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High-Need, High-Cost Patients: Challenges and Promising Models

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Alliance for Health Reform**

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MARILYN SERAFINI: Okay, we are going to go ahead and get started. I'm Marilyn Serafini, I'm with the Alliance for Health Reform, on behalf of our honorary co-chairs, Senator Cardin and Senator Blunt, I would like to welcome you to today's briefing on High-Need, High-Cost Patients: Challenges and Promising Models. As we test new models for delivering healthcare, there is significant attention to those patients with the greatest healthcare needs and who are therefore some of the costliest patients. We often hear the statistic that 5% of the population in the U.S. is responsible for about half of the nation's healthcare spending. Today, we are going to be talking about the challenges of caring for this population and emerging ideas and models.

If you are watching live on C-SPAN today, or if you are also following us – following this conversation on Twitter, we encourage you to submit your questions. The hashtag is #HNHC high need, high cost. Again, it's #HNHC.

I would like to thank our partner and supporter in today's briefing, the Commonwealth Fund, which has done quite a bit of work in this area and especially Melinda Abrams who is also my partner in moderating today. Melinda is Vice President at the Commonwealth Fund and leads its healthcare delivery system reform program. You can see her full bio in our packets today, as you can see the full bios for all of our speakers. I'm going to turn it over to Melinda now. Melinda is going to help us understand this population, the challenges in instituting effective programs and what is in the works. And then she going to introduce the rest of our panel. So, Melinda.

MELINDA ABRAMS: Thank you very much, Marilyn and thanks to our partners at the Alliance for Health Reform for today's briefing.

So I'm just going to do a little bit of context setting, set the stage and really then hand it over to our panelists and experts today. As Marilyn mentioned, health systems, payers, providers, are increasingly focused on the high cost patient. What we refer to as the 5% population that she mentioned – five percent of the patients who account for about 50% of our healthcare expenditures. The reason for the focus on this population is its strategy by which we could try to improve health outcomes and lower costs of care for our neediest, frailest, sickest patients. It's focusing on cost alone, without considering the needs of this patient population, might not properly identify those for which interventions might be most effective or for which the policies really need to change. So, we partnered with Johns Hopkins University and conducted a series of analysis of national surveys. There are two data briefs that are being released today, they are in the back of the room or when you came in. Really one looks at some of the demographic characteristics of the population, their expenditure, their use and the second one looks at how well the system is meeting the needs of the population.

So, who are these high-needs, high-cost patients? In terms of the analysis that are being released today, the way it was defined in this national survey, were people who had – adults who had three or more chronic conditions and a functional limitation, and Karen Davis will get into this a little bit more. But essentially what we looked at was affecting

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their ability to care for themselves or perform routine daily tasks. There are about one in 20 U.S. adults who qualify as high-need, high-cost. It's about 12 million people. What we find is that when you look at this population, they are much more likely than all adults – they are actually more likely than just adults with chronic conditions only, to be older, to have low income, to have public insurance and as one would expect, also to use a lot of healthcare services. So essentially, this population is sick, they are often frail and they are very expensive, they are using a lot of healthcare services.

So in this chart, it kind of brings home the point that in addition to the needs, there is also a lot of costs associated with them and that when you compare those with the function – with the chronic conditions plus the functional limitations, compared to those with multiple chronic conditions alone, you see much higher level of spending. I will also tell you that in addition to their increased total cost of care, there are also higher out-of-pocket costs. So even though they have greater unmet needs, there are greater costs and there are affordability issues for this population.

While they have higher utilization and higher needs, we have also found, as part of this analysis, this is in the second brief about system performance, they also have greater unmet needs. Then in addition to their unmet needs – and these unmet needs are higher, whether you are looking at those with multiple chronic conditions alone or the total population. In terms of system performance and just looking at a few other metrics, they are more likely to report unmet needs. They are more likely to say it's difficult to obtain easy access to a specialist, they are less likely to report good communication with their providers. However, they are more likely to report having a patient-centered medical home, so that is the good news.

One of the important pieces you will hear about on the panel today and will mostly come from Dr. Peter Boling, who will be our last speaker, is that there are a number of models and programs that exist, that can effectively meet the needs of this very sick, frail, functionally limited population. And there is quite a bit that we do know about the programs that work. This is based off of an analysis conducted by my colleagues at the Commonwealth Fund, but this is just one of many analyses. There are several that have been published that look across at the evidence and there are a number of promising programs. And part of what is needed is targeting those that will most benefit from the interventions, engaging patients, good information technology, coordination, monitoring care over time. So we do know some pieces that are needed to effectively meet the needs of this population and there are evidence-based programs that currently are out there. However, there are some barriers to the spread and scale of some of these promising programs and we are going to hear about more of this today, both from Karen Davis as well as also from Katherine Hayes of the Bipartisan Policy Center.

The first and most important, which many of you probably know, is the misalignment of financial incentives that – just to take two quick examples, while there are, with the accountable care organizations or Medicare Advantage Plans, like value based payment to the organization, we are not necessarily seeing that value based payment is the same as

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value based compensation. We are not necessarily seeing that trickle down to the front lines of care. So we are still seeing some misalignment and it's not necessarily being felt at the front lines of care. Second, and we will hear more about this from the speakers, is that the financial incentives do not always accrue to the party that undertakes the investment. So if the front line providers need to invest in the care management program, but the savings go to the payer and not fed back to the provider. We have this misalignment. Of course, with new payment models and under value-based payment, we do see a greater interest and a focus on high-need, high-cost patients and a greater interest in spreading and scaling these models. This is very exciting. And that is why it's so important to have panels like this, hear about the data, hear about how the system could potentially better meet the needs of these patients. There are a number of other barriers and the only other one that I will mention, that I think is really important, is how a lot of these patients have, in addition to having physical health needs, a lot of them have behavioral health needs and social service needs. Sometimes, really to improve their outcomes and lower the cost of care, we probably need greater flexibility to cover some of the non-medical services. Some of the personal care. And also in different settings. Not everybody can make it to the doctor's office. Some need to be cared for at home or in community based settings.

Toward this goal of trying to improve outcomes and lower cost for high-need, high-cost patients, there are five foundations that have come together to support healthcare organizations to adopt evidence based interventions. I'm really proud to announce that I'm working very closely with the John A. Hartford Foundation, the Robert Wood Johnson Foundation, the Peterson Center on Healthcare and the SCAN Foundation. There was a perspective published in the *New England Journal of Medicine* at the end of the July that talked about this collaborative and what we were planning to do going forward.

That's the introduction. Now, I'm going to turn it over to the experts on the panel. First speaker will be Dr. Karen Davis, who is the Director of the Lipitz Center for Integrated Care at Johns Hopkins University. She will be followed by Katherine Hays, who is Director of Health at the Bipartisan Policy Center and then we will hear from Dr. Peter Boling who is Director of Geriatrics at Virginia Commonwealth University, who will give us a really important on-the-ground perspective. A physician treating patients in home-based primary care centers. Thank you very much, Karen?

