ALLIANCE FOR
HEALTH REFORM

Managing Costs and Improving Care: Team-based Care of the Chronically Ill

Alliance for Health Reform
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ED HOWARD: Good afternoon. My name's Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you to this program looking at how to improve the coordination of care for those with multi— with chronic conditions especially those with multiple chronic conditions. And on behalf of Senator Rockefeller, our board of directors, we're very happy to have you here.

Most of the talk around Washington in the recent weeks has been about the need to get our fiscal house in order. And though it may not be immediately apparent to you; that's an important component of today's topic. Let me explain a little bit. We know that particularly in the long-term, projected increases in the cost of federal health programs are going to have a big effect on the fiscal capacity of the country.

And on whom are those health dollars spent? Well, about 80-percent of Medicaid spending is for somebody with five or more chronic conditions like asthma or hypertension or diabetes. And almost all Medicare dollars are spent on folks in that same situation. The people with multiple chronic conditions, the focus of today's program, pose the biggest challenge. Spending on Medicare beneficiaries and others with five or more chronic conditions amounts to about 17 times the amount that's spend on someone who has no chronic condition.

And take a quick look at that in the Medicare context, two thirds of Medicaid spending is on people with five or more chronic conditions. And in general, our current healthcare system doesn't really work very well for these folks. There are exceptions where individual programs are beginning to make a difference not only in the spending on this population but in their quality of life as well.

And I don't know how many of you saw the article by Rahul Gandhi in *The New Yorker* last January. It was titled, I think, *Hot Spotters*. That is people with multiple chronic conditions or multiple conditions who are being helped by a physician, Jeffrey Brenner, in Camden, New Jersey. It's really a compelling story of a program of a physician making a difference in people's lives and having a fiscal impact on the cost of their care. If you haven't read it, you should. There's a follow-up blog post by Dr. Gandhi in your materials.

And today you're going to hear from some folks who are making a difference in different programs. And you're going to hear about others in other programs who are. The question is how do you convert these successful examples into widespread practice? Now our partner in today's program is the Commonwealth Fund. And you're going to hear from Cathy Schoen from the Fund in just a moment.

I want to just do a little housekeeping if I can before we do— get to the program. In your packets, you're going to find a lot of background information including speaker bios, including the PowerPoint presentations for those who have them. If you are watching the Webcast of this briefing, you ought to know that it is arranged as our Webcasts have all Alliance briefings through the support of Kaiser Family Foundation. And some time tomorrow, you'll be able to view the Webcast on their Web site at KFF.org.

And in a few days, you'll find a transcript of the briefing on our Web site at allhealth.org along with and you can find this now electronic versions of the materials in your packets and access to a whole sheet full of additional materials that we didn't want to kill trees to put into your hands but you might find useful.

At the appropriate time, you want to ask a question, you can either go to one of the microphones that is in the middle of the room— that are in the middle of the room or find out a green question card that you'll find in your packets. And after the briefing, we'd appreciate you taking the time to fill out the blue evaluation forms to help us improve the future briefing line-up for you.

And we've been trying to stimulate and encourage a greater response rate among those of you who have the opportunity to fill out that evaluation form and so we have, as I said at our last briefing, adopted a pay for performance plan. We normally get about a fourth of the total attendance filling out the forms. If we get to 35-percent of you handing in a blue form, we're going to donate 35— $50 to La Clinica del Pueblo which is a free clinic here in D.C. serving primarily the Latino community. If 50-percent of you fill out an evaluation form, this is a tiered program. [Laughter] The donation will be $100 to La Clinica. And as you hand in your completed form, we'll throw in a piece of candy as well so how about that? [Laughter]

Let's get to the program. We have a terrific group of experts and they're going to give brief presentations. We'll then open it up for your questions. To get us started, we're going to turn to my co-moderator, Cathy Schoen, the Fund's Senior— the Commonwealth Fund's Senior Vice-President for Policy, Research and Evaluation. You should know that she is the guiding light behind the Fund's score cards on the healthcare system at various levels among many other projects she's involved in. Cathy thanks for being with us.

CATHY SCHOEN, SENIOR VP: Thank you Ed. This is on. I'm delighted to join you with a terrific panel today. And I'm just going to make some preliminary marks to basically build on Ed's on why we're gathered here. I think most importantly as

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you all are thinking about the population we're talking about, it's the minority of people in the United States that have multiple chronic conditions or disabilities. But because they have high health needs, they account for a very high percent of national spending. And this is true is basically every country. It's been true in every population group we look at.

What we find when we look at this group of people is they can be quite diverse. They span the healthcare system in terms of their needs. Some have intense needs for long-term care and support in the community. Some are in and out of hospitals, in and out of nursing homes. There are groups that are in the midst of acute care crisis.

What it means they span the parts of the system but we're organized in silos. So unless— until we start to learn to work in teams with information systems that allow information to follow patients so we even know who these people are, it's not always easy for a doctor to tell you who are my sickest. It's a research project and it shouldn't be.

So this need for teams spanning the care system, we thought two examples here on the panel today but there are multiple in the United States of creative reorganization of the care system, use of information and different ways of paying for care that are achieving strong outcome results and starting to slow the growth of cost if not reduce costs for some populations. So managing costs better by decreasing duplication, decreasing potentially preventable complications for people; we could keep them healthier. They're not going to necessarily get better but we can maintain health. That's where the cost savings come.

I think the good news and we will all talk about this is that the Affordable Care Act has multiple elements that we can build on. But it's important to be creative and strategic with these elements and stay the course. As we start to redesign the care system, continuity rather than sudden changes in some policies as well as creativity are going to be very important.

To look at this, what my point about there are multiple groups, this is distribution that was some data run by John Holahan at the Urban Institute. This is the entire population stepping away from at looking just at Medicare or Medicaid. On the sickest group in terms of how much they account for, they account for about 30-percent of all national spending. If I put more people in, it would be higher. But a lot of it is federal spending and here the federal spending is a combination of the Federal Medicare Program but also the Federal share of Medicaid. We often think that that's a state program but no, the Federal Government's dollars are very much in it.

The private share is lower because we enacted two programs in the United States that take the sickest and the disabled and put them in the public sector. We left the relatively healthy working population under 65 to employer based coverage so they don’t have as many. Simply if you say who these people are, they can't work full time most of them. They are either at retirement stage or out.

So we see the cost in a different way than all other countries who have a whole country system. So they jump out when we look at Medicare and Medicaid. But that's because we're supporting the entire care system. It's not just those programs. It's whole communities.

You've heard a lot, I think, in other sessions. And there'll be more conversations about those that are both on Medicare and Medicaid— the dually eligible. About 9 million people who account for about 38 to 40-percent of the total spending. So that is an important group to focus on because two programs are in action and getting them to think on the same page for that group. They're diverse.

But the point I want to make when you bounce back and forth between the two slides is there are a lot of people in Medicare who are not dually eligible who also have multiple chronic conditions and long-term care needs. There are a lot of people in the Medicaid Program who are not on Medicare who

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are disabled and are chronically ill. So we need to think about both programs globally as well as the duly eligible.

When you look at the distribution, Ed's chart already highlighted this for you. The more chronic conditions you have the more we get to this disproportionate share of total spending. And this slide starts with none to one to two to three to four to five plus. And the reason is that there— those five are often— when we say five plus, the five are also ten— often ten. The people who have multiple tend to have other things going on. They're on multiple medications. Their care is complex.

And as I said earlier, they are a diverse group. Some are only in the acute care sector. Some are really in and out of home care, in and out of nursing home. So this takes us quickly into the long-term care sector where we tend not to think about it when we talk about just Medicare.

The programs that work share multiple characteristics. And Randy will be talking about it. But one of the things we're learning as we start to work with this population is that to make things work, we need to change the way we pay for care. If we fixate on procedures and visits, we miss opportunities of working with people between visits by phone, by telemonitoring. We miss group visits. We miss the ability to spend a long time

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with a sicker patient and just phone time with a healthier patient.

So thinking about paying differently is what is happening and supporting medical homes for patients that are very team oriented, thinking about paying differently in bundled ways allows saving. If we can lower the use of a hospital or an ER, move the money out of that resource makes to primary care or to long-term care de— or part of it. So this notion of shared saving so payment changes is what— the way we pay is very important.

Thinking about teams not just the team in a physician's office but a team that actually moves with the patient that is in those intersections; patients move to the emergency room. Does anybody know they're there that normally takes care of them? When they leave, is it a discharge where just they're thrown out into the world or is it a handoff and a transition? That there's continuity. And those teams need to be accountable for the total care of the patients.

So we've talked about accountable care organizations. But they also need to have information systems that allow them to know about the care the patients had when they weren't seeing them. Often we don't have it. Physicians don't really know all the things that are happening to their patients. And we— there's an increased use not just of electronic medical records but of registries. And this is to feed back information to the clinicians as well as to the patients and the teams. So these information systems are critical.

