion of psychiatrists-to-population (six counties lost all psychiatrists), and 24 had no psychiatrists in either year; and
- 52 counties had either a decline in the ratio of physicians delivering babies to women of childbearing years or had no physicians providing deliveries.[d]

Shortages typically exist in rural areas, but there also are pockets of low provider supply in some low-income areas of larger cities. These shortages have varying impacts on affected communities. For example, despite the decrease in some areas of providers delivering babies, the average distance women across the state travel to deliver children has increased by only one third of a mile. By contrast, losing a general surgeon in a rural community can have a large impact on the financial sustainability of a rural hospital. Additionally, loss of psychiatrists working in the state's local management entities (LMEs) has been particularly acute in small population areas, where 44% of LME psychiatrists have stopped working with public patients.[13] Strategies to increase the number of providers, by type of specialty, are discussed in Chapter 4.

The state also faces a significant shortage of minority providers. In North Carolina, 69% of the state's 8.5 million residents are white, non-Hispanic; 21%

c The Bureau of Health Professions in the US Department of Health and Human Services has designated certain communities, population groups, or medical facilities as Health Professional Shortage Areas (HPSAs). Certain counties, or parts thereof, are considered HPSAs if they have fewer than one primary care provider to 3,500 people, or one primary care provider to 3,000 people in high-needs areas.

d 2004 are the most recent data available for physicians providing deliveries.

are African-American or black, non-Hispanic; 6% are Hispanic; 2% are Asian or Pacific Islander; and 1% are American Indian. By comparison, whites account for 82% of the physician population (17,090), Asians 7%, African-Americans 6%, and Hispanics 2%. Similarly, whites account for 90% and 88% of the NP and PA populations, respectively, while African-Americans account for only 5% and Hispanics account for 1-2% of each group. When given an option, individuals of all racial and ethnic groups are more likely to pick a provider who has a similar racial and ethnic background.[14,15] Studies suggest minority patients are generally more satisfied with care received from providers of similar race and/or ethnicity,[14,16,17] but the state is producing far too few providers from underrepresented minority populations to meet this need. Because minority providers are more likely to practice in underserved areas, increasing the number of minority providers also could lessen the maldistribution problem. Strategies to increase the number of underrepresented minorities in the profession are discussed in Chapter 5.

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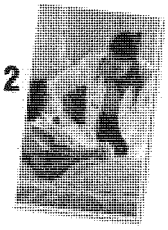
Addressing Provider Shortage by Developing New and More Efficient Models of Care or Increasing Provider Supply

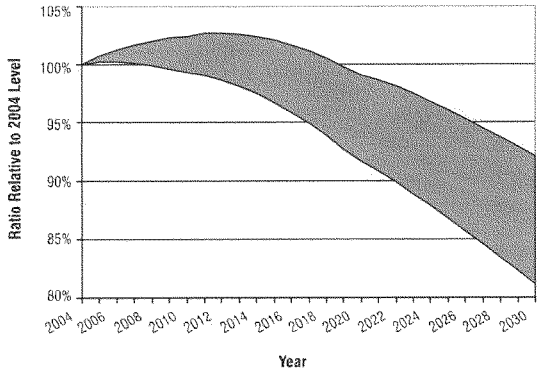
Chapter 2



North Carolina is likely to experience a significant provider shortage over the next 15-25 years. Assuming the best case scenario, North Carolina will effectively lose 1% of the provider workforce by 2020 and 8% by 2030 (measured in provider-to-adjusted population demand ratio).[a] If growth in supply does not continue or estimates of the productivity of nonphysician clinicians is too optimistic, the state may effectively lose as much as 8% of the workforce by 2020 and 19% by 2030.[b] None of these projections factor into increased demand due to an increased number of people with chronic diseases. The increased prevalence of chronic diseases could result in an additional 3% increase in demand for services by 2020 and 5% by 2030.

North Carolina is better positioned than many states to examine impending provider shortages and develop workable strategies to expand the health professional workforce.

Chart 2.1
Range of Projected Provider-to-Population Ratios



Source: Details on the projection method are outlined in Appendix A.

North Carolina is better positioned than many states to examine impending provider shortages and develop workable strategies to expand the health professional workforce. North Carolina has a nationally recognized health professions data system that collects data on different types of healthcare professionals. North Carolina's

a The "best-case" projections are based on current growth of physicians and a higher rate of growth of nurse practitioners, physician assistants, and certified nurse midwives (based on average growth over the last five years). The projections also factor in the current rate of exodus from the professions (due to death, retirement, moving out of the state, or other factors). Nonphysician clinicians are weighted as 0.75 FTE of a physician; however, federal workforce projections factor nonphysician clinicians as 0.5 FTE of a physician.

b The "worst-case" projections are based on current growth of physicians and a lower rate of growth of nonphysician clinicians (based on the yearly increase in supply averaged over the last 25 years). Nonphysician clinicians are weighted as 0.5 FTE physician (as is used by federal workforce projections).

Health Professions Data System is the longest standing state health workforce data system in the country. North Carolina has also been a national leader in addressing health professional maldistribution problems and has a long history of supporting practice innovations. The state needs to use these data for ongoing oversight by stakeholders and policy makers to monitor the state's changing healthcare needs, as well as trends in provider supply, to ensure the emerging needs of the state are addressed. Therefore, the Task Force recommended:

Recommendation 2.1. (Priority Recommendation)

a) The NC General Assembly should appropriate $170,000 to support and expand the health professional workforce research center charged with examining current and future needs for health professionals, which is housed within the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. Research should be conducted at the individual practitioner level as well as the practice level. The Center will expand its current research to include analyses that:

1) identify the need for physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) to meet the healthcare needs of the state 5, 10, and 20 years into the future;

2) identify new models of care that can improve the quality and efficiency of care offered by North Carolina providers;

3) examine the distribution of physicians, NPs, PAs, and CNMs across the state;

4) examine trends in the supply of minority health professionals in comparison to the general population and examine percentage of underrepresented minority students and residents who receive training in North Carolina but who leave the state for practice;

5) examine trends in the number of primary care and specialty providers by specialty area;

6) examine changes in health status and sociodemographic factors that might influence future healthcare needs so as to examine the mix of healthcare professionals necessary to address the state's healthcare needs; and

7) identify barriers that affect entry into the health professional workforce or continued practice, if any.

b) The NC General Assembly should create an ongoing Health Workforce Policy Board that is charged with developing strategies to address impending health professional workforce shortages.[c] The Board will include representation from the NC Office of the Secretary, NC Department of Health and Human Services, NC Office of Rural Health and Community Care, NC Area Health Education Centers Program, five North Carolina academic health centers, NC Community College system, relevant professional associations and licensing boards, NC Hospital Association, NC Medical Society Foundation, and nonmedical public members. The Board shall identify strategies to:

1) develop new models of care that encourage quality and efficiency of healthcare services;

2) increase the overall supply of physicians, NPs, PAs, and CNMs to meet the unmet health needs of the state's growing population;

3) encourage more health professionals to practice in health professional shortage areas;

4) establish priorities for which types of provider specialties are most needed to meet the healthcare needs of the state;

5) increase the supply of underrepresented minorities in the profession;

6) ensure the mix of health professionals is appropriate to meet the changing healthcare needs of the state; and

7) address barriers that affect entry into the health professional workforce or continued practice, if any.

The Health Workforce Policy Board should report its findings and proposed recommendations on an annual basis to the University of North Carolina Board of Governors, the NC State Board of Community Colleges, and the NC General Assembly.

One example of a study the Health Workforce Policy Board could do is an investigation of the amount of care providers of all types, not just geriatricians, provide to adults aged 65 and older and whether there are any current or future supply issues in the state. Current data constraints limit such analyses. The Board could also evaluate potential educational needs that should be considered as population longevity increases and more providers treat chronically ill patients.

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c Utah has established a similar workforce policy board. The legislation that created the Utah Medical Education Council (UMEC) authorized the UMEC to conduct ongoing healthcare workforce analyses and to assess Utah's training capacity and graduate medical education (GME) financing policies. The legislation requires the UMEC to report to the governor and the legislature on these issues and to provide policy recommendations for achieving state workforce objectives. UMEC is comprised of the Dean of the University of Utah Medical School; an educator member of the Board of Regents; the Assistant Dean of Curriculum and GEM at the University of Utah; a risk manager with a community hospital; the President and CEO of a health insurance company; the Director of Family Practice Residency at the Utah Healthcare Institute; and a nurse (RN) member of the Utah State Board of Education. Ha J. *Utah's Physician Workforce: A Study on the Supply and Distribution of Physicians in Utah*. Salt Lake City, UT: The Utah Medical Education Council; 2006.

New Models of Care

The US currently spends 16% of its Gross Domestic Product on healthcare, which is more than any other country.[1] Overall healthcare expenditures have risen between 6.3% and 8.8% between 2000 and 2004, creating an affordability crisis. Some people question whether the cost of training an expanded supply of providers is affordable. Using tuition costs as a proxy for the costs of training new providers, it costs approximately $35,000/year to train a new physician (or approximately $140,000 total for each medical school graduate),[d] $45,000 total to train a new physician assistant (PA),[e] and $35,000 total to train a new nurse practitioner (NP). These cost estimates use private university tuition as a proxy for cost because public universities receive state funding to subsidize program costs.[f] Yet, absent new delivery models that can improve quality and efficiency, the state may need to invest significant new resources into increasing the production of healthcare professionals.

Absent new delivery models that can improve quality and efficiency, the state may need to invest significant new resources into increasing the production of healthcare professionals.

North Carolina should restructure the healthcare delivery system and financing system to increase quality and efficiency, so providers, practices, and healthcare systems can appropriately manage a higher caseload. One way of increasing provider productivity involves reorganizing delivery of care. While conceptually this is a very attractive option, there have been few large-scale system redesigns that have led to major increases in productivity. However, several models have been tried and warrant further study.

Expand use of nonphysician clinicians:
One potential model would expand the use of and role of PAs, NPs, and certified nurse midwives (CNMs) in caring for patients with routine problems while physicians would manage the care of patients with more complex health conditions. These nonphysician clinicians provide direct patient care and can help ameliorate the impending physician shortages. A meta analysis of studies examining the role of NPs found there were no appreciable differences between doctors and NPs or advance practice nurses in health outcomes, process of care, resource utilization, or cost for primary care services.[2] Substituting NPs for physicians could potentially decrease physicians' workloads and direct healthcare costs, but there is no guarantee

d As a rough approximation of education costs per student, Duke University charged ~$34,800 in tuition costs (2005-2006) and ~$7,300 in other fees and books. Available at: http://medschool.duke.edu/modules/som_finaid/index.php?id=3. Accessed December 2006.

The University of North Carolina at Chapel Hill charged ~$9,340 in tuition for in-state students and $33,000 for out-of-state students, and ~$1,500 in required fees for both in-state and out-of-state. Available at: http://cashiers.unc.edu/tuition%20and%20fees%202005-06%20final%20revised%20102405.pdf. Accessed December 2006.

Wake Forest University charged ~$34,000 for tuition and $1,500 for books/supplies. Available at: http://www1.wfubmc.edu/FinancialAid/MD+Student+Cost.htm. Accessed December 2006.

The Brody School of Medicine at East Carolina University charged $7,676 for in-state student tuition and $1,153 for books/supplies. The Brody School of Medicine does not accept out-of-state students. Available at: http://www.ecu.edu/bsomstudentaffairs/FinancialAid/Cost.htm. Accessed December 2006.

Report 2 of the AMA Council on Medical Education (I-00) reports that the annual cost in 1996 dollars of educating a student ranged from $71,672 to $92,836 per year.

e The total tuition (over two years) for the Physician Assistant programs at Duke University, Methodist College, and Wake Forest University is approximately $52,000, $36,000, and $40,000, respectively.

f The total program cost for the Duke University nurse practitioner program is approximately $35,000.

substitutions will have this effect. Nurses tend to spend more time and consult more frequently with patients, which means fewer patients can be seen. While this attention may lead to higher patient satisfaction, as it did in some studies, reducing the number of patient visits in a day could offset any potential cost savings gained from using nurses. Further, nonphysician clinicians are not trained to provide all the same services as physicians—so while they can provide similar and complementary services, they are not a complete substitute for physicians.

Interdisciplinary team-based models can enhance productivity:
Team-based approaches to healthcare can be efficient, cost-effective models of care delivery. There are a variety of models that are utilized depending on the specific patient population and setting. The NC Medicaid program, Community Care of North Carolina (CCNC), uses a team-based approach to provide care to people with chronic illnesses. CCNC is organized around a local network of care that includes, at a minimum, primary care providers, nurse or social work care managers, health departments, hospitals, and social services agencies. In many communities, the nurse or social work care managers are housed in providers' offices, and they help provide disease management education or case management services needed to help patients manage their health problems. In this way, licensed practical nurses, registered nurses, or social worker case managers can help provide more intensive patient education or patient follow-up, leaving physicians more time to see patients.

Team-based approaches to healthcare can be efficient, cost-effective models of care delivery.

Studies have shown that NP-physician collaborative practices are cost-effective and lead to enhanced quality of care in nursing homes, emergency rooms, and surgical inpatient settings.[3] These integrated delivery models enable practitioners to perform the tasks most appropriate for their training and specialization. For example, in a surgical setting the NP can take initial health history, provide both pre and postoperative patient education, and assist with discharge planning.[4] The physician would have more time to work with the patient to make surgical decisions and to perform surgeries. Both NP and physician would be involved in developing the overall plan of care with the patient. Working in a collaborative practice with NPs has been shown to have positive impacts on physicians, including improved job satisfaction, reduced workload, and a higher standard of care.[3] In addition, interdisciplinary teams including healthcare practitioners with different specialties, social workers, and other allied health professionals have been essential to improved quality of care for geriatric patients with multiple health problems and restricted activities of daily living.[5,6]

While teams have been shown to be effective in improving care to patients in certain settings and in leading to higher provider satisfaction, there are barriers to effective implementation of interdisciplinary team approaches. Practitioner groups (eg, physicians, NPs, PAs, CNMs) are generally trained separately and do not have experience working in a fully integrated team environment. More work is needed to ensure that medical students are trained in a collaborative team environment with nurses, PAs, NPs, and other healthcare professionals. Models could be developed around care of people with chronic illnesses. The Task Force made a number of recommendations to provide incentives to health professions training programs to increase interdisciplinary team training. (See Recommendations 2.4, 2.5, 2.7, 2.8,

and 3.4.) In addition, there has not been extensive research, to date, on the impact of interdisciplinary teams on provider efficiency or cost-effectiveness across different healthcare settings. Having more providers see the same patients does not necessarily improve efficiency or quality. More research is needed to understand how to best utilize healthcare teams and to determine the cost-effectiveness of these approaches.

Current payment systems also create barriers to effective use of teams. Public and private insurers and payers do not always pay for the services of certain health professionals in the community (ie, case managers in physician offices and/or nutritionists). Another barrier is that reimbursement policies are generally set up to reimburse individual practitioners separately rather than unified teams of practitioners. In addition, current payment methodologies do not encourage the use of communication through the Internet or other methods that could reduce unnecessary office visits.

Another new trend which may increase the number of patients providers can see in an ambulatory setting is use of hospitalists (discussed more fully in Chapter 3). Hospitalists are physicians who practice exclusively in hospitals. Hospitalists can help free up time that primary care providers would otherwise spend doing rounds caring for their hospitalized patients. Theoretically, hospitalists could enable primary care providers to treat more patients in an ambulatory setting. However, use of hospitalists is relatively new, so there are no data on the impact of hospitalists on primary care practice.

Recommendation 2.2. (Priority Recommendation)

In order to develop and implement new models of care:

a) **North Carolina foundations should help fund new models of care for improving quality and efficiency of primary and specialty care across North Carolina. New models should be evaluated to determine if they improve quality of care and/or efficiency.**

b) **Medical schools, other health professions schools, and residency programs should incorporate successful new models of care into training curricula and ensure that students and residents have the opportunity to practice using new models.**

c) **The State Health Plan, Division of Medical Assistance, and private insurers should modify reimbursement policies to support the long-term viability of new models that are shown to improve quality and/or efficiency.**

New models of care also should be focused on how they can better provide services in underserved areas to reduce the maldistrbution problem across the state. (See Recommendation 3.4.) Furthermore, new models of care should be developed to target psychiatric specialty shortages across the state, but particularly in underserved areas. (See Recommendations 4.6 and 4.7.)

Electronic health records (EHRs) and health information technology, when properly used, have the potential to help increase productivity of providers and

practices. EHRs, integrated with practice billing systems, can help reduce overhead and labor costs. This technology allows practices to successfully operate in sparsely populated communities that may not otherwise be able to support a provider.[g] EHRs can help improve access to accurate, timely patient data; increase the quality of care provided to patients; and improve workflow in physician practices. These improvements will become increasingly important as payers move to pay-for-performance and providers have increased accountability.

There are several burdens associated with implementing an EHR system. Nationally, only about 15% of physician practices had an EHR system in 2005, and the adoption rate was lower for smaller practices.[7] The cost of implementing an EHR system, as well as monthly maintenance costs, can be prohibitive, especially to smaller practices.[h] The time and resources needed to train staff to successfully operate an EHR system is also substantial. Lack of capital resources, loss of productivity during the transition period, lack of support from physicians and other clinical staff, and an inability to find systems that meet practitioner needs are all barriers to implementation. In addition, practices must have effective management systems to realize the benefit of an EHR system. In other words, EHR systems cannot solve underlying practice management problems.

Carolinas Center for Medical Excellence (CCME) has funding from the Centers for Medicare and Medicaid Services (CMS) to offer technical assistance to practitioners in selecting an EHR system.[8] The national initiative, called the Doctor's Office Quality-Information Technology (DOQ-IT), works with physician offices to help practices evaluate their EHR needs and capabilities, evaluate different EHR options, provide assistance with vendor selection, help create workload efficiencies, and improve patient care. The consulting is free to the physician practice and is targeted to smaller offices (with eight or fewer physicians). However, CCME can only work with primary care practices that serve a Medicare population, and CCME only has funding from CMS to work with up to 200 practices for the 2006-2008 time period. Thus, CCME is currently unable to help pediatric practices (which tend to have few Medicare beneficiaries) evaluate their EHR needs.

Recommendation 2.3.

The NC General Assembly should appropriate:

a) $2.5 million to The Carolinas Center for Medical Excellence to increase the number of practices that receive technical assistance under the Doctor's Office Quality-Information Technology project and to expand this assistance to include pediatric offices;[i] and

g In certain communities, a provider's patient panel may not generate the revenues necessary to support a practice. Some of these providers may be able to maintain a financially viable practice if they can reduce overhead costs. The NC IOM Primary Care and Specialty Supply Steering Committee heard presentations from North Carolina physicians who operate low-overhead practices by increasing their use of technology EHRs.

h One study of 14 solo or small-group primary care practices reported that the initial costs of implementing an EHR averaged $44,000 per full-time equivalent provider, with ongoing costs of approximately $8,500/year. Practices generally were able to recoup their start-up and ongoing costs within two and one half years. Miller RH, West C, Brown TM, Sim I, Ganchoff C. The value of EHRs in solo or small-group practices. *Health Aff.* September/October 2005;24(5):1127-1137.

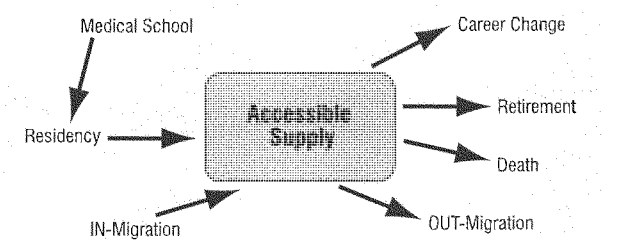
i The Carolinas Center for Medical Excellence estimates it would cost approximately $2.5 to $3 million to extend DOQ-IT technical assistance to between 100-125 non-Medicare practices.

b) $4.8 million to the NC Medical Society Foundation to provide grants to small or solo practitioners to purchase health information technologies to improve quality performance and practice efficiencies.[9]

Increasing Provider Supply

To increase the supply of providers practicing in North Carolina, the state must either increase the number of providers entering practice, decrease attrition, or both. (See Figure 2.1.) There are short-term and long-term strategies to address the provider workforce shortage. Over the short term, the state can put more effort into recruiting providers from other states to practice in North Carolina. North Carolina is a net importer of physicians. Most of the physicians practicing in North Carolina completed their undergraduate medical education and residency training out of state. However, most other states also will be in the midst of a physician shortage.[j,10] Thus, there will be increased competition for the limited number of physicians. Over the long term, there is a need to educate and train more physicians by increasing undergraduate medical education and residency positions. More PAs, NPs, and CNMs also need to be trained. Most practicing NPs and PAs in North Carolina were trained in state. Additionally, North Carolina can improve the

Figure 2.1
Factors in the Supply



practice environment by reducing the number of North Carolina-trained providers who leave the state, retire, or change professions. North Carolina also can make it easier for practitioners who have temporarily left the profession to reenter the workforce.

There are two primary ways to address supply issues related to the impending primary care and specialty provider shortage in North Carolina:

1) North Carolina can produce more practitioners who set up practice in state by increasing the number of medical students, NPs, PAs, CNMs, and/or physicians who complete their postgraduate training in state.

j The following states have issued reports highlighting physician workforce shortages: Texas (2002), California (2004), Mississippi (2004), Wisconsin (2004), Arizona (2005), Georgia (2005), Kentucky (2005), Massachusetts (2005), Michigan (2005), and Oregon (2005).

2) North Carolina can improve the practice environment to encourage more practitioners to move to North Carolina and to reduce the number of practitioners who leave practice in this state.

Both of these options are discussed more fully below.

Increasing production of providers practicing in North Carolina:
In order to practice medicine, physicians must attend an accredited allopathic[k] or osteopathic[l] medical school in the US or attend a foreign medical school and complete other licensure requirements.[m,n] In 2004, 81.7% of the physicians who entered practice in North Carolina graduated from allopathic schools, 8.7% were from osteopathic schools, and 9.6% were international medical graduates (IMGs).[o]

The growth in medical education in the US over the last 20 years has not kept pace with the growth in the overall population. Between 1982 and 2001, the US population increased 23%, but US medical school enrollment grew only 7%.[11] Medical student enrollment per 100,000 population actually decreased 13% during that same time period. Graduates from allopathic schools have stayed relatively constant over the last 25 years (approximately 15,700/year), but graduates from osteopathic schools have increased by more than 200% during the same time period. The number of students trained in international medical schools also has increased substantially.[p]

The growth in medical education in the US over the last 20 years has not kept pace with the growth in the overall population.

Despite the growth in osteopathic graduates and US-IMGs, the overall rate of growth in physician supply is not keeping pace with the growth in overall population or increased demand for services. The Association of American Medical Colleges (AAMC) recently recommended US medical schools increase the number of undergraduate medical students they enroll by 30% in order to meet the need for physicians in the future.[12] While there is a growing recognition of the need to

k Allopathic schools are accredited through the Liaison Committee on Medical Education (LCME).

l Osteopathic schools are accredited through the American Osteopathic Association (AOA). Information on the American Osteopathic Association (AOA) is available at: http://www.osteopathic.org/. Accessed April 3, 2006.

m There is not a standard accreditation process for foreign medical schools.

n All medical students are required to take three licensure exams, one after the second year of medical school, another during the fourth year, and the last during postgraduate education (typically at residency). Allopathic students trained in the US take their United States Medical Licensure Exam (USMLE) through the National Board of Medical Examiners. Osteopathic students take their Comprehensive Osteopathic Licensure Examination through the National Board of Osteopathic Medical Examiners, although osteopaths wishing to pursue postgraduate medical education through an allopathic residency placement must take their exam through the USMLE. Internationally-trained medical graduates (IMGs) take their first two exams through the Educational Commission for Foreign Medical Graduates. In addition to successfully passing the licensure exams, physicians also must complete at least one year of postgraduate education (internship or residency).

o In 2004, 64% of the medical students who entered US residency programs graduated from allopathic schools, 11% were from osteopathic schools, and 25% were international medical graduates (of whom 5% were US citizens trained in international schools, US-IMGs).

p There also has been a large increase in the number of medical students educated overseas. Between 1977 and 2004, there was a significant increase in the number of medical schools established in the Caribbean (from 1 in 1977 to 21 in 2004). US citizens educated overseas are eligible to be matched into US residency programs, but non-US citizens must first obtain a visa to enter the country in order to complete a residency in the US. In 2004, 22.6% of Educational Commission for Foreign Medical Graduates (ECFMG) Certificates were issued to US-born international medical graduates (US-IMGs) (1,360 out of 6,004). From 1980 to 2004, 13.9% of ECFMG certificates were issued to US-IMGs. Boulet JR, Norcini JJ, Whelan GP, Hallock JA, Seeling SS. The international medical graduate pipeline: Recent trends in certification and residency training. *Health Aff.* Web Exclusive. 2006;25(2):469-477. In 2004-2005, 7.5% of all residents in primary care programs were US-IMGs (3,358 of 44,668). Of all IMG primary care residents, 22.0% were US-IMGs (3,358 of 15,225). Brotherton SE, Rockey PH, Etzel SI. US graduate medical education, 2004-2005, trends in primary care specialties. JAMA 2005;294(9):1075-1082. Table 2.

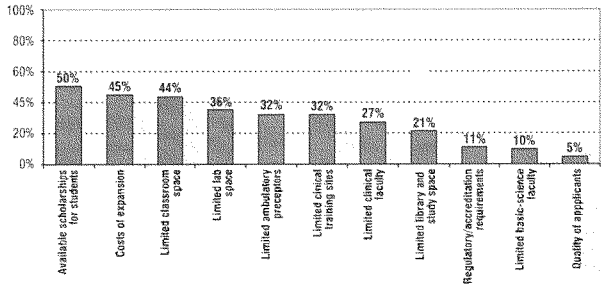
increase enrollment in medical schools, there are several barriers to expansion including financial support for students, costs of expansion, need for additional classroom and laboratory space, and need for additional faculty and preceptors. (See Chart 2.2.)[q]

North Carolina has four medical schools. They are located at Duke University, East Carolina University (ECU), University of North Carolina at Chapel Hill (UNC-CH), and Wake Forest University (WFU). The four schools graduate approximately 440 students per year. The number of students trained in North Carolina medical schools has not changed significantly since 1977 when the Brody School of Medicine at ECU began enrolling students. North Carolina does not have a school of osteopathy.

Even if all 440 of the medical students trained in North Carolina ended up practicing in state, there would still be a need to import physicians trained elsewhere just to replace the physicians who leave the profession.