KAREN DAVIS: I'm going to focus on Medicare beneficiaries with physical or cognitive impairment. Most of the data that you will see relates to Medicare beneficiaries with two or more limitations of activities of daily living or people who are diagnosed with Alzheimer's or people with mild or severe cognitive impairment. Kind of two shifts in your thinking that I'm going to try to stress. First of all, this population needs both medical services and long term services and support. Nearly all of those with physical or cognitive impairment have chronic conditions. Two-thirds have three or more chronic conditions. The second shift, I think we are used to talking about how to save money in the Medicare program and how to reduce hospitalization or use of emergency rooms. What I want to insert into your thinking is the importance of helping people stay at home

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as a goal in and of itself, but also the importance of reducing or delaying nursing home placement and achieving savings. Not just to Medicare but also in Medicaid and in family budgets. So the need for integration of care between medical, long-term services and support and to put this in the broader context of total spending on healthcare.

Melinda mentioned the misalignment of incentives, that is particular true when you try to integrate medical and long-term care services, so I will share with you some policy ideas on how we might move forward on the front. The first point that I want to make is that this population, while it has all the characteristics that Melinda mentioned – being low income, older, multiple health problems – they are not synonymous with duals. One-third of the Medicare beneficiaries with physical and cognitive impairment have incomes below twice poverty, but they are not covered by Medicare and that is the sub-group that is the hardest hit. It is hardest hit whether you look at total Medicare spending – Medicare spending is twice as high for people with physical and cognitive impairments as those beneficiaries without. But you also see that is true in this population without Medicaid, with incomes below twice poverty. Medicare spending over \$11,000 a year. They are also spending an extraordinarily high percentage of their income out of pocket on this range of services. Almost half of their incomes, for those below twice poverty, not on Medicare that goes for out-of-pocket costs for health and long term care services.

The next point that I wanted to make is how high at risk this population is for nursing home placement. Using the health and retirement survey, my colleague, Amber [name] at Johns Hopkins has followed people for 14 years who started out, older Medicare beneficiaries who started out living at home and over the 14-year period, 35% of them wound up in a nursing home. So very high risk for nursing home placement, for those with dementia. 33% for those with two or more limitations of activity of daily living. Even those with mild cognitive impairment, 29% in nursing homes. On average, it takes about five years before somebody with dementia winds up in a nursing home. Six years for those with ADL, but seven years for those with mild cognitive impairment. I stress this because if you could delay by even nine months, nursing home placement or prevent it, on average, saving nine months of nursing home care through effective models of care, you could save \$112 billion in nursing home expenditures over 14 years. Now, not all of that goes Medicaid because a lot of it is out-of-pocket costs by families, but 35 billion in cumulative Medicaid savings, over 14 years, just by delaying nursing home placement by nine months.

In addition, Dr. Welling has looked at entry into Medicare, spend downs, so looking at older Medicare beneficiaries who were not on Medicaid and a trajectory over 14 years into Medicaid coverage. 19% of those with physical or cognitive impairment and high out-of-pocket expenses, which is defined as more than 10% of their income, wind up spending down into Medicaid. Again, that is disproportionately true for the near poor, but even in the very highest income group, those with the incomes more than four times poverty are at risk of spending down into Medicaid. Again, if you could lower the spend down rate that comes with high out-of-pocket costs for people with physical and cognitive impairment, you could save \$1.6 billion in Medicaid outlays.

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So it's time to begin to think about, what are some policy solutions that would bring medical and long-term care together and would provide better financial protection against those expenses? I wanted to share with you briefly and I don't know if you have heard of a proposal called Medicare Help at Home that was published in *Health Affairs* earlier this year, where we found that covering a targeted home care benefit under Medicare, up to 20 hours a week of personal care services or equivalent \$400 a week for home and community based services under Medicare, could be financed by a combination of Medicare premiums, at \$42 a month and an increase in the payroll tax of 0.4% on employers and employees. So, it's possible to start with a targeted benefit, improving Medicare coverage of home and community based care. That would enable organizations that are willing to integrate medical and long-term care services, to begin to take financial accountability for the entire range of services. We refer to these as integrated care organizations, they basically may start out as accountable care organizations that now share in Medicare savings. But these organizations would be eligible to share in savings for reduced or delayed nursing home placement. They would have an incentive to provide support to family care givers, develop individualized care plans based on patient preferences and incorporate innovative models of care that we will hear about today, like independence at home, but others like hospital at home or mind at home, that provides support for family care givers of people with dementia.

So this is a quick overview of this Medicare Help at Home benefit and how it would promote better integrated care. The benefits that would accrue to individuals across the income spectrum, but the main point is that the current Medicare benefit policy is poorly suited to beneficiaries with physical and cognitive impairment that less than a third of Medicare beneficiaries are eligible, about a third have low incomes and are at high risk for future Medicare eligibility and nursing home placement. So there is an important need to expand Medicare benefits, to include home and community based care, to promote the growth of integrated care organizations that would share in savings for reduced nursing home placement. Thank you.

MARILYN SERAFINI: Thank you so much, Karen, we are going to move the conversation now to Katherine Hayes and I will remind you to join the conversation on Twitter using the hashtag HNHC and we are not at our question and answer session yet, but it's never too early to start thinking about your questions. You can start sending us your questions on Twitter using HNHC. When we do reach the question and answer portion of our program, you will be able to ask questions both via Twitter – also we have two microphones in the room, also you have a green card in your packet and you may ask questions that way and we will have staff moving around the room to collect those cards. But right now, let's turn to Katherine.

KATHERINE HAYES: Thank you very much and thank you for including me in today's discussion. First of all, I would like – for those of you who are not familiar with the Bipartisan Policy Center, it's a non-profit organization that was formed in 2007 by four former Senate Majority Leaders. Senators Mitchell, Baker, Daschle and Dole and the

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Health Project – I’m the director of the Health Project and our two co-chairs are also two former Senate Majority Leaders, former Senate Majority Leader Tom Daschle and Bill Frist.

So before I get into any level of detail about this, I would like to tell you a little bit about BPC’s process and coming up with policy recommendations. Our goal and the goal of my health project is to identify pressing issues in public policy in the areas of Medicare, Medicaid, public and private health insurance and long term services and supports. We also have done work in delivery system reform. And a number of us there at BPC have been former Hill staffers and one of the things that I think is really important about coming up with policy recommendations is recognizing what our audience, folks in the agency and folks on the Hill, need. And those are policy recommendations that have a certain level of detail. I can remember so clearly sitting in the Senate and having folks come to me and saying, here is what we need to do. And as a young staffer, my question was, but yes, how do I do that? How do we implement that in the Medicare program? How do we think about reimbursement? Who should be paid for that? What should they be paid? And so our goal here is try to come up with concrete recommendations that can help guide agency and congressional staffers.