There are multiple models. And I just put up some logos of them because we really have very exciting examples. In the last slide in my pack which I won't talk about today just gives you some examples from the literature. And Randy will be summarizing. But when you get close to each of them, the concepts are very similar that they're operating on. But the application is often quite different because of who they started with and the situation the patients are in. And also are they urban? Are they more rural? So they're building up which means we're learning. Each time you apply a similar concept in a different way, you learn a lot. So it's an organic system.

As I said at the beginning, the Affordable Care Act have multiple elements we can build on. The good news is on the payment side, there's both authorizations for pilots, for innovation, for being creative. We're going to be rolling out some bundle payment provisions for accountable care organizations.

But also in the Medicaid Program, provisions for health homes, payment for care management where it could be networks of care that the Medicaid Program will be able to use to support physicians where the teams may not even be in the physician's office all the time. They're shared because they're working with the chronically ill in each of several physicians. And the physicians think of them as our staff even though it's a shared resource.

The Innovations Center has the authority to do pilots. And if they work, roll them out. This was a wonderful idea. We need to give them the power to do it, the resources to do it and the time to do it. So the time schedule's going to be very important.

Information was built into the Affordable Care Act. There are going to be new quality metrics. And I can't emphasize enough how important this is. We have professional, dedicated workers throughout the healthcare system. If people can see something is working better somewhere else, they ask why and how and want to improve. So these are feedback systems. They're not just pay per performance. They're critical for driving care.

Turning to the panel, we have three terrific panelists. We're going to be talking about what works, what we've learned on how to start thinking strategically about care system strategies, what we know about teams and models and variations and strategic policies that could make a difference going forward— Federal policies as well as Medicare and state

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policies. First to speak will be Randy Brown from Mathematica Policy Research Institute who will be summarizing results of some of the literature and his own analytic work.

Then I believe we have Lois Simon who will be talking from Massachusetts' perspective where they've got a very creative umbrella organization that's working sort of spanning this population from very disabled to children with asthma to chronically ill to older adults. So it's a very, very interesting set of activities. And then summing up with Minnesota experiences will be Pam Parker who also oversees a very diverse, exciting mix of programs. Thank you. Randy.

RANDY BROWN: Alright, let's see. This is on it sounds like. Well Cathy and Ed provided a great set up for the importance of focusing on people with chronic illnesses. What I'm going to do very quickly is talk about four things.

What do we know about effective care coordination for Medicare beneficiaries with chronic illnesses? There's a lot of claims out there but we have a pretty good idea now of what works and what doesn't. And by works I mean it reduces hospitalizations because if you don't reduce hospitalizations, you're not going to save enough money.

The second thing I'll talk about is what the ACA Provisions— which of the ACA Provisions are most likely to produce savings for Medicare. Third; what can we do to enhance

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the likelihood of success? Even the options that have some potential for success have also a high likelihood of failure. And fourth, I'll say a little bit about what I see as the major barriers to success. And you might not like that part.

There are a lot of studies. And many of them are weak and unreliable. But there is a solid body of rigorous studies. And here's what I think the best of these studies tells us about which interventions produce real reductions in the need for expensive healthcare services.

The main thing to note is that there are six programs on these slides. Six studies representing nine programs all with significant favorable effects on hospitalizations. And each case the effects are concentrated in the high risk patients. And by high risk I mean patients who have an expectation of one or more hospitalizations per— in the coming year.

The first item on this slide is transitional care models. 20-percent of Medicare beneficiaries who are discharged from a hospital are readmitted within 30 days. These two interventions on the slide use advanced practice nurses to reduce that appalling proportion by about a third.

The second one is the Medicare coordinated care demonstration which is near and dear to my heart. The paper that we published in the *Journal of American Medical*

Association in 2009 had pretty discouraging results overall. Only one of the 15 programs saved money. But the follow-up study that's in your packet that we're trying to get published now shows that 4 of the 11 programs that had enough enrollees to study had significant reductions in the number of hospitalizations for a common high risk subset of easily identifiable chronically ill people. Those that had congestive heart failure, pulmonary disease, artery— coronary artery disease and their condition was serious enough that they were hospitalized in the past year. And these results hold up over six years of follow-up.

The Care Management Plus Model is another one. They targeted people with two or more chronic conditions, half of whom were diabetics. They used registered nurses in primary care clinics, reduced hospitalizations and costs but only for the ones that had diabetics.

The Grace Model targeted low income seniors with multiple chronic conditions and functional impairments. They used advanced practice nurses with a geriatrician and social worker to support the primary care docs. They reduced hospitalizations and emergency room visits but again only for a pre-identified high risk sub group of patients.

And finally the Massachusetts General Hospital High Cost Case Management Program was one of six programs that CMS demonstration to look at high cost Medicare cases. Only two of the six reduced cost – reduced hospitalizations significantly. The NGH Model did it at a pretty low cost of $120 per member per month. So it generated net savings.

One thing that we know doesn't work is telephonic disease management programs. We have multiple studies with randomized designs and large sample sizes to prove this and no credible ones that I can find that disprove it. It's a cheap intervention but it doesn't work.

So given that there is a lot of care coordination programs that fail but some that succeed, what distinguishes the successful interventions from the unsuccessful ones? Here's what we found on the coordinated care demonstration that distinguished the four successful programs from the seven unsuccessful ones that didn't really use hospitalizations. And these findings are consistent with all the other programs noted above that had evidence of success. Here's some differences in how the programs operate but these are some common features across them all.

In the successful programs, care coordinators had frequent face to face contact with patients that's once a month or more plus telephone contacts. They had small enough caseloads with ongoing training and feedback to care coordinators. The care coordinators had face to face contact with the patient's primary care physicians on occasions. They provided evidence based patient education intervention using motivational interviewing or other proven methods for actively engaging the patients.

Fifth; the successful programs found a way for the care coordinators to learn about hospitalizations while the patient was still there and they had a comprehensive intervention to give these patients a good understanding of what they had to do to avoid readmission. Sixth; care coordinators played an active role teaching patients to communication important information to physicians and understand what they hear from them. And they also made sure that test results and other key medical information was communicated across all the many providers that see these patients with a lot of complex problems.

Seventh; they had comprehensive medication management programs involving a pharmacist or physician to make sure that the mix of medications that people were receiving were compatible and appropriate. More medications isn't necessarily better. And eighth; they addressed loneliness, isolation and depression issues which are very common with people with lots of chronic conditions by having social workers, psychologists and other staff with expertise in providing social supports for patients who need these pretty badly.

So, does the ACA have provisions that suggest we're going to implement these lessons learned and achieve some of these elusive savings or are we plunging into new untested approaches that are less likely to succeed? There are a lot of payment reforms and practice reforms that are suggested in the ACA especially for the Innovation Center to consider. A number of them have promise. The Patient Center and medical homes for high risk patients for one, ACOs possibly, the Grace Model fully integrated care for dual eligibles, a test to replicate—to see whether the successful results from the coordinated care demonstration for high risk patients can be replicated.

But the success of any of these is going to depend hugely on whether they're implemented in ways that build on the lessons that we've learned about what actually does work. It doesn't matter if you call it an ACO or a medical home or integrated care. How you design, target and deliver the intervention is going to determine whether it saves money or not.

One option that I don't think has much promise for the chronically ill is bundled payments for episodic illness. It's a nice idea for minimizing cost shifting but what people with multiple chronic illnesses need is help to prevent the adverse health episode not to save money for Medicare once you have one.

So what can we do to increase the likelihood that these ACA options will actually produce real saving for Medicare and tax payers? We need to require that they have the features that all the successful past programs have found to be important. They need to focus on high risk patients. For example, medical homes program wants to provide a home for all beneficiaries. That's great but the savings are going to depend almost entirely on what they do to coordinate care for the sickest 20-percent. And you need to pay enough for those cases and not much for the others.

You need to feed back timely information to programs and physicians. They need to know how they're doing on both quality and costs so they can adapt. And fourth; the intervention should build in studies of operational issues. While we know a lot about what works, there are many, many details about which— you know like which assessment tool works best, which fall prevention program, which motivational interviewing technique and a lot of others.

There's a methodology called orthogonal of design that my colleagues and I are testing now in special needs plans that enables you to test 20 or 30 intervention variants at the same time. So this has a great potential for learning. And finally we need to move into testing the dissemination potential of interventions now that we think we know a lot about what the core features are to look like.

So last, let's talk briefly about three factors that could pose a real barrier to further progress in the efforts to improve the lives and lower the costs of Medicare beneficiaries with chronic illness. The first barrier is the– and excessive attention maybe to rapid cycle learning which is the mantra of the Innovation Center. We all want to learn quickly what works. Certainly more quickly than a 10 year study can provide but we've learned that quick answers are often wrong answers. And I'll give you two perfect examples.