North Carolina schools do not produce enough graduates each year to meet the state's need for additional physicians. Most physicians actively practicing in North Carolina received their undergraduate medical education out of state. A little more than one quarter (26.9%) of North Carolina physicians graduated from a North Carolina medical school. More than three fifths (62.4%) went to other US or Canadian medical schools, and 10.7% were international medical graduates. Between 2001 and 2004, approximately 1,240 physicians left practice each year due to death, retirement, changed professions, or other reasons. Thus, even if all 440 of the medical students trained in North Carolina ended up practicing in state,

Chart 2.2
Barriers to Enrollment Expansion:
Percentage of Schools Identifying Barriers as "Major" or "Very Significant," 2005



Source: Association of American Medical Colleges Center for Workforce Studies. *Medical School Expansion Plans: Results of the AAMC 2005 Survey of US Medical Schools.* Washington, DC: AAMC; April 2006. Figure 14. Available at: http://www.aamc.org/workforce/enroll.pdf. Accessed September 9, 2006.

q Respondents from allopathic medical schools reported that larger increases in enrollment would make it potentially more difficult to find qualified students. For example, only about 14% of respondents from the allopathic medical schools thought there would be a problem finding qualified applicants if there were a 10% increase in enrollment (with 1% being very concerned), but 71% of the respondents thought it would be a problem with a 30% increase in enrollment (with 27% very concerned). Association of American Medical Colleges Center for Workforce Studies. *Medical School Expansion Plans: Results of the AAMC 2005 Survey of US Medical Schools.* April 2006. Figure 15. Available at: http://www.aamc.org/workforce/enroll.pdf#search='AAMC%20Medical%20School%20Expansion%20Plans'. Accessed September 9, 2006.

there would still be a need to import physicians trained elsewhere just to replace the physicians who leave the profession.

Over the last 40 years, approximately 40% of the students trained in North Carolina medical schools ended up practicing in state.[13] Those who complete their training in a publicly funded medical school are more likely to practice in state. This may be

Table 2.1
North Carolina Medical School Enrollment and Graduates Practicing in the State

School	2004-2005 Academic Year			
	Total Enrollment	New Entering Students	% New Students In-State	% Graduates Practicing in NC
Brody School of Medicine, East Carolina University	290	72	100%	59%
Duke University School of Medicine	467	101	20%	24%
University of North Carolina School of Medicine	649	160	85%	49%
Wake Forest University School of Medicine	427	108	40%	39%

Source: American Medical Association. *Medical schools in the United States. JAMA.* Medical Education Issue. September 7, 2005;294(9):1119-1127; NC Health Professions Data System. September 2006.

partially explained by the fact that publicly-financed medical schools (UNC-CH and ECU) are more likely to admit North Carolina students. North Carolina medical students originally from the state are more likely to practice in North Carolina.

The state should target medical school expansions to North Carolina students in order to have the greatest chance of increasing the number of physicians who ultimately set up practice in state. The two state medical schools that admit a higher proportion of North Carolina students also have a much higher proportion of students who choose to practice in North Carolina after finishing their residency programs (eg, retention rates).

Recommendation 2.4 (Priority Recommendation)

North Carolina medical schools should increase enrollment by 30% (AAMC recommendation). Expansion can be accomplished through an increase in enrollment on existing campuses[r] or through satellite campuses.[s] In expanding programs, medical schools should consider

r More than one half of medical schools around the country planning to increase enrollment plan to incorporate innovations in medical curriculum to accommodate expansion. These innovations include: patient simulations and IT-based self-directed/independent learning; use of interdisciplinary courses; community-based services/hands-on learning; and telemedicine, distance learning, and video-conferences. Association of American Medical Colleges Center for Workforce Studies. *Medical School Expansion Plans: Results of the AAMC 2005 Survey of US Medical Schools.* April 2006. Available at http://www.aamc.org/workforce/enroll.pdf#search='AAMC%20Medical%20School%20Expansion%20Plans'. Accessed September 9, 2006.

s Satellite campuses often have basic science education for the first two years at the parent campus, with clinical education the last two years at the satellite location. In 2003, there were 20 medical schools with satellite campuses across the country. Mallon WT, Liu M, Jones RF, Whitcomb M. *Mini-Med: the Role of Regional Campuses in US Medical Education.* Washington, DC: Association of American Medical Colleges; 2003. Available online at: https://services.aamc.org/Publications/showfile.cfm?file=version47.pdf&prd_id=57&prv_id=161&pdf_id. Accessed September 9, 2006.

changing admissions criteria[t] or using other strategies to increase the overall supply of physicians practicing in the state, increase the number of physicians who set up practice in underserved areas, increase the number of physicians who specialize in shortage specialties, increase the number of underrepresented minority physicians practicing in the state, and enhance interdisciplinary team training.

Strategies to increase the number of underrepresented minorities in the profession are discussed more thoroughly in Chapter 5.

Recommendation 2.5

If current medical schools are unable to increase enrollment by 30%, the NC General Assembly should consider creation of a new public allopathic or osteopathic medical school or provide incentives to encourage development of a new private medical school. Specifically:

a) The NC General Assembly should appropriate funds to build a new state-supported allopathic or osteopathic medical school that will focus on increasing the supply of physicians who practice in North Carolina, particularly those willing to practice in medically underserved areas or in shortage specialties.[u,v] Special consideration should be given to creating a medical school that focuses on increasing the number of underrepresented minority physicians in the state, increasing the overall supply of physicians practicing in the state, increasing the number of physicians who set up practice in underserved areas, increasing the number of physicians who specialize in shortage specialties, and enhancing interdisciplinary team training.

b) Alternatively, as part of state efforts to increase economic development in communities across the state, the Department of Commerce should consider incentives to attract private osteopathic or allopathic medical schools into the state.

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t For example, one option medical schools could explore is giving higher preference in the admission criteria to individuals who were raised in medically underserved areas and who express an interest in returning to those areas.

u The exact cost of building a new medical school is unknown. The costs would vary depending on potential enrollment, curriculum design and other factors. One state that recently (1999) developed estimates for a new medical school was Florida. Florida State University developed a proposal for a new medical school that would focus on training physicians to meet the primary healthcare needs of the state, particularly the needs of the elderly, rural populations, and other underserved citizens. They designed a school that would enroll 120 students per class and provide most of the third and fourth year clinical training using a community-based model with a special focus on rural health. Their cost estimates were $50 million for the new school and $39 million annually for operational costs (some of which would be offset by tuition). MGT of America, Inc. Plan for a Four-Year Allopathic School of Medicine at Florida State University. Submitted to: Florida State University. Tallahassee, FL: MGT Management, Inc; November 15, 1999. Available at: http://med.fsu.edu/pdf/10_four_year_allopathic.pdf. Accessed September 13, 2006.

v The cost of building a new osteopathic school would depend on different factors. For example, building a new osteopathic school from the ground up could cost approximately $100 million. Developing an osteopathic medical school within a college or university with existing infrastructure would cost less. The American Osteopathic Association is requiring at least $50 million be held in earnest before creating a new Osteopathic school. Personal communication with M Murphy, Associate Dean, Clinical Sciences, Pikeville College School of Osteopathic Medicine, Pikeville, KY. September 18, 2006.

Despite the fact there is no osteopathic medical school in North Carolina, the population of osteopathic physicians is growing rapidly. Osteopathic physicians remain only a small proportion of the overall physician population in North Carolina (3% in 2005), but their potential to practice could be increased by providing financial assistance to students choosing osteopathic medical schools in other states with an obligation to return for practice in North Carolina and by developing joint accredited American Osteopathic Association (AOA) residencies. (See Recommendation 2.10.)

Recommendation 2.6.

The NC General Assembly should appropriate funds to pay for allocated seats for North Carolina students admitted to osteopathic schools in other states (eg, Alabama or Kentucky model) with an obligation that students return to practice in North Carolina.[w]

Expanding the number of PAs, NPs, and CNMs also can help reduce demand for physicians. NPs and PAs can provide many—but not all—of the same healthcare services provided by physicians. Under North Carolina state laws, NPs and PAs must operate under supervision of a physician and can only provide the services authorized in a practice agreement with the supervisory physician.[x] Within certain limitations, NPs and PAs can diagnose and prescribe medications, tests, and treatments.[y] NPs and PAs often serve as primary care providers, helping to manage the health of patients. They can provide services directly in a physician's office, clinic, hospital, nursing home, or other healthcare facility. While the physician need not be present at the same location, he or she must have a policy to review periodically the NP's or PA's prescribed medicines, tests, and treatments. NPs and PAs also can serve in specialty areas of medicine, and their job responsibilities vary by specialty and supervising physician. CNMs typically provide a range of health services to women and newborns including prenatal, intrapartum, postpartum, newborn, and family planning services.

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w For example, Kentucky provides a primary care scholarship that is the difference between in-state tuition and the tuition at Pikeville College School of Osteopathic Medicine. Students are required to pursue primary care residencies but must return to Kentucky and practice a year for each year the scholarship was received. If they choose not to do a primary care residency, they are required to pay the scholarship back at the normal loan rate. Kentucky has 200 students on the scholarship with 90% completing their obligation to practice primary care in Kentucky. The difference in tuition is currently $15,000 for each student, for a total of $3,000,000 dollars per year. M Murphy, Associate Dean, Clinical Sciences, Pikeville College School of Osteopathic Medicine, Pikeville, KY. September 18, 2006.

x Physicians work with PAs to establish a supervisory arrangement, a written statement that describes the medical acts, tasks, and functions delegated to the PA by the primary supervisory physician. NPs must have a collaborative practice agreement with a supervisory physician. A collaborative practice agreement is an agreement between a physician and NP that provides ongoing supervision, consultation, collaboration, referral and evaluation of care provided by the NP. The scope of services provided by a PA or NP must be consistent with their education, training, skill, and competence.

y PAs and NPs can perform medical acts under supervision of physicians [NCGS §90-18(c)(13)(PA) and NCGS §90-18(c)(14)(registered nurses)]. Both PAs and NPs can prescribe medicine, if they have been authorized by the NC Medical Board (and in the case of NPs, also authorized by the Board of Nursing), and if their supervising physicians provide written instructions about indications and counterindications for prescribing drugs and have a policy to periodically review the drugs prescribed [NCGS §90-18.1(a)(PA) and NCGS § 90-18.2(a) (NP)]. Similar rules apply when a PA or NP orders medications and tests and treatments in hospitals, clinics, nursing homes, and other facilities. [NCGS 90-18.1(d)(PA) and NCGS §90-18.2(d)(NP)].

Expanding the number of NPs and PAs is a less expensive option and yields more immediate results than increasing the number of physicians. Unlike medical schools, which typically require four years of training and three-year, postgraduate residency programs, NPs, PAs, and CNMs can complete their education and training within two to three years after completing their undergraduate degree. Upon graduation, NPs, PAs, and CNMs must pass national certification exams.[z] In North Carolina, there are currently seven NP schools,[aa] four PA schools,[bb] and one CNM program, which collectively graduate approximately the same number of practitioners as do medical schools.

One cost effective way to expand the array of primary care and specialty providers is to increase the supply of NPs, PAs, and CNMs. However, increasing the number of NPs who are trained in state may be particularly challenging as there is currently a severe shortage of nursing faculty needed to train NPs. Without addressing the underlying nursing faculty shortage, it will be difficult to significantly increase NP class size or begin new programs.[14]

Recommendation 2.7. (Priority Recommendation)

a) North Carolina physician assistant (PA) programs should increase student enrollment by 30%. Expansion can be accomplished through an increase in enrollment on existing campuses or through satellite campuses. In expanding programs, PA schools should consider changing admissions criteria or using other strategies to increase the overall supply of PAs practicing in the state, increase the number of PAs who set up practice in underserved areas, increase the number of PAs who specialize in shortage specialties (including but not limited to geriatrics and behavioral health), increase the number of underrepresented minority PAs practicing in the state, and enhance interdisciplinary team training.

b) North Carolina nurse practitioner (NP) schools should increase student enrollment by 30%. In expanding programs, NP schools should consider changing admissions criteria or using other strategies to increase the overall supply of NPs practicing in the state, increase the number of NPs who set up practice in underserved areas, increase the number of NPs who specialize in shortage

z In addition to passing the national exam, PAs must maintain certification by taking 100 hours of CME every two years and passing a recertification exam every six years.

aa There are seven NP programs in North Carolina: Duke University, East Carolina University, University of North Carolina at Chapel Hill, University of North Carolina at Charlotte, University of North Carolina at Greensboro, University of North Carolina at Wilmington, Winston-Salem State University, and Western Carolina University. Each year these programs graduate approximately 240 new NPs (2005-06 data) most of whom stay in North Carolina.

bb There are four PA programs in North Carolina: Duke University (45-49 graduates/year; 39% in primary care; 44% remain in North Carolina); Wake Forest University (44-48 graduates/year; 38% in primary care; 67% remain in North Carolina); East Carolina University (24-45 graduates/year; 40% in primary care; 88% remain in North Carolina) and Methodist College (25-30 graduates/year; 51% in primary care; 86% remain in North Carolina). Strand J. Chief, PA Division, Duke University Medical Center. Presented at: Primary Care and Specialty Supply Task Force Steering Committee Meeting, North Carolina Institute of Medicine; February 13, 2006; Cary, NC.

specialties (including but not limited to geriatrics and behavioral health), increase the number of underrepresented minority NPs practicing in the state, and enhance interdisciplinary team training.

c) The Nurse Midwifery program at East Carolina University should increase student enrollment by 30%.[cc]

The NC General Assembly should tie future financial incentives to existing medical schools and other health professions schools that increase production of healthcare providers who set up practice in North Carolina and that address the state's pressing workforce needs, including, but not limited to: maldistribution issues, underrepresentation among certain minority populations, and supply of specific provider specialty areas.

Recommendation 2.8. (Priority Recommendation)

a) The NC General Assembly should provide financial support to encourage or reward medical schools and other health professions schools that produce physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) who fill the unmet health needs of the state's population. Incentives should be provided to increase the overall supply of healthcare providers, appropriately distribute physicians, NPs, PAs, and CNMs practicing in the state, and promote interdisciplinary training. Enhanced funding should be tied to outcomes that result in:

   1) increased numbers of physicians, NPs, PAs, and CNMs who set up and maintain practices in underserved areas;

   2) increased numbers of physicians, NPs, PAs, and CNMs who obtain qualifications for and practice in primary care or other shortage specialties as identified by the Health Workforce Policy Board;

   3) increased numbers of practicing physicians, NPs, PAs, and CNMs who are members of underrepresented minorities; or

   4) greater interdisciplinary didactic and clinical team training among physicians, NPs, PAs, CNMs, nurses, and other health professionals (eg, pharmacists, social workers, allied health workers).[dd]

b) In order to determine the effectiveness of various training programs in meeting the healthcare workforce needs of North Carolina, the NC

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cc The East Carolina University Nurse Midwifery School estimates it would cost $206,000 annually to increase enrollment by 30%. The program currently enrolls and trains 6-12 students a year from across the state via internet and other distance learning techniques.

dd Section 754 of Title VII of the Public Health Service Act provides federal funding to demonstrate and evaluate innovative interdisciplinary methods and models designed to provide access to cost-effective comprehensive healthcare. The Quentin N. Burdick Rural Program for Interdisciplinary Training program lost federal funding in FFY 2007; however, similar programs should be encouraged through state funding.

General Assembly should amend NCGS §143-613 to require medical schools, PA programs, NP programs, and CNM programs to report information on an annual basis to the Health Workforce Policy Board, the Board of Governors of the University of North Carolina, and the NC General Assembly. Medical schools and NP, PA, and CNM programs shall cooperate with the Health Workforce Policy Board to identify on an annual basis the following data and information:

1) number and location of graduates in active patient care practice and number of graduates no longer in active patient care practice by year of graduation;
2) percentage of graduates who enter residencies in primary care specialties or other specialties that are deemed as shortage areas in North Carolina as defined by the Health Workforce Policy Board;
3) percentage of graduates who practice in federally-designated health professional shortage areas in North Carolina and in areas specified as shortage areas by the Health Workforce Policy Board;
4) number and percentage of underrepresented minorities who are enrolled in and who graduate from these schools and programs and where they practice; and
5) number of graduates who have been involved in formalized interdisciplinary didactic or clinical training programs that involve students from multiple disciplines working together as teams in patient care.

Residency programs in North Carolina that qualify physicians in family medicine, general pediatrics, general internal medicine, and primary care obstetrics and gynecology shall cooperate with the Health Workforce Policy Board to identify on an annual basis the practice status and location of physicians completing those programs.

One precondition to expansion or creation of a new medical school or PA, NP, or CNM program is that the program has the capacity to provide needed clinical training. In the past, there have been attempts to move clinical rotations out of academic health centers and hospitals and into communities, particularly underserved communities, in an effort to enhance clinical training and to encourage providers to set up practice in those locations. However, developing community clinical training sites is challenging. Students need places to live during their temporary assignment to new communities. In addition, the time it takes for a community practitioner to serve as a preceptor reduces the time that practitioner can spend treating patients (thereby lowering revenues). AHEC currently helps support clinical rotations for health professions students; however, resources available to support additional clinical rotations are limited and need to be expanded. (See Recommendation 2.9.)

Increasing number of physicians who complete their residency in North Carolina: After graduating from medical school and successfully passing licensure exams, physicians must complete at least one year of postgraduate training (internship or residency).[ee] Foreign-trained medical students generally have longer postgraduate education requirements before beginning practice. Specialists have longer residency programs and also must take specialty board examinations offered by the American Board of Medical Specialties.

Most residency placements run between three and seven years, depending on the specialty.[ff] Physicians who complete their residencies in North Carolina are even more likely to remain in state than those who go to North Carolina medical schools. Over the last forty years, almost one-half (49%) of physicians who completed their residencies in North Carolina remained in the state to practice. More than two-thirds (67%) of physicians who completed their residencies at AHEC family practice residencies remained in state.

Over the last forty years, almost one-half of physicians who completed their residencies in North Carolina remained in the state to practice.

In 2004, there were 2,648 residents in 12 postgraduate programs across the state. (See Table 2.2.) Of these 2,648 residents, 16% were in internal medicine, 10% in

Table 2.2
Number of Residents by Location, 2004

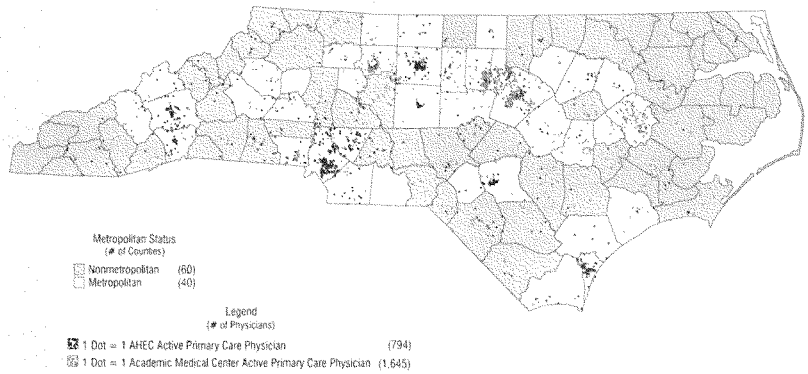
Location	Number of Residents
Duke University Medical Center	880
UNC/UNC Hospitals	648
Wake Forest/Baptist	583
East Carolina University/Pitt County Memorial Hospital	318
Charlotte/Carolinas Medical Center	200
Coastal AHEC/New Hanover Regional	61
Greensboro AHEC/Moses Cone	47
Mountain AHEC/Mission Hospitals	46
Cabarrus/Northeast Medical Center	23
Southern Regional AHEC/Cape Fear Valley	17
Monroe	6
Hendersonville	6
Total	**2,648**

Source: NC Health Professions 2004 Data Book.

ee Each state has its own rules for licensure and practice. In North Carolina, applicants who attend US medical schools must graduate from an accredited medical school, pass the US Medical Licensure Examinations or its equivalent, and complete at least one year of graduate training. If the applicant graduates from a foreign medical school, that individual must be individually certified by the Educational Commission for Foreign Medical Graduates and complete at least three years of postgraduate residency training. NC Medical Board. Available at: http://www.ncmedboard.org/. Accessed April 3, 2006.

ff Postgraduate education is accredited through the Accreditation Council for Graduate Medical Education (ACGME). ACGME includes 27 specialty Resident Review Committees (RRCs) that set standards for residency programs for 199 specialties and subspecialties. Nationally, these programs train approximately 100,000 residents annually. Accreditation Council for Graduate Medical Education. *History and Organization of the Accreditation Council for Graduate Medical Education*. Available at: http://www.acgme.org/acWebsite/25_anniv/25_history.asp. Accessed April 3, 2006.

Map 2.1*
Distribution of Active Primary Care Physicians Who Graduated from a North Carolina Residency Program AHEC and Academic Medical Center Program, North Carolina, 2003



Data are for active, in-state, non-federal, non-resident-in-training physicians indicating primary care specialties of FP, GP, IM, Ob/Gyn or Pediatrics, who were licensed as of October 2003 with residency graduation dates from 1972 and later. Internship data were used if residency data were missing.

Source: NC Health Professions Data System with data derived from the North Carolina Medical Board, 2005; NC Area Health Education Centers Program, 2003; US Census Bureau, 2004.

Core Based Statistical Areas are current as of the December 2003 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

* Color versions of all maps are available at http://www.nciom.org/projects/supply/primary_specialty.html.

family practice, 7% in pediatrics, 6% in OB/GYN, 7% in general surgery, and 47% in other specialty areas (eg, anesthesiology, dermatology, emergency medicine, pathology, surgical specialties, neurology, radiology).[15] North Carolina has a slightly lower than average number of residency spots: 3.1 per 10,000 population compared to 3.4 nationally.

Generally, North Carolina has been able to fill more than 90% of its approximately 630 first-year residency positions over the last ten years; however, the exact percentage of filled positions varies by specialty and location. Family practice has a 72% match rate[gg] whereas general surgery has a 100% match rate.[hh] Most physicians set up practice within 90 miles of where they completed their residency.[16]

gg Family medicine programs across the country are having difficulty filling their residency positions.

hh General surgery is different from preliminary surgery residencies, the latter of which has a 65.7% match rate. Preliminary surgery residents often are not counted in a longitudinal track of residents in general surgery since many subspecialize. Preliminary surgery residency positions (like those of preliminary medicine) are one-year positions tailored to residents who know they want to subspecialize. Residents spend one year in these positions and then move on to other programs elsewhere. As a result, residents are not usually counted in a longitudinal track of residents in that particular specialty because most are headed into a subspecialty area. Preliminary medicine residents are frequently headed to programs in radiology, anesthesiology, or other hospital-based residencies.

As with medical education, North Carolina has more physicians who completed their postgraduate medical education out of state than in state. (See Appendix A.) In 2005 approximately two-thirds (64.7%) of all physicians actively practicing in North Carolina completed their postgraduate education in other states or Canada (2003). One-third (35.3%) of the physicians practicing in state completed their postgraduate education in state. North Carolina does not currently offer enough postgraduate training programs to meet the need for new physicians.

One way to expand the number of physicians who practice in North Carolina is to expand the number of postgraduate education residency spots, since about one-half of all physicians who complete residencies in North Carolina stay in state-to-practice. Residency programs are underwritten through Medicare and Medicaid graduate medical education funds paid to teaching hospitals, clinical income, state funds, grants, and other sources. Estimates for residency training range from $250,000-$400,000 in gross costs per resident. Depending on the residency program, one-half to one-third of these costs can be covered through clinical revenues generated by faculty and residents (eg, surgical or specialty residency programs can generate more clinical revenues than family medicine).

North Carolina does not currently offer enough postgraduate training programs to meet the need for new physicians.

It also is important to track the impact of hospitalists in recruitment and retention of physicians in underserved areas (discussed more fully in Chapter 3). If increased use of hospitalists leads to higher provider retention in underserved areas or greater productivity in primary care settings, then the state should consider the feasibility of creating special tracks for hospitalists within internal medicine residencies and other primary care programs.

The state can increase the number of residency positions, although new Medicare graduate medical education (GME) funds are not available to help support this expansion.[ii] In 1974, the NC General Assembly appropriated $4.5 million to provide stipends of $15,000 per resident to help pay for primary care residency training.[jj] The goal was to expand the number of primary care residency positions. Since 1974, 730 new primary care residency positions have been established, but state funds have grown only to a level capable of supporting 324 positions for a current total of $4.86 million. Efforts also have been made over the years to increase the amount of the stipend, but it remains at the $15,000 level established in 1974.

The NC General Assembly should increase the funding for residency programs either through a direct appropriation or through an increase in Medicaid GME funds.[17] The annual cost of training a resident is approximately $100,000, which

ii The Balanced Budget Act of 1997 capped Medicare GME funds, limiting the number of slots that it would support. In 2005, the US Centers for Medicare and Medicaid Services (CMS) reallocated Medicare GME funded slots from training programs that were unable to fill all of their allocated slots to other programs. North Carolina received the second largest increase in Medicare GME funded slots (6.55%) as a result of this reallocation process. Nevertheless, all of these reallocated Medicare slots simply covered existing unfunded positions and did not result in a growth in residency positions.

jj Residencies in family practice, pediatrics, internal medicine, OB-GYN, and med-peds qualify as primary care residencies eligible for the state-supported stipend.

covers the resident's salary and benefits and pays for a small portion of faculty members' salaries and related costs.[kk]

North Carolina paid $75.7 million in Medicaid GME funds to support graduate medical education.[ll] This amount could be increased and targeted to produce types of physicians or other graduate health professionals needed to meet the state's future healthcare needs. North Carolina currently pays GME funds as part of the hospital's per diem rate. Funding is limited to support graduate *medical* education. However, 12 states also provide GME funding for graduate nursing education, and 13 states use GME funds to support graduate training of other health professionals.[mm] Eleven states specifically link Medicaid GME payments to achieve certain state policy goals such as training in certain shortage specialties (eg, primary care), training in certain settings (eg, rural or medically underserved communities), or increasing the supply of health professionals serving Medicaid beneficiaries.

Recommendation 2.9. (Priority Recommendation)

The NC General Assembly should appropriate $13 million in new funding and/or Medicaid GME funding to the NC Area Health Education Centers (AHEC) Program to support additional and expanded clinical rotations for health science students and expansion of primary care or other residency programs that meet specialty shortages.

a) **$3 million should be provided to develop new clinical training sites for students; to pay stipends to community preceptors who supervise and teach primary care students; and to provide housing, library, and other logistical support for students in community settings. Enhanced payments should be made to preceptors who practice in health professional shortage areas.**

b) **$10 million should be provided to fund 100 new residency positions across the state targeted toward the high priority specialty areas of primary care, general surgery, and psychiatry or targeted toward other specialty shortage areas identified by the Health Workforce Policy Board. This funding should be provided to AHEC, with AHEC then making grants to AHEC- and university-based residency programs that agree to expand residency slots and to create programs designed to graduate physicians likely to settle in rural and other underserved areas of the state.**

In addition to creating new residency positions, the state could more easily attract osteopathic doctors into North Carolina residency programs if North Carolina residency programs were accredited by both the Accreditation Council for Graduate Medical Education (ACGME), necessary for allopathic residencies, and the American

kk The state could support 100 new positions with an additional $10 million in funding. The number of new positions could be increased further if hospitals helped match some of the residency costs.

ll The North Carolina Division of Medical Assistance provides funding to reimburse for the costs of both direct graduate medical education and indirect medical education in hospitals and other settings. GME payments are included as part of the hospital's per diem rate.

mm For example, Minnesota uses its GME funding to support dental students and residents, doctors of pharmacy students and residents, PAs, and chiropractic students.