I’m going to skip over – I just had this as a – Melinda has already talked about this, but this is what we know about caring for high-need, high-cost patients. But the most important thing is that BPC is focusing on barriers to reimbursement for successful models of care. In that, we are looking at programs in both Medicare and Medicaid and trying to come up with concrete policy recommendations to remove those barriers and make it easier for providers to take a look at a patient with high needs, determine what they need, develop a care plan based on what they need rather than what is covered under the Medicare and Medicaid programs. So when Bipartisan Policy Center – when we sit down to work on an issue, we look at the current research, we then embark on significant stakeholder engagement, we usually spend about a year to a year and a half meeting with provider organizations, consumer organizations, health plans and also working with experts in the field – academicians that have done research in this area. Once we have done that, we come up with policy recommendations and then we go out and we vet those again. We go back and ask the questions of those stakeholders: Did we get it right? And so when we have these recommendations put together and we go back to the leaders, we go back to Senator Frist and Senator Daschle, we know what the pros and cons are, we know what the pitfalls are, and we can tell the leaders that they have been thoroughly vetted in trying to come up with proposals. We then take another step, which is something that is very difficult sometimes. It’s recognizing, there are a lot of things, I think we can all come to an agreement on policy recommendations if we didn’t have to worry about the politics and the federal budget. So that is another filter that we sort of run these issues through. We think about what it is going to cost in the Medicare and Medicaid program. We have a lot of these policies costed out. We have a data use agreement and with CMS and we are working through Acumen LLC with Medicare and Medicaid claims data and a few other databases to try to get a sense of what things are going to cost. Then finally, in thinking about it politically, we think about what the

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current environment is on the Hill, what the appetite is for change. Whether or not there is a possibility of getting something done in the near term. We also have long term recommendations, but in the short term, we try to find things that could be done within the next year or so.

So in looking at care for high-need, high-cost patients, we broke this down into two separate reports. The first report will be looking at reimbursement models that serve dual eligibles. And with that, we will be looking at Medicare Advantage Special Needs plans, we will be looking at the demonstrations such as the financial alignment initiative. Looking at the PACE program. And once we came up with those recommendations, we first had initial concrete amendments to each of those reimbursement models, we thought to ourselves, does it make sense to really try to take two programs and starting with the duals, to take two programs that are really meant for two different things. They are meant to address two populations and when you are thinking about dual eligible, or should we think about a way to build a program from the ground up using some of the existing – what we have learned today through Medicare Advantage Special Needs plans, the demos and through the PACE program. So we will be coming out with three sets of recommendations in September. One are amendments to existing programs, the second will be a new framework for providing services and by “new framework”, I recognize, again, being a former Hill staffer, that the last thing you want to hear when you come up to the Hill, is, oh, I have an idea for a new program. And how difficult that is. So what we are thinking about is building on an existing structure and we are looking at the three-way contract that is currently being implemented through the Financial Alignment Initiative that allows states, the Federal government and health plans to work together to serve duals, but we also make recommendations to allow provider organizations to enter into three-way contracts with CMS and the state for dual eligible individuals. And finally, we make some recommendations on improving administration of programs for dual eligible individuals; and we started with duals because we were worried about how we were going to pay for it. We recognized that these are not only health related services, but there are a lot of social services and supports there. And with Medicaid, at least with the duals, we had an infrastructure there. We had a revenue source of both Medicare and Medicaid to help offset those costs.

The next phase of this project will report in April of 2017 and we will be looking at the same programs, but making recommendations for the Medicare only populations. And some of the things that we have been looking at in terms of our preliminary findings is, looking at the existing reimbursement models. What sort of flexibility is there in those reimbursement models to cover services that are not today considered Medicare covered services? So initially, some of the evidence shows that the things that we should be looking at are nutrition services, housing related services and medical transportation. So we are looking at the Medicare Advantage Program, we are looking at Accountable Care Organizations and also looking at – particularly focusing on some of the limits and the alternative payment model such as the comprehensive primary care initiative and a few others, but we will be issuing a report earlier in the fall that lays out what those barriers are and then next year we will issue recommendations. Thank you very much.

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MARILYN SERAFINI: Great, thank you. So let's turn this over now to Dr. Boling.

PETER BOLING: Thanks everybody for inviting me here. I'm going to take you through my journey, which began at Virginia Commonwealth University, when I joined the faculty in 1984 after traditional training in internal medicine, primary care. I thought I pretty well had things figured out. The hospital level care, the clinics, I thought we were doing a great job as a safety net hospital. You can see the award that our hospital won for quality and safety a couple years ago, reflecting the emphasis on that at our place. And I started making house calls. That was the thing that I was given to do as my first job, other than seeing patients in clinic. As I did that, all of a sudden, things got turned upside down because I found out that the patients that I was seeing at home were really not able to access healthcare in a regular way that the patients that were able to come to clinic could do. And they were having a terrible experience of care and landing up in the Emergency Department in the hospital, unnecessarily. It was obvious to me at that point that this approach would be a better approach and my journey since then has been to figure out how to make that happen. So as you can imagine, these patients, having difficulty getting out of their house, difficulty making appointments, transportation, family issues and so on. We are having really discontinuous care and then the care that was rendered in hospitals often didn't translate back into the home and the home-based care plans that were laid out in the hospital oftentimes were poorly aligned with what the patients really needed. I'm sure I'm not telling you anything that isn't obvious common sense. There were poor interactions between the office based medical professionals and the home health agencies that were sent to these patients and ultimately, the patients and their families were basically desperate for help. So, as a result, they were bouncing in and out of the ED and the hospital. Here is a picture of a house where I actually did make house calls. You can see the arrow pointing to the bedroom. The rest are internet pictures, they are not the actual patient, they are not the actual stairwell. But we would tell these patients to come back to the hospital in three to five days for follow-up, obviously impossible – a stretcher down those stairs and that sort of thing. We have already heard today from other panelists how important it is to contemplate a care plan that provides for both integration of social supports and medical care. The social supports are partially supported now. Not sufficiently well in all cases, but the medical care component is typically missing and we are looking to add that back in.