A program called Guided Care that's a very well developed program had early finding that suggested it was reducing hospitalizations. But a longer follow-up publishes it more recently showed the results went away. If CNS had acted on these early results, it would have chosen the wrong horse to go with.

The second example illustrates exact opposite type of mistake. In the Medicare Coordinated Care Demo, the Washington University site had no effects during its first three years. But then it made a big change in how it did its intervention and during the next three years had the biggest effects of any site of all. Early results would have said to kill the

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program. And we would have lost the opportunity to learn from it.

It takes a program some time to learn how to implement interventions effectively and how to adapt the program to their own environment. And it takes time to build a rapport with patients and providers. We can shorten the learning time relative to conventional demonstrations somewhat by looking at key intermediate outcomes and building in tests of program implementation issues along the way using orthogonal design or the Plan D Study Act Approach.

But it's important not to sacrifice rigor of evidence for speed. A quick but wrong answer is going to cost you more—far more than a slower but accurate assessment of an intervention. And you won't realize it's costing you more for years. And existing programs are really hard to get rid of even if they're ineffective.

The saving grace is developing interventions that build on prior successes, should shorten the time to seeing effects. The second major barrier to saving money through care coordination or other AC interventions is the lack of political will. Failure to withstand pressure from special interests with deep pockets will a fort attempts to save. And we've seen this on several occasions. 20 years ago I talked— I did a briefing for Congressional staff about Medicare HMOs and said that instead of saving 5-percent like they thought, they were actually spending 6-percent more than what if these patients had stayed in fee for service. Now we're spending 9-percent more.

Finally the third barrier to controlling costs is lack of adequate information and incentives for providers to do the right thing. Physicians need data on quality and efficiency. Not only their own but also the specialists that they refer to and they need to be held accountable for both. Payment to providers needs to be tied to both cost and efficiency. You can't afford a Cadillac care for everything and you don't need one. And more care— because more care isn't necessarily better care.

And CMS's Research Use Reporting Project will provide this information. But introducing powerful incentives to act on and it's up to Congress too but it would be a great way to get rid of the ineffective and heated SGR. So, thank you. Not was neither in effect— very much.

LOIS SIMON: Good afternoon. So I'd like to take a few minutes to explain what Commonwealth Care Alliance is, how we go about doing the work that we do toward the redesign of primary care, talk some about some of the outcomes both in terms of care and cost and most significantly, what are some of the barriers and the challenges to really bring the work and

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some of our early successes in that work to a larger scale and to replication.

So to begin, Commonwealth Care Alliance is, until recently, not an easy sound bite to describe. We are very much a hybrid organization. We can now think of ourselves as an ACO prototype for special populations which I think conjures up for you perhaps instantly the fact that we're a hybrid organization that is both with payer responsibilities, a substitute, if you will, for both Medicare and Medicaid and bearing full risk for both public payers but also we think of ourselves as a care delivery system. And in fact, we connect and interact with primary care providers across Massachusetts in a very significant way and see our payer responsibilities simply as the means to the end.

So we're a not-for-profit consumer governed organization. It's probably important to say that a basic feature of our organization is our commitment to consumer involvement really at all levels of the organization's functioning from governance to program design as well as in actual care provision in terms of engaging members in their care.

We focus exclusively on the needs of people who are insured through Medicare and Medicaid or just Medicaid, people across the spectrum so therefore people with complex needs both of a medical nature as well as social and issues of poverty alleviation. And we have a care model that's a team based care model where we are enhancing the provision of primary care and care coordination through the capabilities of a number of different disciplines who wrap around physicians in the traditional care setting, very often federally qualified health centers and the like. And then we augment those services through a home visiting approach and highly integrate that into primary care.

We've been around since 2003. This gives you a quick snapshot of our programs. The Senior Care Options Program began as a demonstration under CMS. It really was a clinical program design, sort of a pre-runner to special needs plans as we know them now. But we evolved into a special needs plan in 2006 when that regulatory framework became available. And there's more to say about that perhaps but that— the snip framework has really prompted us to have to respond to more of an insurance model that's changed through the years fortunately since 2006. But our roots were really very much in the demonstration days in a clinical model of care.

We serve very frail and diverse individuals with co-morbid conditions. Again it's a collaborative practice engagement of team based care and we employ both professionals and care professionals. And to keep the model cost efficient, we very much pay attention to trying to continue to innovate to have our professionals operating at the top of their license so to speak in order to ensure the viability financially of the program in what has been difficult times in terms of state and federal budgets.

The elements of the program, if you will, entail very comprehensive assessment, developing care plans at a very individualized level for people with very complex needs. Again the primary care team who's dealing not just with the medical issues, but very often the psycho-social and poverty alleviation issues that pose significant barriers to compliance, if you will, or adherence to any sort of medical sort of treatment issue.

The teams are fully empowered with the checkbook, if you will. There's not a 1-800 may I please back to the health plan before authorizing the services that are needed. We have a very elastic response for episodic care on the part of our midlevel practitioners so that when someone can't get in to see their primary care physician but needs to, there's the ability to bring care to them.

We have a 24 hour 7 day a week clinical response system to in fact avert unnecessary visits to emergency rooms which as you all know often result in the sort of conveyor belt to an inpatient admission and a lot of expense that can be averted.

And we operate with the use of an electronic medical record both with our primary care sites as well as within our own system. And we're— we have a lot of challenges there which I'll speak to in a minute. But it's essential to the well functioning of this program to enhance the communication and coordinate the communication with the other professional caregivers most notably the physician practice but also within the disciplines of the team.

We share a very comprehensive, timely and actionable data with our clinicians as well as the primary care physicians to allow them to continue to inform clinical practice and provide that feedback on a very regular basis. There is a case study that's in your packet that I might suggest you look at that sort of exemplifies the way in which we go about the work that we do.

Some brief look at outcomes. It's all about trying to reduce the unnecessary hospitalizations and institutional care. That sort— saving in that arena more than offsets the cost of what is involved in developing the kind of primary care team enhanced model that I've described. As you can see here, our results have demonstrated that hospital utilization is significantly lowered than is true in the Medicare fee for service environment for dual eligibles. 62-percent lower for the segment of our population which is 70-percent of our elders

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who are in fact nursing home certifiable, who are clinically just like their counterparts in nursing homes and also 20-percent for the more ambulatory seniors.

We are also— JEN Associates performed a study in 2009 that shows significantly fewer long-term nursing home stays for the population that is served by this program. And the opportunity for people to see their physician and receive primary care as determined by the numbers of visits is a significant difference as well.

In terms of bending the cost curve, our annual— average annual medical expense increase has been significantly lower for a senior population than for the average Medicare annual increases. And in terms of care outcomes, quality outcomes; looking at the CMS system for judging quality, we are a four star plan aspiring to be a five star and a four and a half star plan in terms of our Plan D responsibilities. We are fully risk bearing for all of the Medicare and Medicaid services that our individuals require.

The calculus is simple. The kinds of flexibility that is afforded through risk adjusted, global capitation from Medicare and Medicaid enables the kind of team work that I've described and sort of allows for the kind of communication outside of the— sort of the visit context. And when you combine that with the ability to develop those teams, provide

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the episodic care, follow people across the various care setting and deal with the kind of community based supports and long-term care supports people often need which is fundamentally just not a part of primary care and expertise that's within the primary care setting but is critically important to the types of individuals that we serve with multiple chronic illness, what results are really significant reductions in more costly services that are often, you know, hospitalizations that occur somewhat predictably for secondary complications of chronic illness.

So what are the challenges and the barriers to replicating our work? You know heretofore, it's not been the case that program and financing models that enable this kind of approach have been easily assessable to organizations such as us. Our environment is changing. That's very exciting. But the comprehensiveness of the program that we offer in terms of the fully— full integration inclusive of behavioral health and long-term care we feel is quite critical to achieving the kind of success that we have.

I mentioned earlier we started as a demonstration program. The kind of collaboration that occurred in developing that kind of regulatory framework was key. And you know it's a constantly changing regulatory framework. And that's been very challenging for us to keep sort of reinventing ourselves, if you will, to be able to meet those requirements.

Having appropriate risk adjusted reimbursement for individuals with complex care needs is a concern. We've got it somewhat okay for frail elders with a frailty adjuster that's made available to some but not all plans that perhaps need to have that frailty adjuster available. But lots of concerns for the under 65 complex care individuals as to whether the current reimbursement system is sufficiently sensitive to address their needs.

We need to promote collaborative approaches at the provider level. It's a bit of a confusing world out there right now. Many flowers are blooming. That's not a bad thing. It's a wonderful thing. But at the level of trying to actually operate programs, it's challenging. And recognizing that individuals who are on Medicaid only and dual eligible are really clinically the same population is really important. They're indistinguishable clinically but it's important. We're seeing a lot of different programs being developed for duals or for Medicaid only when in fact these people are all the same.