Osteopathic Association (AOA), necessary for osteopathic residencies. There are only two residency programs in North Carolina that have dual accreditation: Wilmington and Fayetteville. Osteopathic students can do their residencies in an ACGME accredited residency program, but they may not be able to continue some of the skills they learned in their undergraduate medical school (eg, manipulation).[nn] Many osteopathic students would prefer to do their residencies in jointly accredited residency programs so it is easier for them to take both sets of board examinations.[oo] By offering more jointly accredited programs, North Carolina may be able to attract more osteopathic trained medical students into North Carolina residency programs.

Recommendation 2.10.

NC residency programs should consider seeking joint accreditation by the American Osteopathic Association along with existing accreditation by the Accreditation Council for Graduate Medical Education.

Improving the practice environment to encourage more physicians to move to North Carolina and to keep existing North Carolina physicians in practice in the state: Other strategies to increase the number of providers in North Carolina include increasing the number of providers recruited to practice in North Carolina from out of state, decreasing attrition from the practice, or encouraging providers who left the practice to reenter the practice. North Carolina is a net importer of physicians: most North Carolina physicians either attended medical schools or completed their residencies out of state. Historically, the state has been able to attract physicians to relocate to North Carolina to set up practice; however, that may become more difficult in the future as more states actively recruit physicians to address their provider shortages.

Historically, the state has been able to attract physicians to relocate to North Carolina to set up practice; however, that may become more difficult in the future as more states actively recruit physicians to address their provider shortages.

One strategy is to encourage retired providers or those on inactive status to reenter practice. Between 2003 and 2004, 193 physicians who had retired or become inactive reentered the practice.[pp] Improving the practice environment for physicians may lead to less out-migration or fewer providers leaving the profession. Physician salary, the complexity of the healthcare system, the malpractice environment, hours of practice, and community factors all affect provider satisfaction and the desire to remain in the profession and/or practice location. Changing some of these underlying conditions could also increase the overall supply of physicians in the state. Similar strategies could be employed for nonphysician clinicians.

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nn Many of the ACGME primary care residency programs in North Carolina are trying to accommodate the interests of the osteopathic residents by offering short courses that focus on skills taught in osteopathic schools such as manipulation.

oo The American Osteopathy Association conducted a survey of graduates of osteopathy medical schools. More than 80% of DO graduates indicated that they would prefer to attend a jointly accredited AOA/ACGME residency program. Murphy M. Presented at: Primary Care and Specialty Supply Task Force Steering Committee Meeting, North Carolina Institute of Medicine; February 13, 2006; Cary, NC.

pp 138 of these physicians were inactive in 2003 and became active in 2004; 48 moved from retired status to active status; 52 physicians did not have business hours or an active practice listed in 2003 but listed one in 2004. (Note: there is overlap between some of these categories).

Physician salaries:
The average salary of North Carolina physicians is higher than the national average and generally ranks in the top 20 states.[qq] According to the 2006 Geographic Practice Cost Indices (GPCI), used to determine variations in costs for physician services for Medicare based on geographic location, North Carolina physicians' practice expenses (including office staff, renting office space, and supplies and equipment) were 8% below the national average.[18]

North Carolina's malpractice environment can affect a physician's willingness to set up practice:
One commonly cited factor contributing to a potential decline in the provider supply is the medical malpractice environment. Practitioners are concerned that supply is inhibited by high malpractice insurance premiums and/or especially litigious environments that discourage training in certain specialties (eg, OB/GYN), encourage relocation to other states with more provider-friendly medical liability environments, hasten retirement and/or transition to other professions, and lead to the cessation of specific medical services (eg, delivering babies).

The American Medical Association (AMA) lists North Carolina as one of the states "in crisis" with respect to medical malpractice liability, although it does not provide data on how this determination was made.[rr] Other evidence suggests that North Carolina does not have a more adverse malpractice environment than other states. For example, information from the National Practitioner Data Bank shows that North Carolina has average per capita malpractice awards and settlements.[ss] Further, the Medicare Geographic Practice Cost Indices (GPCI) noted that professional liability insurance for North Carolina physicians was 36% lower than the national average.[18] It should be noted, however, the "average" malpractice environment in North Carolina may be more positive than that experienced by specific providers practicing in certain specialties, located in certain geographic areas, or covered by certain carriers. In other words, certain subsets of providers may face more acute malpractice pressures than the above "average" data suggest. While evidence on the underlying malpractice environment is mixed, the perception that North Carolina has a worse malpractice environment than other states could potentially discourage practitioners from moving to this state to practice and may accelerate other practitioners to leave practice.[tt] The Task Force was not able to fully consider

qq Family practice physicians in North Carolina average $145,875 annually, compared to $138,235 nationally. North Carolina internists earn, on average, $165,045 annually compared to $157,495 nationally. Similarly, OB/GYNs earn $180,995 in North Carolina compared to $175,380 nationally. Occupational Employment Statistics, Bureau of Labor Statistics, US Department of Labor. May 2004 and November 2004 values averaged.

rr According to the AMA, "In crisis states, patients continue to lose access to care. In some states, obstetricians and rural family physicians no longer deliver babies. Meanwhile, high-risk specialists no longer provide trauma care or perform complicated surgical procedures." Available at: http://www.ama-assn.org/ ama/noindex/category/ 11871.html. Accessed December 2006.

ss For example, the average per capita award in 2002-2003 in North Carolina was $9.39 compared to $7.92 (TN), $8.68 (VA), $9.87 (SC), $13.45 (GA), and $12 (US). National Practitioner Data Bank Public Use Data File, Practitioner Data Banks Branch, Office of Workforce Analysis and Quality Assurance, Bureau of Health Professions, Health Resources and Services Administration, US Department of Health and Human Services. Accessed December 31, 2005.

tt Evidence on the extent to which medical malpractice affects provider supply is also mixed. US Government Accountability Office. Medical Malpractice: Implications of Rising Premiums on Access to Health Care. GAO-03-836 (August 2003).

all the different complexities of malpractice reform.[uu] However, until either the reality or the perception of the malpractice crisis is addressed, it will continue to be an issue that underlies some dissatisfaction with the practice environment.

North Carolina should mount an aggressive outreach and marketing campaign to extol the virtues of practicing in North Carolina. Salaries are comparable, but costs of practice are generally lower. Of the 89 geographic locations measured by the GPCI, only 29 locations had lower practice expenses and only 20 locations had lower liability insurance than North Carolina in 2006.[18]

Recommendation 2.11.

The NC Office of Rural Health and Community Care in collaboration with the Community Practitioner Program of the NC Medical Society, NC Area Health Education Centers Program, and professional medical societies should conduct marketing and outreach campaigns that emphasize positive aspects of healthcare practice in North Carolina.

The data listed above suggest that North Carolina currently offers physicians a positive work environment. North Carolina also provides a positive practice environment for PAs, NPs, and, to a slightly lesser extent, CNMs. In a national study of PAs, NPs, and CNMs, North Carolina was considered to have the most positive practice environment for PAs and the 10th most favorable practice environment for NPs, but only the 24th most favorable practice environment for CNMs.[19] Despite the overall positive work environment for physicians, NPs, PAs, and CNMs, North Carolina cannot afford to rest on past accomplishments. As health professional shortages become more acute across the country, other states are likely to increase their recruitment efforts as well as take steps to improve the regulatory and practice environment. North Carolina should remain vigilant in maintaining and improving the practice environment for physicians, NPs, PAs, and CNMs.

Recommendation 2.12.

The NC General Assembly should help maintain and improve the positive regulatory environment for all licensed health professionals including physicians, nurse practitioners, physician assistants, and certified nurse midwives.

Alterations to the regulatory environment should lead to:

a) more out-of-state licensed health professionals migrating to North Carolina;

b) fewer practicing licensed health professionals leaving North Carolina;

c) licensed health professionals retiring later in their careers;

uu When the NC Institute of Medicine studies an issue, it strives to have all relevant stakeholders participate in the study. The Task Force examining primary care and specialty supply was not properly constituted to fully study the issue of malpractice reform, as trial lawyers and other individuals representing patients injured by medical negligence were not part of this study.

d) more licensed health professionals treating underserved populations in underserved communities;

e) more licensed health professionals offering a full scope of services (within their scope of practice); and

f) greater quality and efficiency of healthcare offered to North Carolinians.

Possible options for the NC General Assembly to consider include, but are not limited to: ensuring adequate provider reimbursement, providing practice supports to help practitioners provide quality care in an increasingly complex healthcare environment, addressing rising malpractice costs, and addressing any other barriers that discourage physicians or other licensed health professionals from continuing to provide services in North Carolina.[vv]

Another strategy is to encourage retired physicians, NPs, PAs, or CNMs or those on inactive status to reenter practice. Between 2003-2004, 193 physicians who had retired or become inactive reentered practice.[ww] The North Carolina Medical Board currently has a process to validate the competence of physicians or PAs seeking licensure after two or more years out of active clinical practice.[20] Physicians and PAs who have applied for reentry have spent between 2-22 years out of practice. Applicants who are interested in resuming practice must develop reentry plans which the Board must approve. The reentry plan must include diagnostic, remedial education, and reassessment elements. However, it has been very difficult for applicants to develop appropriate reentry plans. Many applicants need to participate in a postgraduate training program or set up an alternative method of demonstrating clinical competence. However, there are limits on training slots available for mini-residency training. Reentry applicants also have difficulty obtaining liability coverage for the residency training or mentorship. Applicants who took a hiatus from practice directly out of a residency program face particular problems if they were never licensed.

The North Carolina Board of Nursing has a reentry process for NPs who have been inactive for five or more years.[xx] NPs who have been inactive for at least five years must complete a NP refresher course approved by the Board of Nursing. The refresher course must include didactic and clinical learning experiences and an evaluation of student competencies. The Midwifery Joint Committee does not have a similar process to validate the competence of CNMs who have been out of practice for any length of time. The American College of Nurse-Midwives (ACNM) developed a flexible, individualized pilot program for nurse midwives who would like to reenter practice, which includes continuing education and a clinical refresher depending on the length of time out of practice. Each nurse midwife is individually evaluated and a unique reentry plan is developed. The nurse midwife

vv The Task Force did not specifically address the issue of whether the NC General Assembly should remove the requirement for physician supervision from the practice acts governing PAs, NPs, or CNMs.

ww 138 of these physicians were inactive in 2003 and became active in 2004; 48 moved from retired status to active status; 52 physicians did not have business hours or an active practice listed in 2003, but listed one in 2004. (Note: there is overlap between some of these categories).

xx 21 NCAC 36.0808(d).

is responsible for identifying the site or clinical preceptor to assist with carrying out the plan.[21]

The North Carolina Medical Board should continue its efforts, in conjunction with other organizations, to facilitate reentry of PAs into practice. The Midwifery Joint Committee should develop its own rules to govern reentry of inactive CNMs into practice. Inactive practitioners from other states might be interested in moving to North Carolina if a streamlined process is created that facilitates reentry of competent practitioners into practice.

Recommendation 2.13.

The North Carolina Midwifery Joint Committee should follow licensure reentry procedures established by the American College of Nurse-Midwives to enable inactive practitioners otherwise in good standing to reenter practice.

The complexity of the healthcare billing system requires more highly trained practice managers to ensure that outstanding balances are collected. The managerial skill required to successfully operate a practice has increased rapidly over the past few decades. Most practices have patient populations with multiple insurers, requiring the practice to navigate a vast array of reimbursement forms and procedures to receive appropriate payment for services. Few residencies provide training on the business side of practice management, which discourages physicians from opening their own practices. In general, geographically underserved and rural areas are most dependent on solo practitioners; therefore, reluctance to open a solo practice affects the most at-risk communities. In addition, the rapidly changing business environment of medicine may disproportionately affect small practices that cannot afford to invest in staff training.

One key element in the success of a medical practice is a practice manager who has the skill set to manage the business side of the practice, such as ensuring appropriate reimbursement for medical services, whether from private payers, public programs, or individual patients. Practice managers increase the long-term financial viability of practices, especially in rural and underserved areas, and could increase provider supply in these at-risk communities.

Other organizations also can assist providers in understanding basic financial and clinical management systems needed to successfully manage a healthcare practice. Historically, the NC Office of Rural Health and Community Care (ORHCC) has worked with rural practices and federally qualified health centers to provide technical assistance to both new and current practices through improving billing and management systems, increasing financial performance, and maximizing the chance of long-term provider retention in the community. However, ORHCC funding is limited, and, as a result, their staff are able to reach only approximately 40 practices per year.

The NC Medical Society Foundation is developing a practice management program (PractEssentials) to provide technical assistance to physicians, NPs, and PAs who

receive support through the Community Practitioner Program.[yy] The goal of PractEssentials is to help providers in medically underserved areas develop and maintain financially viable practices.

Recommendation 2.14. (Priority Recommendation)

In order to improve practice management across the state:

a) The University of North Carolina system, NC community colleges, and NC independent colleges and universities should offer courses that will increase the supply of practice managers across the state, particularly in underserved areas, and improve the skills of existing practice managers.

b) The NC Area Health Education Centers Program, NC Office of Rural Health and Community Care, Community Practitioner Program, NC community colleges, and NC independent colleges and universities should develop a continuing education curriculum for existing practitioners and staff to enhance the business skills needed to maintain a viable practice.

c) North Carolina foundations should consider funding start-up programs to community colleges and other organizations to enhance the skills of practice managers and providers and programs targeted to underserved areas.

yy The Community Practitioner Program (CPP) provides financial assistance to physicians, PAs, and family NPs in return for healthcare service in an underserved community. It is run through the NC Medical Society Foundation. CPP funds help support approximately 50 providers per year. More information is available at: www.ncmsfoundation.org. Accessed April 28, 2006.

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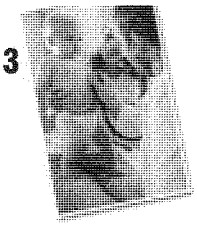
Acute Provider Shortages in Certain Areas of North Carolina

Chapter 3



Some areas of North Carolina have an abundance of health professionals while others lack sufficient providers, forcing individuals to travel long distances for healthcare. Healthcare providers tend to congregate around academic health centers or around major hospitals in metropolitan areas.[a] However, while there may be an abundance of healthcare providers around these large hospitals, there also are many areas of the state where health professionals are in very short supply. Shortages typically exist in rural areas, but pockets of low provider supply also are found in some low-income areas of larger cities. This chapter focuses on how the state can address maldistribution of healthcare providers and refers to recommendations described in Chapter 2 that could ameliorate the maldistribution problem. In addition, this chapter includes other recommendations that focus specifically on addressing maldistribution issues. Chapter 4 focuses on shortages of specific specialties. In nearly all cases, deficiencies in supply of individual specialties are primarily of a *geographic* nature: a specialty is in sufficient supply but is poorly distributed. Solutions aimed at particular specialties also are addressed in Chapter 4.

Because healthcare providers tend to congregate around academic health centers or around major hospitals in metropolitan areas, there are many areas of the state where health professionals are in very short supply.

Overall, North Carolina has more than 17,800 physicians. The ratio of all physicians per 10,000 population reached 20.7 in 2005. This ratio is lower than the average of 22.77 per 10,000 for the US but is consistent with ratios for states that border North Carolina.[1] North Carolina has 7,660 primary care physicians or 8.8 primary care physicians per 10,000 population compared to a national average of 9.43. North Carolina is slightly ahead of neighboring states in primary care-to-population ratio.

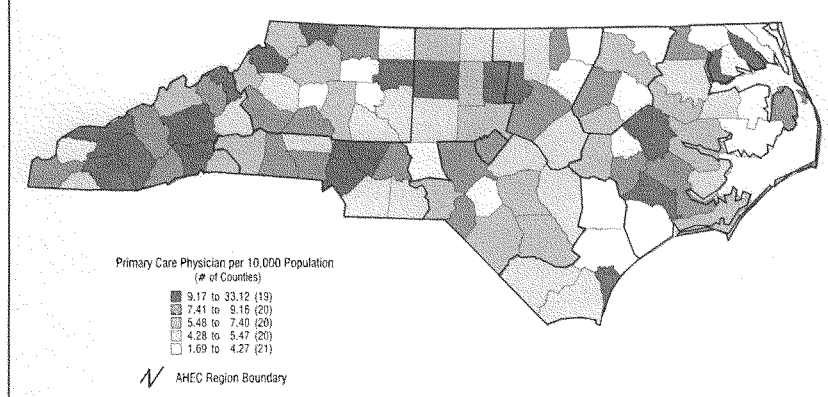
There is wide variation in the ratio of physicians to population in different areas of the state. Orange and Durham counties, home to the University of North Carolina Health Care System and Duke University Health System, respectively, had the highest primary care physician per population ratios in 2005 with 33.7 and 22.5 per 10,000 population. By contrast, Gates and Camden counties, neither of which have hospitals, had the lowest primary care physician per population ratios with 0.9 and 1.1 per 10,000 population. Eight of the 10 counties with the lowest ratios of primary care physicians per 10,000 population are located in eastern North Carolina.[b]

The Bureau of Health Professions in the US Department of Health and Human Services has designated certain communities, population groups, or medical facilities as Health Professional Shortage Areas (HPSAs). HPSA designations

a North Carolina has five academic medical centers: Brody School of Medicine at East Carolina University, Duke University School of Medicine, University of North Carolina at Chapel Hill School of Medicine, Wake Forest University School of Medicine, and Carolinas Medical Center in Charlotte. Each of these entities is a major healthcare center that employs and attracts a multitude of healthcare providers in the surrounding area. Similarly, there are other metropolitan areas across the state that are served by major hospitals and likewise have many healthcare providers.

b According to the 2005 NC Health Professions Data Book, the 10 counties with the smallest primary care physicians per 10,000 ratios were Gates, Camden, Warren, Perquimans, Currituck, Hyde, Hoke, Pender, Tyrrell, and Northampton. Hoke and Warren are the only counties located west of Interstate 95, traditionally considered the boundary of eastern North Carolina.

Map 3.1
Primary Care Physicians per 10,000 Population by County, North Carolina, 2004



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2004.

Primary Care Physicians include active or unknown activity status, in-state, non-federal, non-resident-in-training allopathic and osteopathic physicians indicating a primary specialty of Family Practice, General Practice, Internal Medicine, Ob/Gyn, or Pediatrics.

qualify communities as eligible for certain federal subsidies and interventions aimed at increasing health profession supply and access to care.[2] The federal government has separate HPSA definitions and designations to show shortages of primary care physicians, dentists, and mental health providers. For example, certain counties, or parts thereof, will be designated HPSAs if they have more than 3,500 people per primary care provider.[c] Population groups can be designated HPSAs if they have specific access barriers and there is a high ratio of people in that population group to practitioners serving the population.[d] Facility designations are limited to prisons or Community Health Centers.[e,3]

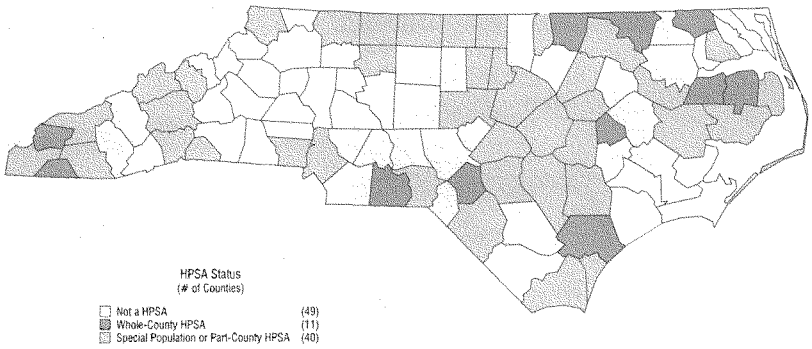
c Areas that are designated HPSAs must define and justify a rational service area for the delivery of health services (often a county), have a sufficiently low provider-to-population ratio, and show evidence that nearby resources are overutilized, too distant, or otherwise inaccessible. For primary care professionals, areas with more than 3,500 people per primary care provider can qualify as HPSAs, although the standard is lower for certain "high need" areas. An area is designated as "high need" if the area has more than 100 births per year per 1,000 women aged 15–44, has more than 20 infant deaths per 1,000 live births, or has more than 20% of the population (or of all households) with incomes below the poverty level.

d In North Carolina, most of the "population" HPSA designations are low-income populations; however, there also are some migrant farm worker (MFW) HPSAs in the state.

e Facility designations are for those facilities that serve an underserved area or population and have insufficient capacity to adequately serve the needs of that area or population. Bureau of Health Professions. *Health Professional Shortage Area Primary Medical Care Designation Criteria: Relevant Excerpts from 42 Code of Federal Regulations (CFR).* Criteria for designation of areas having shortages of primary medical care professionals. October 1, 1993:34-48. Washington, DC: US Department of Health and Human Services. Chapter 1, Part 5, Appendix A. Available at : http://bhpr.hrsa.gov/shortage/hpsacritpcm.htm. Accessed Sept 30, 2006.

Most of North Carolina's whole-county HPSAs are rural, and many are located east of Interstate 95. Partial-county HPSAs are more common and can be found throughout the state, including urban and rural counties. The majority of partial-county HPSAs are special population designations focused on access barriers for low-income or migrant populations. Although rural areas may be more likely to be designated a HPSA, four of the five North Carolina counties with academic health centers are designated currently as partial-county HPSAs.[f,4]

Map 3.2
North Carolina Health Professional Shortage Areas, 2005



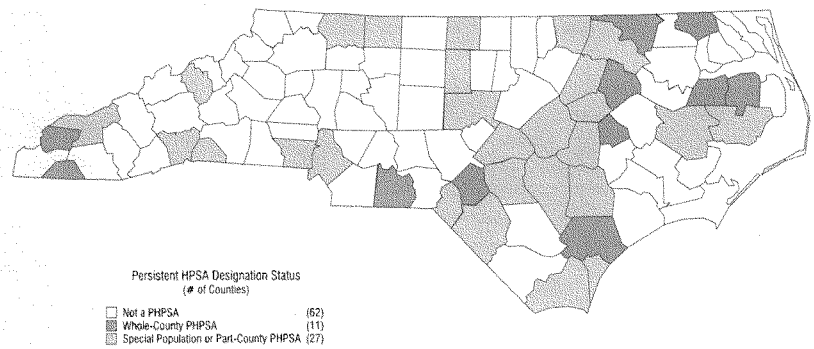
Source: Bureau of Health Professions, Shortage Designation Branch, 2005.

In the long run, areas of greatest concern are those repeatedly designated HPSAs. Populations with lower physician supply may be less able to address healthcare needs in a timely manner. In fact, many studies find that areas with lower primary care supply have higher mortality rates.[5,6,7,8,9] Counties designated HPSAs in six of the last seven years can be considered "persistent health professional shortage areas" (PHPSAs). In North Carolina, these counties tend to be disproportionately rural and poor. Whole-county PHPSAs are more likely to be rural than non-PHPSAs and have a higher percent of the population living below the poverty line (15.2% for whole, 10.4% for non-PHPSAs).[10] Map 3.3 illustrates the 2005 North Carolina PHPSAs. The majority of whole-county PHPSAs are located in eastern North Carolina. The central area of the state has fewer whole-county PHPSAs but does have a number of partial-county PHPSAs.

Rural areas face more critical shortages than most urban areas. For example, Perquimans, Hyde, and Currituck counties (all in the east) have ratios at or below

f Forsyth county has a Low Income Population HPSA, and Durham, Mecklenburg, and Orange counties have Facility HPSAs.

Map 3.3
Persistent Health Professional Shortage Areas in North Carolina, 2005



Source: Area Resource File, HRSA, DHHS, 2005; Bureau of Health Professions, Shortage Designation Branch, 2005.

Persistent HPSAs are those designated as HPSA by the Health Resources and Services Administration (HRSA) from 1999 to 2005 or in 6 of the last 7 releases of HPSA definition.

Providers choose their location of practice for a variety of reasons, but two significant factors include economic potential and lifestyle preferences.

1.9 per 10,000 population.[11] The growth in nurse practitioners (NPs) and physician assistants (PAs) is important because they provide a significant amount of care in rural areas compared to their physician counterparts. Between 1998 and 2003, 53% of the 464 primary care providers gained in rural North Carolina counties were either NPs or PAs. The proportion of primary care providers in rural areas who are NPs and PAs has increased over time. In 1998, 22% of primary care providers in rural areas were either NPs or PAs, but this increased to 28% in 2003. NPs and PAs are an even larger proportion of primary care providers in whole-county PHPSAs. In 2005, they accounted for 36% of total primary care providers in whole-county HPSAs compared to 33% of primary care providers in counties not designated as HPSAs.[12]

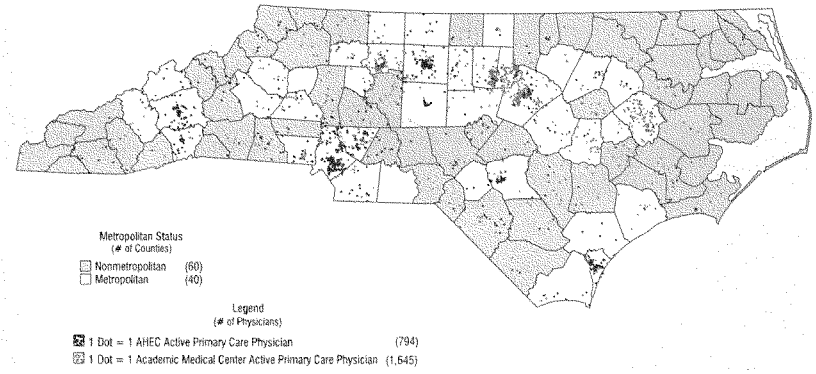
Along with the relative lack of primary care providers in many rural communities, rural residents may have additional barriers to accessing needed services. Rural communities are much less likely to offer a full array of specialty services. Lack of public transportation, coupled with greater travel distances to obtain care, also can create access barriers for rural residents. These barriers are particularly problematic for lower income individuals who may lack their own private transportation and the financial resources to pay for needed transportation.

Providers choose their location of practice for a variety of reasons, but two significant factors include economic potential and lifestyle preferences. In an economic sense, a physician's practice is a private business that needs to be financially sustainable. In HPSAs, sustaining a practice may be difficult because population density in

rural areas may not provide enough volume to ensure sufficient revenues to cover minimum operating expenses. In addition, many rural areas have higher than average numbers of uninsured individuals who may be unable to pay for the services provided; full-county PHPSAs and partial-county PHPSAs have uninsured rates approximately 1.5 percentage points and 1.1 percentage points higher, respectively, than non-PHPSAs.[13] These factors discourage providers from practicing in those areas. High population density, higher-income residents, and proximity to major medical centers provide income potential that draws physicians to places where the physician supply may be fully adequate.

Provider location also is influenced by lifestyle and family preferences. Urban areas offer many more cultural and recreational opportunities as well as more options for schooling and employment for spouses. Rural areas also provide amenities that are desirable, but these may not be valued as greatly by professionals seeking to advance their careers and build families. Providers' backgrounds play a major role in their preferences for where they want to practice. For example, a provider who has no prior exposure to rural life may find life in rural parts of North Carolina challenging. The vast majority of medical residency programs are located in metropolitan and suburban areas. Physicians make strong professional and social connections in those communities while they train and tend to cluster around those academic medical centers when they go into full practice. (See Map 3.4.)