So now I will talk to you a little bit about the house calls program mechanic. We are going to take patients who are too sick to go to clinic, basically, and take care of them at home. We are going to look them over thoroughly at home in a comprehensive way and then we are going to see them as often as they need to be seen. So our team is going to go out there on a same day basis if they have an urgent problem, on a scheduled basis otherwise. And as we go into the home, we are going to see what is really wrong and what needs to be addressed. Somebody once said to me, the only true medication reconciliation is done at the kitchen table. You can call people up and ask them if they are taking their medicines, but until you go to the kitchen and you see all the pill bottles, some half-filled, some duplicative and all that and sort it out, you really haven't done

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medication reconciliation. These are the things that happen at the same time: You assess functional and cognitive status more accurately, you get a picture for what the environmental safety issues and the real needs are and you also induce a supportive therapeutic relationship which is unique really, I have worked in pretty much every environment and that doctor/patient relationship in the home is completely different. In order to do this well, I found out after a couple of years of doing it by myself, you have to have a team. So you have to – I'm not going to show you a lot of evidence to tell you about the team, but I'm going to say that you have to have a team working with you. You need social worker, you need triage nurse, you need other people to support the effort. And now, as we move forward into an era where we are looking for evidence-based models of care, you need somebody to analyze and track your data and your outcomes to make sure that in fact, you are delivering the goods.

So, there is a core team here at the Center, which includes the patient and the family and then all of the other usual cast of characters around the edge. We have already talked about the 550 calculation and targeting the sickest, most needy population. So in the world where I live, there are probably two million patients in the country qualified for independence at home. Probably three or four who are chronically ill and limited enough in their abilities to get out of the house, that they should probably receive most of their care in their residential setting. And there are some others who are short term in this similar situation. So my friends and I had been working at this for a couple of decades, trying to figure out how to do this fee-for-service. We worked hard on getting the fee-for-service reimbursements raised as much as we could, and at that point, we still found that the team was not adequately supported. So we were looking for a way to construct a mechanism using shared savings as a way of paying for the team based approach that we felt was most appropriate for these patients. So we said, it's going to be voluntary participation, we are not going to take away people's health insurance. This would make it popular for people to sign up. They would have to agree to have their data analyzed and then we were gonna target very sick people. So the criteria for that were hospitalization within the last 12 months, subsequent use of Medicare post to keep care services, which also would give us functional measures. Two or more serious health problems and our patients are more like five or six serious health problems, to a more ADL deficit and in the demo, it's 60% or five to six ADL deficit. A care model, which is a house calls team, use of electronic health record and a program size of at least 200 capacity at each local site. Those were the criteria. Then we wanted to make sure that the beneficiaries were going to be protected, so we put in requirements for quality measures and guaranteed minimum savings, which was important to getting the bill passed through Congress. Finally, the ineffective programs would be either remediated or dropped so that we wouldn't have people in this business who didn't belong. We had very strong Congressional support, so Ed Markey and Ron Widen were the original introducers of the bill, as you can see here, and we passed legislation – it was concurrent with the ACA to modify Medicare to start this demo at 19 sites around the country. The demo involved sites of a variety of different types. You can see here listed, the variety as well. We put together a collaborative so that we started working together to standardize the process of care and to learn from each other as we went along, since not everybody was at the same

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level of proficiency from the beginning. And here are the results from the first year, as published by CMS, showing it was very popular last summer to hear this news come out - \$25 million save across about 8400 high cost beneficiaries that were enrolled at that point, \$3,000 per beneficiary was the estimate. Most of the programs participating had enough savings to participate in the shared savings component and all of the programs improved on at least three of the six core quality measures. Seven sites met all six. These are some of the data, again, from the CMS website, so we are talking, at least in the program I'm working in, at around \$1,000 per month, per patient, in terms of Medicare savings, was the estimate - or 12% total cost reduction in these very costly patients. This led to extension of the demo by two years. A bill introduced into Congress by Representative Burgess and passed unanimously. This summer, second year savings were announced on the order of 10 million, a total of 35 million over two years. By providing better care to patients who are very function limited, very seriously chronically ill, very expensive and absolutely sort of disenfranchised from healthcare without this model of care.

Work is ongoing now on a very important aspect of this, which was to calibrate the shared savings model, because it is critically important to provide sufficient incentive for these programs - small, local programs, to grow and thrive in an environment which is very rapidly changing and I will tell you from having looked around, that most of the other organizations that are doing healthcare for chronically ill beneficiaries have not incorporated the house calls concept nearly as much as I would think logically they would do, given the extent of need and what we have demonstrated, I think, at this point, as the effectiveness of the model. I will stop there, thank you.

MARILYN SERAFINI: Thank you. So we are going to turn now to the Q&A section of our program and again, please feel free to come to the mics in our room. You also have a green card in your folder. If you would prefer to write a question, our staff will be circulating around the room to collect your cards and they will bring your questions up to us. Again, if you are watching live on C-SPAN or following on Twitter, you can tweet your questions to us at #HNHC, so we already have a question up here at the mic. If you would kindly introduce yourself.

AUDIENCE MEMBER: Tony Housner, formally with CMS. One of the issues that I encountered there was the lack of arrangements across the post-acute care settings. So when a patient was released from a hospital, there was no coordination between the nursing home, rehab center, home health and other forms of post-acute care care. There is nobody making a decision as to who should - where the best place should be for the patient, integration of the services, coordination between the different programs. That struck me as a great deal of fragmentation. I know some of the models you talked about today address that to some extent, but that is a major issue that, I don't know that that has been adequately addressed.

KAREN DAVIS: I think you have certainly touched on a major issues and the importance of improving transitions in care that involves having information, flow across

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the settings that you have identified. It involves working with the patients. Dr. Boling talked about having a follow-up appointment with a primary care physician within a certain period of time. That certainly is important. Other models that are being tried are using personnel from the hospital setting, whether it's nurses, nurse practitioners or specialists, to actually follow the patient's post discharge. But I think we have got a long way to go to really improve those transitions in care. And I would say, also importantly are having quality metrics that look at things like SNF rehospitalization rates or SNF discharges to home versus discharge to long stay nursing facility. So an important problem, a lot of pieces to make that work well.

MARILYN SERAFINI: Okay, great. Let's move to this microphone.

AUDIENCE MEMBER: I'm Dr. Caroline Poplin, I'm a primary care physician, I'm also an attorney and have spent some time representing Whistle Blowers who allege Medicare and Medicaid fraud. You haven't talked about non-profit versus profit. I assume that means you are assuming everything is for profit. Out in the field, you see a big difference between say, a visiting nurse association, which is non-profit and the way healthcare is delivered by private or profit organizations. The home care is directed towards the people who need it – in the broad category – the people who need it least. So the difference between cost and reimbursement is greatest. It is more profitable to treat people who aren't as sick. And you haven't said anything about developing non-profit community services, which would be available to people on different plans – some Medicare, some Medicaid, day programs that are non-profit. This all seems to be in a business setting and I think – well, no one has said, “profit, non-profit”.