And last thing I'll say at this point is that there really needs to be more opportunities for continued innovation and shared learning. We've been at this. Dr. Robert Master, who co-founded the organization and is certainly our clinical leader, has been at this for many decades. And we, as an organization for eight years but we still feel very much that we're just at the beginning of the learning curve. And there's a lot more learning to be had. Thank you.

ED HOWARD: Okay. Pam.

PAM PARKER: Okay. Well good afternoon and thank you so much for having— including us in this illustrious company of a part— being a part of the solution. We're very glad to be considered that way.

I'm going to give you a little bit of a state level view particularly focused on the dual eligible population which is where our large experience has been. And perhaps a little bit of reality orientation here in terms of what's possible on a state level to get to the kind of perfect clinical model that that common with Care Alliance and Lois has— have laid out.

We have three programs— managed care programs in Minnesota for dual eligibles and people— senior and people with disabilities. Two of them are integrated with Medicare. We have the Minnesota Senior Health Options Program. And that one has Medicare in it. It's been fully integrated. For a number of years we were, like Lois started, as a dual demo years ago. And then transferred into snip world and it serves over 70-percent of our seniors in Minnesota's Medicaid Program.

We also have a small program for people with disabilities called Special Needs Basic Care. I'm going to be focusing mostly on the Seniors Program today. We've had 15 years of experience now with this program. We've seen it evolve. And as you've heard from some of the other speakers, it does take time for these things to evolve and become mature and see what they can really do.

What we have seen is that we've been able to build a platform of integrated aligned Medicare, Medicaid, primary, acute and long-term care financing for these seniors throughout the entire state. As I said, 70-percent of the seniors are enrolled. They have multiple chronic conditions. 60-percent of them have more than two chronic conditions, means three or more. And 72-percent of them need long-term care services with 40-percent being in the community and being retained in the community for their long-term care services.

What our care model has been is that we have combined home and community based case management resources with care coordination resources from healthcare home type models. Whether they are actually healthcare home certified at this point or whether they're those kinds of models; that's basically what we've done. And that has enabled us to have more comprehensive care coordination functions so that each member has an assigned care coordinator. There's in home

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assessments, transition protocols that are across all of the— all of the health plans uses the same kinds of transition tracking protocols. And, that— you know they're— we've really been able to get out there and touch every one of the members.

The combined financing has also incented care delivery reforms and innovations, payment reforms and care delivery reforms. And we've had a— this platform has enabled us to have many flowers blooming, let's say, in terms of the various kinds of care management models that we have. So we have care management models that are, what I'd call, total cost of care models where the— there might be a primary care physician or a group of physicians in a clinic that have a team of social worker, nurse practitioner and they— there may be some gain in sharing or risk sharing across all the Medicare, Medicaid, primary, acute and long-term care dollars. Maybe even the drug money.

So these are very effective models. But we've also had to rely on other models because when you're trying to bring something to scale on a whole state; obviously, you have to work with what you have. And in many of our rural areas, it just isn't possible to get these kinds of intense clinical models going. And we have to instead rely on education of our nurses and social workers and county community based services, programs and rely on them, education them about chronic care

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conditions, provide them clinical support to help manage those chronic care conditions. And in many cases then, they have a harder time linking with the community physicians. You know kind of— you kind of have to chase the doc. We call it the chase the doc model. And they do the best they can.

We're trying now to link these community— home and community based care models of care coordination where they are trying to do chronic condition improvement. But we're trying to link them now with health homes to strength those primary care connections.

So what we have is lots of different models. Many flowers blooming; some are more effective. But we kind of have to work with what we have. Now the reason it's hard to bring these models to scale across the whole state is first of all, duals are not a very large population and you don't have a critical mass with any one physician group. So it's very hard to get a physician group to change just for dual eligibiles even though as it has been stated, they are making up a huge proportion of the funds. And they are— you know they're an extremely expensive group.

We fortunately are a state where we're seeing more statewide models. So we are getting further along with that. It's helping push our programs along as well. We've also got lots of physicians in rural areas particularly that really don't have the resources or the capacity to take this on. And again, turning them into health homes, we're hoping, is going to help with that.

And then you know you just end up having— you've got a lot of county based care coordination models already out there. We're trying to use the resources we have. So it's hard to get the perfect models going in all parts of the state.

As we have the opportunity now to build on an all pair system in Minnesota which is what we're implementing on health homes, we're hoping that this will give us a vehicle to resolve of this. Despite all this variation in the clinical models, we have had some good results.

Just a few highlights of our results with our MSHO Program; we've had very high satisfaction in consumer report— consumer support, very little disenrollment. We've increased access to community services. We have 48-percent increase— 8-percent increase in people using community services, a 22-percent drop in nursing home utilization. And for every 100 people that we've kept out of a nursing home, we've served 86 people in the community. And that balance has kept us very cost effective.

98-percent of our MSHO members— seniors have annual primary care visits. We have shown reduced hospitalization rates for ambulatory care sensitive conditions in asthma, bacterial and pneumonia, congestive heart failure, dehydration and diabetic complications just in the last few years of 2006 to 2009. We're doing lots of performance improvements and like Lois' program, we've done our program— our eight health plans that we have that are working on this, do— have been doing well on the star rating system.

And the one thing that I do want to say though that it's not just the clinical results in these programs that's important. It's also the reason for doing it is to simplify things for the members. Because a beneficiary that's dually eligible now faces such a complicated world with the Medicare issues, the Medicaid issues, long-term care system often being kind of separate from that, various kinds of case management coming at them without coordination. It's really important to make it seamless.

The member materials alone are just a huge challenge to how to walk through the— how frail elderly can walk through what Medicare is telling them verses Medicaid when it's completely maybe not even correct when you— unless you can put it all together and can do that. So it's important for other reasons as well.

So where do we need to go? We're very excited and— about the new pathway in ACA especially the integrated platforms coming through the coordinated care office for dual

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eligibles. We're— I think that's a very exciting development. And we're looking very closely at that. It's kind of everything we, as a state, and other states have been asking for for years. And now they're putting it in front of us. Now we'll see if we can actually make it work and do it.

We think it's very odd that right now Medicare— Medicaid has to pay for healthcare home payments instead of Medicare. Now true the all payer Medicare Healthcare Home Demonstration, it's called the Advanced Practice Primary Care Model. That they are paying for some Medicare but that's just for a few states that are doing a demonstration. We happen to be one of those and we'll build on that. But it's still odd that it can't be a Medicare paid function instead of a Medicaid paid function for dual eligible. It's— Medicare is primary for all other physician visit— services, it should be primary for that. So that's an odd thing.

And as Lois alluded, there is a problem for Medicare risk adjustment especially for people with disabilities. We've had a number of our special needs plans have to drop out for people with disabilities. We do want to maintain separate programs for our people with disabilities. There are differences in the population that consumers feel better about it and we're running those slightly different. By definition, all the people with disabilities in our programs have multiple

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chronic conditions. And so we're concerned that the risk adjustment system perhaps for SNIPS does not work as it should for people with multiple chronic conditions especially when you have them all on one plan. But you want— we want plans that are designed for that group. So that's a real barrier for us right now.

And we also we're one of those plans that Lois alluded to that does not qualify for the frailty adjuster. Why? Because we require the health plans to enroll all the population. We don't want a person having to change from one kind of plan to another kind of plan just because they crossed some long-term care threshold. It's not right. They want— we want continuity of care and we want across time and place so that a health plan is thinking about things all the way down the line. It doesn't say oh, we'll just get rid of them, you know, if they get to a certain level, they'll be in a different program so we don't have to worry. So we're concerned about that. We— that we haven't gotten the frailty adjuster even though we're one of the first plans to become a fully integrated dual eligible snip.

And then we need some flexibilities state— for states to better target their community resources. This is more on the Medicaid side but right now we require this institutional— institutional care is the entitlement so to speak. And home

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and community based services are kind of an alternative that some people get. Somehow we need to rearrange that. It just—we can't target the way we need to and tier people in the way we need to with services. We have to give everybody everything instead of being able to adjust those services to the needs. So I think we need more flexibility in that area. So thank you.

ED HOWARD: Terrific. Thank you Pam. Okay. An awful lot of information and just so I am certain and on behalf of others that might not be certain, the FIDES SNPs are the fully integrated dual eligible special needs programs, right?

PAM PARKER: Yes.

ED HOWARD: Okay. So you have a chance to join the conversation. There are microphones as you can see. If you use the microphones, we'd ask you to identify yourself and be as brief as you can. If you fill out a green question card, hold it up and we'll have somebody come by and bring it forward. And we'll go from there. I believe you were first.

