ALLIANCE FOR
HEALTH REFORM

Integrating Care for Dual Eligibles: What Do Consumers Want?
Alliance for Health Reform
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ED HOWARD: My name's Ed Howard. I'm with the Alliance for Health Reform. Thanks for coming. On behalf of Senator Rockefeller and the Board at the Alliance, I want to welcome you to this program that takes a look at a very current topic, care for people dually eligible for Medicare and Medicaid, the so-called dual eligibles and especially at the plans to better coordinate or integrate care despite the separate payment systems that duals represent but this time, we're going to look at it from the viewpoint of the dual eligibles themselves as well as from the viewpoint of other stakeholders and partly here's the reason.

Back in the 1990s, there was a widespread movement toward managed care for the general population. The idea was and this will sound familiar, better coordinated even integrated care toward the goal of better quality and constraining costs but back then frankly, the enterprise went awry. People were very skeptical the motives of those managing their care, which they experienced, for example, as not being able to see the doctors they had been seeing without advanced permission. One lesson I'd like to take away from that experience is that if you want care coordination to succeed, you need to be aware of and respond to the needs and preferences of the people whose care is being coordinated. Hence today's program.

We're going to explore some of the research through focus groups and other methods for exploring those needs and those preferences. We're pleased to have as a partner, in today's program, the AARP Public Policy Institute, which is as you can see from the red logo, celebrating 25 years of informing and stimulating public debate on issues affecting Americans as they age. They do it through analysis, research, and dialogue like today's and we're very pleased to have co-moderating this discussion Susan Reinhard who is the Director of PPI and a Senior Vice President at AARP. Susan nice to have you back.

SUSAN REINHARD: Thank you. Thank you. This isn't the first time we have collaborated. Rick Deutsche who is very much involved in developing today's program and now we're trying to remember, we think it's four or five times. We hope it's 10 times and more in the future and I also heard this is your last event of the year. This is an honored place for us to be co-sponsoring this event. Thank you very much. As Ed noted, there are more than 3.2 million people eligible for both Medicare and Medicaid. You'll forgive me because as the consumer organization, you wouldn't expect us to use labels for people like duals because we don't think that people understand they're even a dual or they wake up one day and they have a sign, a tee-shirt that says I am a dual but to keep saying people on both Medicare and Medicaid is a little long-winded. We are going to keep using that term and we care a lot about these individuals who we all know are the sickest and most vulnerable of people that we serve.

AARP and the Public Policy Institute has a great deal of interest in this population and has for many, many years. We have been looking at the data, the latest data and it's not new to many people here. I'm looking around this room and there are experts who could be sitting here just as easily as some of us that are sitting here and we acknowledge that but you know that nearly 40-percent of Medicaid spending, 40-percent of Medicaid spending is spent on people who are dually eligible for Medicare and Medicaid. Much of that long-term care of course but what a lot of people don't really think about is that more than a quarter of Medicare, Medicare spending is for these individuals too. Clearly there's a lot at stake here for these individuals that we already talked about being among the most vulnerable in our society but we are also worried about the cost, the cost effectiveness of this program as well as the quality of care that people in these programs receiving services from both Medicare and Medicaid receive and about access.

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That pillar we always talk about, access, quality, and cost, major concerns but this is imposed on a system traditionally fragmented among the federal and state programs and has been for a long time. We are delighted that in response to this growing interest that there are federal initiatives and we have a colleague here that will be sharing that and I'm sure many of you, if not all of you, know that that these federal initiatives have been launched to explore how we can both simultaneously reduce costs and improve both access and quality of care for these individuals. Much of this effort has been focused on coordinating care. You'll hear about that very soon.

In general, AARP supports these federal efforts, these initiatives, However, you can imagine, I would hope that as a consumer organization we are very well aware, as Ed has already pointed out, that changes to the way care is organized for these people who are dually eligible could have profound effects on their lives and frankly the lives of the families that surround them and support them in many different ways. Today, the voices of these people have really not been a big part of the conversation. Lots of analyses on the dollars and potential structural ways we could consider how we could make these reforms but we really wanted to bring the voices of these individuals into this discussion about how they would like to receive care, what they're experiencing in the current delivery models that exist today and particularly models of coordinated care and any problems that they're experiencing, to hear from them and put it out there for this discussion today and hopefully in the future. That's the genesis of the study that we are releasing, the Public Policy Institute is releasing today. Lynda Flowers, who is going to be sharing with you very soon, is the main leader and author of this study. She'll be sharing that in just a few moments but first, let's turn it over to Ed.

ED HOWARD: Thanks Susan. We're very pleased to be able to cooperate once again with the Policy Institute and with AARP. Housekeeping, in your packets, there's a lot of information that we hope will lead you to the next level of sophistication after you finish the discussion today. That list of materials and some additional ones are available on the website of the Alliance at allhealth.org. Tomorrow there will be a web cast of this briefing available through our colleagues at the Kaiser Family Foundation through their website kff.org and a transcript in about a week on our website. You'll be able to go back and review every lovely moment.

Two specific things in your packets that I want to call attention to is the blue evaluation form, which I hope you will fill out in a timely fashion to help us improve these programs and when we get to the Q&A part of the program, a green question card that you can fill out and have the question read by one of the very competent co-moderators. Let me give inadequate introductions to our entire panel up front so that we can have a conversation that flows without interruption. We've got a very knowledgeable group, folks with both analytical experience and on the ground experience and sometimes both. They'll give some brief presentations and then we'll save a lot of time for interaction and questions and answers.

We're going to start with Lindsay Barnette from the Medicare and Medicaid Coordination Office, so-called Office of Duals, at CMS where she's part of the models and demonstrations group. She's also done some extensive technical assistance to state Medicaid programs on duals in her role as a senior staff member at the Center for Health Care Strategies. Next to me is Linda Flowers who, as Susan Reinhard indicated, in her role as a strategic policy advisor for the Institute's health team, has been taking the lead in developing the paper that you find in your packets encapsulating the experience that has been put together by the Institute with respect to these focus groups. She's held senior positions with the National Academy of State Health Policy, the National Conference of State Legislatures,

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the League of Women Voters, the D.C. Medicaid program, I can't go on, and she's going to tell us about those focus groups.

Corrinne Altman Moore is up then and she's the Director of Federal Finance for Mass Health, which is the Medicaid Program of Massachusetts. She's busy now with, among other things, the Commonwealth's new initiative on duals. She has information about some of their focus groups that the department has conducted around the issues involving that group. Then finally, Suzanne Gore, who's the Director of Integrated Care for Duals at the Center for Health Care Strategies. She's heading up the center's extensive technical assistance effort to reach states who are working on dual eligible questions and she's also spent time working on research and policy matters with the Virginia Medicaid program. We have a richly experienced and highly qualified group of folks to begin this examination of the attitudes of dual eligibles toward the care the care they get. We're going to start with Lindsay Barnette from CMS.

LINDSAY BARNETTE: Great, thank you so much Ed and Susan for having us here today. Again my name is Lindsay Barnette. I'm with the CMS Medicare/Medicaid Coordination Office. For those of you who may be less familiar with our office, it was created by section 2602 of the Affordable Care Act and is really designed to improve the quality, reduce

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costs, and improve the experience of care for individuals who are eligible for both Medicare and Medicaid. If you're familiar with the legislation at all, you'll see a long list of goals that the office has but I think some of the key ones that we tend to focus on is really ensuring access to services, improving coordination between the state and federal governments, developing innovative care coordination opportunities, and trying to eliminate the financial misalignments that exist currently between the two programs.