KATHERINE HAYES: When I say – you know, I think about our recommendations and we are looking at contracts between the states, the Federal governments and neither plans nor providers, there is no expectation on our part that they would all be for-profit. In fact, I think one of the largest providers of care for dual eligible individuals are non-profit plans and non-profit providers, when you think about the community health centers, when you think about a lot of the non-profit hospital systems out there that are central to care for low income populations. And certainly in the way we are trying to restructure reimbursement, we are hoping that this will encourage providers to contract with local community based providers who have the experience in providing services to these populations.

KAREN DAVIS: If I could add to that, I think you are getting at a key issue. It's one thing to share in savings or giving plans a financial incentive to take accountability for the full range, but how well do they perform? And we know that there is a difference by non-profit, for-profit ownership. But we don't seem to have a policy that moves in that direction and even non-profit status doesn't mean that they really perform as opposed to just being a subsidiary of a for-profit entity. So I think the important thing are the right quality metrics and public performance and that goes beyond the sorts of things we have looked at, to really getting family experiences with care, with having patient experiences with care and with having that information broadly available.

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AUDIENCE MEMBER: Let me say one more thing, quickly. It also changes the treatment of the providers at the front end. The home health aide; for-profit sometimes take people right off the boat, pays them minimum wage, gives them no benefits, gives them no possibilities for advancement or training and when they become disabled from lifting heavy patients from one place to another, they fire them and get somebody new. A non-profit is less likely to do that.

MARILYN SERAFINI: Okay, thank you. We have a number of questions here for Dr. Boling about the independence at home. So I'm going to group them together and give them to you in a package. A lot of them are asking about the savings. First, what factors are accounting for most of the savings in the model and regarding the savings, the evidence that you already have for the savings, are you concerned that the savings in your one is ten million, versus your two, 25 million? So let's start there and then I will follow up with the rest.

PETER BOLING: Okay, thank you. So the evidence related to the savings is predominantly being driven by unnecessary hospitalization. So hospitalizations that were occurring for ambulatory care sensitive conditions such as diabetes, congestive heart failure, where an easy action, early on in the course of post hospital care, would result in the patient being able to remain safely at home. The same with Emergency Department visits and rehospitalizations, post hospital – I think I'm repeating myself. So, the difference in savings between year one, which was reported out at 25 million and year two, which was reported out at ten million, is the subject of an ongoing discussion about the best way to measure the expected costs, which is a complicated matter. Those of you who are involved in health policy as actuaries may have a better understanding of this, but it is very challenging to figure out what the reference standards should be and we think we have learned a lot of from the demo at this point, that should enable us to do that effectively in the future.

MARILYN SERAFINI: So regarding information you have in your evidence so far regarding severity, functional status, et cetera – what kind of information do you have that feeds into your evidence so far? This questioner wants to know how you will find eligible participants for your program. Do you have any issues finding participants?

PETER BOLING: The matter of finding eligible participants is simply a matter of looking around the community and seeing who is having difficulty accessing healthcare as a result of being functionally impaired and seriously ill. I think many of you who are listening, may have had some experiences within your own families of individuals whose need to access healthcare was not easy to meet. You might have to take a day off to go with your mom or your dad to the hospital or find somebody to go with them. How do we find these people in real life? So people who are discharged from nursing homes oftentimes are in a recuperative phase, may not get back to a level of functional status where they are able to easily transport themselves or be transported. There are lots of people like this in the community, it's merely a matter of putting systems in place to

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identify them. Home health agencies know who they are, the nursing homes know who they are, the patients and their families know who they are. The ED physicians know who they are, because they keep turning up back in the ED and people wonder, why are they here again? We just saw them last month for the same thing. So it's not actually a matter of difficulty in finding these people, it's a matter of aligning the care design with their needs and referring them to programs which need to be created, that will ultimately meet those needs. So the goal with independence at home is to create a model which can be transformed and available to everybody, that is our goal. And I will mention that four senators, Corn and Markey, Bennett and Portman have introduced Senate Bill 3130 now, which is making its way into the legislative process to take independence at home and transform it into a national program.

MARILYN SERAFINA: Okay, let's move to this microphone.

AUDIENCE MEMBER: Thank you, Caitlyn Connolly with the National Employment Law Project. Thanks, this has been fantastic and I think it's very enlightening and hopeful to see such great reforms and proposed deliver models. I wonder if any of you have looked at, what I would say, would be the greatest barrier to their success, which is workforce shortages and vacancies and specifically with the direct care home care workforce. We could argue that someone who sees an individual five times a week is going to be the best champion and person to prevent rehospitalizations and prevent unnecessary complications. How is that integrated into any of these models or the larger workforce issues?

KATHERINE HAYES: In addition to the project that we are working on right now that looks at high need, high cost individuals, the Bipartisan Policy Center is also looking at long term services and supports, financing long term services and supports. One aspect of that is finding caregivers and providing appropriate support for caregivers and I will say quite candidly, the leaders for that project are Senators Daschle and Frist and also former CVO Director, Alice Ribland and former Governor and Secretary Tommy Thompson. When we have had discussions about these issues, it's so difficult. The question of, we are trying to find ways to help support family members and if you look within the existing system of care, could you allow an individual? Could you allow a plan, for example, to provide support for a family caregiver? There is the issue of – as you know, I'm sure the labor laws that have recently come out with respect to reimbursement, it seems like there are so few easy answers out there and we are really struggling with them and we are looking at them to try to strike the appropriate balance by making sure that there is an appropriate number of caregivers. But at the same time, the issue of buying out existing care, which is so difficult – so much of the long-term services and supports that are provided, are provided out-of-pocket by family members and the consequence of trying to pay for that and buy that out, seems almost overwhelming to policymakers. So if you have some great suggestions, we would love to hear them.

MELISSA ABRAMS: You suggested this in your question, but what we find when we look across the country at some of the successful evidence-based models is how it

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requires a different kind of team. That it isn't – and Dr. Boling talked about this, when he listed the members of the team, but it often requires more social work and sometimes the mind at home, or the capable at home, sometimes requires bringing a handyman in to the house and lifting up rugs and putting on bathroom bars and tub bars. And I think part of where we see – when we think about workforce, we really need to broaden our perspective – not that you were suggesting this, but we need to broaden the perspective and think beyond doctors and nurses to the complex care managers and the social workers and community health workers and I think we are still learning, I think we are still very much in transition about well, not so much the functions, but exactly like, well, what kind of licensing and accreditation and how does that work across states and do we need better training programs? Certainly. But maybe what we need more of is not necessarily at the physician level as much as training of physicians and nurses and PA's and MPs to work in these teams that are much bigger and broader, that include community, pharmacy and complex care managers. And there is a lot of intensive TA to kind of get to that new paradigm, both of care but also of delivery and of training.