Map 3.4
Distribution of Active Primary Care Physicians Who Graduated from a North Carolina AHEC Residency Program or Academic Medical Center Program, North Carolina, 2003



Data are for active, in-state, non-federal, non-resident-in-training physicians indicating primary care specialties of FP, GP, IM, Ob/Gyn or Pediatrics, who were licensed as of October 2003 with residency graduation dates from 1972 and later. Internship data were used if residency data were missing.

Core Based Statistical Areas are current as of the December 2003 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

Source: NC Health Professions Data System with data derived from the North Carolina Medical Board, 2005; NC Area Health Education Centers Program, 2003; US Census Bureau, 2004.

National research has shown that physicians who are most likely to practice in rural communities have a rural background, have a spouse who was raised in rural areas, are male, are white, or have expressed an interest in rural practice. In attracting physicians to rural areas, it is important that the community is a good fit for the physician and that the physician is well integrated into the community.[14] Strategies for addressing maldistribution, particularly as it affects rural, low-income, and other underserved populations, should consider these factors.

Classical economic theory suggests that as the number of providers per population increases in a given area, the market eventually encourages providers to locate outside of that area.[15] As a result, one option for addressing the issue of maldistribution is to increase the overall supply of providers. However, if current projections of a slowdown in growth of physician supply holds, and providers become more scarce, the opposite may occur, and practitioners may flow away from underserved areas.

Potential solutions should focus on developing a "pipeline" into professional medical practice for young North Carolinians with those characteristics that make them more likely to serve the underserved; recruiting more providers to work in rural and underserved communities through financial incentives; and retaining providers in underserved communities by improving practice patterns.

Recommendation 3.1

The NC Department of Public Instruction, NC Community College System, University of North Carolina, NC Area Health Education Centers Program, and other related programs should collaborate to create more intensive programs and to coordinate and expand existing health professions pipeline programs so underrepresented minority and rural students likely to enter health careers are offered continued opportunities for enrichment programs in middle school, high school, and college and then receive continued support in medical and other health professions schools.

Another more targeted approach on this continuum would be to focus efforts on college students and graduates with interests in medical school. Potential medical students who have characteristics consistent with likely service to or interest in rural medicine or with serving underserved populations could be offered assistance with medical school applications and MCAT preparation courses. By selecting individuals likely to locate in underserved areas, there is greater likelihood that supply in underserved areas will be increased. Additionally, medical school programs should make a more direct effort to include such individuals in medical school classes. East Carolina University's Brody School of Medicine is a good example of a program that has a specific mission to train healthcare professionals interested in serving underserved populations. It is not necessary that all medical students trained in North Carolina have this focus, but North Carolina medical schools should ensure they admit a meaningful cohort of students who are interested in or likely to serve in underserved areas or with underserved populations.

Recommendation 3.2.

Duke University School of Medicine, Brody School of Medicine at East Carolina University, University of North Carolina at Chapel Hill School of Medicine, Wake Forest University School of Medicine, and North Carolina residency programs should create targeted programs and modify admission policies to increase the number of students and residents with expressed interest in serving underserved populations and/or practicing in rural areas of North Carolina. Targeted programs should be designed to provide intensive and longitudinal educational and clinical opportunities to practice with medically underserved populations in medically underserved areas of the state.

Enhanced state funding should be targeted to medical schools and residency programs that increase the production of physicians who practice in North Carolina's underserved areas or with underserved populations. (See Recommendations 2.8 and 2.9.)

Direct economic incentives can be used to recruit providers to practice in underserved communities.

Recruitment through economic incentives:
Direct economic incentives can be used to recruit providers to practice in underserved communities. There are four main direct incentive mechanisms: scholarship, loan, loan repayment, and direct incentive (payments for capital costs or as income guarantees). Incentive mechanisms can be applied at different points along the pathway into community-based practice, including incentives for medical school students and residents as well as for new or established practicing providers. These incentives may or may not be tied to specific service obligations in return for financial incentive. (See Table 3.1.)

Table 3.1
Direct Incentive Mechanisms for Physician Recruitment[16,17]

Program Type	Who is eligible for the program	Required or optional service	How funds are used	Six year retention rate
Scholarship	Medical Students	Required	Training	30%
Loan	Medical Students	Optional	Training	65%
Loan Repayment	Practicing Providers	Required	Repay loans	69%
Direct Incentive	Practicing Providers	Required	Anything	57%

Source: Pathman et al, 2000; Pathman et al, 2004.

These four mechanisms are recruitment tools—they place physicians in underserved locations. The goal is for providers to have sufficiently positive experiences that retention is improved as providers remain in locations after financial incentives expire. In general, loan repayment programs tend to have the best retention and be the most efficient program to manage. One study found that the largest federal program of this type, the National Health Service Corps, increased supply in underserved communities by approximately 10%.[18] Although most of these programs deal exclusively with physicians, there has been a rapid increase in nursing incentive programs as well. For example, inventory of nursing incentive programs in an eight state region found over 80% of existing programs were instituted after 1988.[19]

North Carolina currently has two state-managed incentive programs:

- The Office of Rural Health and Community Care (ORHCC) manages a program to recruit providers to underserved areas that provides either loan repayment or a high-needs service bonus for those who have little or no loans.[g] Approximately 75% of all loan repayment and high-needs service bonus recipients fulfill their obligation. The maximum grant is $70,000 (plus 39% tax subsidy) over four years for physicians and dentists and $30,000 (plus 39% tax subsidy) over three years for PAs and NPs. In 2006, 52 grants were awarded. At the beginning of state fiscal year (SFY) 2007, 32 candidates were awaiting contracts due to inadequate funds in SFY 2006. The Office was able to contract with these candidates. In doing so, all SFY 2007 loan repayment and high-needs service bonus funds have been committed.[20] The state should appropriate additional funding to increase the number of providers recruited into underserved areas.
- The NC Student Loan Program for Health, Science, and Mathematics, managed by the NC State Education Assistance Authority, provides an in-school loan option for North Carolina residents.[21] This option is an additional incentive to encourage students to pursue practice in underserved areas. However, the maximum amount a student can borrow is $34,000 total for all four years. In 2004-2005, $261,635 was disbursed to 31 students pursuing medical degrees. For the past five years, the program has experienced an increase in eligible applicants, but the program is too new to track its success in keeping providers in North Carolina.

The NC Medical Society Foundation Community Practitioner Program is a private incentive program that pays up to one-half of the medical education debt of physicians, NPs, and PAs who agree to serve at least five years in an underserved area.[22] The program has had tremendous success after the participants complete their commitment. Nearly two-thirds of participants remain in the community after the five-year commitment. Nearly three-quarters remain in rural or economically distressed communities and over 80% remain in North Carolina.[23] The average grant is $50,000.

ORHCC, in the NC Department of Health and Human Services, has been an effective resource for communities in their efforts to recruit healthcare professionals. It has assisted rural communities in recruiting healthcare providers since its founding in 1973. Expanding the capabilities of ORHCC could increase both the number of providers looking to practice in rural areas as well as the ability of communities to offer attractive packages that meet the interests and capabilities of potential physicians. The market for physicians and other healthcare providers is national in scope, and the ability to increase provider supply in rural and underserved locations is enhanced if the appeal and visibility of rural underserved

g Personal communication with John Price, Assistant Director at the Office of Rural Health and Community Care, Raleigh, NC. September 2006.

communities is increased. Therefore, the NC General Assembly should appropriate $65,600 to ORHCC to expand the number of ORHCC staff who recruit practitioners into health professional shortage areas.

Recommendation 3.3. (Priority Recommendation)

The NC General Assembly should appropriate $1,915,600 to the NC Office of Rural Health and Community Care (ORHCC). Of this amount:

a) $350,000 should be appropriated to provide technical assistance to communities to help identify community needs and practice models that can best meet these needs and to provide technical assistance to small practices or solo practitioners practicing in medically underserved communities or serving underserved populations;

b) $1.5 million should be appropriated to pay for loan repayment and financial incentives to recruit and retain physicians, physician assistants, nurse practitioners, and certified nurse midwives to rural and underserved communities; and

c) $65,600 should be appropriated to expand the number of ORHCC staff who recruit practitioners into health professional shortage areas.

ORHCC should place a special emphasis on recruiting and retaining underrepresented minority, bilingual, and bicultural providers to work in underserved areas or with underserved populations.

Foundations also should help fund regional, multi-county demonstrations to test new models of care in rural and urban underserved areas. If successful in improving access, quality of care, and efficiency, these models should be supported by state and private insurers.

Recommendation 3.4. (Priority Recommendation)

North Carolina foundations should fund regional, multi-county demonstrations to test new models of care to serve patients in rural and urban underserved areas.

a) New models should be developed collaboratively between the NC Office of Rural Health and Community Care, NC Area Health Education Centers Program, healthcare systems, medical sehools, other health professions training programs, licensing boards, and other appropriate groups and should be designed to tcst new models of care that focus on integration of care, management of chronic illness, and prevention. Such models should emphasize the creation of medical homes and interdisciplinary practiee environments to enhance care to underserved populations.

b) New models should be evaluated to determine if they improve access, quality of care, and/or efficiency.

The State Health Plan, Division of Medical Assistance, and private insurers should modify reimbursement policies to support the long-term viability of successful models of care for underserved populations.

Retaining Providers

Retaining providers who work in underserved communities is very important. Research indicates that retention rates in underserved areas and areas with a high supply of providers are similar. However, when a provider leaves a rural or underserved area, it is often more noticeable and has a greater impact on the community than it does in a community with higher supply. Therefore, it is important to take steps to try to encourage providers to remain in underserved areas of practice. The three factors most closely associated with higher retention include a good match between the physician and community; satisfaction, especially with the community, and professional fulfillment; and ownership, or sense of control, in one's practice.[24]

When a provider leaves a rural or underserved area, it has a greater impact on the community than it does in a community with higher supply.

Programs that can help improve provider satisfaction and feelings of ownership often are related to practice patterns. Since ORHCC was first developed, it has assisted with implementation of many different types of healthcare practice models and has developed healthcare organizations that work in a variety of community settings. Examples include solo physician practices, with or without NPs and/or PAs, and multi-physician practices. The ORHCC portfolio of practice models allows the Office to tailor a practice model to particular needs and resources of the community, allowing the practice (and providers) to maximize the likelihood of a successful practice. ORHCC, in conjunction with the Community Practitioners Program, should expand technical assistance provided to communities to help identify community needs and practice models that can best meet community needs.

Another approach to improving retention in underserved communities is to introduce medical students to careers serving underserved populations or to assist medical students and residents interested in such service in acquiring the skills necessary to operate a successful practice in those communities. Studies indicate that brief exposure to rural areas in *medical school* does not seem to affect recruitment, but longer exposure (12-24 months) does increase selection of primary care as a specialty. Additionally, rural *residency* rotations appear to increase the likelihood of a physician choosing to practice in a rural area.[25] The longitudinal rural/underserved curriculum could be considered a component of Recommendation 2.9 in Chapter 2.

Physicians serving underserved communities may have difficulty covering practice costs and experience decreased efficiency, which can lead to greater provider dissatisfaction. Some of these factors can be directly addressed through policy interventions such as support for practice management systems, and others can be addressed by creating systems of care designed to increase efficiency or satisfaction with the practice environment. For example, improving the administrative skills of the practice manager and/or implementing electronic health records, coupled with automated billing systems, can improve quality and efficiency. These issues are discussed in more detail in Chapter 2. Creating systems of call coverage or hospitalists also can help improve the practice environment for physicians, particularly in rural communities where they may be solely responsible for weekend call coverage.

Hospitalists, support for call coverage, and after hours care:
One of the growing trends in hospital care across the state is use of hospitalist physicians (eg, doctors who become experts in and only provide care for hospitalized patients). This need is particularly acute in rural hospitals where services of these hospitalists help retain local primary care physicians by minimizing disruption of outpatient schedules and lowering intensity of night call. Most hospitalists receive their training from internal medicine residency programs that emphasize a comprehensive generalist approach (eg, the AHEC internal medicine residency programs).

Because they are so new, data on the optimal number of hospitalists and their exact impact on physician retention and quality of care is quite limited. Nevertheless, anecdotal evidence suggests both urban and rural hospitals are employing hospitalists in increasing numbers. Many people believe they are an essential component in stabilizing a hospital medical staff, creating a more attractive environment for ambulatory primary care physicians, and possibly improving the quality of care in the inpatient setting. It will be important to monitor continued growth in the use of hospitalists and its impact on recruitment and retention in underserved areas.

The services of hospitalists help retain local primary care physicians by minimizing disruption of outpatient schedules and lowering intensity of night call.

In addition to the problem with call coverage, physicians who are sole providers in the community face pressure to not take extended vacations or be away from the community. *Locum tenens* programs place a physician temporarily in the community while the local physician is on vacation. These opportunities to "recharge" can increase satisfaction of the physician and potentially prolong his or her stay in the community. Several *locum tenens* programs have been introduced in North Carolina. However, these programs encountered obstacles that forced them to end. Some of the problems included difficulties faced by *locum tenens* physicians who had to travel extensively and practice in a brand new environment with a different administrative and service structure at each location. Additionally, one program offered free *locum tenens* services, which made it difficult to sustain the necessary funding. New Mexico has developed a viable *locum tenens* program through the University of New Mexico. Since its formation, the program has received widespread support from faculty and residents, whose participation also was strongly encouraged and supported by the University's administration.[26] Between 1993 and 1997, 111 residents and 35 faculty members provided *locum tenens* services throughout New Mexico, which allowed residents to choose their *locum tenens* sites and compensated faculty for services rendered. Partial funding is provided for the program through a state appropriation, which helps cover meal and mileage costs for physicians providing *locum tenens* services, but the majority of program costs are covered through payments to the program for the *locum tenens* services. Practice sites pay an hourly fee that is approximately $10-20 greater than the wages paid to the physicians providing the services. Fees are on a sliding scale based upon type of service provided. Practice sites also cover costs of accommodations for those providing *locum tenens* services.[h] The important lessons learned from successful programs are to find physicians appropriate to provide *locum tenens* support and to support mechanisms that work.

h Additional information regarding New Mexico's program provided through a conversation with Mary Turner, Program Coordinator for the *Locum Tenens* Program, June 26, 2006.

The state should explore other financial incentives to recruit and retain providers in underserved areas. Some physicians would be interested in practicing in underserved communities but do not have the financial support to start a new practice in those areas. Providing help with the up-front costs of developing a new practice could be provided as an incentive to encourage providers to serve in underserved communities. The state also should consider use of tax credits or increased Medicaid, State Health Plan, or NC Health Choice reimbursement to encourage practitioners to locate in underserved areas or serve underserved populations. In addition, other types of support may be necessary to retain physicians in rural areas, including *locum tenens* or help with call coverage through the use of hospitalists.

Physicians and other healthcare practitioners enhance the economic well-being of rural and underserved communities in addition to providing positive health benefits.

Recommendation 3.5. (Priority Recommendation)

The NC General Assembly should explore financial incentives or other systems to encourage providers to establish and remain in practice in underserved areas or with underserved populations. Financial incentives may include, but not be limited to, tax credits or increased reimbursement. Other strategies to encourage providers to locate and practice in underserved areas or with underserved communities may include, but not be limited to, help with call coverage or use of hospitalists.

Economic development effects:
Provider supply helps increase access to care, which can lead to better health outcomes.[8,27,28,29] In addition, healthcare is a major industry in North Carolina, responsible for 6% of the value of all goods and services produced[30] and 11% of total wages and employment.[31] Healthcare, as a percentage of the state's economy has steadily grown over the last 7 years. For underserved communities, recruiting a provider may have community effects beyond the direct effect on population health. According to the US Census Bureau, in 2002 (the latest year available) 61,834 North Carolinians worked in 4,459 physician offices operating in the state with an annual payroll of over 3.5 billion dollars.[32] With approximately 17,000 physicians, simple estimates suggest that for every physician there are *at least* 2.5 other employees (although certainly this varies considerably depending on the size of the practice). This is similar to the AMA's estimate of 3.1 FTE nonphysician employees per physician.[33] In addition, physicians help support other healthcare institutions in a community. For example, hospitals rely on physicians to provide essential health services. In many rural communities, hospitals are one of the largest employers in the community. Without physicians and other healthcare practitioners, many of these healthcare institutions would close. Thus, physicians and other healthcare practitioners enhance the economic well-being of rural and underserved communities in addition to providing positive health benefits.[34]

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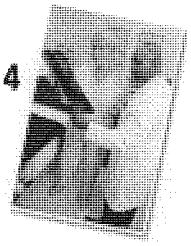
Examining Provider Need by Specialty Area

Chapter 4



Examining the overall supply of physicians and nonphysician clinicians can mask shortages in particular specialty areas and overlook the importance of having an appropriate mix of practitioners. The NC IOM Task Force on Primary Care[a] and Specialty Supply examined the overall supply of medical practitioners as well as the supply of specialty providers to determine if there are critical shortages.[b] The Task Force noted the need to ensure that North Carolina has an appropriate mix of provider types, especially with respect to primary care and specialty care, which are critical to cost-effectiveness and quality of care for the entire population.[1] The Task Force examined the supply of primary care providers, providers who deliver babies, general surgeons, and psychiatrists.

North Carolina needs to have an appropriate mix of provider types, especially with respect to primary and specialty care, which are critical to cost-effectiveness and quality of care for the entire population.

The Task Force was unable to explore supply issues related to every specialty. For example, the Task Force was unable to fully explore the adequacy of providers trained to address the needs of our aging population or to fully explore all the pediatric subspecialties. North Carolina's elderly population is growing rapidly, and individuals over the age of 65 make more office visits to providers than younger individuals. However, data limitations prevent accurate assessment of the supply of physicians who care for geriatric patients. Licensure data identify the physician's primary and secondary specialties but do not give any information on the type of patients the physician typically sees in practice. In 2005 there were 293 physicians who reported a primary or secondary specialty of geriatrics or family practice/geriatric; however, the number of physicians actually providing care to the elderly is higher. Older individuals may comprise a large percent of the patient population of family physicians, internists, and other primary care physicians, but the data do not capture this information. Similarly, the Task Force realized that the number of child-related specialty providers may be limited across the state, but it was not able to analyze all potential shortage areas. For this reason, in Chapter 2 the Task Force recommended support and expansion of the health workforce research center at the Cecil G. Sheps Center for Health Services Research. (Recommendation 2.1.) The workforce center could do a more comprehensive evaluation of potential shortage areas and identify needs for new data collection.

Available data indicate the overall supply of many provider types is probably sufficient to meet the current needs of the state's population. However, there is significant geographic maldistribution, which leads to the undersupply or insufficient mix of provider types in some areas.

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a Throughout this document, primary care providers are defined as those who indicate a primary specialty of general practice, family practice, internal medicine, obstetrics/gynecology, or pediatrics. Providers who choose a sub-specialty as their primary specialty are not included in these data.

b The licensure data used in this analysis are derived from the NC Health Professions Data System (HPDS). The HPDS is maintained by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. The system was initiated in 1975 to collect and disseminate timely and reliable data on licensed health professionals in North Carolina. Data on 18 health professions are collected with the cooperation of the independent health professional licensing boards. Data on physicians, physician assistants, and nurse practitioners are provided by the NC Medical Board. Data on certified nurse midwives are provided by the NC Midwifery Joint Committee. Support for the HPDS is provided by the NC Area Health Education Centers Program and the University of North Carolina Office of the Provost (Health Affairs).

Primary Care Providers

What is Primary Care and Who Provides It?

Primary care providers (PCPs) provide preventive, primary, and acute medical services that can address most of a person's healthcare needs. Primary care providers serve as the entry point into the healthcare system for most patients. Good primary care should be comprehensive, accessible to the patient, coordinated, and accountable and should provide for continuous care.[2] Primary care visits account for approximately one-half of all visits to physician offices.[3]

Primary care providers include physician assistants (PAs), nurse practitioners (NPs), certified nurse midwives (CNMs), and doctors both of allopathic medicine (MDs) and osteopathic medicine (DOs) who are family practitioners, general practitioners, internists, pediatricians, and obstetrician/gynecologists. Table 4.1 illustrates growth of primary care provider professionals between 2000 and 2005.

Table 4.1
North Carolina Primary Care* Provider Growth, 2000-2005

Active in Profession (October)[c]

	2000	2001	2002	2003	2004	2005	Percent Change (2000-2004)	Percent Change (2004-2005)
North Carolina Population	8,078,429	8,198,279	8,312,755	8,422,375	8,540,468	8,683,242	5.7%	1.7%
Total Primary Care Providers (physicians, NPs, PAs, CNMs)	8,480	9,022	9,434	9,650	9,916	10,226	16.9%	3.1%
Total Primary Care Physicians	6,696	6,908	7,125	7,265	7,401	7,660	10.5%	3.5%
Total Primary Care Allopathic Physicians (MD)	6,567	6,764	6,942	7,086	7,195	7,424	9.6%	3.2%
Total Primary Care Osteopathic Physicians (DO)	129	144	163	179	206	236	59.7%	14.6%
Family Practice	2,713	2,224	2,294	2,347	2,376	2,452	-12.4%	3.2%
General Practice	199	176	164	151	142	141	-28.6%	-0.7%
Internal Medicine	2,203	2,313	2,395	2,481	2,542	2,652	15.4%	4.3%
Obstetrics/Gynecology	919	937	955	960	981	988	6.8%	0.7%
Pediatrics	1,202	1,258	1,317	1,326	1,360	1,427	13.1%	4.9%
Primary Care Nurse Practitioners (NP)	826	1,016	1,144	1,198	1,259	1,287	52.4%	2.2%
Primary Care Physician Assistants (PA)	791	926	972	991	1,061	1,081	34.1%	1.9%
Certified Nurse Midwives (CNM)	167	172	193	196	195	198	16.8%	1.5%

* Primary care providers include those who indicate a primary specialty of general practice, family practice, internal medicine, obstetrics/gynecology, or pediatrics.
Source: NC Health Professions Data System. North Carolina State Demographics: Annual North Carolina Population Growth.

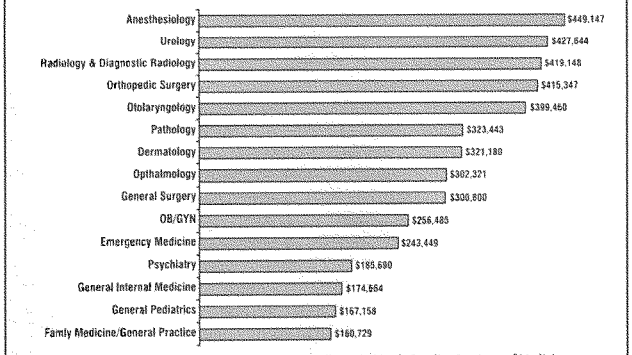
c Data are for in-state professionals and include physicians with an unknown activity status because these individuals are generally new graduates who have not yet secured employment at the time of data collection.

Primary care provider growth is occurring in the areas of internal medicine, obstetrics/gynecology, and pediatrics, and among NPs and PAs. However, evidence indicates that fewer providers of all types, including physicians, PAs, and NPs, are going into primary care than in the past. For example, between 1997 and 2005, the number of medical student graduates choosing primary care residencies dropped 50%.[4] Instead, students are moving into specialty areas. Similar trends are experienced among NPs and PAs.[5]

One reason for declining interest in primary care is that primary care physicians experience increased demands with lower overall reimbursement. The number of and need for recommended preventive and chronic care treatment services has increased to the point that it is impossible for physicians to provide all recommended care to their patient mix in a regular workday. A primary care practice serving a panel of 2,300 patients has to work more than seven hours a day to provide all recommended evidence-based preventive services to patients, plus more than 10 hours a day to provide all recommended services to patients with chronic illnesses.[5] Although the scope of care has increased, primary care provider reimbursement has decreased in inflation-adjusted dollars. Between 1995 and 2003, inflation-adjusted salaries decreased 7.1% for all physicians, but 10.2% for primary care physicians.[6] Primary care physicians are paid less for their services than are specialists, as insurers generally pay more for procedures and less for cognitive and diagnostic skills. (See Chart 4.1.) The median income of specialists is approximately twice that of primary care providers. In 1992, the Centers for Medicare and Medicaid Services developed a Resource-Based Relative Value Scale (RBRVS) fee schedule to assign payment rates for medical services in an effort to more fairly and accurately value all physician services. Despite these adjustments, which increased the relative value of physician evaluation and management work, some services continue to be undervalued while others are overvalued.[7] Many consider primary care services to be some of those most undervalued.

One reason for declining interest in primary care is that primary care physicians experience increased demands with lower overall reimbursement.

Chart 4.1
Median Physician Salary by Specialty, 2006



Source: Cohen J. Presented at: Primary Care and Specialty Summit, North Carolina Institute of Medicine; December 21, 2006. Citing MGMA Physician Compensation and Production Survey 2001-2006.

Trends away from primary care could impact population health.[8] Primary care is very important for preventing disease, increasing quality of care, and reducing costs. Evidence indicates that unnecessary hospitalization rates are higher in communities with limited access to primary care providers. Studies also show quality of care is higher and expenditures are lower in states with higher generalist-to-population ratios compared to those with higher specialist-to-population ratios.[4,8]

One way to encourage greater interest in primary care is to decrease payment inequities. To address payment inequities, the Task Force recommended:

Recommendation 4.1. (Priority Recommendation)

a) **The State Health Plan, Division of Medical Assistance, and private insurers should enhance payments to primary care providers to recognize the value of diagnostic and cognitive skills, particularly those payments that incentivize primary care providers to create comprehensive primary care homes that include lifestyle interventions, preventive health services, chronic disease management, and case management through use of case managers.**

b) **Reimbursement levels for primary care services through Medicaid, NC Health Choice, State Health Plan, and private insurers should be continually evaluated to ensure they are adequate to meet the costs of care across the state, particularly in underserved areas.**

As physicians continue to specialize and move away from primary care, the growth of NPs and PAs, who are more likely to work in primary care, is very important to the provision of primary care services. However, NPs and PAs are not necessarily complete replacements for primary care physicians because the scope of allowable activities for PAs and NPs is based, in part, on the services and tasks negotiated in the practice agreement with the supervising physician.[d] Thus, NPs and PAs may not be able to provide the full range of services provided by a physician. As a result, federal workforce programs calculate NPs and PAs as 0.50 the full-time equivalent (FTE) of a physician. Other research suggests that a more accurate FTE is in the range of 0.75.[e,9] The FTE for an individual NP or PA will vary by provider based on a number of factors including the provider's scope of practice, patient population/acuity, healthcare setting, supervisory agreement with the physician, and specialty.