KATIE ADAMSON: Hi. I'm Katie Adamson. I work with the YMCA of the U.S.A. And so my question to you and it's a question we have at the Y is how do we define community partners in the medical home? And with that, how do we think outside of the traditional medical model when we do that?

We're doing really creative and innovative work around diabetes prevention that's showing incredible outcomes. The best of which are 70 years old and older and falls prevention. We're doing cancer survivorship work, arthritis prevention and control. And so we're— a lot of these people are lay to have degrees but they're not medical providers. So from payment systems to the medical home itself, where do groups like the Y fit in the community definition? And how do we make sure they do?

ED HOWARD: Go ahead. Lois.

LOIS SIMON: Thank you for that question because it's a wonderful opportunity to highlight the magnitude of work that we do in Massachusetts with non-medical providers that make all of the difference. And I can't say that we are working as closely with YMCAs although we do have some relationship around exercise programs for some of our participants. The Councils on Aging for example who offer evidence based programs and self management of chronic illness as do we but we do that together.

And all different kinds of organizations in the community are critically important. It's one of the ways in which the flexibility of a global payment system has enabled us to be creative, to be cost efficient and to be responsive also to the social context within which many programs such as the one that you've described exist which is very beneficial for

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particularly frail elders who may be otherwise quite isolated in their home environment.

ED HOWARD: Anyone else?

AL GUEIDA: Yes. Hi.

ED HOWARD: Wait please for us. Pam, you want to add something?

PAM PARKER: I was just going to say our plans also sponsor programs such as fitness programs through like Silver Sneakers Program which are housed in the YW or YMCAs. And I think a lot more we've especially done targeting of those programs to immigrant seniors who have different ethnic backgrounds so that the classes are in their own languages and things like that. And that's been very effective.

But I think— I see those programs. I think states are starting to see those programs as more and more important. And I think what you're bringing up is really critical. And I don't know that I have the answer but I think that we're starting to see that in what we're doing as well. And we need to build on that further.

ED HOWARD: Yes, go ahead.

AL GUEIDA: Yes. Hi. My name's Al Gueida. I'm a consultant primarily for mental health organizations. And I wanted to ask Mr. Brown and Miss Simon or a question about— well Melanie Bella, the head of the new duals' office, testified before the Energy and Commerce Committee well it might have been about six weeks ago. And she referred to mental illness as a game changer. So that if you are mentally ill, if you are dual eligible and one of your chronic conditions is a mental disorder that seems to significantly escalate the cost of that patient.

And I wanted to ask specifically about the— and I'm hoping you can speak more specifically about what the successful models do to specifically address cognitive impairments among dually eligible and individuals with chronic mental illnesses. I would imagine that if you have a chronic impairment, a mental disorder or some other condition of that nature that it impacts things like self care and your ability to help the clinician manage your own case. I'm just interested in just a few more thoughts on that.

ED HOWARD: Do you want to start Randy?

RANDY BROWN: Sure. Actually Lois, I think, can probably tell you more specifics about how their program does it. I'll tell you a little bit about there's a Pennsylvania— a program in Pennsylvania to serve exactly these types of patients that have both chronic physical illnesses and mental problems. And what they are doing now is trying to— because of the— like you say, the difference in how you— what those people need and what their costs are, what they're doing is giving—

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making the overall care coordinator be a behavioral health specialist rather than a registered nurse or an APN.

And because— and so we're— on another project that I'm doing, we're doing a study of exactly that issue to see whether that leads to better outcomes for these patients both on the physical side and the mental side than the more traditional kind of care coordination for patients that look like this.

ED HOWARD: Lois.

LOIS SIMON: So a very important member of our primary care team are— is indeed the behavioral health care manager who services the role of augmenting the work of our midlevel practitioners and nurses and physicians both in terms of helping with screening and identification of mental illness, referral to a more traditional mental health system when in fact there is one available and appropriate which is challenging.

Over 60-percent of our population speaks a language other than English as a primary language and those kinds of bilingual mental health practitioners are not as available as we need for them to be. So the behavioral health clinician plays a very important role in trying to sort of serve as the glue, if you will, between primary care and the mental health and substance use intervention systems.

The other piece in terms particularly with our elderly program, we are contemplating a new program in the coming year to all— to train, similar to what Randy's describe, train our existing care managers regardless of their discipline in depression care management in a sort of collaborative model.

And we've actually been doing a lot of work over the last year. Don't feel satisfied that we're doing enough and need to do more and that's other, again, cost effective approach that we can take to at least identify those individuals who need care beyond ours and to do some short-term intervention with patients and families that we can appropriately serve.

ED HOWARD: Pam.

PAM PARKER: I'd like to come at that from the other direction. Our mental health community advocacy groups have come to us and to the health plans to work on better integration of physical and mental health because they're the large group that's already been diagnosed with mental health conditions are finding that they're not getting their primary and preventive care. They're getting mental health care and they're getting targeted case management for mental health but they're not getting their primary and preventive care.

So some of the strategies that we've been using particularly in our disability program which is small at this point but may remain so because of the risk adjustment. But it— have been co-locations of various sorts. So for instance, one plan brings their physician NPs into a mental health center where people— a drop-in center where people with mental health go and brings the primary care to them instead of trying to get them to come to the primary care.

And another program in the rural area is bringing their behavioral health to their— the primary care clinics and trying it the other direction. So we've got a number of innovations that are going on that we would like to be able to build on if we can help that program survive.

ED HOWARD: Pam, both you and Lois mentioned risk adjusters. And you just mentioned it in your response. Are the payment rates adjusted in such a way that it takes into account the fact that as the gentleman said someone with a behavioral problem and multiple chronic conditions is likely to generate a highly level of expenditure?

LOIS SIMON: I'm not an expert in terms of specific risk adjustment system but I will tell you my instinct is to say not sufficiently and for two reasons. One is because people are under diagnosed. And if there isn't a documented diagnosis encoded correctly and everything else, we don't even get to the discussion about reimbursement on acknowledging a mental health issue. And secondly, I don't know that— the system well enough to feel assured that in fact the current mechanism is inclusive enough or weighting enough the complexity of care when there are those co-morbid conditions.

PAM PARKER: I think also risk adjustment systems by design are built to, you know, go across a broad population. And with programs that are designed like ours to really target people with lots of chronic conditions which SNPS are, especially dual eligible, SNPS are by definition duals are the population with many chronic conditions and certainly people with disabilities out of that group have the most chronic conditions all at once. But, and so you get a whole pile of them in one program which is desirable in terms of how to serve the people but it isn't– it doesn't fit with the payment model where you're assuming a kind of a bell curve shaped group. It's all eschewed to one end and it doesn't work for the risk adjustment.

LOIS SIMON: I should also add before coming here today, I had the pleasure of being invited to a meeting that may be groundbreaking in this particular area that occurred across just a couple blocks away with HRSA and SAMHSA and Health and Human Services that is all about workforce issues necessary to be addressed in better integration of primary care and substance abuse. And I think that that's a very important component of the discussion that we're having as well.

ED HOWARD: Thank you. Yes, go right ahead.

SUZANNE NINS: Suzanne Nins, National Family Caregivers Association. I have one comment and two questions. The comment is I'm really disappointed that nobody mentioned the role of family caregivers on the healthcare team because it is a critical and vital one.

And my first question is specifically for Cathy. You talked about registries of patients which, you know, I think is a great idea. Have you ever thought about the value of having a registry of family caregivers because we need to treat both together because they are the center of the care team?

And my second question relates to the community care team programs in CMMI. I believe in it fully but it is not funded. And there are some who say it won't be funded. And if not, what can we do to promote more community health team programs across the country? Because they have been shown to improve care and save money; I mean they're a no brainer in some ways.

CATHY SCHOEN: I'll try to actually take a stab at both and then see whether anyone else on the panel wants to talk about— comment on the community care teams. I think the notion of registries or having a fuller health record is another way of thinking of a registry of knowing your patients are

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increasing putting information on who else is there, whose in the family.

And just to give you one example that I found extremely exciting on creative use of electronic medical records. In Parkland Hospital, they've started to take from their administrative records everything they know about their patients particularly those who use them a lot including is there anyone at home, who are they, is there anyone not at home. Because if there's no one at home and every phone number is out of state, we've got someone without a family support.

And as they start to factor in those support systems, they can predict readmission rates along with the clinical things at a much higher rate than they could with just clinical. And what they've done is where there's a family support member, get them in sooner. Where there is no one, before the person leaves the hospital, start to bring in their best home care and community resources. And they are also linking to homeless shelters, linking to support systems. So trying to think of there's a larger support network.

So I think the notion of basic systems that no patients, you can put patient reported outcomes in. You can put information about family caregivers. So I think it's a great idea. And getting that information in is perfect.