About a little over a year ago in the fall of 2010, our office contracted with Thompson Reuters to do a number of things to help our office succeed in its' objectives, one of which really had to do with trying to better understand the beneficiary experience today and launched a series of focus groups that were really meant to gain insight into how enrollees are making enrollment decisions particularly in places where coordinated or integrated care is available, to learn more about how they experience various types of service delivery combination whether it's through a single coordinated plan, through multiple health plans for both Medicare and Medicaid or some combination of fee-for-service or health plans on either side.

We also wanted to identify language that are used by enrollees themselves so that we can improve our communication efforts at CMS as well as to help states, plans, and other community organizations improve communication efforts as well. Since as Susan points it out, we tend to use labels, which is not necessarily the best way to go about it but trying to better understand what resonates with individuals is important to ensuring quality. Over probably the last six or nine months, we conducted a series of focus groups in five different states, which I'll talk a little bit more about. The key site selection factors really had to do with the choice of options in the various settings. Each state had at least one focus group that focused on receiving care through a single coordinated plan, the majority of their Medicare and Medicaid benefits through a single plan, as well as one focus group that in which individuals received their services through separate settings.

We looked at states where we could focus in on specific subpopulations of the dual eligible group itself. They're a very diverse mix. We wanted to be able to outreach to different people, those with serious mental illness, individuals with physical disabilities and the likes. We wanted to make sure that we could reach those people. It was important to make sure that we had partners who were willing to help at the local level either at the state or health plan level in terms of identifying and outreaching towards to beneficiaries. Then in some of the states, there was an opportunity also to use the focus groups as a way to contribute to some of the demonstration planning that was already going on in those states.

Our five state focus groups reached more than 150 people through 21 different groups. The majority of the groups were focused on individuals 18 to 64 and that was primarily because we knew that our colleagues at AARP were doing a set of focus groups on the over 65 population. We wanted to leverage their experience to the degree possible. We, again, focused in some states on subsets of the population but in some instances, it was focused on all duals as well. Interestingly, we did have one group that was with Chinese-speaking individuals in California and another that focused on American Indian population in New Mexico.

Through the focus groups, we came across a number of key themes from across them and I should say that Thompson Reuters, our contractor who did this work with their subcontractor, the Zacharias Group, is working on a research brief that will summarize a lot of these findings in more detail but one of the first things that jumped out at us as we took a look was just the wide variation in participant understanding of Medicare and Medicaid differences. There were some savvy consumers who could tell you in great detail the

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differences between the two programs and then a number of people that really didn't know much about them. They knew that they were two programs. They vaguely knew that they were receiving care through both of them but couldn't necessarily go into a lot of detail and then there was a lot in between but it certainly highlights the fact that this is not a homogeneous population in any sense of the word that there's a lot of variety in terms of the sophistication and understanding.

Again one of the things that we really wanted to tease out or try to tease out, begin to tease out through this effort was to understand how individuals make choices particularly when there are multiple types of service options available to them. We did look at how individuals made decisions to enroll in integrated settings or made the decision not to enroll in integrated plans and sort of what the experience is. We were interested to find that for both those that were enrolled in integrated plans or more integrated plans and those that were receiving them through separate systems, most participants cannot really tell you in great detail how they came to have their current delivery options. It was true across the board they couldn't quite articulate when they made the decision or what went into the decision but of those that did have switched their current arrangement and remembered making the decision to switch to their current arrangement. A lot of them talked

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about trusted individuals helping them to make those decisions whether it was a provider or a family member or care coordinator and using that advice to help them make determinations.

Some participants who could recall making the decision to enroll in coordinated plans mentioned several specific reasons for doing so. I think the one that is somewhat surprising that was pretty much universal regardless of the group was the importance of dental and eye care benefits. Other things that were mentioned were reduced costs as well as just the overall reduction and what they call the hassle factor. In the coordinated programs, they had a single card that could help them get access to service. There was a single customer service line they could call but regardless of the delivery combination, the thing that was most cited as being important to beneficiaries in terms of making decisions about what type of care is received were provider and whether or not they were going to be able to continue to see their provider as part of that.

In order to understand the experience of beneficiaries and enrollees, we talked a little bit about how they're currently receiving information. I think the overwhelming sentiment across all the groups was that it was a frustrating experience that the information that was provided tended to be confusing or overwhelming and when asked what would be preferable, they talked a lot about having things written that would be very simple, that would say what was covered, what was not and if there was any cost involved. The more simple you could make it, the better. Not surprising really, I think we would all like information about our coverage in that way. The other big thing that came from that was just making sure that the information on providers was up to date and reliable.

Most participants that were engaged as part of this focus group effort reported having regular access to primary care physicians. When they asked what they valued in their PCPs, they emphasized things that I don't think are necessarily surprising. They wanted people to take the time to listen to what they had to say, to be able to access them when they needed to, to get them on the phone or make an appointment in a timely fashion. Those are the things that really resonated with them in terms of wanting to have relationships with their providers.

Many of the participants in the focus groups did report having at least one hospitalization or emergency department visit over the last year. The issue of transitions between the hospital and home came up as part of the conversation. Many of the individuals reported that sometimes their primary care physicians were aware when they had these events that resulted in a hospitalization or a trip to the emergency room but oftentimes they had to tell their physicians themselves. I think there was a lot of concern about kind of the discharge planning and being uncertain about what was to happen after they got home particularly when medication changed as a result of the hospitalization, they got home and did not really understand what medication they were supposed to take. This was very prevalent among individuals with serious mental illness for whom prescription drugs can play a very key role in their care.

One of the other things that we really wanted to tease out was the importance of care coordination and interestingly, participants seemed much more focused on coordination of benefits than actual coordination of care. For them, coordination of benefits had to do with things like balance, billing, difficulty getting authorizations, trying to get the help to access problems between the different programs. Individuals who are in more coordinated programs expressed greater satisfaction with coordinated benefits than those who were in separate programs. When coordination of care did come up, it tended to have to do with kind of communication between their various managers and providers and those who are in more integrated plans reported having a single point of contact that they could go to for help whereas those who weren't in those types of plans had multiple people that they had to try to figure out who they needed to go to for what type of service.

Very, very quickly, I know I'm about out of time here but interestingly in getting back to Susan's original point, one of the things we also wanted to tease out really was what language resonates with individuals and not surprisingly they do not think of themselves as dually eligible. It is important to remember to look at things from the beneficiary perspective and try to understand how they see things at their local level and to try to ensure that we're providing information that will really resonate with them. Then finally, in terms of how all this fits in with where we are going, I think overall to us it was a great reminder and reinforce the fact that we really do need to look at things from the beneficiary perspective or to remember to do that. If we want to have really person-centered care, we need to think about ensuring that care management and care coordination is not compartmentalized, that there is a single place that individuals can go to receive assistance for the totality of their care and really not to forget the things that we may take for granted, those administrative things that beneficiaries tend to experience on the front end, whether they are the insurance cards or the member materials or the customer service line, things that we may not think of as cool or sexy, to think about it from a policy perspective are the things that

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really tend to matter on a day-to-day basis with individuals. We look forward to working to ensure that a lot of the information that we received are built into some of the work that we're already doing in order to align the Medicare and Medicaid programs and we'll move forward from there. Thank you very much.

ED HOWARD: Thank you Lindsay. Let's turn now to Lynda Flowers.

LYNDA FLOWERS: Alright, before I start, I'd just like to do some acknowledging. I'd like to thank Susan Reinhard and Lina Walker for their support of this project. I also want to acknowledge my co-author, Keith Lind, who has really been a tremendous help in making this final report what it is. I want to thank Mike Perry and his team from Lake Research Partners for the really, really difficult task of helping us identify who these dual eligibles are. finally I'd like to recognize our advisory group and they are listed in the report who helped guide and shape this project.