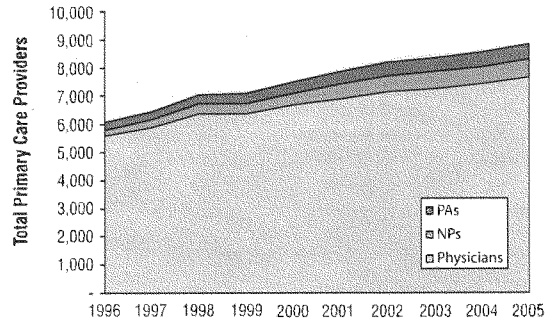
The FTE also is related to the environment in which an NP or PA practices. The National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, conducted an analysis of professional practice environments for NPs and PAs in each state. It found that, as of 2000, North Carolina had the most favorable practice environment for PAs and was the 10th most favorable practice environment for NPs.[10] Therefore, it is likely that the FTE for PAs and NPs in North Carolina would be on the higher end of the spectrum across the country.

d As with other healthcare providers, PAs or NPs may only provide the services that are consistent with their education, training, skills, and competence.

e The study was done for PAs, but in North Carolina NPs' scope of practice is substantially similar to that of PAs; therefore, the research is being extrapolated to NPs as well.

Depending on the equivalency used, NPs and PAs account for a varying portion of the primary care workforce in North Carolina. Based on the federal designation of 0.50 FTE, primary care NPs and PAs accounted for approximately 13% of total primary care providers in 2005. (See Chart 4.2.) On the other hand, using a research-based FTE such as 0.75, NPs and PAs accounted for approximately 19% of primary care providers in 2005. (See Chart 4.3.) Regardless of the FTE used, NPs and PAs account for an increasing percentage of primary care providers in the state and play an important role in providing primary care services. While they are critically important providers of care,

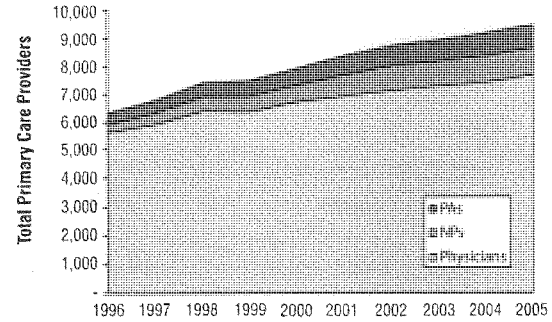
Chart 4.2
Total North Carolina Primary Care Workforce: Physicians, PAs, NPs Adjusted to Federal FTE Weight (50%)



Source: NC Health Professions Data System. FTE is full time equivalent.

NPs and PAs account for an increasing percentage of primary care providers in the state and play an important role in providing primary care services.

Chart 4.3
Total North Carolina Primary Care Workforce: Physicians, PAs, NPs Adjusted to Research-Based FTE Weight (75%)



Source: NC Health Professions Data System. FTE is full time equivalent.

it is unlikely they can completely fill the needs left by a decreasing growth rate in primary care physician supply. The state health professional workforce research center recommended in Chapter 2 would be a valuable entity for evaluating the supply and relative work of these different types of primary care providers. Furthermore, it could use that information to analyze the need for specific primary care provider types.

Primary Care Physicians

While recent data indicate overall primary care physician supply has experienced moderate annual growth (generally between 2-5%), there is a risk that this growth rate will fall below the population's growth rate in the near future. In recent years, the difference between North Carolina primary care physicians' growth rates and the state's population growth rate has narrowed. For the past five years the growth of primary care physicians has slowed, from a rate of 5.2% (between 1999-2000) to 1.9% (between 2003-2004).[11] Provisional data suggest that annual growth in primary care providers increased to 3.5% this year; however, because the North Carolina Medical Board has adopted a new registration system, it is unclear whether this is a one-year aberration or the beginning of an upward trend in primary care. North Carolina's annual population growth rate remained relatively stable throughout 2000 and 2004 (approximately 1.4%) but increased to 1.7% between 2004 and 2005.[11]

Regardless of aggregate state population and provider growth rates, county-level data indicate that over the past ten years North Carolina experienced an increase in the number of counties in which provider-to-population ratios declined. Table 4.2 illustrates between 2001 and 2005 30 counties experienced a decrease in primary care providers-to-population ratios compared to 11 counties between 1996 and 2000. Fourteen of the 30 counties with a decrease in primary care providers per population are persistent shortage areas, meaning they have been designated as primary care health profession shortage areas in six of the past seven years.

Table 4.2
Change in Primary Care Providers (Physicians, NPs, and PAs) per 10,000 Population (Number of counties)

	1996-2000		2001-2005	
County Type	Loss	Gain	Loss	Gain
Rural				
Not PHPSA*	4	35	12	27
Whole-County PHPSA	3	7	5	5
Part-County PHPSA	3	13	5	11
Urban				
Not PHPSA	1	22	4	19
Whole-County PHPSA	0	1	0	1
Part-County PHPSA	0	11	4	7
Total	11	89	30	70

*PHPSA is a persistent health professional shortage area, meaning the area has been designated as a health professional shortage area (HPSA) by the federal government for six of the previous seven years.

Source: NC Health Professions Data System.

There are a number of strategies that could be introduced in North Carolina to try to impact these changes in the primary care provider-to-population ratios. Some strategies focus on increasing the overall supply of providers; other strategies focus specifically on increasing primary care or other needed provider types. Some of these ideas are outlined in Chapter 2. They include increasing enrollment at North Carolina medical schools (see Recommendation 2.4); targeting state financial support to North Carolina health professions schools that produce the greatest proportion of professionals who meet healthcare needs of the state (see Recommendation 2.8); developing a new state-supported medical school (see Recommendation 2.5); and developing new primary care residency positions (see Recommendation 2.9).

Doctors of Osteopathy (DOs):
Osteopathic medicine is a field of medicine that includes additional training in the study of the body's musculoskeletal system and in hands-on diagnosis and treatment. Osteopaths often use a treatment method called manipulation, which involves gentle application of force to the body to promote movement of tissue, prevent abnormal movement, and release compressed bones and joints.[12] Osteopathic medicine emphasizes achieving wellness through health education, injury prevention, and disease prevention.[13] In North Carolina, 55% of all active DOs have a primary care specialty compared to 43% of all active physicians. Therefore, osteopathic physicians could play an important role in providing primary care services in North Carolina. In 2005, DOs accounted for only 3.1% of primary care physicians practicing in the state. Nonetheless, osteopathic medicine is growing rapidly, and between 1995 and 2005 the number of practicing DOs increased 298% (108 to 430). During that time, 69 counties experienced an increase in the DO-to-population ratio, and only seven counties experienced a decrease. The other 24 counties had no DO in either year.

Osteopathic physicians could play an important role in providing primary care services in North Carolina.

There are only 26 osteopathic physician training programs across the country, and none are located in North Carolina.[14] Doctor of Osteopathy programs will soon produce over 3,500 medical graduates per year, but only approximately 50 of those students will be from North Carolina. Strategies to expand the DO population in North Carolina, particularly those practicing primary care, include financially supporting North Carolina osteopathic students to train in other states in exchange for returning to practice in North Carolina, developing an osteopathic training program in North Carolina, and developing joint American Osteopathic Association-approved primary care residency positions in the state. (See Recommendations 2.5, 2.6, and 2.10.)

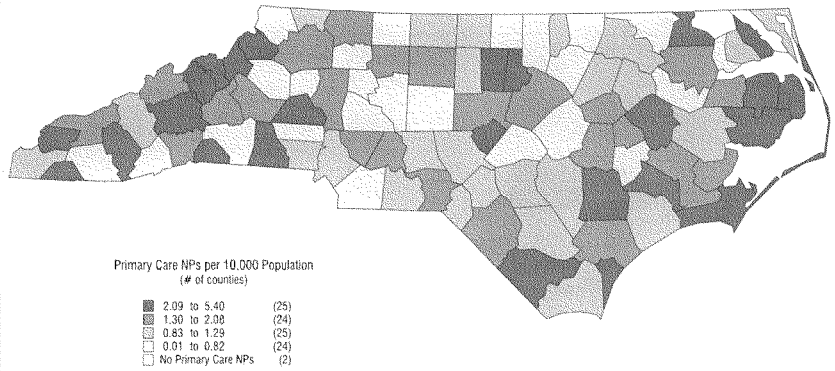
Nurse Practitioners and Physician Assistants

The numbers of NPs and PAs have increased over the last decade. Between 2001 and 2005, both the number of NPs and the number of PAs practicing in North Carolina grew by 32%.[15,16] In 2005, there were 2,440 NPs and 2,674 PAs practicing in the state. The supply of both professions has grown faster than the population in recent years.

Nurse Practitioners:
Between 2001 and 2005, 63 of North Carolina's counties experienced an increase in the NP-to-population ratio. Thirty-six counties saw a decrease in the ratio while

one had no NP in either year. Two counties, Camden and Gates, have no NP practicing in the area, while Mecklenburg (243), Durham (235), and Wake (199) counties have the most total NPs. The greatest concentrations of NPs per 10,000 population are located along the western and eastern borders of the state and in the very center. (See Map 4.1.) The counties with the highest NP-to-10,000 population ratios are Durham, Orange, and Hyde counties. According to an analysis of practice environments by the National Center for Health Workforce Analysis, North Carolina has the tenth most favorable practice environment for NPs.[f,10]

Map 4.1
Primary Care Nurse Practitioners per 10,000 Population, North Carolina, 2005



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2005.

Counts include active, instate, nurse practitioners indicating a primary specialty of family practice, general practice, internal medicine, ob/gyn or pediatrics.

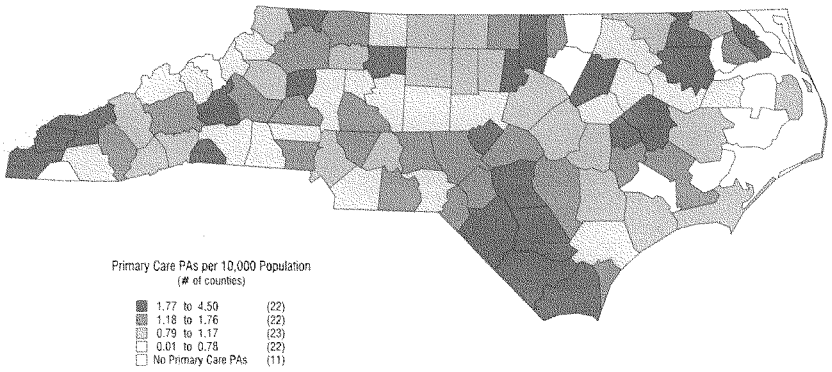
Physician Assistants:
The 7.0% (+176) increase in PAs from 2004 to 2005 continues a pattern of growth. In 2005, 52 counties increased their PA-to-population ratio, and 44 counties decreased their PA-to-population ratio. An additional four counties had no PAs in either year. The counties with the largest PA-to-10,000 population ratios are widely distributed across the state. (See Map 4.2).

Currently, PAs view North Carolina as having a regulatory environment conducive to practice. In a national study that examined practice environments for PAs, North Carolina was considered to have the most positive practice environment for

f The factors that keep North Carolina from being one of the most favorable practice environments for NPs, according to the National Center for Health Workforce Analysis, include not having a specific NP licensure, language mentioning a collaborative relationship with a physician, regulation by the Board of Nursing with another entity, the necessity to have a written practice agreement, and periodic review of records by a physician.

PAs.[g,17] Further, the authors found that a positive practice environment was strongly correlated with supply of PAs. Legislators and regulators should be vigilant so as to avoid regressive moves to restrict practice unless there is compelling evidence that such moves are needed to protect the citizens of North Carolina.

Map 4.2
Primary Care Physician Assistants per 10,000 Population, North Carolina, 2005



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2005.

Counts include active, instate physician assistants indicating a primary specialty of family practice, general practice, internal medicine, ob/gyn or pediatrics.

NPs and PAs offer a valuable opportunity to more quickly increase the number of primary care providers in North Carolina. Training NPs and PAs takes between two and three years, on average, compared to more than four years for medical school and approximately three years of residency training for a physician. Thus, compared to training physicians, it is less costly to train NPs and PAs, and it is possible to see a more rapid increase in the available provider population. Furthermore, NPs and PAs provide a significant amount of care in rural areas compared to their physician counterparts. Between 2001 and 2005, almost half (47%) of the 264 primary care providers gained in rural North Carolina counties were either NPs or PAs. NPs and PAs comprised 26% of total primary care providers in rural counties in 2001 and 28% in 2005. In 2005, they accounted for 42% of total primary care providers in whole-county persistent health professional shortage areas (PHPSAs) compared to 23% of primary care providers in counties not designated as PHPSAs.

g The authors examined the states' legal, reimbursement, and prescriptive authority for PAs in establishing the rating system for PAs' practice environment. North Carolina, Oregon, and Montana were the only states that were rated as having an excellent practice environment.

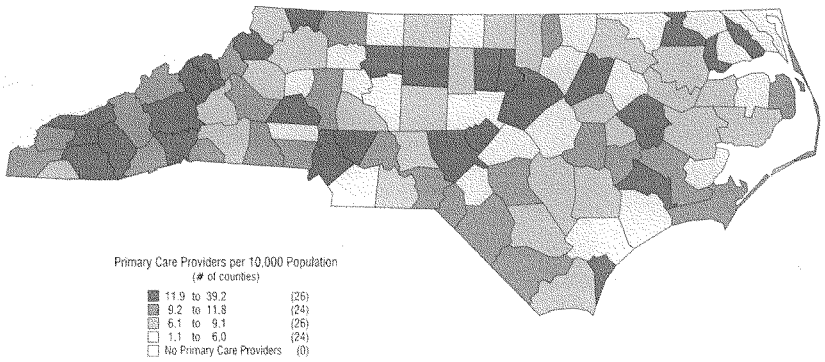
Strategies for increasing the supply of NPs and PAs include increasing student enrollment in North Carolina NP and PA programs, developing a new PA training program in North Carolina, and maintaining or improving the regulatory environment for NPs and PAs. (See Recommendations 2.7, 2.8, and 2.12.)

Obstetrician-Gynecologists and Certified Nurse Midwives:
Many obstetrician-gynecologists (OB-GYNs) and CNMs serve as primary care providers for women. Increasing their supply also can help address primary care shortages. Strategies to increase the supply of OB-GYNs and CNMs are discussed more fully in the section below on Providers Delivering Babies.

Primary Care Provider Distribution Is a Major Challenge Currently Facing the State

While the current supply of primary care providers may be adequate to meet the healthcare needs of most North Carolinians, providers are not well distributed across the state. Maldistribution of healthcare providers has historically been a problem in North Carolina and in the rest of the nation, particularly in rural areas. The problem appears to be getting worse after several years of improvement. Fifty-eight counties have primary care provider-to-10,000 population ratios below the state average (9.8 per 10,000 population). Map 4.3 illustrates ratios are typically larger in urban areas, but there also are large proportions in some less-populated areas, especially in the western part of the state.[16]

Map 4.3
Total Primary Care Workforce: Physicians, Physician Assistants, and Nurse Practitioners, North Carolina, 2005



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2005.

Counts include active, instate, nonfederal, non-resident-in-training physician assistants, nurse practitioners, and physicians indicating a primary specialty of family practice, general practice, internal medicine, ob/gyn or pediatrics.

Although there were increases in the primary care provider-to-population ratio in health professional shortage areas (HPSAs)[h] between 1979 and 2001, beginning in 2002 that ratio leveled off. The most recent (2005) data indicate a slight drop in whole-county HPSA primary care provider-to-population ratios. Rural areas face more critical shortages than most urban areas. For example, in 2005 all 11 of the whole-county HPSAs in the state were rural.[11]

The most significant immediate problem with primary care provider supply is distribution of providers across the state. Strategies to address such maldistribution are outlined in Chapters 2 and 3. They include using new state financial support for health professions training programs to encourage or reward programs producing providers who serve in underserved communities in North Carolina (Recommendations 2.8 and 2.9); increasing funding for loan repayment or other financial incentives to recruit and retain providers in underserved areas (Recommendations 3.3 and 3.5); and providing funding to support *locum tenens* programs or other systems of support to help providers establish and remain in practice in underserved areas (Recommendations 2.14 and 3.5).

Ensuring that women have continuous and early prenatal care is critical to the well-being of the infant and mother.

Providers Who Deliver Babies[i]

There were 119,773 live births in North Carolina in 2004.[18] The number of births grew in the mid-1990s but then held relatively stable at approximately 120,000 for the last five years. By 2020, state demographers expect approximately 135,000 live births per year.[19] Ensuring that women have continuous and early prenatal care is critical to the well-being of the infant and mother. Women need access to physicians and other clinicians who are trained to deliver babies and who can address any complications that might arise during delivery.

Most births occur in hospitals and are attended by physicians, generally obstetrician-gynecologists (OB-GYNs) or family physicians. In 2004, 89.4% of births in North Carolina hospitals were attended by physicians, and 10% were attended by CNMs.[18] The number of births attended by CNMs has increased steadily since 1990, when only approximately 2% of all births were attended by midwives.[20]

There has been steady growth in the number of OB-GYNs over the last five years (2000-2004); however, not all OB-GYNs deliver babies. The percentage of OB-GYNs delivering babies increased gradually over the same time period until 2003 when both the number and percentage of OB-GYNs who reported delivering babies declined. (See Table 4.3.) There has been a more precipitous drop in the number of family physicians who report delivering babies. Between 2003 and 2004, the number of family physicians delivering babies declined by 12% (from 232 in 2003

h The Bureau of Health Professions in the US Department of Health and Human Services has designated certain communities, population groups, or medical facilities as Health Professional Shortage Areas (HPSAs). Certain counties, or parts thereof, will be designated as HPSAs if they have more than 3,500 people per primary care provider. Population groups can be designated as HPSAs if they have specific access barriers, and there is a high ratio of people in that population group to practitioners serving the population. For more information on HPSA designations, see Chapter 3.

i Data for providers delivering babies will be based on 2004 data collected by the NC Health Professions Data System. 2005 data had too many missing values to be reliable for comparing changes in the numbers and percentages of providers delivering babies compared to previous years.

to 205 in 2004). Of the 101 physicians who stopped providing deliveries between 2003 and 2004, 56 (56%) were family physicians.[21] Family physicians who offer delivery and prenatal services are extremely valuable in rural areas, where they provide over a quarter of the prenatal (33%) and delivery services (26%) available in rural communities.[11] Recently, some advocates have recommended removing obstetrical training from family physician training, but such a move could have a strong negative impact on the prenatal and delivery services available in rural communities.

While the overall supply of providers who offer prenatal care and deliveries may currently be adequate, there is a maldistribution issue.

Table 4.3
North Carolina Providers Delivering Babies, 2000-2004

	2000	2001	2002	2003	2004
Total Live Births	**120,245**	**118,112**	**117,307**	**118,292**	**119,773**
OB-GYNs total	919	937	954	960	981
OB-GYNs delivering	651	701	742	750	748
% OB-GYNs delivering	70.8%	74.8%	77.8%	78.1%	76.2%
Family Physicians (FPs)	2,173	2,224	2,293	2,327	2,040
FPs delivering	212	227	228	232	205
% FPs delivering	9.8%	10.2%	9.9%	10.0%	10.0%
Total Physicians delivering	863	928	970	982	953
Births/physicians	139.3	127.3	120.9	120.5	125.7
CNMs	167	172	193	196	195

Source: NC Health Professions Data System.

At this point, it is unclear whether the one-year decline in physicians delivering babies is the beginning of a trend or a one-year aberration. Providers who deliver babies have experienced a significant increase in malpractice premiums in recent years. For example, between 2001 and 2002, premiums for OB-GYNs increased 15%.[22] Increased liability insurance costs may deter some providers from offering delivery services. North Carolina state government used to offer payments to help rural practitioners who delivered babies offset some of their malpractice costs through a program called the Rural Obstetrical Care Incentive (ROCI) Program. This program, which ran from 1988 through 2001, had a beneficial impact on retention of rural providers who deliver babies.[23]

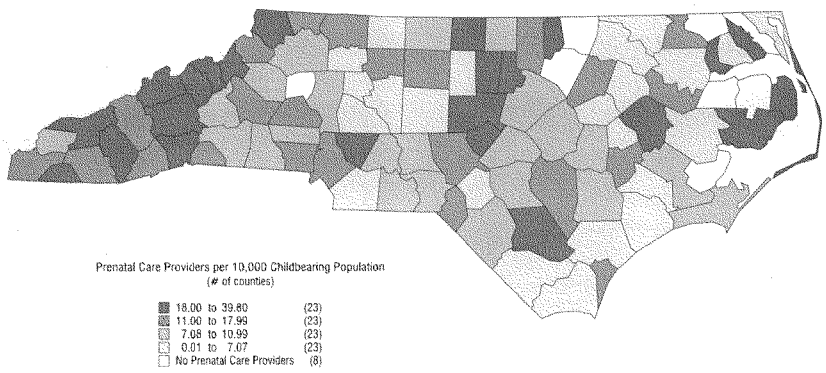
CNMs also are licensed to provide prenatal, intrapartum, postpartum, newborn, and family planning services. In 2004, there were 195 CNMs licensed to practice in North Carolina. CNMs practice in a variety of settings, including private practice, health departments, federally qualified health centers, hospitals, and university settings. Most CNMs provide prenatal care, but not all CNMs deliver babies.[j] Under state law, a CNM must have a supervising physician in order to practice;[24] thus CNMs can deliver babies only in communities where they have arrangements

j CNMs are not required to report on their licensure file whether they deliver babies. However, in a survey of CNMs in the state, 10% of CNMs (14) who responded to the survey (137) reported they did not attend births. Most midwives who attend births deliver 80 or fewer babies per year. Personal correspondence from Francie Likis, CNM, doctoral candidate at the University of North Carolina at Chapel Hill, April 3, 2006.

with supervising physicians. High malpractice costs also are an issue for CNMs who deliver babies. CNMs face a number of challenges with respect to their practice environment in North Carolina. A study by the National Center for Health Workforce Analysis of the most favorable professional practice environments for CNMs in each state found North Carolina ranked 24th among states.[k,10] This ranking is less favorable than the practice environment for PAs (top rank) or NPs (tenth).

While the overall supply of providers who offer prenatal care and deliveries may currently be adequate, there is a maldistribution issue. Currently 13 counties in the state have no physicians reporting a practice location[l] that provides prenatal care services. Eight of these counties have no providers (physician, CNM, PA, NP) who report providing prenatal care on their licensure files. (See Map 4.4.) Community members in these counties have access to some prenatal care through their local health departments, but delivery services would not be available in these counties. Even in counties with prenatal providers, there is wide variation in the ratio of providers to women of childbearing age.

Map 4.4
Prenatal Care Providers per 10,000 Childbearing Population, North Carolina, 2004



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from North Carolina Medical Board and North Carolina Board of Nursing, 2004.

Counts include active, in-state, non-federal, non-resident-in-training physicians, PAs, and NPs who report providing prenatal care, and also includes CNMs. Counts for physicians, PAs, and NPs include primary, secondary, and other practice location. Childbearing age: 15-44.

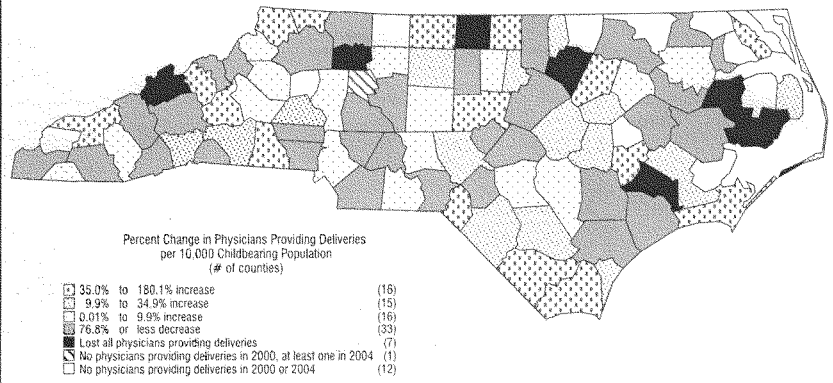
k According to a study conducted by the National Center for Health Workforce Analysis in 2000, some of the factors restricting the positive practice environment for CNMs in North Carolina include regulation involving the Board of Medicine, a restricted scope of practice, the inability to practice autonomously, and the inclusion of physician supervisory language in practice statutes.

l These data include physicians' reports of primary, secondary, and tertiary practice locations.

There is even more of a maldistribution issue for physicians who deliver babies. There are currently 19 counties without physicians who report delivering babies; 12 of these counties have not had a physician deliver a baby in the last five years.[m] More than one-half of all North Carolina counties (52) had either a decline in the ratio of physicians delivering babies to women of childbearing years over the last five years (40 counties) or no physicians providing deliveries in either 2000 or 2004 (12 counties). Almost two-thirds (63%) of counties with no physicians delivering babies in 2004 were health professional shortage areas as were 45% of other counties that experienced a decrease in the ratio of physicians providing deliveries to the population.[n] However, loss of physicians delivering babies appears to have a minimal impact on average distance traveled to deliver babies.[25]

Strategies for increasing access to prenatal care and delivery services can be targeted either to increasing overall supply of providers offering obstetrics/gynecology services

Map 4.5
Percent Change in Physicians Performing Deliveries per 10,000 Childbearing Population, North Carolina, 2000-2004



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2000-2004.

Counts include active, in-state, non-federal, non-resident-in-training physicians who report providing obstetric deliveries. Counts include primary, secondary, and other practice location. Childbearing age: 15-44 years.

m The counties with no physicians providing deliveries in 2000 or 2004 include Alexander, Camden, Currituck, Gates, Graham, Greene, Northampton, Pamlico, Perquimans, Stokes, Tyrrell, and Warren. The counties that had at least one physician delivering babies in 2000 but none in 2004 include Caswell, Franklin, Hyde, Jones, Madison, Washington, and Yadkin.

n Fifteen of the 33 counties (45%) that experienced a loss in the ratio of physicians providing deliveries per childbearing population; four of the seven counties (57%) that had at least one physician providing deliveries in 2000 but none in 2004; and eight of the 12 counties (67%) that had no physicians delivering babies in either 2000 or 2004 were health professional shortage areas in 2005.

or addressing unequal distribution of such providers across the state. Given the maldistribution of providers, it is important to encourage use of CNMs in low-provider areas. In this effort, it is important to support a more positive practice environment for CNMs across the state. Strategies for addressing the maldistribution issue include providing more funding to the Office of Rural Health and Community Care to expand their efforts to place providers in underserved areas (Recommendation 3.3), changing admission policies in medical schools and other health professions programs to accept more students from underserved areas and offer students training opportunities in these communities (Recommendations 2.9 and 3.2), and creating other incentives or practice support to assist providers who establish practice in underserved communities (Recommendation 3.5). Other recommendations follow below.

Recommendation 4.2.

The NC OB/GYN Society, NC Area Health Education Centers Program, East Carolina University Nurse Midwifery program, NC Academy of Family Physicians, and North Carolina medical schools should change the practice environment to encourage acceptance of certified nurse midwives into practice.

Recommendation 4.3.

The NC General Assembly should appropriate $206,000 annually to expand the East Carolina University Nurse Midwifery program by 30%.

Recommendation 4.4. (Priority Recommendation)

The NC General Assembly should appropriate $2 million to provide malpractice premium subsidies (similar to the Rural Obstetrical Care Incentive Program) for physicians and certified nurse midwives who provide delivery services in medically underserved areas.