On community care teams, it— the ACA is very rich with lots of different innovations and pilots. And I think to the extent one doesn't zoom all by itself. There are multiple opportunities to support this idea of community care teams. The health home money was put in under the Medicaid side of the equation and could and probably rightfully could. But people are looking and states are starting to say we can take those health home dollars and they can support the kind of care teams that North Carolina has built, that Vermont is building—

SUZANNE NINS: Right.

CATHY SCHOEN, SENIOR VP: —that Oklahoma is building where the care managers are part of community care teams but shared. And Pam mentioned that you often have a physician that may only have two or three of these extremely sick people. But all of the commissions in the community have a lot. And it's the care team that starts to work with that.

And just on the mental health side, there's a huge amount of on the ground cross training that's going on depending on the group that people are learning that geriatrics set of skills, the nurses as well as psychosocial skills and either going more in one direction or more the other. So I think we've got an opportunity under the medical home title as well as affordable care organizations which give this more flexibility. Figure out how to build the way you're

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integrating care with multiple models working, it won't necessarily be under one roof.

ED HOWARD: Anyone else? Lois.

LOIS SIMON: Yes. I— thank you for correcting us in relation to not talking about the important role that family caregivers play in the care of the individuals that we serve.

SUZANNE NINS: That's my job.

LOIS SIMON: And, well it's— I'll tell you it's— as the daughter of two octogenarians on— I'm ashamed of myself. I will tell you that in our program, the— if we were doing a pie chart, the largest slice of the pie in terms of our medical expenditures is for personal care assistant services. And very, very often in our program, we are funding personal care assistants to be provided by family caregivers.

So there's two aspects to this. One is all of the unfunded work that families do that is the backbone of the care for people. And then additionally we have found creative ways in which to enable the daughter-in-law to remain at home instead of working at a— you know at relatively minimum wage job in work to care for the mother-in-law who would much prefer the care to be provided by the daughter-in-law personally.

PAM PARKER: So, and I just want to say right now, my cousin is saving the state gobs of personal care attendant money by staying with my mother, 400 miles away from me, for a

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couple of weeks after we— she had successful hip surgery at age 86. And so my mother is an AMSHOW member. The care coordination system has worked very well for her. But we're also saving a lot of money because of family based care. So I'm also sorry we didn't mention it because it figures into our programs in so many different ways. It's so important to states to encourage that because you can imagine the amount of dollars we'd have to put out if it weren't for the family care members.

SUZANNE NINS: Have you extrapolated [interposing] from all of this in your various programs to how much money the presence of a family caregiver is saving?

PAM PARKER: We did years ago. I don't remember what we came up with. Probably some of my colleagues in the department would maybe remember that. But I know there have been estimates in the past and it's— it was —

SUZANNE NINS: But—

PAM PARKER: —it was immense.

SUZANNE NINS: The reason I bring it up is Tony Rogers said in order to do programs to educate and support family caregivers; he needs proof of their impact.

PAM PARKER: Well—

SUZANNE NINS: And so gathering that proof I think is an important research task. Thank you so much.

ED HOWARD: Okay. Yes, go right ahead.

JENNA NION: Hi. Thank you for your time. I'm Jenna Nion for a resident physician in California. I had a question for, I believe, Dr. Brown. And that's basically how to square one of the recommendations you gave about frequent provider visits as a way to increase or decrease Medicare spending with your other goal in one of your packets which is reduce variation, geographic variation in healthcare spending.

My understanding is the number of provider visits is one of the— one of the criteria that drives up the dispirit spending geographically. And it seems that if one were— if physicians were to go to a national benchmark of sorts in terms of how many patients they were seeing or the number of patient visits that could potentially reduce hospitalizations but it may end up driving costs in the long run. I'm not sure if I'm understanding properly.

RANDY BROWN: Well I don't think so because I wasn't suggesting that people have more physician visits. Some people may need more. And that's one of the things that care coordinators can identify is the— and more often it's that they don't get there fast enough. One of the things that these care coordination programs have found to be the most effective way of helping people stay out of the hospital is by having this ongoing contact between physician visits via the phone or a visit to the person in their home. They identify— you know the person will say they're not feeling very well or whatever. And then they start talking and have you called the doctor. No. And when they hear the symptoms, they say well you better call him right away. The care coordinator can facilitate making sure they get seen right away because it's not just a call out of the blue from a patient that— and so to the physician's office.

So that's one of the big ways that they have effects. But it wouldn't necess— but I'm— I wasn't saying that physicians should do more visits. But rather that the care coordinators, when they see the patients, they need to do that in person. They can't just pick up the phone and have these telephone contacts. You get some person sitting in a telephone bank in California trying to tell somebody in St. Louis that they've never met or laid eyes on what— how they should changed their behavior. It just doesn't work.

JENNA: Okay.

RANDY BROWN: Doesn't that help?

JENNA: Yeah.

LOIS SIMON: Very important, Randy's first comments, he's talking about extremely sick people and this notion that if someone is accessible to them and the contact may be by phone. I can call you at midnight and I know you're going to answer that phone as well as in the home. It may be that the visits go down but the way of contacting go up. And for a lot of patients, we don't need to go as often.

RANDY BROWN: Right. [Interposing]

LOIS SIMON: If we could get through by phone or by email, we might never need to be there because it's—

JENNA: Right.

LOIS SIMON: —a worried well check-in. Right now everything's around the visits so we don't use visits the way we could be using them.

JENNA: Yeah.

LOIS BROWN: And we don't have these multiple points of access which includes phone, Web, home.

JENNA: Right.

LOIS SIMON: For most of us, it's only a visit. You can't get through any other way.

RANDY BROWN: Right. Yeah.

JENNA: Which many patients don't really look forward to doing anyway so trying to get them to come often may not be very successful.

RANDY BROWN: Right. And there are some programs that have home— physician home visits. You know the— which never— you know the thing from the past, well that's coming back in some cases for these people that don't have access. And it's a

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big burden and even a health risk for them to get out of the home and try to go to a physician's office. So.

JENNA: Thank you.

ED HOWARD: Okay. Thank you. Yes, go right ahead.

GAYLE MCGINNIS: My name is Gayle McGinnis. I work for the Pair Professional Healthcare Institute, PHI. For those of you who don't know, we work to improve the quality of long-term care by improving the jobs of the direct caregivers, direct care workers. So I first just wanted thank all of you for being here today. I find the information that you've shared fascinating and really appreciate the work that you've done.

My question and comment builds on what Suzanne had to say. So many of these people in this population do have long-term care needs, need assistant with the activities of daily living. And we at PHI have been doing some thinking about the role that direct care workers can play in the care coordination teams. And have found that many of the existing models, a lot of the models that Randy referred to, haven't— don't incorporate them at all and really although they're open to the idea, it's very primary care focused and doesn't consider the role of these caregivers who spend so much time with these individuals that have long-term care needs.

So, I wondered whether— Lois had some comments about how Commonwealth Care Alliance incorporates direct caregivers

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and just would encourage all of you to consider with us the role that they can play in recognizing early warning signs. You know working with the individual on prevention. And, I think they present a tremendous resource in terms of helping with transitions and care and preventing hospitalizations.

CATHY SCHOEN: So thank you on very complicated issue and it's in our experience. And the reason for that is because there are different kinds of direct care workers. There are those that are employed by agencies. And I would say to you that they are often the eyes and the ears of the medical care system in reporting the changes on a day to day basis. And that's critically important as are the transportation workers and the like.

And then there are personal care assistants who are in the context of the roots of the personal care program, you know, that are employed directly by the participant in the program. And that's where it gets complicated because that's a very important value that many of our participants hold which is that they are in fact directing the work of that individual.

So we are actually doing some work. PHI is actually involved in that work in Massachusetts with us along with other organizations to really try and think about appropriate ways with the participants' permission in engagement of sort of bringing those issues together and really involving to the maximum extent possible the work that personal assistants do into the context of the team. But again, that important value I want to underscore is something very important to us to uphold in terms of that patient's autonomy.

ED HOWARD: Okay. I think actually you were in line first. Go right ahead.

SHANA MONTROSE: Hi. I'm Shana Montrose from the Center for Consumer Information and Insurance Oversight at Health and Human Services. My question is about the payment model and which model best serves this population. And maybe it doesn’t make a difference. But I was wondering if a model where providers and payers are integrated makes a difference for this population verses having those separate. So a model like Kaiser or Group Health verses my insurance where I know what network I'm in and where to go but it's not the same entity.

CATHY SCHOEN: Oh, I can say something about that because we have experience with those kinds of— we have one kind of a— it's a group health partners kind of a model in Minnesota. And it's been very, very effective. But a lot of those models are also having to use a lot of contracted providers in order to flush out their networks and whatever.

So I don't think it rests just on that. Certainly, in these total costs of care models, they're highly integrated.

But I think what's really important is that the teams are highly integrated not so much that all of the other providers are necessarily a part of that system. You know the hospitals may be outside. Even the home health may be outside. But as long as that doc and the nurse practitioner and social work team is kind of working with those providers, I think a lot can be done through those kinds of models.