We wanted to look at duals who are receiving care across a variety of models of how care can be delivered. We looked at folks in fee-for-service. We looked at people in the enhanced primary care case management programs and these are all defined in detail, for those of you who are not familiar with them, in the report. We looked at duals in partially

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integrated SNPs, Medicare special needs plans, fully integrated SNPs, and then finally those who are enrolled in PACE. In terms of our study subjects and limitations, again like Lindsay said, we wanted to be complementary to what the federal government was doing in their focus group project. We chose to focus on those duals who are aged 65 or older that are both enrolled in Medicare and Medicaid. They are receiving care through one of the specified delivery models that I outlined. They didn't have cognitive impairments both to be complementary to what CMS was doing but also to make sure that people were able to participate meaningfully in the discussion groups and would be able to travel to the interview sites.

Then we wanted people who were currently managing multiple chronic illnesses so we could get a sense of the needs of people who are really challenged medically and then we wanted to have at least one half of the participants had had a recent interaction with the hospital. That was because we wanted to really better understand their care transitions. Now I just want to highlight briefly the limitations of the study, bias in the selection process. Many of the folks that we recruited for the study were recruited directly by people who were associated with the program. There could've been some bias interjected there. We also think that the phenomena of group think could have influenced their responses although we

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think that may have been limited because of the skill set of our interviewers. Finally we say that these findings may not be generalizable because of the qualitative method involved.

With those caveats, I will say that we went to the, you can see there the focus group sites that we went to. We were in Baltimore. We were in North Carolina. We were in New York City. We were in O'Claire, Wisconsin, and we were in San Diego, California. Now what did we hear? I just want to stop and say here that it's so uncanny that so much of what Lindsay talked about from the findings that they had were really validated by our findings as well. We think that gives a little bit more strength to some of the things that we will report out to you. The first thing we found, we want to talk about both the positives. These are some of the positive things we found from the duals. The duals in the study were generally satisfied with their care and those who were receiving care coordination were especially satisfied. The happiness with the care coordination is underscored by the fact that those who were in the primary care case management program in North Carolina were less satisfied if they were not receiving care management because not everybody in the program gets care management services. That's what underscores people's happiness with that service.

The PACE participants were especially enamored of the social aspects of their care. They loved going to the PACE center and when we asked other groups would they like an opportunity to have those kinds of social outlets, the unanimous almost verdict was yes with the exception of the New York group and I'll talk about the New York City fee-for-service group in a minute. Most of the duals in the study lacked experience with both the Medicare and Medicaid appeals processes but they were really happy and satisfied with the processes that they would engage in with their plans.

Before they would go on to these more formal appeals processes, most of them were finding that their problems could be resolved at the plan grievance and appeal levels. I think that is a very positive thing. Very few of them had had any interaction with the exception maybe of one or two people, had any experience with either the Medicaid or the Medicare appeals process. Those in PACE, they had their grievances resolved through that process, they wanted something less formal. They were more concerned about being viewed as complainers and wanted like a little box where they could slip in their concerns. New York was our outlier.

Duals in most of these models were also receiving bills. That validates what I think many, many in the policy community already recognize and in fact, I wanted to take a

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moment just to highlight a brief that I think was released by In Help, the National Health Law Program, maybe a week ago that underscores this balance billing problem and also puts forth some policy solutions. As we all know, federal law does not allow Medicaid providers to balance bill Medicaid beneficiaries and in addition, it doesn't allow Medicare providers to balance bill people who are either full duals, Quimby-only duals or Quimby-Plus duals.

ED HOWARD: I bet there are a few people who don't know who Quimby-only duals and Quimby-plus duals are.

LYNDA FLOWERS: I'll explain that. Those are qualified Medicare beneficiaries. These are people with incomes at or below 100-percent of the federal poverty level. The Quimby-only folks and limited resources, the Quimby-only people are people who are only getting help with their Medicare cost sharing. They're getting their deductibles, their premiums, and their co-insurance paid for by Medicaid. The other group is the same as the only group except that they are also eligible for the full Medicaid benefit package. One group's only getting help with cost sharing. The other group's cost sharing plus the Medicaid benefit package. Then across all of the models of care except for the fully integrated SNPs and I'm not really sure, I want to caveat that because I'm not really sure that question got asked directly but across almost all of

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the models, people said they were receiving bills from their providers so it’s a real problem.

Now duals, in some of the models of care, reported having problems accessing some services. Most of those problems centered around finding doctors who would accept Medicare and Medicaid, finding dental providers, and accessing specialists. People were especially concerned that more and more Medicare doctors are not wanting to accept the Medicare reimbursement rate and they see that as a big problem. Duals also do not have a systematic way to learn about their care options. The ways they were finding out about these programs. They were family. They were friends, planned sponsors, someone would come to the senior center, health care provider who was knowledgeable might mention a program like PACE but one of the striking things was the number of times people said oh I was just riding the bus and I just happened to see a sign. It really does highlight the need for a little bit more systematic way to inform people about their care options.

Now I’d like to present our areas of further exploration and research. We didn’t go the next step to try to propose policy options because of the methodology and because we didn’t feel there was a question about the generalizability of our findings but some of the things that we feel warrant further consideration is the question of social isolation and

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whether or not it increases health care costs. Is there evidence that supports assessing duals for social isolation as a part of their Medicare wellness visit and if so, what would be the appropriate interventions? We also think another valid question is what are the best ways to educate beneficiaries and their providers about balance billing? We know it's a problem but how do we get that education out there so that people know they should not be receiving these bills? What are the effective strategies for educating beneficiaries about what to do when they get these bills?

We found a tremendous amount of variation in what people did once they got the bills. Some take them to the PACE center and they were really satisfied that their social workers handled those for them. Others were much more confused about what to do. We even had a few people who were on their very limited incomes making an attempt to pay these bills and going without other care needs as a result.

How can access to providers and specialists be improved for duals regardless of their service delivery model? We also would like to know what are some of the promising strategies for helping duals get objective information about these various care options? How can policy makers and service providers work together to develop programs that help duals and their families find the care models that best meet their needs and finally we

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ask, we say that duals were interested in sharing their experiences and advice about their own care. They were interested in having an opportunity to network with one another. We found this across all of our programs. As soon as we take a lunch break or some kind of break, the duals would just be sharing information left and right with each other, helping each other understand how the system worked, really seemed to bond. From that, the take away was there needs to be more opportunities for peer-to-peer discussions with the duals and can this be accomplished in the fee-for-service area? With that I turn it over to our next panelist and I'm happy to take questions at the end.

ED HOWARD: That's terrific. Thank you Lynda. Let's turn to Corrinne Altman Moore.

CORRINNE ALTMAN MOORE: Thank you. Thank you everyone. It's so exciting to be here today and in particular to Susan and Ed and the Alliance for Health Reform and AARP for putting this event together today. I'm going to spend my time telling you a little bit about the new demonstration proposal that we are developing in Massachusetts and in particular about the role that our stakeholder outreach efforts and member focus groups have played in helping us to shape our proposal. Massachusetts is one of 15 states that were awarded a design contract by the Medicare/Medicaid Coordination Office to develop a demonstration proposal to integrated Medicare and Medicaid for individuals eligible for both programs, dual eligibles. The purpose of the demonstration opportunity is to test and evaluate models of care that will integrate the full range of benefits that the population uses and those are things like acute and primary care, behavioral health services, and long-term services and supports. Massachusetts is fortunate to have a comprehensive program of care that serves our elder population, those 65+ and through that program, our senior care options or skill program, those members are able to access the full range of their Medicare and Medicaid benefits. We are building a lot on the lessons that we have learned from that program and in this new demonstration, we're targeting our younger dual eligibles, those ages 21 to 64 that have full Massachusetts Medicaid or in Massachusetts, we call it Mass Health benefits and Medicare benefits. This is about 115,000 people that were hoping to reach.