General Surgeons

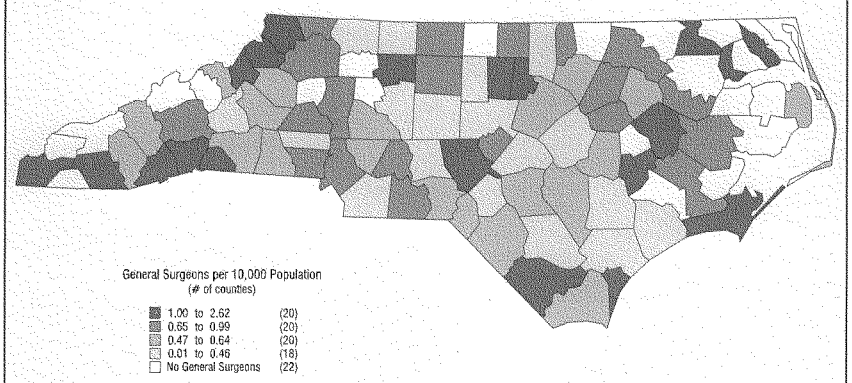
Population growth and, particularly, aging of the population are increasing demand for all medical services including surgeries. Older individuals use more medical services than younger populations. Therefore, increased life expectancy and retirement of the baby boomer generation will have, beginning in 2011, a profound effect on need for surgical services in the future. Research indicates that utilization rates of surgical services will surpass overall population growth rates.[26] Traditionally, general surgeons have provided a significant amount of needed surgical care, including care in the following nine content areas: alimentary tract surgery, surgery of the abdomen, breast/skin/soft tissue surgery, head/neck surgery, vascular surgery, endocrine surgery, surgical oncology, management of trauma, and care of critically ill patients with underlying surgical conditions.[27]

North Carolina has more general surgeons per 10,000 population (0.75) than the nation as a whole (0.60) or the south (0.64). However, access to surgeons varies drastically in different areas of North Carolina. In 2005, North Carolina had 22 counties with no surgeons,[o] while another 35 counties had below the state average

o The counties with no general surgeons include Alexander, Bertie, Bladen, Camden, Caswell, Clay, Currituck, Gates, Graham, Greene, Hyde, Jones, Madison, Northampton, Pamlico, Perquimans, Swain, Tyrrell, Warren, Yadkin, and Yancey.

of 0.62 general surgeons to 10,000 population. The majority of the counties with no surgeons or fewer than 0.62 surgeons per 10,000 population are found in the eastern and western parts of the state. (See Map 4.6.)

Map 4.6
General Surgeons per 10,000 Population, North Carolina, 2005



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2005.

Counts include active, instate, non-federal, non-resident-in-training physicians indicating a primary specialty of general surgery.

Between 1995 and 2005, 47 North Carolina counties experienced a decline in the number of general surgeons per population, and another four lost all general surgeons. Eighteen counties had no surgeons in either year. Only 31 counties experienced an increase in the ratio. More recent trends from the last five years (2000-2005) indicate an even more alarming development, with 53 counties experiencing a reduction of general surgeons and five counties losing all general surgeons. Seventeen counties had no general surgeons in either year. Only 25 counties had an increase in general surgeon supply. (See Table 4.4 and Map 4.7.)

A number of different issues may be contributing to the decline in general surgeons in North Carolina and across the nation, including decreased interest in general surgery as a career; increased demand for specialists; less interest in surgery than other medical specialties among women who now represent an increasing percentage of the physician workforce; and aging of the general surgery workforce. Surgical training programs have had limited success attracting women. Between the academic years 1996-1997 and 2001-2002, women accounted for almost 43% of US medical graduates, but in academic year 2002-2003 they accounted for only 25% of general surgery residents.[27]

General surgery is not only less attractive to women, it is losing popularity among both genders. In 1987, 7.8% of medical students across the country chose general

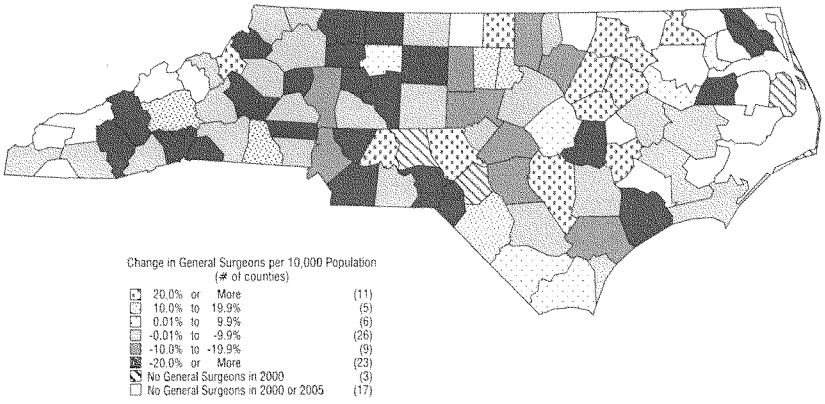
surgery as a career compared to only 5.8% in 2002.[28] In addition, the general surgical residency attrition rate reached 20% in 2000. This decline in general surgery interest may reflect medical students' perceptions that general surgeons have poorer quality of life because of relatively long work hours and intensive training.[26,27] In fact, data indicate general surgery residents traditionally work more hours per week than residents in

Table 4.4
Percent Change in General Surgeons per 10,000 Population, North Carolina (Number of counties)

Percent of Change	Number of counties 1995-2005	Number of counties 2000-2005
20% or More	19	11
10% to 19.9%	6	5
0.01% to 9.9%	5	6
-0.01% to -9.9%	14	26
-10% to -19.9%	11	9
-20% or More	22	18
Lost all General Surgeons (decrease)	4	5
No General Surgeons in initial year (increase)	1	3
No General Surgeons either year (no change)	18	17

Source: NC Health Professions Data System.

Map 4.7
Percent Change in General Surgeons per 10,000 Population, North Carolina, 2000-2005



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2000 & 2005.

Counts include active, instate, non-federal, non-resident-in-training physicians indicating a primary specialty of general surgery.

other specialties.[28] There also is increased demand for specialists as a result of foci on healthcare quality and standards.[27] Technical developments in surgery also may influence medical student career choice away from general surgery.[28] A trend is growing among general surgeons toward progressive specialization during the fellowship following residency training. Progressive specialization occurs when physicians voluntarily narrow their scope of practice within the course of their training.

A decline in general surgeons will likely have the largest negative impact on rural areas. Aging of the general surgery population is of greatest concern to small/isolated rural areas because general surgeons aged 50 years or older, a group likelier to retire sooner, are significantly more likely to live in those areas compared to urban areas.[29] Furthermore, general surgeons are integral to the sustainability of many rural hospitals. General surgeons generate valuable revenue for rural hospitals, and many hospital administrators see general surgery as a key component of a rural hospital's financial viability.[30] Certain aspects of rural practice pose challenges for general surgeons, including changing referral patterns, limited reimbursement, rural hospital closures, and recruitment difficulties. Fortunately, some of the reduction in general surgery interest by US allopathic medical students is offset by international medical graduates (IMGs).[28] In fact, IMG general surgeons are more likely to work in rural areas than in urban areas.[29]

Certain aspects of rural practice pose challenges for general surgeons, including changing referral patterns, limited reimbursement, rural hospital closures, and recruitment difficulties.

Strategies for addressing overall supply and maldistribution issues related to general surgeons in North Carolina include those focused on overall supply and maldistribution issues. Related to overall supply, state funding should support academic health centers that increase the number of providers who obtain qualifications for and practice in shortage specialties such as general surgery and report their data to the Health Workforce Policy Board. (See Recommendation 2.8.) Additionally, funding could be provided to expand the number of general surgery residency positions. (See Recommendation 2.9.) Special consideration should be given to funding a track in an existing residency program that focuses on training general surgeons for rural practice. To improve distribution, strategies include providing more funding for loan repayment programs to general surgeons in underserved areas or developing a *locum tenens* program to give general surgeons time off. (See Recommendations 3.3 and 3.5.)

Psychiatrists[p]

Nationally, in a given year almost one-third of nonelderly adults experience a mental disorder.[31] A sizable number of children also have behavioral or emotional disorders. Nearly 15% of North Carolina children exhibit a behavioral disorder such as attention deficit disorder, anxiety, or depression.[32] Despite the widespread need, most individuals with serious mental problems do not receive treatment. Factors limiting access to needed services include the stigma attached to mental illness and inadequate supply or maldistribution of mental health professionals who are able to treat people using both medications and psychotherapy. Some people who need mental health services are unable to afford care because they lack health

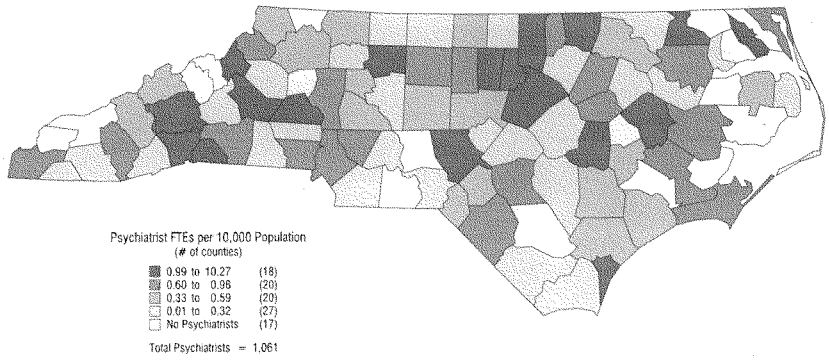
p Excerpted, with permission, from: Fraher E, Swartz M, Gaul K. The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform. 2006. Available at: http://www.shepscenter.unc.edu/hp/Psychiatrist_Brief.pdf. Accessed May 2, 2006.

insurance coverage or, if insured, they may have less comprehensive coverage for mental and behavioral health services than they have for other health services.

Many types of health professionals treat mental health disorders, including, but not limited to, psychiatrists, psychologists, primary care providers, social workers, and clinical nurse specialists. While these practitioners are all trained to treat people with mental disorders, certain patients need consultation and treatment by psychiatrists, who are able to treat people using medicine and psychotherapy. Psychiatrists are generally among the lowest paid of physician specialties, which may discourage some physicians from choosing to specialize in psychiatry. (See Chart 4.1.)

North Carolina has a higher psychiatrist-to-population ratio than most other states in the south with the exception of Virginia.[33] North Carolina has 2.4 psychiatrists per 10,000 population. Between 1995 and 2004, the ratio of psychiatrist-to-population remained relatively steady. However, psychiatrists are not evenly distributed throughout the state. In 2004, there were 17 counties with no psychiatrists,[q] and another 27 counties with ratios low enough (0.33 or below) to be designated as mental health professional shortage areas.[24] Psychiatrists are most heavily located close to the state's four mental health hospitals, in counties with major medical centers, and in large metropolitan areas. (See Map 4.8.)

Map 4.8
Psychiatrist Full-Time Equivalents per 10,000 Population, North Carolina, 2004



Source: North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with data derived from the North Carolina Medical Board, 2004.

Psychiatrists include active (or unknown activity status), instate, nonfederal, non-resident-in-training physicians who indicate a primary specialty of psychiatry, child psychiatry, psychoanalysis, psychosomatic med, addiction/chemical dependency, forensic psychiatry, or geriatric psychiatry, and secondary specialties in psychiatry, child psychiatry and forensic psychiatry.

q The counties with zero full-time equivalent psychiatrists in 2004 include Alexander, Alleghany, Anson, Bladen, Camden, Gates, Graham, Greene, Hyde, Jones, Mitchell, Montgomery, Pamlico, Perquimans, Swain, Washington, and Yancey.

Between 1999 and 2004, nearly two-thirds of North Carolina counties either experienced a decline in the proportion of psychiatrists-to-population or had no psychiatrists. Five counties lost all their psychiatrists, 48 counties experienced a decline in the ratio of psychiatrists-to-population, and 12 counties had no psychiatrists in either 1999 or 2004. North Carolina's mental health reform also has had an impact on the provision of care to mental health patients in the public sector. Mental health services in North Carolina are coordinated by local management entities (LMEs). Between 2003 and 2005, the number of LME psychiatrists' per capita fell 16%. Per capita losses were higher in rural areas (20%) compared to urban areas (14%), and small population LMEs lost 44% of their psychiatrists.[35]

Between 1999 and 2004, nearly two-thirds of North Carolina counties either experienced a decline in the proportion of psychiatrists-to-population or had no psychiatrists.

In general, psychiatrists are less likely than all other physicians to locate in rural areas or in health professional shortage areas. (See Table 4.5.) In 2004, 15.6% of psychiatrists had their primary practice in a nonmetropolitan county, compared to 21.6% of physicians with other specialties. Similarly, 28.5% of psychiatrists were located in areas that were designated as health professional shortage areas compared to 37.9% of other physicians.

Table 4.5
Primary Practice Location of Psychiatrists and Non-Psychiatrist Physicians, North Carolina, 2004

	Non-metropolitan counties	Metropolitan counties	Whole-county HPSAs	Part-county HPSAs	Not a HPSA
Psychiatrists (%)	15.6%	84.4%	2.1%	26.4%	71.5%
All other physicians (%)	21.6%	78.4%	3.3%	34.6%	62.1%
Ratio of Psychiatrists per 10,000 population	0.58	1.49	0.30	0.83	1.63

Source: Fraher E, Swartz M, Gaul K. *The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform.* 2006. Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research.

In the absence of psychiatrists, primary care providers are often faced with the responsibility of diagnosing and managing the care of people with mental illness. However, seven of the 17 counties with no psychiatrists also are whole-county primary care health professional shortage areas. Viewed from another perspective, 11 of the 19 counties that have persistently (six out of the last seven years) been designated as primary care health professional shortage areas also are designated as mental health professional shortage areas.

The supply of child psychiatrists is even more limited. In 2004, 43 counties had no child psychiatrists, and another 42 counties had less than one child psychiatrist per 10,000 population age 18 and younger. Further, the supply of physicians with a primary specialty in child psychiatry has declined 24% over the past decade.

Strategies to address such shortages may target overall supply and education, distribution of providers across North Carolina, and new models of care. A strategy

r LME psychiatrists include those that are directly employed by the LME, individually contracted, or contracted through a provider agency or member of the provider community.

focused on overall supply includes targeting state funding to support academic health centers that increase the number of providers who obtain qualifications for and practice in shortage specialties such as psychiatry and report their data to the Health Workforce Policy Board. A recommendation focused on addressing maldistribution concerns includes increasing funding to the Office of Rural Health and Community Care to increase recruitment efforts to shortage areas. (See Recommendation 3.3 in Chapter 3.) Another includes increasing funding to the NC Area Health Education Centers Program to expand residency positions in child psychiatry and general psychiatry. (See Recommendation 2.9.) Residency funds should be targeted to adding residency positions as well as providing funding to create model community-based teaching sites to prepare psychiatrists to serve rural and other underserved populations. Additional funds are required to provide incentives to residents and other trainees to participate in rotations in underserved communities. Other recommendations related to these strategies are listed below.

In the absence of psychiatrists, primary care providers are often faced with the responsibility of diagnosing and managing the care of people with mental illness.

Recommendation 4.5.

North Carolina medical schools and other health professions programs, specialty societies, and the NC Area Health Education Centers Program should strengthen and expand the mental and behavioral health and psychopharmacology components of training and continuing education to increase competencies in mental and behavioral healthcare for all graduates, with a special emphasis in integrating behavioral health and primary care. Innovative approaches may include special tracks in psychology/behavioral health, better integration of behavioral health content into current curricula, postgraduate programs in behavioral health, and education for psychiatrists and other mental health in working collaboratively with primary care professionals in more integrated models of care.

Recommendation 4.6. (Priority Recommendation)

The NC General Assembly and the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should provide funding to targeted rural communities to establish new models of care to serve public patients in rural and underserved communities.

a) New models of care should be developed collaboratively with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the NC Area Health Education Centers Program, the NC Office of Rural Health and Community Care, academic healthcare institutions, and primary care and specialty societies.

b) Models should include psychiatrists and other mental health professionals and have close linkages to primary care providers in the service area.

c) To improve the professional environment in these settings, these sites should qualify for higher levels of reimbursement, have strong linkages to academic health centers, and have a strong focus on integrated care.

Recommendation 4.7. (Priority Recommendation)

The NC General Assembly, public and private insurers, and payers (including, but not limited to, the State Health Plan, NC Division of Medical Assistance, and NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services) should pay for:

a) psychiatric consultations for primary care providers and other clinicians either through face-to-face consultations or telemedicine; and

b) services provided by primary care providers to patients who have been diagnosed with a psychiatric diagnosis.

Reimbursement levels for mental and behavioral health services through Medicaid, NC Health Choice, State Health Plan, and other payers should be continually evaluated to ensure they are adequate to meet the costs of care across the state, particularly in underserved areas.

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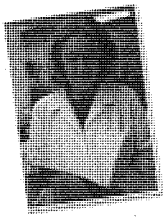
Underrepresented Minorities in the Health Professions

Chapter 5



Minority populations comprise almost one-third of the state's population. African Americans, American Indians, and Hispanics have lower per capita incomes and, as a result, are more likely to lack health insurance[1] or rely on publicly-funded health insurance than are whites.[2] These groups also have lower reported health status and are more likely to suffer from certain chronic health problems.[2] Despite their greater healthcare needs, they are more likely to report health access barriers. Some underserved minority groups face discrimination in healthcare settings and may be distrustful of some healthcare providers and institutions.[3,4] Fortunately, some of these issues can be ameliorated by making it easier for members of underserved minority groups to select providers with ethnic backgrounds similar to their own. Healthcare providers from underrepresented minority, ethnic, and racial groups are more likely to serve patients of their own ethnicity or race and patients with poor health.[5,6,7]

Not only are underrepresented providers more likely to serve patients of their own ethnicity or race, they also are more likely to practice in underserved areas.

When given the option, individuals of all racial and ethnic groups are more likely to pick providers who share their racial and ethnic backgrounds.[7,8] Minority patients have lower levels of trust in providers of other racial groups.[5] Studies suggest minority patients are generally more satisfied with care received from providers of similar race and/or ethnicity (racial and ethnic concordant patient-physician relationships)[5,7,9] and are more actively involved in making decisions about their own care when visiting providers of their own race and ethnicity. In addition, patient-centered care (ie, respect for the patient's preferences and coordination of care) is emphasized more during visits in which the patient and provider are of the same race compared to when they are not.[3] The duration of visits to the physician is considered an important proxy measure for determining quality of care. Studies indicate that visits are longer for both African American and white patients when the provider and patient are of the same race/ethnicity.[4]

Not only are underrepresented providers more likely to serve patients of their own ethnicity or race, they also are more likely to practice in underserved areas. North Carolina has 11 whole-county and 27 part-county persistent health professional shortage areas (PHPSAs).[a] The significant number of areas in North Carolina lacking sufficient health providers makes it particularly valuable to have providers who are willing to serve the state's minority populations and underserved communities. In North Carolina, nonwhite physicians, physician assistants (PAs), and nurse practitioners (NPs) are more likely than white providers to practice in whole-county PHPSAs.[b]

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a The Bureau of Health Professions in the US Department of Health and Human Services has designated certain communities, population groups, or medical facilities as health professional shortage areas (HPSAs). Areas that are designated as HPSAs must define and justify a rational service area for the delivery of health services (often a county), have a sufficiently low provider-to-population ratio, and show evidence that nearby resources are overutilized, too distant, or otherwise inaccessible.

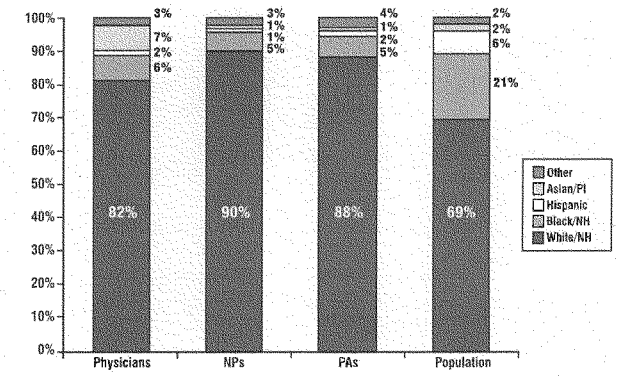
b Persistent health professional shortage areas are those that have been designated as HPSAs in six of the last seven years. An entire county or part of a county can qualify as a HPSA. Whole-county HPSAs refer to entire counties that qualify as HPSAs.

Ratio of North Carolina Minority Providers to Population

Minority populations comprise 30% of North Carolina's population, but they account for only 18% of physicians, 12% of PAs, and 10% of NPs in the state. Graph 5.1 illustrates the race of North Carolina's population compared to the race of the state's providers, including physicians, NPs, and PAs. Of the state's 8.5 million residents, 69% are white, non-Hispanic; 21% are African American or black, non-Hispanic; 6% are Hispanic; 2% are Asian or Pacific Islander; and 1% are American Indian. By comparison, whites account for 82% of the physician population (17,090), Asians 7%, African Americans 6%, and Hispanics 2%. Similarly, whites account for 90% and 88% of the NP and PA populations, respectively, while African Americans account only for 5%, and Hispanics account for 1-2% of each group.

Minority populations comprise 30% of North Carolina's population, but they account for only 18% of physicians, 12% of PAs, and 10% of NPs in the state.

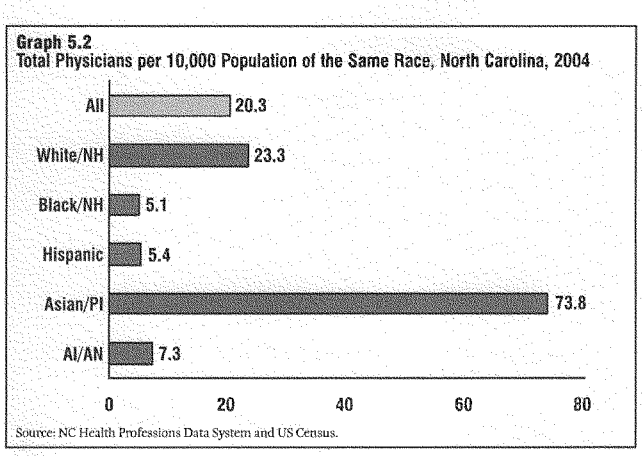
Graph 5.1
Race of Population and Providers, North Carolina, 2004



Source: NC Health Professions Data System and US Census. Other includes American Indian.

Availability of providers from a variety of ethnicities and races is important because studies indicate patients are more likely to choose providers of the same race or ethnicity[9] and are more satisfied with visits to providers of the same race or ethnicity.[4] Racial and ethnic differences in provider-patient relationships often create barriers and limit effective communication.[10] Underrepresented minority providers (African American, Hispanic, and Native American) are more likely to practice in persistent health professional shortage areas (39% for minority providers compared to 29% for white providers).

Graph 5.2 compares physician to 10,000 population ratios by race. There are only 5.1 African American, 5.4 Hispanic, and 7.3 American Indian physicians per 10,000 population compared to 23.3 white physicians per 10,000 population. The ratio of Asian physicians to population is high (73.8 per 10,000 population) due to lower numbers of Asians in the state and because a high proportion (58%) of Asian physicians in the state move to the US as international medical graduates (IMGs).



Evaluating the same data for physicians who practice primary care show similar results. There are 3.2 African American, non-Hispanic primary care physicians per 10,000 population, with 2.6 Hispanic and 4.7 American Indian primary care physicians per 10,000 population, compared to 9.4 white and 36.8 Asian/Pacific Islanders. Ratios of NPs and PAs to 10,000 population who practice primary care are approximately five times and four times higher, respectively, for non-Hispanic whites than they are for African Americans and Hispanics. Data indicate that American Indian provider-to-population ratios for these professions are similar to those of whites.

Minority Access to Healthcare and Health Professions Education

Historically, nonwhite individuals faced significant discrimination in access to healthcare services and inclusion in the healthcare professions. Minorities received care in segregated healthcare settings and were excluded from most medical professional training and practice opportunities. Even after the Civil Rights Act in 1965 precluded discrimination in higher education, most African American physicians were trained at Howard and Meharry. It was not until 1969 that the number of black medical students at Howard and Meharry was exceeded by the number enrolled in all other medical programs in the country. Fortunately, after targeted efforts to increase opportunities for minority students in these other medical institutions, underrepresented minorities accounted for 10% of all medical school enrollees in 1974 and 12% in 1994.[3]

Unfortunately, those numbers have since declined,[3] and with a state population that is more than 25% minority, North Carolina has a long way to go before enrollment in medical schools and NP, PA, and certified nurse midwife (CNM) programs mirror the state's population. Furthermore, to create an environment that is attractive to

minority health professional students, the faculty populations of health professions training schools need to include underrepresented minorities. Underrepresented minority faculty also may serve as better mentors to these students. Finally, it is important that these faculty members also serve as department chairs. Department chairs make important decisions regarding curricula and student populations, and minority chairs may be more sensitive to issues related to underrepresented minority student populations. They also may help place greater value on cultural diversity and diverse student bodies.

One of the most direct options for increasing underserved minority providers in North Carolina would be to develop new health professions training programs at historically minority public or private colleges and universities.

One of the most direct options for increasing underserved minority providers in North Carolina would be to develop new health professions training programs at historically minority public or private colleges and universities. Historically, minority colleges and universities educate students of all races and ethnicities, but focus on education of the African American population. North Carolina is fortunate to have a number of historically minority colleges and universities, both public and private, including Elizabeth City State University, Fayetteville State University, North Carolina A&T State University, North Carolina Central University, Winston-Salem State University, Bennett College, Johnson C. Smith University, Livingstone College, Shaw University, St. Augustine's College, and the University of North Carolina at Pembroke. Most of these schools offer strong science curricula, and there needs to be a continued effort to offer health professions training programs through these historically minority colleges and universities. North Carolina Central University offers a Bachelor of Science degree in nursing as does Winston-Salem State University. However, Winston-Salem State University is the only program in the state also to offer training programs in occupational therapy, physical therapy, and clinical laboratory science. Beyond that, the majority of historically minority colleges and universities have psychology majors, but as of 2004 there were few, if any, other health professions training programs in these schools.

One innovative new program initiated in 2005 was a partnership between Elizabeth City State University (ECSU) and the University of North Carolina at Chapel Hill (UNC Chapel Hill) School of Pharmacy. The UNC Chapel Hill/ECSU Doctor of Pharmacy Partnership Program will enroll 10 to 15 students each year.[11] The program provides instruction to students on the ECSU campus through synchronous video-teleconferencing, on-campus seminars, and ancillary web-based instruction. Students in the program will interact through computer-mediated communications with UNC Chapel Hill students, faculty, and advisors. Pharmacy training for ECSU-based students will be the same as that of UNC Chapel Hill-based students, with preferential scheduling for the ECSU students in the northeastern region of the state. Such an innovative program through a historically minority college or university will help increase the number of minority providers in the state and also may have the benefit of increasing the number of providers willing to work in underserved areas of North Carolina. Similar partnerships or satellite programs should be considered or consideration should be given to development of completely new health professions training schools at historically minority colleges or universities. (See Recommendations 2.4, 2.5, and 2.7.) These strategies would increase underrepresented minority enrollment in health professions programs and the number of practicing providers statewide. Other strategies include

increasing the enrollment of minorities in existing health professions schools (Recommendations 2.4 and 2.7), providing financial support to health professions schools that increase their production of minority healthcare professionals (Recommendation 2.8), and additional strategies listed below.