They are being— in these total cost of care models, they're being held responsible for the— you know in a virtual way not necessarily a full capitation on the front end but maybe a partial cap with a virtual surround looking at the overall cost of care. I think they're being held accountable that way. So I don't think everybody has to be— it's just not possible to co-locate everybody, to have everybody, you know, doing everything with everybody. I mean you just— those kinds of models. Well Paste is one of those models, a very wonderful model but very small, intense model maybe too expensive to bring it to scale for everyone. So we have to think about scale models.

And so I think we— what we need to find is ways to build links where people are and make them effective. And I think it's going to be a variety of models that— well at least what we've seen. I think that these total cost of care models are very effective. But I think we also can't use those in all

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the rural areas. So I think we've got to develop a variety of models that connect to each other in different ways. And maybe some of that's incented through different kinds of payment.

ED HOWARD: We are— we're going to be doing some studies in the next two years— year and a half on dual eligibles that are covered by plans that are integrated between Medicare and Medicaid and ones that are not. And so that hopefully will give us some indication about how much better you can do when the financial incentives are aligned and integrated. [Interposing]

CATHY SCHOEN: Yeah, definitely the incentives of having the payments aligned is critical at the beginning —

ED HOWARD: Yeah.

CATHY SCHOEN: —of whatever we do. That has to happen.

ED HOWARD: Yep.

LOIS SIMON: Yeah. And I just I think that the payment part's critical in information systems that underlie that. So, to give a very different kind of example of a way of integrating, in New York, the Visit A Nurse Association has been dealing with very frail and they finally opened up the equivalent of a special needs for homebound, long-term care. The networks they've built has been over time very explicit relationships with certain physicians and certain specialists that have a lot. But they've got an information system that

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works with all of them so they're more in the home and community than in any one place.

But each of those patients is seeing— each physician that sees those patients is only seeing a handful of patients like that. So in the organization where the physicians are whether they're working at Mt. Sinai or Columbia Presbyterian, it would— they would never build out the same kind of network that the VNS is building out because they're cutting across the whole community. So it's this nature of team and information but the information and the payment have to work because the resources have to be able to be moved around.

ED HOWARD: Yes. Okay. Thank you. Bob.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. Most of the discussion has been about program models that work or don't work for patients with certain characteristics. Different disabilities, different needs for different kinds of services and it's interesting how many of those services are non-clinical that seem to make a huge difference.

But what I don't hear— well actually I hear it more on this panel than on any of the other sessions that have been sponsored here. But what I don't hear enough about is how systems at a geographical level can be held accountable for making programs efficient, effective, and equitable at a

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geographical level. In other words, it's one thing to say yeah, if you give the provider a flexible checkbook, they can compensate for the lack of particular services that a specific individual needs.

And Lois' program is a good example of that. But institutionalizing that the way Minnesota is trying to do for its home health— for its community health plans is a very different kind of challenge. It's not just going to scale. I'm looking for mechanisms of public accountability that ensure that resources are distributed in the most efficient, effective and equitable way.

And I'm not sure they're going to evolve from the kind of studies that Randy's conducting where the focus is on, you know, some specialized population and whether we can reduce their hospitalization use when so many communities, you know, don't even have doctors much less the rest of the health— the comprehensive healthcare delivery system that's needed. So my question is really what— how can the federal government and states governments take more responsibility for ensuring that the community is supportive of the kinds of programs that do make a difference?

ED HOWARD: Pam, you want to try that?

PAM PARKER: Okay. Well just one thing to say in Minnesota, we have— we are trying to do that. I think that

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accountability is a key word. And I appreciate your bringing that up. And I think we are trying to do that because of our all payer health home program. It is an all— it— payer, we mean commercial payers are getting involved. Medicare is involved with the primary care practice demo. And we're involved as the Medicaid system in all of our health plans, implementing that demo or implementing the healthcare homes as part of the all payer process.

The all payer process has all kinds of accountabilities built into it in the sense that in return for an additional payment for— based on multiple chronic conditions, it— there is accountability. There are provider feedback mechanisms. They are expectations. There is data collection. And we're trying to build that in. Now how— whether we can get every single clinic in the state to become a health home I don't know. We're working on it and we've got, I think, a hundred— and about a 140 of them— clinics serving a fairly large population already in. And we're going to be continuing. There is more in the pipeline. So that's one way.

ED HOWARD: And correct me— oh, go ahead Cathy. No, I'd rather have somebody talk who knows what they're talking about. Go ahead.

CATHY SCHOEN: I think that's right. And as you start to build these up, I mean these networks sound small but we've

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been talking about working with the sickest of the population because that's where most of the spending is. And that's where the potentially preventable death is occurring and a complication is occurring. Someone going blind that didn't need to, losing a limb that didn't need to, being in a nursing home that didn't need to.

These— the case study of Anna; she got better in that she could cope with more of what was wrong with her with a more intense. What you've seen is people start to focus this way. It changes the whole community care system.

The Rahul Gandhi article that Ed referred you to is now going— trying to go to scale by doing a Medicaid ACO. And they've gone the Medicaid route because they're dealing with all of Camden and pockets of New Jersey where the whole community's at risk. So they're— they've moved it out to union members, to others. But what they discovered is shortages. So extremely high use of specialists and hospitals and just pockets where you just couldn't get into anything that looked like a community based care. So they're retooling.

But I think that it's this notion of these very high needs focus you very broadly quickly because you see how many places these more expensive patients are touching. And so it moves you to a community approach. Whether we can get to scale with everyone in like— you know it's gone— it will be— need to

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bring all payers because we will drive the physicians crazy if not others crazy if every payer tries to do this differently. You can't build out accountable care systems unless you're moving in the same direction.

RANDY BROWN: One of the other things that Minnesota's doing that's great too is also an all payer initiative is we're— what we're doing for them is to rate every physician practice in the state on their quality and on their cost effectiveness. And those are going to be published. And the state law requires that that information be used by payers to set up tiered pricing. So there's a— that's a whole statewide taking responsibility for it.

There are also a number of neighborhood or community kind of interventions that are out there. More public health days, none of the ones we talked about today because we were focusing on the chronically ill. But there are those kinds of things out there. There's an RWJS intervention.

There's a Dr. Aroreo [misspelled?] I think is his name. I don't have that name quite right. But anyway, he published an article in *New England Journal* recently to provide services to physicians in rural areas by teleconferences with physicians in the rural areas that when in— talking to specialists at that nearest academic medical center. And so they have these kind of virtual rounds.

So there's all kinds of things like this that are going on. It's just that, you know, in our 30 cumulative minutes between us we couldn’t care all this kind of stuff.

LOIS SIMON: And just the telemedicine is extremely excite— you know I think we just scratched the surface on this. The VA is doing a lot. But this virt— it's not just a virtual consult with the physician in the rural area, it's with the patient. It's talk to me and you get your— and with digital, they can get lab test results back at the same time.

And so you've got some very interesting examples coming out of a Tennessee and a tri-state area that are bringing services back out to the community. And so the scope of the geography is bigger. They're thinking about hubs and spokes and regional care systems.

ED HOWARD: Right. And, just a brief commercial, if you go to the Alliance Web site, there is an interactive map that has Minnesota's and a number of other community initiatives on the map. You can get information about; I guess it's close to 50 different programs in different parts of the country and what's going on in the way of accountability and quality, information being shared in very real time. So yes, Toby, you've been very patient.

TOBY ETTELMAN: Thank you Ed. I'm Toby Ettelman with the Center for Medicare Advocacy, a public interest law firm

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that represents Medicare beneficiaries. The success of some of the programs and demonstrations discussed today has been measured in large part by the reduction of inpatient hospital care.

Over the last three years, we've seen an explosion in hospitals' use of observation status. That means a patient whose put in a bed often from the emergency room receiving diagnostic tests, medical care, physician care, nursing care, consultations, treatments, medications, food, little wrist band may stay five - six days, 13 days, several months but they're called outpatients. They're not called inpatients. People primarily call us because they're concerned when they go to the nursing home it's not paid for by Medicare because they didn't have a qualifying three day inpatient stay although they've been there for a week or two.

But for today's discussion my question is whether any of the research has looked at the impact of the increasing use of observation on hospitalization. Because it seems that some of the reduction in the inpatient hospital care maybe could be attributed to the increase in observation. These are patients who should be called inpatients but they're called outpatients. It doesn't count against hospitals as an inpatient admission.

RANDY BROWN: It's possible.

ED HOWARD: And but—

RANDY BROWN: But, you know, these are— these care coordinators in the projects that we're— I'm talking about are working closely with the patients for the patient's best interest. They're not— they don't make any money by say— it's not like an HMO. They get their— they get a fee for providing care. So they have no incentive whatsoever to shift costs onto the patient here. And so they're all about for the patient. So I don't think [interposing] that that's what's going on for these programs.