Our demonstration is going to include all of the Medicare and Medicaid services, a full continuum of behavioral health diversionary services, and those are services that people might use in lieu of or to prevent more acute in-patient utilization. We'll be adding additional community support services, those are things like community health workers, nutrition and wellness counseling, and peer supports and we'll be putting it all together with integrated care management to manage the benefits and help people access all of the services that they need. Care teams are going to be housed in person-centered medical home practices and members are going to be actively involved in developing our care plans and deciding what kinds of services are going to help them meet their goals.

Bidders seeking to become contracted integrated care organizations or ICOs as we're calling them at the moment, will have to meet certain baseline requirements. Those are going to be things like having a pretty robust network of person-centered medical home practices, having core competencies in team-based care and care coordination, having really highly developed provider networks that can address the full range of our members' needs, and having robust health information technology to support things like electronic medical records. Contracted organizations are going to receive a global payment for the full slate of services and part of that payment will come from Mass Health and part of it will come from Medicare. We'll be looking for organizations with demonstrated experience and competencies in serving the target population.

Our ICOs will be measured on and held accountable for their performance. We've developed a range of measurement domains. These are things like access to care, effective care coordination and transitions, health outcomes, and patientcenteredness, and an important series of conversations we've been having with our stakeholders are what exactly are the quality measures that we should be using to manage the ICOs under the demonstration. Mass Health will be using these measures to closely monitor the ICOs and to make sure that they are delivering the services that our members need. We think that it's really critical to ensure that the ICOs are operating at the highest standards of quality and to ensure that everyone is able to access all of the services that they need and the way that they choose to and that they are really involved in developing their care plans. This kind of measurement in monitoring will help us learn and make decisions about how to improve the integrated care model going forward.

Our expectation is that this new approach will create value for members and for the system overall in several ways. Specifically eliminating the competing incentives between the two programs' requirements, offering additional services and care coordination to our members, and providing flexibility for the member and their care team to make decisions that support the members' needs and help the member to meet their goals.

One of the most important and valuable parts of our development process has been the conversations that we've had with stakeholders. We've been fortunate to have engagement from a wide range of participants in that process including members, consumer advocates, providers, and potential bidders. This relationship has given us extensive input as we have developed the demonstration and has enabled our stakeholders to better understand what our goals are as we have been working on our development parts of the demonstration. We've been able to partner together to make sure that we're working to achieve the same goals and to resolve areas where we see things differently. We see this as truly critical to ensuring that we're designing a program that is going to meet the needs of our members but also building on previous experience and knowledge in the market place about how to implement this vision.

To date, we've had a series of public meetings to discuss the new model and we've also partnered with the Massachusetts Medicaid Policy Institute for data analysis to help us and our stakeholders better understand this population. Their analysis included demographic information, data on service utilization and spending, and information on health conditions that are prevalent among the population. It is a pretty varied population particularly in this age group. Sharing this work with our stakeholders helped us all to establish a common knowledge base about the population and to deepen our development discussions. We're hoping to build on this analysis with more robust and recent Medicare data and

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we'll be continuing to use the analysis to help inform design and implementation decisions as we move forward.

We've also done a number of focus discussions with a variety of consumer groups out in the community and perhaps, most importantly, we conducted member focus groups with randomly selected dual eligible members from our target population to understand what their experiences have been, what their preferences are, and what kinds of things they would be looking for in a new model, what would help them to see that there is value in it for them. In June and July, the Center for Health Policy and Research at the University of Massachusetts Medical School, on our behalf, conducted four member focus groups with dual eligibles ages 21 to 64. The groups were conducted in both urban and rural areas, one in Spanish and the other three in English. Moderators asked questions to understand participants' basic knowledge about Medicare and Mass Health and to understand how people were accessing and receiving services as well as to get reactions to the integrated model that we're developing.

Of the 40 participants, 16 were women. Twenty-four were men and ages ranged from 37 to 64 years. The individuals participating in the groups had a variety of disabilities and self-care needs. After completing the focus groups, the summary became part of our conversations with our broader

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stakeholder group. I believe there's a copy of the presentation that we did with our stakeholders in your packets today. This has really helped us to be on the same page about what is important to our members, what we should be including in the demonstration, and how to make sure that it's an attractive choice for people. Directly from the focus groups, participants had a range of perceptions about their health care experiences. Some of those were positive, some were negative, and some were in between. Here are a couple of direct quotes about some of the positive experiences.

Wherever I've gone, you hand them the two cards and done, whatever needs to be done in your body is done. When I first got in the system, they did blood work and tests and a full tune-up. They recommended where I needed to go. You go and you're seen and it's led to a complete medical turnaround. It's phenomenal. I've had a lot of medical problems since August, been in the hospital, had major surgery twice but I've had no worries. They've paid for everything, doctors, hospitals, surgeon, and medicine. I now take five shots a day. If I didn't have the coverage, I would have probably have died. There are some things that we heard that aren't working quite so well that give us some ideas about what we need to improve as we put the new models together.

When you see a dentist and want to work a payment out, it’s impossible. They look at you like you’re not going to come back. They don’t give you a break and materials need to be printed for people other than a college graduate so you can understand what they’re talking about. Finally, because of my equipment being incompatible, it takes two PCAs, those are personal care attendants, to do one job. It’s a poor delegation of time because I need more PCA hours than would be necessary and it does cost more money.

Similarly when our moderators described the new model, our participants had a mix of reactions and gave several suggestions for what would make the model attractive to them and how to best let members know about it. Some of the positive reactions were people are afraid of change but it would be cost savings plus they could share information. Maybe some integration would get rid of the excess. If they’re worried about health care costs, they have to make some moves toward that direction. Several members also described their concerns about change and give us suggestions for how to alleviate these concerns as we build the new model.

For example, I don’t want to change because I have that interaction with him, their doctor, I don’t want to start my medical history with a different doctor. Some other people talked about increases in cost of prescription medications, worry about having the same coverage before, and disruptions in coverage. I realize I'm getting close, I'm just going to try to go quickly through the rest of this. In order to make it attractive, some of the suggestions that we heard were to make sure that their current providers are included in the network, have the same or better cost sharing for prescriptions, make sure that enrollment doesn't disrupt current care relationships and support services and make sure that members have control over their care decisions. Improve the dental, vision, transportation, durable medical equipment benefits, and make sure that care coordination is in the new benefit package.

Some of the member concerns and some of their explicit recommendations have helped us understand exactly what we need to be doing as we're approaching the demonstration model. As we've thought about benefit design, we are improving our dental benefit in the new integrated care package. We're improving the way that people can access their vision coverage and improving durable medical equipment, DME, coverage. We're also adding key supports that we heard were important. Those are things like peer supports, nutrition and wellness and community health workers.

As far as the enrollment process, we believe that it's important to have a neutral and impartial enrollment broker but also make sure that people have someone that they are

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comfortable with that they can talk about their enrollment decision and options with. Making sure that people have enough time and information to make a choice is important and as far as provider networks, it's important that we're preserving all of the connections that people currently have with providers and care givers as much as possible. We're going to be doing a lot of outreach with the current providers in our networks and making requiring our contracted entities to continually enroll providers that are meeting network requirements.

Finally this is our website and email address. We would love to hear from you and I'll just put a plug out there that our draft demonstration proposal for public comment is posted now on the website as of last Wednesday and we hope that some of you will review it and send us public comments. Thank you.

ED HOWARD: Great, thanks Cory. We turn now to Suzanne Gore.