MARILYN SERAFINI: I'm just going to follow-up on that for a minute, because it raises another question. That was a question about workforce, but the kinds of care you are talking about, raises a question about non-medical services, which a number of our panelists raised today, we have a need for non-medical services. And I would like to ask our panelists to dig into that just a little bit deeper. We talked a little bit about what kinds of non-medical services – housing, medical transport, nutrition – I'm sure there are others. How much of the current movement toward new delivery system's models is helping to find new ways to pay for those non-medical services? How far down the road are we in getting there?

KAREN DAVIS: All of those services are important. I tend to focus first and foremost on personal care services, certainly for people who can't take care of themselves. That is the number of issue about being able to maintain their independence. One of the models that I'm very excited about is the Medicaid community first choice program, which for people who meet the qualification for nursing home placement, can qualify for personal care services in the home, that actually can even be family members other than the legally responsible guardian for an individual and kind of relevant to one of the points that was made earlier. Those services are provided through agencies that the state, for example, in Maryland, certifies. That the people providing the personal care services are trained, qualified to perform that role as well as providing the labor requirements, whether it's over time or other types of labor conditions. Community first choice, using an agency model to employ personal care workers to assist individuals who otherwise would qualify for nursing home care.

MARILYN SERAFINI: I wanted to point out that in your packets, you actually have a number of materials on the left side of your packets that list various models that we are referring to today. So if you would like more information about some of these models, you can refer to those materials. If you are not in the room with us today, you can find them on our website, www.allhealth.org and you will find this both in the packets and on

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the website. Also, we tried to pull some of them together with the URL's and if you find it online, you will get the hyperlinks. So you will see this – and there are other documents in your packet that also list some of these models.

KATHERINE HAYES: I think a lot of the non-clinical services that we are talking about today, this is one of the reasons we started with dual eligible individuals, because so many of these services are covered today under the Medicaid program. Targeted case management services in particular helps get through a lot of these issues and take care of a lot of these issues, in addition, states have the ability to provide home and community based services under the Medicaid program. There are a number of waivers as well as state plan options that aren't currently being used at this point. And one of the things that we looked at in our February report, which was related to long-term services and supports, was a means of streamlining those waivers and state options to make it easier and to encourage more states to offer home and community based services. That is through the Medicaid program. That addresses low income populations, but frankly, a very small percentage of individuals who need these types of service are actually receiving them and this is a time in which states are being asked to expand just acute care under the Affordable Care Act and to expect them to reach out and provide additional home and community based services, is a really tough thing to do right now. So, whether you are looking at the Medicare program or whether you are looking at Medicaid, I think it's important to address those particular home and community based services.

MARILYN SERAFINI: Question at the mic?

AUDIENCE MEMBER: Yes, my name is [name] and I'm a registered nurse and a data analyst for one of the District's NCO's and I guess my question is for Dr. Boling. For your program is a closed program? Meaning that no more new participants can be enrolled? Also, is it a local program and if not, do you have plans to have some sites locally in the District and the DMV?

PETER BOLING: Fantastic question. The accrual of patients into the demo is still ongoing and will be for another year or so. There are 15 sites operating around the country including the District and I can put you in touch with friends who work in the District. We would think of ourselves as open and we have – most of the programs have been involved in seeking contractual relationships with MCO's and ACO's and other entities that are trying to provide this kind of model, because we think that what we are providing is valuable not only in fee-for-service Medicare, but also in other kinds of finance models where people are assuming risk for high-risk populations. So there are lots of opportunities – if you contact me, I can put you in touch with colleagues and friends.

AUDIENCE MEMBER: Hi, I'm [name], I'm Director of the Center for Elder Care and Advanced Illness at [unintelligible] Institute. I have to tell you that this kind of meeting is so exciting. It has been so long since we took these issues seriously and now there is demos and exciting ideas bubbling up everywhere. I think I am at four today already.

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This is a really very positive set of developments. But when we look at the horizon, I want to throw out three very important ideas that haven't yet made center stage. One is that we are all duals in training. If we live long enough, seriously disabled, almost none of us are protected against the costs that we will run up. One of the first patients I picked up when I started working in a nursing home, was a woman who had had her disabling stroke in her 40s and the whole time I was growing up, the whole time I was going to medical school, getting ready to be her doctor, she was living in the nursing home. No one here has insurance that covers that. So we are all duals in training and duals is just an accident of how you worked in your lifetime and how your state deals with Medicaid. So we need to have those Medicare-only reports that Katherine is planning to bring out soon. So because we will be Medicare only and then some of us will be Medicaid. The second big idea is that the biggest political force and the one we desperately need is those very frustrated caregivers. We need to mobilize that not just as a service destination, but as a political force. It's really unlikely that [inaudible] Pharmaceuticals is going to step right up to lobby for a cheaper medical care system. Or that hospitals and health plans are. But caregivers could and caregivers could be really looking for a balanced approach. But we haven't even thought to make them a political force and yet, almost everybody here has been, will be, or now is a family caregiver and it will be the biggest leveling force among us. And if it stays as bad as it is now, it just cries out for organizing. Then the third thing, and I would real interested, Peter, whether some of your teams are running into it yet, is that so much of what people need is really community based. Melinda was mentioning this a minute ago. That if your town has had universal design in housing for a decade, you have places people can live. If they haven't, you have only got nursing homes. So, so much of what makes it possible to live well is actually in the housing, food, nutrition, workforce development and so forth, that is geographically anchored. What could we do if we freed up a dozen communities to really move ahead and show us how good it could be, and how inexpensive. I am sure that if we took the savings from the Medicare waste and put it into the social services in any community in the country, we would end up coming out much better. And I bet that some of your IAH teams are running into this, because they are geographically anchored. They are not doing telehealth; they are going into people's homes. So I bet that some are starting to show up at county council hearings on Meals on Wheels allocations and things like that. I don't think we have to convert all of medical care into a community anchoring, but some degree needs to go into a community priority setting and some funding that the communities can use to meet those needs. And if we did those three things as well as the kind of clinical service delivery here, we can build the care system that would be adequate to serve the Boomers in the 2030s when we all get sick and frail together. So it seems that we have about ten years to do our experimentation. Then if we don't, we will enhance our ability to walk away. I was just in Detroit – they have 800 people on the wait list for home-delivered meals. Most of them will die or go to nursing homes before they ever get a meal delivered. Why is that not shocking? If we had 800 people on a wait list for cardiac valve surgery, we would all be up in arms. There isn't a lobbying group for hungry old people. Work with those a little and tell us if some of those things are starting to come up in your work.