Recommendation 5.1. (Priority Recommendation)

The state and existing medical and other health professions schools should implement strategies to expand the number of underrepresented minority physicians, nurse practitioners, physician assistants, and certified nurse midwives and to decrease professional isolation.

These strategies may include but are not limited to:

a) developing minority-focused health professions schools in historically minority public or private colleges and universities;

b) creating satellite campuses with historically minority public or private colleges and universities;

c) creating and expanding minority scholarship programs, particularly in NP and PA programs;

d) developing healthcare mentorship programs in historically minority public or private colleges and universities to encourage more underrepresented minorities to consider health professions;

e) hiring faculty and chairs in health professions schools who are members of underrepresented minority groups and providing them with professional support to reduce professional isolation;

f) modifying admission policies to facilitate the enrollment of minority applicants; and

g) developing a state strategy to aggressively retain health professional graduates for residency or practice in North Carolina or to specifically attract North Carolina health professions school graduates doing residencies outside the state.

Language Barriers and Cultural Competence

Language differences create additional barriers to access to healthcare services. In North Carolina, approximately 150,000 Spanish-speaking residents do not speak English well or do not speak English at all.[12] Studies show people who do not speak English well (limited English proficiency) are not only more likely to report being in fair or poor health but also are more likely to defer needed medical care, miss follow-up appointments, and experience drug complications.[13,14] Language barriers are more likely to create communication problems leading to medical errors. Multilingual providers can help address language barriers for growing Latino or immigrant populations. Multilingual practitioners who are native speakers are more likely to understand how patients' cultural beliefs and practices can impact their health. They also can help practices meet Title VI requirements to ensure that

services are linguistically accessible.[c] The NC Office of Rural Health and Community Care (ORHCC) has placed a priority on recruiting multilingual professionals; ORHCC can offer providers a bonus if they are multilingual and agree to practice in medically underserved areas. Since July of 2001, ORHCC has recruited 88 multilingual health professionals into North Carolina.

In addition to recruiting native Spanish-speaking practitioners into the health professions and/or into practice in North Carolina, other training models can be used to teach Spanish to health professionals who are native English speakers. Successful models, developed in the state, exist to train health professionals to speak Spanish and thus improve communication between providers and patients. These models include the North Carolina Area Health Education Centers Spanish Language and Cultural Training Initiative, *A Su Salud* intermediate language tapes for healthcare professionals developed by the University of North Carolina at Chapel Hill, Wake Forest Spanish education for medical students, the NC Latino Health Resource Center, and others.

In addition to addressing language barriers, it is also important to ensure providers are trained to respect and understand cultural differences of diverse populations. Research demonstrates that cultural sensitivity training for healthcare providers improves knowledge, skills, and attitudes of providers while increasing patient satisfaction.[15,16] Thus, cultural sensitivity training has overall benefits for the provider-patient relationship. However, medical students often are not required to complete cultural diversity training.[17,18] With assistance from the American Medical Student Association, two of the four North Carolina medical schools are participating in the Achieving Diversity in Dentistry and Medicine (ADDM) contract awarded by the US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine and Dentistry.[19] The University of North Carolina at Chapel Hill School of Medicine is part of the pilot testing of a cultural competency curriculum. Brody School of Medicine at East Carolina University is part of the pilot testing of an ethnogeriatrics[d] curriculum.

Additionally, the Brody School of Medicine at East Carolina University received a Pre-Doctoral Training in Primary Care grant from the Health Resources and Services Administration of the US Department of Health and Human Services. The goal of this project is to decrease health disparities for the Spanish-speaking population of eastern North Carolina. The proposed program is designed to plan, implement, and evaluate a cultural literacy/fluency curriculum that would improve the ability of medical students to deliver care to the Spanish-speaking population.[20]

Some low-cost models for improving cultural competency or at least cultural awareness are available on the Internet. For example, America's Health Insurance

c Title VI of the Civil Rights Act requires that federal fund recipients (eg, healthcare providers who receive federal Medicaid/Medicare funds) make their services linguistically accessible to people with limited English proficiency (LEP). 42 U.S.C. §2000d-1; 45 CFR §80.3(b)(2).

d Ethnogeriatrics integrates the influence of race, ethnicity, and culture on the health and well-being of older adults.

Plan's (AHIP) "Quality Interactions: A Patient-Based Approach to Cross-Cultural Care" is a free continuing medical education course for physicians. Through an interactive patient case study, physicians can improve their ability to effectively communicate with and care for patients from diverse backgrounds. This module also discusses the business, medical, and legal reasons why cultural competence is essential in the practice of medicine. Although institutional approaches such as integrating cultural competency into medical school curricula would likely be more effective and have greater impact, low-cost models offer some alternatives if no more intensive program is available.

Recommendation 5.2. (Priority Recommendation)

a) North Carolina medical and other health professions schools including university and community college programs should:

   i) recruit and admit more multilingual and multicultural students into health professions classes;

   ii) offer and encourage students to take Spanish medical language courses as part of health professions training;

   iii) develop innovative programs to prepare more multilingual and multicultural graduates; and

   iv) build cultural sensitivity training into curricula.

b) North Carolina foundations should create through a competitive process a Center for Excellence to inventory, evaluate, and disseminate best practices in healthcare professional programs.

Recommendation 5.3.

The NC Area Health Education Centers Program should work collaboratively with key partners including the Center for New North Carolinians and the Office of Minority Health and Health Disparities to:

a) expand existing Spanish language programs to train more interpreters and practicing health professionals; and

b) expand cultural competency and cultural sensitivity training for all health professionals.

Recommendation 5.4.

The NC General Assembly should create a grants program to incentivize medical schools and other health professions training programs to produce more multilingual and multicultural healthcare professionals.

For example, grants could be awarded for programs that create opportunities for intensive language training and immersion courses to produce multilingual and multicultural healthcare professionals or that offer loan forgiveness or scholarships tied to students who meet certain multilingual and cultural competency requirements.

Recommendation 5.5.

The NC Community College System should place greater emphasis on recruiting and training multilingual and multicultural medical office staff, nurses, and allied health professionals.

Other strategies include those listed in Recommendation 5.2.

North Carolina Programs to Promote Representation of Underrepresented Minorities in Healthcare Professions

Many programs throughout North Carolina are focused on promoting the representation of underrepresented minorities in healthcare professions. These programs target a variety of students including those in grades K-12, undergraduate programs, and medical schools. Two examples of such programs, which are particularly successful in reaching larger numbers of students, include the NC Health Careers Access Program (NC-HCAP) and programs conducted by the NC Area Health Education Centers (AHEC) Program.

NC-HCAP has campus-based health career centers at the University of North Carolina at Chapel Hill, Elizabeth City State University, North Carolina Central University, and the University of North Carolina at Pembroke. Campus-based activities involve identifying, recruiting, motivating, and strengthening the academic and basic skills of disadvantaged students in health training and professional health programs. NC-HCAP also offers programs in conjunction with several other campuses, school systems, organizations, and agencies. NC-HCAP offers activities for upper elementary through undergraduate students, including programs such as the Clinical Health Summer Program, health careers information and enrichment workshops, health professions forums, Inspirational Speakers in Science lecture series, NC-HCAP Ambassador Program, NC-HCAP enrichment seminars, parent workshops, and Science Enrichment Preparation program. (See Appendix B.)

The large number of students involved in precollege activities makes tracking difficult for NC-HCAP, but there is focused tracking for students involved in its undergraduate programs.[21] Since 1979, NC-HCAP has supported 935 students in college enrichment programs targeted at rising college sophomores and juniors; approximately 60% of those students now are health professionals, and approximately 39% are continuing along the pathway to becoming health professionals.[22] In the future, NC-HCAP hopes to develop a statewide directory for tracking participants in all North Carolina programs promoting health careers for underprivileged or underrepresented youth.

Unfortunately, NC-HCAP is currently struggling to support its existing programs. The federal government recently cut funding for Title VII of the Public Health Service Act, which supported programs aimed at increasing the representation of underrepresented minorities among the health profession disciplines. NC-HCAP received Title VII funds for its programs and that support was eliminated as a result of the federal cuts.

AHEC also conducts activities to increase minority representation in healthcare professions through its Health Careers and Workforce Diversity initiatives. In

2002-2003, 39,000 individuals participated in these programs.[23] See Appendix A for a list of North Carolina agencies and groups providing programs focused on promoting representation of underrepresented minorities in health professions.

Recommendation 5.6. (Priority Recommendation)

The NC Area Health Education Centers (AHEC) Program should work collaboratively with key partners to explore issues that need to be addressed in creating a statewide, uniform student tracking and evaluation system of federal and state funded programs across the educational pipeline. AHEC should report findings back to the Health Policy Workforce Board. The goal of this report should be to determine how best to:

a) evaluate existing minority health professions pipeline programs and expand the most successful programs, particularly those with a focus on intensive, longitudinal programs that work with small numbers of students over a longer period of time;

b) develop a statewide, uniform student tracking and evaluation system and program inventory of formal and informal programs across the educational pipeline which is shared by precollege and university health career advisors and counselors.

Future state funding should be tied to programs found to be the most successful in increasing underrepresented minorities in health professions.

Recommendation 5.7.

The Office of Rural Health and Community Care in collaboration with minority professional associations, such as Old North State Medical Society and other key partners, should provide practice support to underrepresented minority health professionals who choose to practice in underserved areas. Support can include, but not be limited to, creation of community mentoring programs or other strategies to support retention of underrepresented minorities in underserved areas.

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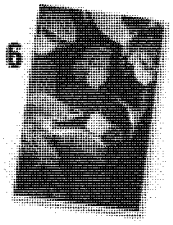
Conclusion and Recommendations

Chapter 6



Access to healthcare providers, including physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs), is very important to the health of individuals and populations. In the past 20 years, the ratio of providers-to-population has increased in North Carolina, but the rate of increase recently has slowed. In 2005, the state had 20.7 physicians to every 10,000 people, which is about average compared to all US states. However, in the future, North Carolina will face challenges in meeting the population's demands for care. The state's healthcare needs are expected to increase due to population growth, aging of the population, and an increase in the prevalence of chronic diseases. If nothing is done to change the supply of providers in North Carolina, the ratio of physicians-to-population is expected to drop 8% by 2020 and 21% by 2030. The ratio of all providers-to-population, including PAs, NPs, and CNMs, is expected to drop between 2% and 13% by 2030. The problem is projected to grow even more acutely if increased needs of an aging population (adjusted population figures) are factored into the shortfall.[a]

Table 6.1
Projected Change in Provider-to-Population Ratios, North Carolina, 2020 and 2030

	Projected Change in Provider-to-Population Ratios		Projected Change in Provider-to-Adjusted Population Ratios	
	2020	2030	2020	2030
Physicians only	-8%	-21%	-12%	-26%
All providers				
Best case	4%	-2%	-1%	-8%
Worst case	-4%	-13%	-8%	-19%

Source: NC Institute of Medicine and NC Health Professions Data System.

Although the potential shortfall is considerable, a number of policies could be used to ameliorate this deficit, if the state acts soon and plans ahead. Options to improve quality and productivity of existing practices should be identified so health professionals can provide high-quality health services to more North Carolinians. The state should concurrently examine options to develop new models of care that would reduce the need for healthcare providers and/or expand the supply of physicians, NPs, PAs, and CNMs. North Carolina needs to engage simultaneously in multiple strategies to increase supply. If new medical school slots are created but new residency slots are not, in-state retention of the expanded number of medical school graduates will be lower as many will need to leave the state for residency and are not likely to return. Similarly, initiatives to increase awareness of health careers among rural and minority middle and high school students will have little impact without also expanding available enrichment programs to help students overcome hurdles to being accepted into medical school. In addition,

a NC Institute of Medicine and the NC Health Professions Data System. (See Appendix A.)

initiatives should expand medical school support programs to help stem the higher dropout rates of minority medical students. North Carolina also should explore ways to recruit physicians and other providers into North Carolina and to encourage existing practitioners to remain in practice in North Carolina. In short, many of these policy options are interdependent. Effectiveness of any specific policy option is dependent, in part, on the success of other efforts that affect the provider production pipeline. Thus, there is no single policy option that will resolve the impending provider shortage; success requires adoption of many complementary strategies.

The wide constellation of policy levers available to address this potential problem offers the opportunity to develop solutions before the provider shortage reaches crisis proportions. Full adoption of all recommendations listed above would ensure that North Carolinians continue to have the access to quality healthcare they do today. Implementation of the recommendations would help improve provider distribution problems, ensure a more adequate supply of primary care providers and other providers in specialty shortages, and increase the number of underrepresented minorities in the profession.

North Carolina need not implement all provider supply strategies in order to maintain the current provider-to-population ratio. For example, the state does not need to increase the number of physicians, NPs, PAs, and CNMs each by 30% in order to maintain current ratios. To some extent, these are alternate strategies that depend, in part, on when other strategies are implemented. If implemented *today*, the state could maintain its current ratio over the next 25 years by:

1) increasing the yearly educational production of physicians by 20%, *or*
2) increasing the production of nonphysician clinicians by over 30%, *or*
3) increasing in-migration to produce a *net* increase of physicians by 15%, *or*
4) increasing the capacity of the health system to effectively manage the health of North Carolinians or improving the health of North Carolinians to reduce the need for health services by 15%.

The Task Force recognized that the multiple goals outlined throughout the report makes it unlikely that implementation of one Task Force recommendation would solve all future workforce problems. Instead, some combination of recommendations would be the most promising strategy. Pragmatically, the degrees of expansion outlined above are all ambitious undertakings. While a 30% increase in physician production may be infeasible, a 5% increase in all four strategies may be realistic and would maintain North Carolina's access to quality healthcare.

The longer the state waits to implement the strategies, the greater the number of providers it will need to produce on a yearly basis to address the anticipated provider shortages. The Task Force recognized that ambitious goals may be necessary to achieve the momentum needed to address the issue sufficiently. Furthermore, although North Carolina is facing a potential provider shortage in the future, it faces other provider supply issues *today*. The state must take necessary steps to ensure North Carolina has the right mix of providers in the right locations.

The following table summarizes the Task Force recommendations. Priority recommendations are highlighted in bold.

Table Legend

* Recommendations that are in bold font have been identified as priority recommendations.

** Recommendations that examine the mix of specialists are marked with a "✓". The recommendations that apply to specific provider specialties are listed as PC (primary care focused), Del (providers who deliver babies), Psych (psychiatrists or mental health providers), Surg (general surgeons), Ger (geriatrics), DOs (Doctors of Osteopathy), PA (physician assistants specifically), NP (nurse practitioners specifically), or CNM (certified nurse midwives specifically).

*** The column entitled "New Models" includes any recommendation that focuses on new models of delivering care to meet the changing healthcare needs of the population, including, but not limited to, interdisciplinary team training or greater use of telemedicine.

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Overall Provider Supply						
Rec. 2.1. (Priority Recommendation)*	✓	✓	✓	✓	✓	✓
a) The NC General Assembly should appropriate $170,000 to support and expand the health professional workforce research center charged with examining current and future needs for health professionals, which is housed within the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. Research should be conducted at the individual practitioner level as well as the practice level. The Center will expand its current research to include analyses that:						
1) identify the need for physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) to meet the healthcare needs of the state 5, 10, and 20 years into the future;						
2) identify new models of care that can improve the quality and efficiency of care offered by North Carolina providers;						
3) examine the distribution of physicians, NPs, PAs, and CNMs across the state;						
4) examine trends in the supply of minority health professionals in comparison to the general population and examine percentage of underrepresented minority students and residents who receive training in North Carolina but who leave the state for practice;						

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
5) examine trends in the numbers of primary care and specialty providers by specialty area;						
6) examine changes in health status and sociodemographic factors that might influence future healthcare needs so as to examine the mix of healthcare professionals necessary to address the state's healthcare needs; and						
7) identify barriers that affect entry into the health professional workforce or continued practice, if any.						
b) The NC General Assembly should create an ongoing Health Workforce Policy Board that is charged with developing strategies to address impending health professional workforce shortages. The Board will include representation from the NC Office of the Secretary, NC Department of Health and Human Services, NC Office of Rural Health and Community Care, NC Area Health Education Centers Program, five North Carolina academic health centers, NC Community College system, relevant professional associations and licensing boards, NC Hospital Association, NC Medical Society Foundation, and nonmedical public members. The Board shall identify strategies to:						
1) develop new models of care that encourage quality and efficiency of healthcare services;						
2) increase the overall supply of physicians, NPs, PAs, and CNMs to meet the unmet health needs of the state's growing population;						
3) encourage more health professionals to practice in health professional shortage areas;						
4) establish priorities for which types of provider specialties are most needed to meet the healthcare needs of the state;						
5) increase the supply of underrepresented minorities in the profession;						
6) ensure the mix of health professionals is appropriate to meet the changing healthcare needs of the state; and						
7) address barriers that affect entry into the health professional workforce or continued practice, if any.						
The Health Workforce Policy Board should report its findings and proposed recommendations on an annual basis to the University of North Carolina Board of Governors, the NC State Board of Community Colleges, and the NC General Assembly.						

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Rec. 2.2. (Priority Recommendation) In order to develop and implement new models of care: a) North Carolina foundations should help fund new models of care for improving quality and efficiency of primary and specialty care across North Carolina. New models should be evaluated to determine if they improve quality of care and/or efficiency. b) Medical schools, other health professions schools, and residency programs should incorporate successful new models of care into training curricula and ensure that students and residents have the opportunity to practice using new models. c) The State Health Plan, Division of Medical Assistance, and private insurers should modify reimbursement policies to support the long-term viability of new models that are shown to improve quality and/or efficiency.	✓				✓	
Rec. 2.3. (Priority Recommendation) The NC General Assembly should appropriate: a) $2.5 million to The Carolinas Center for Medical Excellence to increase the number of practices that receive technical assistance under the Doctor's Office Quality-Information Technology project and to expand this assistance to include pediatric offices; and b) $4.8 million to the NC Medical Society Foundation to provide grants to small or solo practitioners to purchase health information technologies to improve quality performance and practice efficiencies.	✓				✓	✓
Rec. 2.4. (Priority Recommendation) North Carolina medical schools should increase enrollment by 30% (AAMC recommendation). Expansion can be accomplished through an increase in enrollment on existing campuses or through satellite campuses. In expanding programs, medical schools should consider changing admissions criteria or using other strategies to increase the overall supply of physicians practicing in the state, increase the number of physicians who set up practice in underserved areas, increase the number of physicians who specialize in shortage specialties, increase the number of underrepresented minority physicians practicing in the state, and enhance interdisciplinary team training.	✓	✓	✓	✓	✓	
Rec. 2.5. If current medical schools are unable to increase enrollment by 30%, the NC General Assembly should consider creation of a new public allopathic or osteopathic medical school or provide incentives to encourage development of	✓	✓	✓	✓	✓	

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
a new private medical school. Specifically: a) The NC General Assembly should appropriate funds to build a new state-supported allopathic or osteopathic medical school that will focus on increasing the supply of physicians who practice in North Carolina, particularly those willing to practice in medically underserved areas or in shortage specialties. Special consideration should be given to creating a medical school that focuses on increasing the number of underrepresented minority physicians in the state, increasing the overall supply of physicians practicing in the state, increasing the number of physicians who set up practice in underserved areas, increasing the number of physicians who specialize in shortage specialties, and enhancing interdisciplinary team training. b) Alternatively, as part of state efforts to increase economic development in communities across the state, the Department of Commerce should consider incentives to attract private osteopathic or allopathic medical schools into the state.						
Rec. 2.6. The NC General Assembly should appropriate funds to pay for allocated seats for North Carolina students admitted to osteopathic schools in other states (eg, Alabama or Kentucky model) with an obligation that students return to practice in North Carolina.	✓			DO		
Rec. 2.7. (Priority Recommendation) a) The North Carolina physician assistant (PA) programs should increase student enrollment by 30%. Expansion can be accomplished through an increase in enrollment on existing campuses or through satellite campuses. In expanding programs, PA schools should consider changing admissions criteria or using other strategies to increase the overall supply of PAs practicing in the state, increase the number of PAs who set up practice in underserved areas, increase the number of PAs who specialize in shortage specialties (including but not limited to geriatrics and behavioral health), increase the number of underrepresented minority PAs practicing in the state, and enhance interdisciplinary team training. b) North Carolina nurse practitioner (NP) schools should increase student enrollment by 30%. In expanding programs, NP schools should consider changing admissions criteria or using other strategies to increase the overall supply of NPs practicing in the state, increase the number of NPs who set up practice in underserved areas, increase the number of NPs who	✓	✓	✓	PA NP CNM Ger Psych		

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
specialize in shortage specialties (including but not limited to geriatrics and behavioral health), increase the number of underrepresented minority NPs practicing in the state, and enhance interdisciplinary team training. c) The Nurse Midwifery program at East Carolina University should increase student enrollment by 30%.						
Rec. 2.8. (Priority Recommendation) a) The NC General Assembly should provide financial support to encourage or reward medical schools and other health professions schools that produce physicians, nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) who fill the unmet health needs of the state's population. Incentives should be provided to increase the overall supply of healthcare providers, appropriately distribute physicians, NPs, PAs, and CNMs practicing in the state, and promote interdisciplinary training. Enhanced funding should be tied to outcomes that result in: 1) increased numbers of physicians, NPs, PAs, and CNMs who set up and maintain practices in underserved areas; 2) increased numbers of physicians, NPs, PAs, and CNMs who obtain qualifications for and practice in primary care or other shortage specialties as identified by the Health Workforce Policy Board; 3) increased numbers of practicing physicians, NPs, PAs, and CNMs who are members of underrepresented minorities; or 4) greater interdisciplinary didactic and clinical team training among physicians, NPs, PAs, CNMs, nurses, and other health professionals (eg, pharmacists, social workers, allied health workers). b) In order to determine the effectiveness of various training programs in meeting the healthcare workforce needs of North Carolina, the NC General Assembly should amend NCGS §143-613 to require medical schools, PA programs, NP programs, and CNM programs to report information on an annual basis to the Health Workforce Policy Board, the Board of Governors of the University of North Carolina, and the NC General Assembly. Medical schools and NP, PA, and CNM programs shall cooperate with the Health Workforce Policy Board to identify on an annual basis the following data and information: 1) number and location of graduates in active patient care practice and number of graduates no longer in active patient care practice by year of graduation;	✓	✓	✓	✓	✓	

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
2) percentage of graduates who enter residencies in primary care specialties or other specialties that are deemed as shortage areas in North Carolina as defined by the Health Workforce Policy Board; 3) percentage of graduates who practice in federally-designated health professional shortage areas in North Carolina and in areas specified as shortage areas by the Health Workforce Policy Board; 4) number and percentage of underrepresented minorities who are enrolled in and who graduate from these schools and programs and where they practice; and 5) number of graduates who have been involved in formalized interdisciplinary didactic or clinical training programs that involve students from multiple disciplines working together as teams in patient care.						
Rec. 2.9. (Priority Recommendation) The NC General Assembly should appropriate $13 million in new funding and/or Medicaid GME funding to the NC Area Health Education Centers (AHEC) Program to support additional and expanded clinical rotations for health science students and expansion of primary care or other residency programs that meet specialty shortages. a) $3 million should be provided to develop new clinical training sites for students; to pay stipends to community preceptors who supervise and teach primary care students; and to provide housing, library, and other logistical support for students in community settings. Enhanced payments should be made to preceptors who practice in health professional shortage areas. b) $10 million should be provided to fund 100 new residency positions across the state targeted toward the high priority specialty areas of primary care, general surgery, and psychiatry or other specialty shortage areas identified by the Health Workforce Policy Board. This funding should be provided to AHEC, with AHEC then making grants to AHEC- and university-based residency programs that agree to expand residency slots and to create programs designed to graduate physicians likely to settle in rural and other underserved areas of the state.	✓	✓	✓	PC Psych Surg	✓	
Rec. 2.10. NC residency programs should consider seeking joint accreditation by the American Osteopathic Association along with existing accreditation by the Accreditation Council for Graduate Medical Education.	✓			DO		

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Rec. 2.11. The NC Office of Rural Health and Community Care in collaboration with the Community Practitioner Program of the NC Medical Society, NC Area Health Education Centers Program, and professional medical societies should conduct marketing and outreach campaigns that emphasize positive aspects of healthcare practice in North Carolina.	✓					✓
Rec. 2.12. The NC General Assembly should help maintain and improve the positive regulatory environment for all licensed health professionals including physicians, nurse practitioners, physician assistants, and certified nurse midwives.	✓					✓
Rec. 2.13. The North Carolina Midwifery Joint Committee should follow licensure reentry procedures established by the American College of Nurse-Midwives to enable inactive practitioners otherwise in good standing to reenter practice.	✓			MD DO PA CNM		
Rec. 2.14. (Priority Recommendation) In order to improve practice management across the state: a) The University of North Carolina system, NC community colleges, and NC independent colleges and universities should offer courses that will increase the supply of practice managers across the state, particularly in underserved areas, and improve the skills of existing practice managers. b) The NC Area Health Education Centers Program, NC Office of Rural Health and Community Care, Community Practitioner Program, NC community colleges, and NC independent colleges and universities should develop a continuing education curriculum for existing practitioners and staff to enhance the business skills needed to maintain a viable practice. c) North Carolina foundations should consider funding start-up programs to community colleges and other organizations to enhance the skills of practice managers and providers and programs targeted to underserved areas.	✓	✓				✓

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Maldistribution						
Rec. 3.1. The NC Department of Public Instruction, NC Community College System, University of North Carolina, NC Area Health Education Centers Program, and other related programs should collaborate to create more intensive programs and to coordinate and expand existing health professions pipeline programs so underrepresented minority and rural students likely to enter health careers are offered continued opportunities for enrichment programs in middle school, high school, and college and then receive continued support in medical and other health professions schools.		✓	✓			
Rec. 3.2. Duke University School of Medicine, Brody School of Medicine at East Carolina University, University of North Carolina at Chapel Hill School of Medicine, Wake Forest University School of Medicine, and North Carolina residency programs should create targeted programs and modify admission policies to increase the number of students and residents with expressed interest in serving underserved populations and/or practicing in rural areas of North Carolina. Targeted programs should be designed to provide intensive and longitudinal educational and clinical opportunities to practice with medically underserved populations in medically underserved areas of the state.		✓				
Rec. 3.3. (Priority Recommendation) The NC General Assembly should appropriate $1,915,600 to the NC Office of Rural Health and Community Care (ORHCC). Of this amount: a) $350,000 should be appropriated to provide technical assistance to communities to help identify community needs and practice models that can best meet these needs and to provide technical assistance to small practices or solo practitioners practicing in medically underserved communities or serving underserved populations; b) $1.5 million should be appropriated to pay for loan repayment and financial incentives to recruit and retain physicians, physician assistants, nurse practitioners, and certified nurse midwives to rural and underserved communities; and e) $65,600 should be appropriated to expand the number of ORHCC staff who recruit practitioners into health professional shortage areas.		✓	✓			✓