SUZANNE GORE: Good afternoon. Thank you so much for having me, the AARP Institute, the Alliance, and also thank you all for being here and being interested in dual eligibles and integrated care. It is incredible to see this big of a turnout and this much interest in the population. I'm Suzanne Gore with the Center for Health Care Strategies. For those of you not familiar with CHCS, we're a small nonprofit that provides state technical assistance to state Medicaid programs. My specialty and my area of interest is integrated care. Really integrated care is the single best opportunity to improve the quality of care and the overall cost effectiveness of any services within the U.S. health care delivery system. There is such a fabulous opportunity here. It is a win-win for everyone involved and I think that is the challenge really to help people see how this can improve care and how it can improve quality and really when done right, integrated care is greater than the sum of its' parts. I think that's something that we really need to be focused on.

Cory really, you all in Massachusetts have done a phenomenal job with your stakeholder engagement and incorporating those pieces, what's important to stakeholders and to your program design. I think with the new report from AARP and Lindsay, all the work that you've done with CMS, really looking at what beneficiaries want in a program, there's now this new richness of information that can help states design programs but I'm just going to briefly talk to you today about really why stakeholder engagement is important and this is also from the perspective of states that may not have quite the resources that say Massachusetts does to really engage stakeholders, also talk about some key stakeholder groups, how

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states are reaching stakeholders, and then just briefly some lessons that we've learned at CHCS from other states.

Why is stakeholder engagement important and basically change is scary. We all know this and this is a population that, these people's lives depend on their mastery of a system and people spend a lot of time and a lot of energy understanding how the system will work for them and now we're talking about changing it. That is truly scary. States really do need to have input from beneficiaries in order to develop a program that meets their needs. Also states need to know what isn't working but also what is working so that those key features can be incorporated into a program design. Also stakeholder engagement process allows states to really share their vision for what integrated care can be.

Stakeholder engagement though, for a state, isn't a one-time focus group to see what's going on and then develop a program in a vacuum. It really is and needs to be a partnership and a process with stakeholders. States do need to convey that your input, stakeholders, is very important and it's critical to the design. For states to move forward with integrated care, stakeholder input is and buy-in is crucial. I actually learned that from the school of hard knocks, from real life, prior to coming to CHCS I worked for the Virginia Medicaid program and one of my projects while I was there was

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to develop an integrated care program for Virginia. This was 2007 and we started working on this I think it really was just basically my boss and myself who wanted this program. There was no support from any stakeholders, no support from beneficiaries. Everyone was scared and it was a total uphill climb.

Our process basically looked like we developed this program, which is the QE2, this beautiful cruise ship, it's a gorgeous program, had all the bells and whistles, truly integrated services, and by the time we finished our stakeholder work, I should call it work, it was basically explaining our program and stakeholders launching grenades at us, we ended up carving out services left and right just to keep the process moving. We ended up with this little rowboat and I saw the picture, I was like oh he's falling on a waterfall, it's even perfect because that's what happens. With integrated care, if you don't have stakeholder input and you can't keep all the services in, which is so important to keep long-term care and behavioral health services in your primary and acute care services in then you end up with weird cost shifting and you end up with the rates don't work. Other plans aren't interested. The program just kind of basically falls to pieces. With stakeholder input and buy-in along the way in finding champions is incredibly important for states.

One reason that stakeholder work for integrated care is especially challenging is that you're integrating all different types of services, typically in a state you're working on one area maybe behavioral health and you know those players, you worked with them for a long time and you can kind of navigate through those stakeholders but with integrated care, you're pulling stakeholders from long-term supports and services. You're pulling them together from behavioral health. You're pulling them together from primary and acute care. You're also tapping into Medicare, which a lot of states aren't familiar with those stakeholders. You have this mass number of stakeholders that you need to bring through the process with you.

For states, this is an incredibly heavy lift. It[s like you have to invite everyone to the party and sometimes the party gets a little crowded but the good news is there are many ways that states to work with stakeholders and to gain their input into their program designs. A lot of states, some are using focus groups. Massachusetts did and focus groups can really garner some fabulous information but they're often very expensive to do for a state and time consuming. States also often use cross disciplinary stakeholder meetings. These are kind of the big meetings where basically you have all the stakeholders in there and sometimes it's great because you can get a really good cross-pollination of ideas but it can also be bad because you're going to have a few people who are very boisterous and possibly not excited about the program that end up shifting the dynamic of the whole group. Sometimes those seem efficient from a state's perspective but don't work quite as well.

Also stakeholder work groups are really good options for states. Sometimes these can be quite effective. When stakeholders are actually helping solve the problem and working through the issue, they have some skin in the game so they're more likely to feel a part of the process and become a champion for the program but the problem of smaller work groups is people do feel left out. There's always challenges that way. Some states have had some great success with public webinars but a lot of times this is better when you're a little bit further along with the program design process. California did some fabulous webinars for including their seniors and persons with disabilities and their managed care program. They made these webinars accessible, they had sign language interpreters on the webinars. They really did great outreach to make sure that people who were interested could participate in the webinars.

As Cory mentioned, states' specific websites, a great area for information, and also requests for information, a lot

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of states are getting ready to issue these. Massachusetts, you all had a fabulous response to request for information where the state basically asked for solutions for the community, for stakeholders to provide information about what they want to see in a program and program design elements and I think you all had about 50 responses in Massachusetts. I know California had put out a request for information and had about 39 responses, so lots of good information, detailed information for states.

We've heard a lot about what stakeholders want in a program but just a few things we've learned working with states, at the Center for Health Care Strategies, is that Medicare and Medicaid combined, it's a very complex system and people want single point of coordination and they want anything that can be done to truly simplify that system. People also want increased flexibility and I think this is also, if you did a stakeholder group of states of what they would want, they want more flexibility in program design because again integrated care should be greater than the sum of its' parts and states need flexibility in order to make that happen for their programs. Stakeholders definitely want, in the full continuum, services and they want to be able to stay in the setting of their choice for as long as possible and truly have person-centered care. Those are very important.

In conclusion, with integrated care, there are numerous stakeholder groups, countless priorities, and it really is a balancing act to make sure that as many people are satisfied and as happy with the program as possible. Stakeholder work is very time consuming and can be quite exhausting for states. I think it’s fabulous now that there are new focus group studies like the ones we’re discussing here that states can use that information and help their state move forward and without having to do quite all of the ground work at the state level for each state. States really do need partners. They need stakeholders to champion their program and to help them really want to move the program forward. When done right, integrated care truly is a win-win. It’s basically the best way out there to improve care, improve quality, improve cost effectiveness and really improve the quality of life of beneficiaries. Thank you.

ED HOWARD: Terrific. Thank you Suzanne. Let me take this opportunity to draw you into this conversation. I want to make sure Susan Reinhard is poised to ask them the tough questions that I know you’ve been storing up. There are microphones, some of you have already discovered that you can use to ask questions with your own voice. If you do that, please keep the questions as short as you can and please identify yourself. We’ll start with you sir.

STUART GORDON: Stuart Gordon from Amerigroup. Corrinne, you've been operating the senior care options program for a while in Mass Health and I have a feeling there's been a lot of outreach to stakeholders in that. Is any of that outreach valuable in giving you input for this population and then secondly, are you able to use any of the structure for the SCO program for this new population?

CORRINNE ALTMAN MOORE: Thank you. Those are great questions. To the first question, have we been able to use any stakeholder engagement from the original Cisco development process? We have been able to generally build on a lot of the lessons from building that program and we do invite all of the plans to participate in our public meetings. The Scope program was developed back in, it was implemented in 2004. I think a lot of the players have changed over time but we do welcome everyone into our public conversations. Then the second part as far as infrastructure, we are able to access a lot of the same providers will be in the network. We're learning a lot from the way that the plans are doing care coordination. There's some things that we want to do a little bit differently because this population is different, does have different needs. In our younger population, 69-percent have a behavioral health diagnosis. They have physical disabling conditions, chronic conditions. There's a significant DD and ID

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population, developmentally disabled and intellectually disabled.