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PETER BOLING: Well, Joanne, thanks for those comments. Certainly by virtue of being out in the community, you do see what works and what doesn't and there are lots of things like what you are talking about, starting to occur. Buildings that were intended for another reason and then repurposed to provide shelter for older individuals at an affordable price with governmental support, would be an example. So our team – I was going to speak to the workforce question that was put forward earlier. Part of the workforce issue is about money. People need to get paid well and have an opportunity, but part of it is about being part of a collective effort, where you feel like you are making a valuable contribution. It's not just a job, it's a mission for a lot of the best people who work in this field and they do better when they are in the game with someone else who cares about it and who also is engaged in the kind of thing like Joanne discussed, where you are looking to find the right place for a person to reside safely in the community. People don't necessarily like to go in the nursing homes. I have met very few people who clamored to go into a nursing home. My team does round in a lot of nursing homes. I have been in almost all the nursing homes in Richmond, so I have a pretty good feel for that. People would much rather stay in the community. So we are better off if we find ways to empower people to remain in the community, which often requires some transformative work, because not everybody is in a circumstance where you weren't thinking this way in 1950-1960 when the houses were built and the streets were laid and the rest of those things were done. We are going to have to do some changing of the way we have got things organized, obviously. But I think the way you figure out how to do that is you go to where the action is, which is the community itself. You have to understand what it looks like and how things really run.

MELINDA ABRAMS: I'm going to turn to some of the questions raised on Twitter. There have been a number of questions that have asked about high-need, high-cost children. So I just wanted to say at the outset that when we designed this panel, the intention was for it to focus on high-need, high-cost Medicare beneficiaries. But to those who have been asking, well, to what extent is their applicability or transferability. Certainly, and this is based on years ago and work that the Commonwealth Fund supported around child development and complex care for children, the integration of care is equally important, particularly when you are dealing with children. Again, both for the physical health, the behavioral health and also on the social service side. But when you start turning to the policy solutions, it's very different from the conversation that we had organized and structured for today. So I apologize to those of you who thought we would talk more about children, but we really had intended for this to be a conversation in terms of the policy solutions, focusing more on Medicare. Complex patients covered by the Medicare or Medicaid program together. So there have been a number of more detailed questions, actually, Karen, particularly on your proposal. In particular, one person asked that nine month of Medicaid – the 112 billions in savings for nine months of Medicaid, if we could just keep them off of Medicaid for those nine months. The question is: Do you know if that is savings to the Federal government or state? Is it a combination? Have you don't that analysis?

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KAREN DAVIS: Well, let me make two points. First of all, on children, I do think I mentioned the Medicaid community First Choice Program, obviously Medicaid has a lot of experience dealing with children with development disabilities. That is a good model to look at. The limitations are the income eligibility is quite low, so the need to expand that up to at least twice the poverty level in order to reach and help more families. But to turn specifically to the savings of delaying nursing home placement. First of all, we picked nine months because we are involved with CMMI Healthcare Innovation Award for minded home., maximizing independence for people with dementia. And the early pilots of this intervention with memory care coordinators doing home visits and providing trained specific support to family members caring for people with dementia, found that this on average resulted in a nine-and-a-half-month delay in nursing home placement. So we didn't just pick these nine months out of the air. Wouldn't it be nice to do that? There actually is an innovative model that has achieved that. Let me just go over those numbers again. It's 112 billion in nursing home savings over 14 years. A lot of that is savings to the family who are paying it out-of-pocket. So 35 billion of the savings are to Medicaid and that split Federal and state, roughly the 55/45 split financing between Federal and state government for Medicaid.

MELINDA ABRAMS: Since some of the work being done by Karen and her colleagues has pointed out, the importance of protecting Medicare beneficiaries from kind of spending down and going into poverty to avail themselves of become duals and because of lack of home and community based services, one of the questions is really if the Bipartisan Policy Centers work in long-term care insurance, does it present an opportunity to address at risk beneficiaries from becoming dual?

KATHERINE HAYES: Yes, we are looking actually a number of different proposals. I think that when our leaders began looking at options for covering long-term care, they realized very quickly that in the current political and fiscal environment, it's going to be a very difficult thing to do and that it is going to take a range of solutions, one of which is private, long-term care insurance for those who can afford long-term care insurance. Personal savings has certainly been a main provider or main financer of long-term services and supports. But even for those with really high cost. Those that need care in excess of two to three years, I think there is a recommendation, first of all, a recognition that people can't save that much money. It's not possible to set aside savings. And if you look at the private long-term care insurance industry, you will see that they are writing policies – they wrote policies that were lifetime policies for a long time and many of those companies have had to drop out of the market, because they didn't have the return on investments because the economy – we had a stagnation in the economy, they weren't getting the interest rates they expected and they didn't have the reserves to cover all those costs. So I think one of the key things from our February report is our leaders recognize that at some point there has to be a role for the Federal government in picking up catastrophic costs or some sort of public system, because people can't take care of it, private insurance is not covering that population and the state certainly under the Medicaid program are not going to be able to address these costs over the long term. And so I think through these three programs in the short term, whether it's Medicaid, private

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long term care insurance or personal savings, those are not easy answers, but over the long term, I think once someone needs catastrophic care, we are going to have to come up with some sort of solution to address this.

MARILYN SERAFINI: Okay, I would like each of our panelists to get really practical for a minute and if you could have a direct line to Congress and the administration, what three things would you like to ask or what do you think are three things that Congress and the administration could do to improve the care for the high-need, high-cost population? What could and would you like to see them do?

KATHERINE HAYES: I think the most pressing thing that I see right now is what is going on with care for dual eligible individuals. I didn't realize this – I have worked on Medicaid and worked on duals issues for two decades and it wasn't until I really started digging down in the weeds in this project that I saw how uncoordinated care is for low income populations and how difficult it is. Did you know that in some states, you have dual eligible who are in Medicare fee-for-service, they are in Medicaid for Medicaid covered clinical services? They are in one managed care plan. They are in a separate managed care plan for behavioral health service and yet, a third managed care plan for long term services and supports. So you could have a Medicare beneficiary, who remains in fee-for-service, but they are still enrolled in three managed care plans. That is three cost sharing arrangements, three membership cards, three enrollment periods – so we really, really need to get serious about integrating care for Medicare and Medicaid beneficiaries. It is unconscionable that we are asking people to navigate this system today. Congress needs to give CMS the authority to unify the grievance and appeals process in fully integrated duals plans. Patients are – there are so many things. I should stop at that.

PETER BOLING: So, three wishes, right? Obviously I'm going to go with my first passion, which is making the Independence at Home demonstration a national program with a solid shared savings model that will encourage its growth and be sustainable over time. I think this will have wide reaching benefits. I will go along with the idea of doing something about the duals. I have been involved centrally in the duals demo in Virginia. I am involved in planning our response to the MLTSS evolution, which is going to be the next stage of that, and I will endorse the notion that it is an enormously complicated work that needs to be resolved. And then past that, look at all of the older patients that are in my care and their stunned 50 and 60-year-old family members who realize the gap that exists between what is available and funded by Medicare and the requirements of the care process for long term supported care and services for people who are not eligible for Medicaid. Before they have spent down, as Joanne said, we are all potentially destined to do, those folks that are still in that fringe, where they still have enough money left in the bank or some property that they are going to sell or some stock dividend that they are going to release that will allow them to spend out their money, to remain in the Medicare fee-for-service program without other benefits. They are really in a very precarious situation. There are a lot of people in the Medicare near poor world, who are having an extremely traumatic experience at the end of their lives and their families are sharing in

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that. It's embarrassing how far we are behind all of the industrialized nations in grappling with this at a societal level. I don't have the answers, but I talk to my patients and their families about this all the time and they are just beset, so I think we need to fix it.