TOBY ETTELMAN: But the hospitals— but the hospitals are calling [interposing] are the ones who are making the decisions— [Interposing]

RANDY BROWN: No, the physician is the one that admits the patient to the hospital or not.

TOBY ETTELMAN: Well under federal rules, the hospital's utilization review committee can retroactively reverse a physician's decision for inpatient status and make the person an outpatient. I— [Interposing]

RANDY BROWN: Yeah, I haven't heard of that happening.

LOIS SIMON: You know for the particular instances of what the studies we reported on, they are capturing the total costs of care. So if they— if they were in the hospital being paid in some— under some other rubric but I know what happened in Mass General for example. They actually, as part of their

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demo, waived the three day rubric because many case they didn't need to get— be in a hospital for a day. They needed to go some place else and have permission.

So they were very much tracking any contact with something called hospital. So I don't know enough about the phenomenon you're talking about but I know in these controlled, when they measuring costs, it's everything. So it— they wouldn't miss it if there were a bunch of days being paid under some— in some other way with the hospital.

PAM PARKER: Yes. And I just want to say under our programs in Minnesota for duals, all of them do waive the three day hospital stay. That's a part of our program. And again, that— the health plan is on— their responsible for total cost of care. So they would be just as concerned about that as anybody would be. Because they're going to have to pay for it whether it's you know a— whether it's a— and for duals, of course, there isn't— they don't have to pay the cost sharing so it's not burdening the person as much. But they're looking at the total cost of care not just whether it's a hospitalization or not.

CATHY SCHOEN: And also I believe there is a time limitation on observation day status. At least there— we employ one in Massachusetts.

TOBY ETTELMAN: There is in the Medicare manuals. It says 24 to 48 hours.

CATHY SCHOEN, SENIOR VP: Exactly.

TOBY ETTELMAN: But MedPac has found last September, there was like a 78-percent increase in observation stays exceeding 48 hours. So it's definitely a serious problem. [Interposing]

ED HOWARD: Well it's worth looking— yeah, and [interposing] we're going to be using some age cup data which captures all pairs. And so I'll take— we'll take a look at that.

TOBY ETTELMAN: Observation's paid under Medicare Part B. It is a Medicare service but it's— the reason we hear from people is that they— they're not in a Part A stay in the hospital so their nursing home care isn't paid for. But —

ED HOWARD: Right.

TOBY ETTELMAN: — it's Medicare Part B. Thank you.

ED HOWARD: They ask tough questions.

RANDY BROWN: Right.

ED HOWARD: Yes, Cathy.

CATHY HURWIT: Hi. Cathy Hurwit with Congresswoman Schakowsky. I want to thank you for this panel. It's not just very information but I think inspiring for those of us congressional staff who are dealing with some of the budget

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issues and changes that we see being proposed for Medicare and Medicaid.

And I wanted to ask you, it's nice to know that there's such wonderful, exciting things that are going on. If you could give us some things that you think we should not be doing considering at the federal level because they would hamper your ability to expand and do things?

I know Ms. Parker, you just mentioned cost sharing. There's a lot of discussion about increasing cost sharing under both Medicare and Medicaid. And what impact that would have on the ability to do the care coordination. Just some of the things we shouldn't be doing that would make your life harder and maybe some of the things we should be doing that would make it easier to expand and scale up these programs.

ED HOWARD: That's a terrific question to end on which is what I think we're going to be doing.

PAM PARKER: When you're— two things that come to my mind is yes, on the cost sharing, right now we have our health plans picking up the cost sharing in Medicaid. Whenever we put in any cost sharing, they have to pick it up and eat it basically. Because they feel so strongly that having that barrier there for the member is too big of a barrier for clinical care that’s needed. So for instance even— well while you know, there may be a few dollar co-pay on a Medicaid drug

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or something like that, they pick that up because they don't want the person not to have that drug. We have that same problem in Part D. The co-pays are low enough for the low income people that it's not so much of a barrier. But I think we do have to be very careful about it.

The other thing that I'm really concerned about is— you know and I'm going to say a Minnesota specific thing here, is that Medicare payments all across the country are not the same. You know? Places with high utilization and where the Rahul Gandhi articles have shown that it's been driven by, you know, lots of utilization practices that are maybe questionable. Those places get paid more. And places like Minnesota where we've made a more conservative medicine approach and lots more health plans and HMO type approaches over the years, we get paid a lot less. We're below the national average.

When we then build in physician payment cuts into our health plan costs, it's a very big hardship for states like ours. So cuts in Medicare Advantage could sink these integrated programs if there's not a way to make sure that we continue to pay the physicians at a decent level.

ED HOWARD: Lois before you speak let me just say this will be— we're right at the end of our time. And if you would both listen to our panelists respond to this question and fill

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out the blue evaluation form, you can help us and La Clinica del Pueblo. So, go ahead Lois.

LOIS SIMON: Thanks. Great question. I will say that the efforts being made by Melanie Bella and her staff in the Federal Coordinated Care Office have been really fantastic in asking that same question of all kinds of constituencies not the least of which is those of us who are trying to deliver these programs. And we've certainly given them a lot of feedback about what might be done differently or what to preserve.

I guess I would say taking that up one notch, I can continue to ponder the question of whether the insurance model of Medicare Advantage however embellished through the requirements of special needs plans is the best framework for the work that we do. You know we have another example in PACE. We have the special needs plans. You know it— are we needing something different. That's a complicated thing to say. It's be careful what you wish for. But you know there's just so much, so much in that framework that is makes the work harder than it needs to be. And so, I'll just end with that.

ED HOWARD: Randy.

RANDY BROWN: I just add that if you're— there's a big push towards medical homes now. And I think if that doesn't— if that doesn't get the payment structure right so that there's

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incentive to really attract people that really need a lot of care like this and we don't overpay for people that are essentially healthy and don't need a lot of the— and have what a medical home would have to offer then that's not going to be very effective either. We're going to spend more money than what we should be spending if you pay a flat rate for monies.

ED HOWARD: Cathy, go ahead.

CATHY SCHOEN: You know in the reforms you've already built in, some with a lot of creative work, can very well work together. What you've got in front of you both on the cost sharing side for either Medicare or Medicaid, we absolutely know from all the research that as you go down the income scale how sensitive people are on cost sharing. So to the extent there's movement on that, it should really only be moved— should be with a notion of value. You should have flexibility.

And I'll just give you one country's example. When France looks at its drug formula or it puts on the lowest cost sharing tier the most effective drugs irrespect of the price of the drug. And so if we know this works, we want you to get it. And then they bargain hard over the price of the drug. But to be thinking about the more questionable, to be thinking about referenced pricing, allowing some flexibility.

If there was movement on the exact fees we pay in the fee schedules particularly to address in Minnesota area, if you

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allow the flexibility that you worry about the fees but you're allowing all the increases to go into these medical home payments paying in a different way, it will be more attractive for people to join these networks and be part of these care teams but ear market.

I mean it— you know we know that you don't want to give every mem— put a per person amount that's exactly equal for very kind of patient. But there are differential ways of doing it. And there are also ways that care teams, if they think this way and I'm thinking both within the United States but internationally. People may be getting a similar mix of per capita and fee for service. And the physician and the teams that most of that infrastructure stuff is going for my sickest. You know so that it's done based on my overall case mix but I'm getting more or less because it's a tough population but not getting so narrow that for this person to get this and for this person to get that.

So I think there's some creative things as you get into the SGR discussions that, you know, that if we're changing the relative values, we should be careful on how we change them make sense. But think of increases going more into having Medicare start to pay not just fee for service but also a medical home payment so a different way of paying for primary care.

PAM PARKER: I forgot to mention one of the more important things. And that is the Medicare Advantage Bid Process does not work for dual eligibles. This is the— it generates premiums. We've had four SNPs have to drop out because they generated premiums. Dual eligibles can't pay premiums. States don't have the money to pay premiums. It doesn't work. It has to be changed. I think SNP platform could work but we've got to get rid of— we've got to adjust for that bid process. It just does not work to try to charge dual eligibles premiums.

ED HOWARD: Okay, pretty good roster of specific and general things to keep in mind. Another small commercial; we are going to be doing in cooperation with the Commonwealth Fund and others in this fall season a series of briefings on the deficit reduction process and how it might be effected by or effect the healthcare programs that the government operates.

Tomorrow you'll be able to look at the Webcast and Podcast of this briefing on KFF.org. I want to thank the Commonwealth Fund for its active participation in the program and its support and co-sponsorship of it. Thank you for filling out the evaluation forms and for your good attention. And I apologize to those of you who write green question— green card questions. We just didn't have the time to get to them.

And I would ask you to join me in thanking the panel for a really useful discussion of this problem. [Applause]

[END RECORDING]