The group is a little bit more diverse than our elder population. That does mean that we need to make sure that the providers and the services that are in the plan are appropriate for that age group.

MICHELLE GETTY: Michelle Getty with Families U.S.A. given the importance of network adequacy to ensuring that an integrated program actually works, I'm wondering Corrinne, if you can talk about whether or how the state of Massachusetts will define adequacy and to what extent the state will actually monitor and ensure there's network adequacy given that in other states, we've seen when you rely on the managed care plan to ensure network adequacy that often doesn't happen.

CORRINNE ALTMAN MOORE: Thanks. I think your question is a little bit more oriented towards implementation. It's a little bit more advanced than where we are now but it's definitely important to us that we make sure we have coverage for all of the services that are in the plan for everyone who's going to be enrolling. That means we need to have statewide coverage if we want a statewide product and we want to make sure that people have choice of providers that there's not only one provider in the network. I imagine the one key way that we'll be measuring this is with our quality measurement. We're

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working with stakeholders as I mentioned, to make sure that we're asking the right questions, we're measuring the right things.

I would imagine that would be things like the number of providers of a particular service and a particular area and making sure that there is appropriate coverage statewide, making sure that we have all of the community long-term service and support providers in the network to make sure that there's adequate coverage. That is a concern that we've heard from our stakeholders that we are trying to get more specific to address. Thank you for the question. I think we'll develop more to be more specific about how we'll ensure that as we go forward.

ED HOWARD: Yes Rich?

RICH BRINGEWATT: Yes, Rich Bringewatt with the SNP Alliance and the National Health Policy Group. Before I ask a question, I first want to just thank everybody here for all you've done. The Alliance and each of the focus groups and the organizations, it's absolutely vital that we have a more active consumer voice in on the midst of the dual policy development. Perhaps the one policy issue that has had as much attention over the last six months relates to the question of enrollment, enrollment relative to passive enrollment, mandatory enrollment, opt-out, volunteering enrollment, I was wondering whether there were any questions asked in the focus group or anything that was pursued in the different studies that might lend a voice of the consumer to that particular question.

LINDSAY BARNETTE: Sure. The focus groups were generally focused on trying to better understand the current experience of care for individuals and, as I mentioned, really to understand how enrollment choices are made in places where there are opportunities for more integrated care but the focus groups sponsored by our office did not really get into the specific question of mandatory versus voluntary versus something else. Certainly it's an important topic and I think will be gotten addressed as part of stakeholder work that we're undergoing as a part of our work in our office but not specifically focused on in these initial set of focus groups.

LYNDA FLOWERS: I would just echo what Lindsay said. we did not directly ask that question although I can say that most of the people that we spoke with were liked to be able to make their choices. Whatever you can derive from that kind of a sense is what we learned.

CORRINNE ALTMAN MOORE: In Massachusetts, we didn't specifically ask about enrollment policy but we did get important feedback about what would be important to people in the new plan and the key thing we heard was keeping their providers. I think our focus on in our enrollment policy

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conversation with our stakeholders has been what kinds of member protection do we need to make sure that we're building in, how do we make sure that the process is transparent and simple and clear and how do we make sure that we're helping people feel like they do have choice throughout the process and they are always able to make a different choice if that's what is right for them.

LINA WALKER: Lina Walker from the Public Policy Institute and AARP. I have a question for those who had the focus groups. So for Lindsay, for Lynda, and for Corrinne, did you by any chance, include caregivers in your focus groups and if you did, what did you hear from caregivers?

ED HOWARD: Did everybody hear that question? the question was involvement of caregivers in these focus groups.

LINA WALKER: Yes, I wanted to know if you interviewed caregivers and if you did, what did you hear from caregivers in the focus groups?

LYNDA FLOWERS: We had some caregivers in some of our groups and one of the main things we heard from them was that they really appreciated having their person in an integrated care program because it freed them up to be in relationships with folks with their loved one instead of having to always be worried and focused on organizing the care. They were able to be more in a familiar relationship and enjoy and be social.

That was quite a relief to them. That was the main thing and we also found that they loved their care coordinators. They just thought that the ability to sort of have the care coordinator organize and help them navigate the system was an invaluable service to them.

CORRINNE ALTMAN MOORE: Our focus groups, I believe, had a couple of family members who might've acted as caregivers occasionally participating in the group but we didn't get differentiated responses from those family members that were in the focus groups. We do have some family members that have also participated in our public stakeholder processes and a lot of their questions have been again things like what would the provider networks look like, what would enrollment look like, and how do we sort of move through into the new process and make sure that our family members' rights are being protected.

ED HOWARD: I neglected to remind you that if you do have a question that you want to write on a green card, please do. These folks did and their questions will be answered and yours can be too.

SUSAN REINHARD: there are a number of questions for Massachusetts. I'm just going to pick one and then I have some actually questions for others as well. You noted in your PowerPoints and I'm not sure how much you emphasized this, the addition of community health workers as a key benefit of your demonstration. How do you envision shaping the function and role of the community health workers? That's the only workforce question, which is kind of interesting.

CORRINNE ALTMAN MOORE: It is. We definitely want to make sure that people can access community health workers. We think that these individuals would be helping in the number of different service function ways. One important way would be as a tool for primary care practices the person-centered medical homes and for the care teams there to actually implement the care plan with the member, to help with things like chronic disease health management training, nutrition and wellness. Perhaps it could be for follow-up activities from something that happens in a more formal setting, working with the member at home or in a community setting. I think there's a lot of important ways that we can use community health workers. It's a fairly diverse work population. We hope that some of our plans will also be very creative about how they're using this tool and might be able to use community health workers in lieu of some more intensive support services, intensive activities. I think they can do everything from working with someone to implement the care plan at home, to perhaps informal monitoring in helping to alert a care team when something is needing to be paid attention to.

SUSAN REINHARD: I'm just going to add a very broad question which might be best by Suzanne or perhaps by Lindsay but the Public Policy Institute has been holding a sort of a series of off the record roundtables both with state offices and with experts around the country in general, just in general, about long-term care, managed care, duals coming at this from different directions. One recurrent theme, it seems to be, is how quickly everything is moving that some states like New Mexico for example, took about two years of stakeholder engagement as they were designing and other states are moving within months, it seems, to not only design but implement. I guess the general question is how quickly can you get stakeholder input in a meaningful way? Does it take six months, a year, what would you recommend to states in doing this?

That's number one and number two is another theme, which is it's really all about the contract language. When you're designing, that's great but how specific is the contract language going to be and what role can stakeholders have in helping to really get that language specific enough that it will affect their daily lives? I don't know whether Lindsay has any comments on any of that?

LINDSAY BARNETTE: I mean I would say in terms of the first question in terms of the kind of time for stakeholder engagement, I mean I think in some ways it may be quality versus quality and to the extent that it's ongoing and it's not just we're going to do this for a couple of months and then we're going to have our plan and then it's over but it's more of an ongoing process that's throughout the planning, implementation, and beyond I think is really what's key and that you're ensuring that you're reaching out to a broad base of stakeholder groups, whether it's beneficiaries and their caregivers or advocacy groups or providers or whoever it is that it's not just a single focus in a vacuum but that you're really looking across the spectrum and that it's something that is happening from start into infinity essentially in terms of making sure that the program, as it changes even after it's implemented, is being doing so with stakeholder input.