KAREN DAVIS: Well, if I had three things on my wish list, I would say, CMS authority to demonstrate the integrated care organization concept. I think we got where we are today in part from the physician group practice model that was tested for five years and became a forerunner of the ACO initiative and I think we need that kind of sustained testing of integrated care organizations to really work through how you structure the financial incentives, how you structure the standards for participation, how you structure the reporting. How you go about developing individualized care plans. What is the reporting on quality? What is the performance and what do we know about the effectiveness at different models of care that those ICOs can adopt? We have heard of independence at home, that is a very important one. I would also stress others like hospital at home. Melinda mentioned capable with handyman services. I mentioned mind at home, maximizing independence. We need these integrated care organizations with the tool box of innovative delivery models that really work for this population with physical and cognitive impairment and we need the track record of the performance on that. The current CMMI is not structured well to do those kinds of demonstrations. Partly the assurance on the reduced cost, whereas it may cost additional money, even with some offsetting savings, to cover long term services and supports for people who are not dual. So that is the first thing. A dedicated, at least five-year demonstration effort on the part of CMS to test the integrated care organization concept. The second, I agree with Dr. Boling, we need to focus on the near poor. This is not a problem of just the duals and therefore turning to Medicare to offer at least a targeted home care benefit under the Medicare program, so it would provide financial relief to those who are hardest hit. You have seen the striking numbers on the out-of-pocket costs and the burdens on those families and how much that puts them at risk for spending down to the Medicaid program. And then third thing, I have mentioned the Medicaid community First Choice program. For those who aren't familiar with it, there is an additional six percentage point federal matching for states that do that. About eight states have now adopted that model, but it needs to spread across all states. It needs to have the eligibility level raised to at least 200% of poverty if we are really going to provide these types of home and community based services to those who are most at risk. Thank you.

KATHERINE HAYES: I was remiss in mentioning, we have two task forces at BPC that have been working in this issue, both a LTSS task force and our health and housing task force and the leaders from both of those have supported extension and expansion of the independence at home demonstration.

MELINDA ABRAMS: So my three are: I think one, and I'm going to be at a higher level, it's around promoting and redesigning and further spreading value based payment models, because I think that part of the reason Joanne Lynn, if you are still here, the reason that we are able to have this conversation with so much success and so much urgency today, is because of the shift in the payment models, away from fee-for-service,

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away from volume and toward value. There is still more that we need – we need to spread those models, we need to learn more about them, we need to improve them, as I said before. Not just at the organizational level, but also trickle it down to the teams and to the frontline providers. So that would be one. The second, which we have talked a lot about today, but is really increasing the flexibility of organizations and payers to cover non-medical services. There has been work done to show which services are most effective, which are most needed. There are some really tangible proposals that have been – some that have been discussed, some that will be coming on ways that it would really help to improve outcomes, allow people to stay at home and also reduce overall cost of care. So to me, it seems like it's incredibly important for delivering person-centered care as well as helping to lower our overall expenditures. And the third is also high level, but really important, is the continued experimentation. There are limits currently, as Karen mentioned, with CMMI, but I think that there is a lot of what – we know a fair bit about – we have some models that work, we know a fair bit about what some of those attributes of those models are, but we are still running into problems in terms of sustainability, spread and scale. And we just need to kind of continue – we need to continue to invest and continue to experiment and learn from the spread and scale and more multi-site demonstrations.

MARILYN SERAFINI: We have a question at the mic?

AUDIENCE MEMBER: Thank you to the Alliance and the Commonwealth Fund and all of your participation. It's very exciting, the models that we are currently experimenting with. The one thing I really feel is really critical to address and particularly with these really high touch, difficult situations where an educational kind of background may not exist at the level necessary for them to have guidance and assistance when there really is that end of life reality. So it's very important, I think, that we have to include those strategies to address that need that many times their may not be a family member, a real advocate there that can really help that individual understand where they are headed to. And how we have to absolutely include that. Because the real high cost of this really exist in those last days or weeks of that individual's life. Thank you.

KAREN DAVIS: I think that is an important point. We haven't talked enough about palliative care and the fact again, that Medicare does not cover palliative care in the home unless you are in a hospice situation of being six months from prognosis. So improving palliative care under Medicare, I think is very much a part of this. And then if there is not a family member that can take this role at least to provide those kinds of services, information and support through a structured palliative care program.

PETER BOLING: If I may, I would support that notion as well. I would say that my crew have been doing palliative care before palliative care was named, as a field. As testimony to that, compared to the 25% of dying people in America who end their lives in the home where they prefer as opposed to in a hospital, is something like 60% in patients who are served by an in-home medical care design. So I think when people have come to grips with those issues of the impermanence that we all share on this planet and have accepted

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that their health is not going to allow them to continue living, chose to die in a way that is more peaceful and more consistent with their prior values and their preferences in life. That is something that is best sorted out with a trusted professional team and family environment where you can discuss those matters privately and with people you know well. I think that is how those conversations go best. We force those conversations in hospitals and other places now in very awkward ways that lead to results different from what I think most people would want. So I think there is a great opportunity there and we do know from our work that the – as you know, the costs tend to increase at the end of life, but patients who are dying in an at-home care managed kind of design, tend to have relatively lower costs compared to people who are dying in the usual care mode where they land up in the hospital ED, pressed with an emergency decision, live or die right now. Oftentimes get intubated, have the surgery, go to the ICU and that kind of stuff. I think we have opportunities there.

KATHERINE HAYES: I would be remiss in not mentioning that this is an issue that is also very important to Senators Daschle and Frist. We are not addressing it in either this proposal or our long term services and supports proposal because we are focusing on cost of care and we are trying very deliberately to keep end of life and palliative care issues separate from a discussion of cost. So we will be addressing that down the road, but just not a part of this.

MARILYN SERAFINI: Okay, so we have come to the end of our time. We have heard a lot of important discussion today. We have heard that there are promising models, that there are challenges when it comes to scalability, work force, interoperability of electronic medical records and other areas. We have heard about the importance of including non-medical services. So I would like to thank our panelists for a very interesting discussion today and I would also like to thank the Commonwealth Fund for its partnership in bringing us this discussion today and I would like to thank you for being here as well. We will see you next time, thank you.

[applause]