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
ORHCC should place a special emphasis on recruiting and retaining underrepresented minority, bilingual, and bicultural providers to work in underserved areas or with underserved populations.						
Rec. 3.4. (Priority Recommendation) North Carolina foundations should fund regional, multi-county demonstrations to test new models of care to serve patients in rural and urban underserved areas. a) New models should be developed collaboratively between the NC Office of Rural Health and Community Care, NC Area Health Education Centers Program, healthcare systems, medical schools, other health professions training programs, licensure boards, and other appropriate groups and should be designed to test new models of care that focus on integration of care, management of chronic illness, and prevention. Such models should emphasize the creation of medical homes and interdisciplinary practice environments to enhance care to underserved populations. b) New models should be evaluated to determine if they improve access, quality of care, and/or efficiency. The State Health Plan, Division of Medical Assistance, and private insurers should modify reimbursement policies to support the long-term viability of successful models of care for underserved populations.		✓		PC	✓	
Rec. 3.5. (Priority Recommendation) The NC General Assembly should explore financial incentives or other systems to encourage providers to establish and remain in practice in underserved areas or with underserved populations. Financial incentives may include, but not be limited to, tax credits or increased reimbursement. Other strategies to encourage providers to locate and practice in underserved areas or with underserved communities may include, but not be limited to, help with call coverage or use of hospitalists.		✓				

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Primary Care and Provider Specialties						
Rec. 4.1. (Priority Recommendation) a) The State Health Plan, Division of Medical Assistance, and private insurers should enhance payments to primary care providers to recognize the value of diagnostic and cognitive skills, particularly those payments that incentivize primary care providers to create comprehensive primary care homes that include lifestyle interventions, preventive health services, chronic disease management, and case management through use of case managers. b) Reimbursement levels for primary care services through Medicaid, NC Health Choice, State Health Plan, and private insurers should be continually evaluated to ensure they are adequate to meet the costs of care across the state, particularly in underserved areas.				PC		✓
Rec. 4.2. The NC OB/GYN Society, NC Area Health Education Centers Program, East Carolina University Nurse Midwifery program, NC Academy of Family Physicians, and North Carolina medical schools should change the practice environment to encourage acceptance of certified nurse midwives into practice.				CNM		
Rec. 4.3. The NC General Assembly should appropriate $206,000 annually to expand the East Carolina University Nurse Midwifery program by 30%.	✓			CNM		
Rec. 4.4. (Priority Recommendation) The NC General Assembly should appropriate $2 million to provide malpractice premium subsidies (similar to the Rural Obstetrical Care Incentive Program) for physicians and certified nurse midwives who provide delivery services in medically underserved areas.		✓		Del		
Rec. 4.5. North Carolina medical schools and other health professions programs, specialty societies, and the NC Area Health Education Centers Program should strengthen and expand the mental and behavioral health and psychopharmacology components of training and continuing education to increase competencies in mental and behavioral healthcare for all graduates, with a special emphasis in integrating behavioral health and primary care. Innovative approaches may include special tracks in psychology/behavioral health, better integration of behavioral health content into current curricula,				Psych PC	✓	

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
postgraduate programs in behavioral health, and education for psychiatrists and other mental health professionals in working collaboratively with primary care professionals in more integrated models of care.						
Rec. 4.6. (Priority Recommendation) The NC General Assembly and NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should provide funding to targeted rural communities to establish new models of care to serve public patients in rural and underserved communities. a) New models of care should be developed collaboratively with the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NC Area Health Education Centers Program, NC Office of Rural Health and Community Care, academic healthcare institutions, and primary care and specialty societies. b) Models should include psychiatrists and other mental health professionals and have close linkages to primary care providers in the service area. c) To improve the professional environment in these settings, these sites should qualify for higher levels of reimbursement, have strong linkages to academic health centers, and have a strong focus on integrated care.		✓		Psych PC	✓	✓
Rec. 4.7. (Prioity Recommendation) The NC General Assembly, public and private insurers, and payers (including, but not limited, to the State Health Plan, NC Division of Medical Assistance, and NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services) should pay for: a) psychiatric consultations for primary care providers and other clinicians either through face-to-face consultations or telemedicine; and b) services provided by primary care providers to patients who have been diagnosed with a psychiatric diagnosis. Reimbursement levels for mental and behavioral health services through Medicaid, NC Health Choice, State Health Plan, and other payers should be continually evaluated to ensure they are adequate to meet the costs of care across the state, particularly in underserved areas.		✓		Psych	✓	✓

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Underrepresented Minorities						
Rec. 5.1. (Priority Recommendation) The state and existing medical and other health professions schools should implement strategies to expand the number of underrepresented minority physicians, nurse practitioners, physician assistants, and certified nurse midwives and to decrease professional isolation.			✓			
Rec. 5.2. (Priority Recommendation) a) North Carolina medical and other health professions schools including university and community college programs should: 1) recruit and admit more bilingual and bicultural students into health professions classes; 2) offer and encourage students to take Spanish medical language courses as part of health professions training; 3) develop innovative programs to prepare more bilingual and bicultural graduates; and 4) build cultural sensitivity training into curricula. b) North Carolina foundations should create through a competitive process a Center for Excellence to inventory, evaluate, and disseminate best practices in healthcare professional programs.			✓			
Rec. 5.3. The NC Area Health Education Centers Program should work collaboratively with key partners including the Center for New North Carolinians and the Office of Minority Health and Health Disparities to: a) expand existing Spanish language programs to train more interpreters and practicing health professionals; and b) expand cultural competency and cultural sensitivity training for all health professionals.			✓			
Rec. 5.4. The NC General Assembly should create a grants program to incentivize medical schools and other health professions training programs to produce more bilingual and bicultural healthcare professionals.			✓			
Rec. 5.5. The NC Community College System should place greater emphasis on recruiting and training bilingual and bicultural medical office staff, nurses, and allied health professionals.			✓			

	Overall Supply	Maldistribution	Underrepresented Minorities	Specialty Supply**	New Models of Care***	Practice Environment
Rec. 5.6. (Priority Recommendation) The NC Area Health Education Centers (AHEC) Program should work collaboratively with key partners to explore issues that need to be addressed in creating a statewide, uniform student tracking and evaluation system of federal and state funded programs across the educational pipeline. AHEC should report findings back to the Health Workforce Policy Board. The goal of this report should be to determine how best to: a) evaluate existing minority health professions pipeline programs and expand the most successful programs, particularly those with a focus on intensive, longitudinal programs that work with small numbers of students over a longer period of time. b) develop a statewide, uniform student tracking and evaluation system and program inventory of formal and informal programs across the educational pipeline which is shared by precollege and university health career advisors and counselors. Future state funding should be tied to programs that are found to be the most successful in increasing underrepresented minorities in health professions.			✓			
Rec. 5.7. The Office of Rural Health and Community Care in collaboration with minority professional associations, such as Old North State Medical Society and other key partners, should provide practice support to underrepresented minority health professionals who choose to practice in underserved areas. Support can include, but not be limited to, creation of community mentoring programs or other strategies to support retention of underrepresented minorities in underserved areas.		✓	✓			✓

Provider Supply Projection Method

Appendix A

To project the relative supply of healthcare providers over the next 25 years, trends in physician and nonphysician supply over the past few decades were analyzed. Projections of demand for healthcare also were necessary to compute the availability of providers in North Carolina relative to the increasing population. These three projections—physicians, nonphysician clinicians, and demand—are discussed in turn below.

Physicians

The projection method for physicians was complex. There are multiple years of data on physician supply that include individual data on:

- physicians new to practice in North Carolina;
- physicians who cease practice in North Carolina;
- physicians recently completing residencies who practice in North Carolina;
- physicians recently completing undergraduate medical education who will eventually practice in North Carolina; and
- hours in direct patient care for licensed physicians in North Carolina (ie, the degree to which physicians in some age groups practice less than full time).

A baseline projection was made that assumed no changes in past patterns of entry and exit into practice in North Carolina. This involved the following steps:

1) Compute the number of active, nonfederal, nonresident physicians that practice in North Carolina by age and gender in 2004. Age is generally measured in one year increments.

2) Compute the annual percent change in the size of each age-gender cohort from 2000 to 2004. This captures the net effect of retirement and exit and entry into practice in North Carolina. For example, approximately 10% of male physicians aged 60-64 leave practice each year.

3) "Smooth" these transition rates by using regression methods to model change rates to be less variable across ages—for example, rather than a 10% growth for age 42 and 44 and a 5% decline for 43 year olds, smoothing might result in a 5% increase for all three ages. This smoothing improves the prediction power of the model by eliminating "lumpiness."

4) Calculate FTE-equivalent weights for each physician cohort by age/gender. This allows the projection to trend forward the productivity of physicians as they age as well as predict the productivity of new physician as they enter practice. For example, males 40-44 have the highest FTE equivalent while older and female physicians tend to work fewer hours per week in patient care. Thus, the projections move beyond counting "bodies" to count "potential patients consulted."

5) For each year subsequent to 2004,

   a) adjust the supply of physicians by the net growth rate in each age/gender group;

   b) age the workforce by moving the cohort in each group into the next older age group; and

   c) calculate the FTE equivalent based on age/gender cell size.

After the baseline projection is made, theoretical policy options can then be modeled. A number of policy options have been formally modeled. The first is an expansion in the size of the education pipeline (both UME and GME). Using historical patterns of physician location and sizes of training programs, there is an annual net increase of roughly 480 physicians who are trained in North Carolina (either at medical school or residency) and eventually practice in North Carolina. This increase is incorporated in the baseline model via the net growth rate. A 30% increase in education throughput, for example, would add an additional .3 * 480 or 114 physicians per year to the North Carolina supply. The increases are timed to account for the delay after implementation until increases are realized. That is, a 30% increase in 2007 assumes those physicians who were first-year residents in 2007 enter the NC workforce in 2010 and those physicians who were first-year medical students in 2007 enter the NC workforce in 2014.

The second theoretical policy option is an increase in the number of physicians who migrate into North Carolina. The average number of "new-to-file" physicians is calculated by age/gender group for the past five years. The net increases due to students and residents are netted out to leave only those physicians who are currently practicing elsewhere. Presumably most are practicing elsewhere in the United States. This serves as the baseline recruitment influx to which an increase in the recruitment rate is applied. For example, there is an average of 104 new-to-file 40-44 year old male physicians annually. A 20% increase in recruitment would increase the net supply by .2 * 104 or 21 per year. These are allocated uniformly across the five ages in the group, so a 20% increase would increase the number of 42 year old physicians by about 4 (20% * 104 /5 years in the 40-44 age group).

Nonphysician clinicians

Projections for nonphysician clinicians (NPC)—Certified Nurse Midwives (CNM), Physician Assistants (PA), and Nurse Practitioners (NP)—were more straightforward than projections for physicians due to more limited data and historical labor supply patterns. Multiple projection methods were attempted; many theoretically reasonable approaches did not yield results with face validity (eg, a 300% increase in NPC supply). The age pyramid method used for physicians was not considered due to the variability of supply trends associated with the smaller number of providers in these three groups. CNM growth was deemed reasonable since 2000—a net increase of about 7 per year. Some members of the Steering Committee deemed the growth in NPs and PAs over the 2000-2004 time frame as an aberration that would not be sustained in the long run; they advocated using average growth since 1979. Other members expected the recent growth to continue. In the end, projections

were performed using both averages. Recent growth is deemed "high" growth, and historical growth is classified as "low" growth. Users of the projection spreadsheet (see below) can chose which growth they would like to assume.

Combining NPC and physicians is problematic since there are multiple "FTE Physician" equivalents used for NPCs. Ultimately, the choice of FTE weight represents the degree to which a NPC can "substitute" a physician. Although there are widely varying opinions on this matter, two alternative weights were used here. The Health Resources and Services Administration uses .5 for NPCs when calculating provider supply when designating Health Professional Shortage Areas. This served as the default weight. Given that new models may increasingly shift primary care to NPCs, this FTE weight may be low; in this analysis we also used .75 as an alternative estimate to test for sensitivity. Again, users of the projection spreadsheet can choose which FTE they would like to use (or specify their own, for that matter). Furthermore, users can specify an assumed growth in education throughput.

Population

As outlined in the report, there are three factors likely to lead to an increase in the demand for healthcare services. The population is increasing, the population is getting older, and the prevalence of chronic disease is increasing. Estimates of the first two were obtained from NC State Demographer population projections out to 2029—projections to 2030 assumed the rate of growth from 2028 to 2029 would apply to 2029 to 2030. The effect of aging was determined by calculating the average number of office-based physician visits for the national population in 2002 (Medical Expenditure Panel Survey) and applying the same rate to each age cell in subsequent years. Note that this is likely an underestimate—other data show that the average number of visits per age group grew considerably from 1990 to 2004,[a,b] at least partially due to increasing chronic disease burden. There were some attempts to estimate the effect of increasing chronic disease on demand for healthcare services. Net increases (over and above the effect of population growth and aging) were in the single digit range; the method was deemed insufficiently tested to be included in this report. Thus, we mention the potential magnitude of, but do not formally include, chronic disease as a driver of projected demand.

Productivity

New healthcare delivery models were of great interest to the Steering Committee. With little empirical evidence to guide estimation of the net effect of new models on the demand for healthcare services, productivity factors were used to inflate the effective supply of providers. Thus, a 10% increase in productivity would increase the number of effective providers from 20,000 (for example) to 22,000. Again, the user can incorporate these assumptions into the model.

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a Hing E, Cherry DK, Woodwell DA. *National Ambulatory Medical Care Survey: 2004 Summary*. Number 374. Hyattsville, MD: National Center for Health Statistics; 2006. Available from: http://www.cdc.gov/nchs/data/ad/ad374.pdf.

b Schappert SM. *National Ambulatory Medical Care Survey: 1990 Summary*. Number 213. Hyattsville, MD: National Center for Health Statistics

North Carolina Organizations Providing Programs to Increase Underrepresented Minority Representation in the Health Professions

Appendix B

NC Area Health Education Centers (AHEC) Program

- Area L AHEC (Programs for elementary and middle school students)
- Charlotte AHEC (Programs for middle and high school students)
- Coastal AHEC (Program for middle school students)
- Eastern AHEC (Programs for high school students)
- Greensboro AHEC (Programs for middle and high school students)
- Mountain AHEC (Programs for elementary, middle, and high school students)
- Northwest AHEC (Programs for elementary, middle, and high school students)
- Southern Regional AHEC (Programs for elementary, middle, and high school students)
- Wake AHEC (Programs for middle and high school students)

Other Programs

- NC Health Careers Access Program (NC-HCAP) (Programs for upper elementary through undergraduate students)
- NC Health Careers Opportunity Program (Programs based at universities such as UNC Pembroke and North Carolina Central University for middle school, high school, and college students)
- Medical Education Development (MED) Program (Program at UNC Chapel Hill for rising college seniors or college graduates)
- Summer Medical and Dental Education Program (SMDEP) through the Robert Wood Johnson Foundation (Program provided at Duke University and other sites for early college students)
- Student National Medical Association (SNMA) Chapters at Duke University, East Carolina University, UNC Chapel Hill, and Wake Forest University (Programs for elementary school, high school, and college students)

North Carolina Health Careers Access Program: Programs and Services[a]

Appendix C

NC-HCAP sponsors a variety of programs and activities throughout the state to promote careers in the health professions. Some of these programs are listed below. For more information, visit the NC-HCAP website at http://nc-hcap.unc.edu/.

CHSP: Clinical Health Summer Program
CHSP is a seven-week, full-time summer program geared toward disadvantaged students accepted to or enrolled in a health-related curriculum at Elizabeth City State University, North Carolina Central University, or the UNC-Pembroke. CHSP consists of full-time clinical experiences in healthcare agencies and academic enrichment experiences in healthcare agencies as well as supplementary coursework provided by NC-HCAP Careers Centers. Participants are paid at or above minimum wage.

HCIE: Health Careers Information and Enrichment Workshops
The HCIE Workshop is a hands-on outreach program designed to increase the interest, number, and motivation of disadvantaged students in upper elementary, middle, and high school who are considering a career in the health professions.

HPF: Health Professions Forum
Conducted at a North Carolina college or university campus once or twice each year, the Health Professions Forum provides disadvantaged undergraduate students with information about the health professions programs available in North Carolina and arranges opportunities for them to talk with current health science graduate students as well as graduates and representatives of health professions programs. Forums are free and open to all undergraduate students interested in a health career.

ISIS: Inspirational Speakers in Science Lecture Series
Held once each year in conjunction with the Health Professions Forum, the ISIS Lecture Series exposes undergraduate students to prominent minority health professionals and scientists who discuss how they overcame the obstacles often faced by students of color while pursuing their educational and professional goals. The ISIS Lecture is free and open to all undergraduate students interested in a health career.

NC-ARC: North Carolina Access, Retention, and Completion Initiative in the Allied Health Sciences
NC-ARC prepares disadvantaged undergraduate students at five UNC System institutions for successful matriculation into professional allied health degree programs through a series of teleconference courses offered each semester by the Department of Allied Health Sciences (DAHS) at UNC Chapel Hill as well as through a network of mentors provided to all participating students.

a NC Health Careers Access Program. Programs and Services. Available at: http://nchcap.unc.edu/programs.html. Accessed August 4, 2006.

Appendix C

North Carolina Health Careers Access Program: Programs and Services

Seminars: NC-HCAP Enrichment Seminars
NC-HCAP Enrichment Seminars are a series of seminars targeted at undergraduate students considering careers in the health professions and are held on the campus of UNC Chapel Hill throughout the fall semester.

Parental Warfare: Parent Workshops
The Parent Workshop provides parents and significant others of disadvantaged students with strategies and support to help their children develop into caring, engaging adults who are proactive in their personal, educational, and professional pursuits. Workshops are conducted in the community at Area Health Education Centers (AHEC), public schools, and various community-based organizations.

SEP: Science Enrichment Preparation Program
Held each summer on the campus of UNC Chapel Hill, the Science Enrichment Preparation (SEP) Program is an eight-week, honors-level academic program for disadvantaged undergraduate students (rising sophomores and juniors) who plan to pursue careers in healthcare.

July 27, 2011

The Honorable John D. Dingell
Rayburn House Office Building, Room: 2328
Independence and S. Capitol St., S.W.
Washington, DC 20515

Dear Mr. Dingell:

The National PACE Association (NPA) appreciates the opportunity to respond to your question for the record on the Program of All-inclusive Care for the Elderly (PACE), as follow-up to the House Committee on Energy and Commerce, Subcommittee on Health hearing, *Dual-Eligibles: Understanding This Vulnerable Population and How to Improve Their Care*, on June 21, 2011. The following addresses the question submitted to NPA:

The Honorable John D. Dingell

I would like to ask my questions of Mr. Bloom. As you know Mr. Bloom, Michigan has four PACE providers currently, including Henry Ford Health System- Center for Senior Independence located in Detroit and which serves Wayne County, and also has two additional sites under development. PACE has proven successful in Michigan by taking a patient-centered approach to care that has provided significant savings to Medicaid and Medicare. I particularly commend the PACE program's ability to help keep individuals in their homes, which is far less costly than nursing home care.

PACE serves those under the age of 55 years who are eligible for nursing home care. According to your testimony these individuals have significant disabilities and chronic illnesses, and rely on family caregivers or others to help them with their daily activities.

1. Now Mr. Bloom, I would like to ask you the same question I asked Mr. Egge, given the unique challenges these individuals face in accessing care and navigating the system, what guidance would you provide to the Administration to help engage this unique population and their caregivers in the design and implementation of any new care model?

Response from the National PACE Association

The National PACE Association's response is divided into two areas: (1) guidance to the Administration to help engage dual eligibles and their caregivers in the design and implementation of any new care model and (2) demonstration proposals for expanding PACE services.

NPA's recommendations are based on over 25 years of successfully integrating Medicare and Medicaid covered services into a single, comprehensive benefit package for a frail, nursing home qualified, largely dual-eligible population. With monthly capitation payments from both Medicare and Medicaid, PACE organizations fully integrate both Medicare and Medicaid financing and service delivery at the provider level. Program participants receive a seamless, comprehensive benefit inclusive of all Medicare and Medicaid covered services as well as any additional services determined necessary to improve and maintain participants' overall health status. Today, 76 PACE organizations in 29 states provide care to approximately 22,000 adults aged 55 or older who are certified eligible for nursing home care. For beneficiaries enrolled in PACE, challenges in coordinating benefits across the Medicare and Medicaid programs and accessing necessary care are minimized to a great extent due to the fully integrated nature of PACE service delivery.

(1) Guidance to the Administration to help engage dual eligibles and their caregivers in the design and implementation of any new care model.

The following recommendations focus on the design and implementation of new models of care that would benefit and engage dual eligibles and their caregivers. Specific suggestions include providing integrated, accountable, and coordinated care; complete information about all available care choices; and options for enrollment.

Integrated, Accountable, Coordinated Care. NPA believes that many of the challenges Medicare and Medicaid beneficiaries face in accessing the services they need can be addressed by coordinated care programs like PACE that are held accountable for the full range of Medicare and Medicaid services required by dual eligible beneficiaries. The integration of Medicare and Medicaid financing at the plan or provider level eliminates existing fee-for-service incentives to shift responsibility for providing care between the two programs, and incentivizes the timely provision of preventive and primary care in order to avoid the need for more costly services in the future. Because the costs of providing inadequate care are ultimately borne by PACE organizations, they address program participants' care needs timely and comprehensively. While most other entities have the flexibility to recoup payment reductions by imposing premiums or cost-sharing requirements on beneficiaries or by altering program

benefits, the PACE organizations are prohibited from doing so and instead rely on high quality and timely efficient care to ensure program viability.

Integrated financing, however, is not sufficient to assure that all dual eligible beneficiaries' needs are appropriately met. It is essential to recognize differences among individuals within the dual eligible population, such as those with different levels of Medicaid coverage and distinctly different needs for health and supportive services. It is critical to understand these differences to develop successful approaches to ensuring that care provided to dual eligibles is both appropriate for the conditions and health status of those involved as well as integrated between the two programs. Efforts to integrate benefits that may be effective for a relatively healthy dual eligible population for whom Medicaid involvement is relatively limited are insufficient for dual eligible beneficiaries with more extensive long-term care needs, such as those enrolled in PACE. Our experience with PACE-eligible individuals, all of whom qualify for nursing home level of care, suggests that a provider-sponsored care delivery model is an effective approach to integrating care for this population. Insurer-based plans that integrate financing may not be designed to effectively integrate beneficiaries' care and manage their continuously changing needs across numerous, unrelated contracted providers.

Informed Choice and Educational Materials. Dual eligible beneficiaries must have the information necessary to make informed choices about their care. NPA recommends that the Medicare-Medicaid Coordination Office work with the Administration on Aging, States, Aging and Disability Resource Centers, single entry point systems and others to assure that complete, clear and accurate information about integrated care models is available to dual eligible beneficiaries. This information should include details describing integrated models' target populations, processes used to integrate Medicare and Medicaid benefits, and programs' performance on relevant quality measures, including beneficiaries' utilization and satisfaction.

It is important to recognize that the dual eligible beneficiary population is diverse in terms of its health care needs, ranging from relatively healthy individuals to those in need of extensive medical care and long-term supports and services. As beneficiaries' health care needs change, they should be informed of alternative choices. For example, at the point a beneficiary becomes eligible for nursing home level of care, in recognition of changes in their health care needs and the need for integration of medical care and long-term supports and services, they should be informed of services that are designed specifically to meet their needs.

Further, it is essential that CMS, other Federal and State Agencies, as well as private organizations undertake regular active efforts to educate dual eligibles about integrated care programs, and the information materials must be integrated as well. These educational informational materials should not be descriptive of Medicare and Medicaid as distinct programs; rather, to be meaningful, they should describe how these integrated care programs

work from the perspective of the dual eligible beneficiary. Medicare and Medicaid marketing requirements for integrated care programs should be written and reviewed with this specific objective in mind. Another area that requires explanation is the benefit of enrolling in an integrated care model from the perspective of improving care coordination and reducing fragmentation of care.

Enrollment. In addition to assuring that dual eligible beneficiaries are fully informed of their choices, they must have access to the various integrated care models and be able to enroll in them throughout the year in recognition of the fact that changes in health status may precipitate a need for a more integrated approach to care. It is critical that States' eligibility determination processes facilitate timely access to community-based long-term supports and services. In our experience, individuals pursuing initial Medicaid clinical eligibility and financial determinations are often faced with significant delays in the processing of these determinations, thereby delaying their access to needed community-based services and, in some cases, leaving little in the way of alternatives to nursing home placement. For example, a hospital discharge planner can complete a care assessment, based on a physician's order, and refer an individual to a nursing home for immediate placement. However, placement in community-based services, including PACE, can take six or more weeks in some states.

To assure that care is available in the least possible restrictive environment and to facilitate cost savings associated with use of community-based care, CMS should encourage and support states' efforts to implement eligibility determination processes that allow for expedited Medicaid eligibility determinations. In the context of PACE and potentially other integrated Medicare-Medicaid managed care options, it is important to allow greater flexibility in the coordination of enrollment dates. Currently, Medicare enrollment for PACE occurs on the first of the month and must be coordinated with Medicaid enrollment dates, thereby precluding PACE organizations from initiating the provision of formal care for as long as several weeks after an eligibility determination is made. Ideally, both Medicare and Medicaid enrollment could begin immediately following eligibility determination.

(2) Demonstration proposals for expanding PACE services.

In addition to developing new care models for the dually eligible population, NPA recommends that the Administration consider demonstration proposals that would expand access of PACE services to more dually eligible individuals and other vulnerable populations. The advantage of expanding PACE is that it is a tangible program with a proven track record of providing high quality care to the frailest segment of the dual-eligible population. While not all dual-eligible beneficiaries require the intensive services provided by PACE, for the individuals who do, PACE is a good alternative to permanent nursing home placement. Below are three demonstration proposals that are being developed by NPA and its members. These ideas have been submitted

to CMS and are outlined in my testimony from the House Committee on Energy and Commerce, Subcommittee on Health hearing on June 21, 2011.

First, is a demonstration allowing PACE organizations to enroll individuals under the age of 55 who meet their states' eligibility criteria for nursing home level of care. Under this demonstration, PACE organizations would be required to provide comprehensive, coordinated, accountable care but would have substantial flexibility to implement modifications to current PACE regulatory requirements in order to best meet the needs of this younger population.

Second, is a demonstration to allow PACE organizations to enroll high-need, high-cost beneficiaries, as defined by states, who may not yet meet their eligibility criteria for nursing home level of care and currently are not well served.

Third, is a demonstration to reduce PACE organizations' reliance on the PACE Center as the primary location for the delivery of service and expanding PACE organizations' use of alternative care settings and contracted community-based providers. A demonstration to test expanded use of alternative care settings and expanded use of contract providers would allow CMS, states and PACE organizations to evaluate the impact of these significant changes on a variety of participant outcomes, including quality of care and overall program viability.

If you have any questions or would like additional information, please contact Shawn Bloom at Shawnb@npaonline.org or at (703) 535-1567.

Thank you for your interest in PACE and for your long-standing commitment to serving the needs of vulnerable individuals.

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