SUSAN REINHARD: Suzanne?

SUZANNE GORE: To your first question Susan, is this timeline long enough for meaningful stakeholder engagement, it's awfully tight for states to be frank. You kind of end up with a chicken and an egg problem for states. States pretty much have to have a good idea of what they want their program to look like by this point or even by the fall and in order to do that, you had to kind of assume what your stakeholders would want. There's not a lot of time to really help get the stakeholder vision and their input and then help design a

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program from that. I mean it's fabulous for states to have tight deadlines because otherwise things just don't happen but I think a lot of states really are trying to figure out what the most effective ways are to keep meaningful engagement and to really make the most out of a process that is in a compact type timeframe.

SUSAN REINHARD: Okay, thank you.

ED HOAWRD: Yes go ahead?

SARAH GRANTHAM: My name is Sarah Grantham and I'm a PhD candidate at GW University and I'm in the midst of writing my dissertation about care coordination from the duals perspective in North Carolina. It's going to be a detailed look at not only the PCCM system but also the Medicare 646 demonstration.

SUSAN REINHARD: Bless you.

SARAH GRANTHAM: My question was in all my extensive lit review, I haven't learned a lot about the billing problems and I was wondering, at the federal and/or state level what's to be done about that? What's sort of the next step? Is this something that is just beginning to be noticed and again how should we deal with that?

ED HOWARD: Lynda?

LYNDA FLOWERS: Well as I spoke about earlier, InHealth put out a really extensive brief on this but some of this

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policy's solutions that they were advancing included provider sanctions, having Medicare pay the entire amount instead of having that split between what Medicare pays and then Medicaid picks up the rest of the payment, which often doesn't get made because federal law does not require the Medicaid program to pay more than what Medicare would pay. The providers are basically assuming the loss. There are a number of policy solutions aimed at making these providers whole without having to implicate the beneficiaries. You might want to take a look at that. Then of course educating consumers so that it can't be a really solution to anybody if consumers aren't having to pay the balance.

The more consumers know that they don't have that obligation, the less providers are inclined to bill them because they're not going to get what they're after anyway. They're not going to be made whole in that way. I think it's a multifactorial policy approach but where people are on it. I think CMS recently issued a letter to providers letting them know that if they would continue in those behaviors that they would be sanctioned. There is some federal activity out there as we speak. In that letter, there's a hyperlink to that letter in the InHealth brief that I mentioned.

ED HOWARD: Is there any way to use the plans or the contract language that the plans that are into to make them take some initiative in this area?

LYNDA FLOWERS: I think that's certainly something that we can explore. I think where we're talking about traditional plans or providers then I'm not sure how much latitude there is on that but on some of these newer models where we have discretion about what's going into the contract language but certainly a path we can pursue.

LYNDA FLOWERS: Just to add to that, I think it might be a promising strategy for people who administer health plans to let their participating providers know that this behavior is not going to be tolerated and maybe even from the plan perspective start to implement some sort of punishments if they are out of compliance.

ERIN KENNEDY: I have a question or a comment on that point.

ED HOWARD: Excuse me, on that point go ahead.

ERIN KENNEDY: Yes, I know he was waiting for us but I'm Erin Kennedy. I'm with the Association for Community-Affiliated Plans and we represent the non-profit Medicaid-focused plans about half of whom also have special needs plans. First I'm really excited to see people really now talking about duals as people and I applaud what you're doing with the focus groups. I think there's a huge problem with the QMB SLMB-only categories of eligibility in the fact that for the most part, they're kind of accounting issues between the state and federal government and not focused on the care needs that those people may have. Intrinsic to that is that the eligibility systems don't identify them.

There are problems for health plans and physicians and other providers to understand what category somebody's in and of course those categories are so, you can move between one and another rather quickly. I do urge CMS, I know as part of your work in the duals office you're looking at the experience of the beneficiary. I think eligibility, consistent eligibility, and then understanding and having a way to communicate between social security and the states and health plans is important. It's particularly bad for the under 65 person who's on Medicaid as a person with disabilities and becomes a dual after two years of being on Medicare. Nobody seems to know when that date is and it's treated as a retroactive accounting issue and not as a care management opportunity for the person. That payment gap that we were talking about and physicians and other providers not understanding that they cannot bill the dual, that same payment gap is also a problem for the health plans that are operating within the special needs plan category because it is a payment gap that they have to bid against to

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get a zero premium. It’s an unrecognized payment gap that, in fee-for-service, ends up with a lot of this balance billing and the SNPs, it ends up being some plans having to not continue particular problems again because of that payment gap and because of risk adjustment for the plans that are most focused on the people with disabilities.

ED HOWARD: Thank you Mary. Yes Bob?

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. This panel is talking about planning specialized services for a unique population, a very heterogeneous population, but Medicaid and Medicare-eligible and the coordination problems between the providers, the plans, and consumers and family caregivers. That’s a lot of things. It certainly justifies a specific focus and maybe even an office in CMS to help the planning but I’m wondering what the connection is between this kind of planning effort for this population and the generic health care planning that states are probably not undertaking for the total population.

In other words, we talk about how fragmented the health care delivery system is and I’m wondering what lessons there are from this kind of focus that you are providing for a more generic health care planning process at the state and community level so that there’s a better coordination of resources,

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clinical and nonclinical resources, to address the health needs of the population. Anyway that's my main question.

CORRINNE ALTMAN MOORE: Sure, thank you for that. I can say in Massachusetts I think we're fortunate to be a little bit further ahead on some parts of health reform where we have an exchange already and we have an insurance mandate but for our duals initiative, we are seeing this as it's one foundational piece in a lot of the broader health reform work that we're doing. Earlier this year, the governor put out a bill to address payment reform in Massachusetts and to create ACOs or in Massachusetts, we may call them ICOs, which coincidentally is what we're calling our duals plans right now coincidentally. We are thinking that our foray into the duals integrated plans is going to look a lot like what's next going to happen with forming ACOs in Massachusetts particularly for our disabled Medicaid population.

I should say when we get our bids in for the duals ICOs, we expect to see a wide range, we hope to see a wide range of bidders. We expect they'll be some of our current plans and could be anywhere from our managed care plans, to our SCOs, from PACE plans. We expect that we're going to see some new bidders and we expect that some of those are probably going to look more like ACOs than like traditional health plans. We're excited to see a mix and I think that that is really

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helping us and helping a lot of the players in our state to think about what comes next and how can we use this as a platform or as a stepping stone.

LYNDA FLOWERS: Just to add to that, I would point you to some of the part of our study that looks at the experiences of the duals in fee-for-service Medicare and Medicaid because these are people that are not operating in any close types of systems. It can tell us a lot about what we can think about for broader system reform. They like having their choice of providers but in the case of the New York group, they were generally more healthy than the other groups we looked at but they were also often affiliated with major hospital systems where their primary care provider was affiliated with a hospital system. It was sort of a non-transparent way of integrating their care although it was. I mean these are broader themes that one can look at when one is looking at how to address the broader health care reform, how you reform systems, if you have systems operating that seem closed to the individual but somehow are able to coordinate their care.

Is there some hope in that on the broader scale for people like you and I who are not really at that point but could be in sort of something like that. I think the other thing that they highlighted was that as long as they could be in the system and functioning well, they wanted to stay. If

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they needed to move toward more integration because they needed those needs met, they were willing to go. I think like you said earlier, they're not a homogeneous group and their needs are varied.

SUZANNE GORE: Actually I also think that this really integrated care is states looking at their most complex population and trying to really trying to figure out how to best serve and meet the needs of this population and then they can pull lessons learned from targeting that complexity. I think states are looking at integrated care as somewhat of a building block for their health reform and Medicaid expansion planning activities but I think it's just part of the continuum.

DIANE STOLLENWORK: My name is Diane Stollenwork and I'm a Vice President of the National Quality Forum and one of the projects that I staff is the measure application partnership work to provide input to HHS on what measures should be used to improve care for people who are dual eligible. I'm interested in the comments about the ICOs and you had said earlier, Corrinne, about your discussing what measures should be used and you reference that they are like the ACOs. The question for you is are you looking then to start with the crossover with the federal measures for ACOs and how is it different particularly addressing multiple chronic conditions and also the high prevalence of mental health needs. generally I have a question for the group regarding rural areas or areas where integrated care might be more of a challenge just because of the availability of providers. Do you use a difference in the approach to integrating care in rural areas? So two distinctly different questions. Thank you.

CORRINNE ALTMAN MOORE: To the first question about quality measures, right now we're focused on gathering together a solid set of quality measures that will address all of the different service areas and that will address that we're creating this new integrated care model. We're certainly pulling from all the resources that are out there. There are some areas that have more and some areas that have less. I would say that we're not giving any more particular attention to what's happening on the federal level with the ACOs. I would say that my understanding is that most of that has been oriented towards the fee-for-service system, ACOs, operating in Medicare through the fee-for-service system. While some of the quality things could cross over, it's not quite the same delivery system that we're working with as we're looking to use more of a managed care or managed care plus next generation model.

I think the areas that we do need a lot of help on are for long-term services and supports. We really hope to do a

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lot of good work with our stakeholders. We think they can really help us there as there isn't as much out in the field on that realm of services but it's an iterative conversation. We hope that we produce good solid results that help us to measure the effectiveness of the plans.

LYNDA FLOWERS: I'd like to invite Laurie Faya who's with us from Community Health Partnerships in O'Claire, Wisconsin. It's a fully integrated SNP and they have some experience operating in rural areas in Wisconsin. I'd like to invite you to go to the mic and maybe offer some comments on that question if you don't mind as I already invited you to the mic.

FEMALE SPEAKER: She thought she was here for a free lunch.

FEMALE SPEAKER: No such thing.

LAURIE FAYA: I'm also going to ask Donna Martin to come up. She's one of the administrators with Community Health Partnership. We are in a rural community in O'Claire, Wisconsin and we integrate with our providers and some areas are more difficult than others. We really work on our provider network and make sure we have adequacy across the organization and across our five counties that we serve. We have a provider relations staff that go out and search out quality providers and work with them to be partners with us so that we can serve our members and meet the member outcomes. Do you have anything else to add?

DONNA MARTIN: Donna Martin, I'm also with Community Health Partnership in O'Claire, Wisconsin and I just wanted to point out that we are this rural program and we do serve developmentally disabled, physically disabled, as well as the elderly frail in the program. There certainly are definite challenges being that it is a rural program and we only have about 2,000 duals that we serve so we are quite small. We do serve that population using teams, social workers, nurses, nurse practitioners and again we were one of the programs that were interviewed and we are all about focusing first member and on member outcomes. It's certainly costly. There are many challenges because we are fully integrated and we just continue to look for this Office of Medicare/Medicaid and all the possibilities there of helping smooth out some of those challenges too. Thank you.

ED HOWARD: We've got a couple of questions that sort of suggest the observation that although we've been talking an awful lot about consultation and not a lot about money, it's probably not unconnected. Part of this has to do with, it was triggered by the reference of the global fee payment that Cory mentioned but more generally as states, not just Massachusetts, but otherwise have conducted the kind of stakeholder and consumer involvement we've been talking about, there's been a lot of discussion about what the consumers want that would improve what was on the paper in the way of added services, filled in services. Those things cost money and the question is how does that get figured into what finally emerges as the program? What kind of limits are there in how much money can be added, if any can, to meet the kinds of demands or desires that are unearthed in these focus groups?

CORRINNE ALTMAN MOORE: We have done some preliminary work with our actuaries and we have what we're sort of thinking of right now is proof of concept. With the additional benefits that we are proposing, putting into the package, our actuaries are projecting one-and-a-half to two-percent savings in the first year that the program is fully implemented, so after the ramp up period. Most of the savings accrues on what you think of as the traditional Medicare benefits by diverting from more expensive in-patient and acute services and by investing in our community long-term services and supports and some of the newer things like community health workers, care coordination. We can really prevent some of the more acute hospitalizations.

We can prevent things like prescription medication conflicts. There are some real savings that we can get out of the model over time by putting all of the benefits together, by purchasing it together, by having really clear accountability

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between the plans and the governance with the state and CMS. That's where we're really focusing how can we put everything together in an efficient way that meets the needs of the member, is attractive to the members, and where the financing works because obviously that's a critical component as well. I'll just add that we are planning to take advantage of CMS' three-week capitated model, which they put out in the State Medicaid Directory July 8th, very excited about that model. That allows us to really look at the whole benefit package as one and to essentially, each contribute funding streams to the capitated payments that will be going to our contractors. It's a very exciting collaboration. We're looking forward to actually getting in and implementing it in partnership with CMS.

ED HOWARD: Lindsay, do you have something to contribute here?

LINDSAY BARNETTE: I would just echo what Cory said in terms of the promise of integration is really the opportunity to improve the quality of care and reduce the costs by reducing fragmentation and certainly this notion of proof of concept is what we are trying to get to as part of a number of the state-focused demonstrations that we're working on in our office. We're happy to follow up with folks that have additional questions about this demonstration after the briefing or in the future as well.

ED HOWARD: Susan, as you have been going around, are there friendly actuaries in other states that can project savings the way Cory has described?

SUZANNE GORE: Well I have yet to hear of a state that actually is putting money, additional funding into their integrated program design. I think that states are looking at these programs being at least budget neutral, hopefully finding savings but I mean I think what Cory said, states do need all of the services in because then you have a pool of funding from which you can, if someone has a social issue that could resolve a medical issue. The plan or the integrated care organization could put funding that way versus what traditionally is laid out in the Medicaid state plan for services or Medicare. I think it really is allowing flexibility and truly having integrated benefits that will help these programs find savings, achieve budget neutrality and hopefully savings.

SUSAN REINHARD: I just want to add that we have been, again in the series of discussions, becoming quite interested in talking with states about the extent to which they’re including all state plan services, which you said, which would include nursing home care, full nursing home care as well as the home and community-based services or is it in or out or somewhere in between. We're really interested and of course that affects the friendly actuary I guess and the full set of services that can be. We will be pursuing this further.

ED HOWARD: Good. Yes, sir, a familiar face.

MALE SPEAKER: Second question, Corrinne, I'm glad you mentioned the three-way contract because the three-way contract as I understand it, is based on the senior care option three-way contract that existed before senior care options became a SNP. I have been searching valiantly but without any success to try to determine if Massachusetts had any issues with that senior care option three-way contract, whether there were any difficulties that you experienced that could maybe serve as a lesson to everyone else who's going to have to deal with that three-way contract.

CORRINNE ALTMAN MOORE: Yes, thank you for that. I should say that I think that our senior care options program was one of a couple of programs in a couple of states that had three-way contracts. I believe that there were a couple of others a number of years ago. What I have heard are some of the things that have become less integrated once our three-way contract for the SCO program went away and that program became a SNP, operated under a SNP and a Medicaid managed care structure. That's what operates today. I've heard things like when that change occurred, some of the enrollment alignment suffered. Before it used to be coordinated but now sometimes the Medicare timing and the Medicaid timing can be different and that can create some issues. I understand that the appeals and grievance process used to work a little bit better when it was integrated under the three-way contract but now there are separate appeals and grievance processes that go up through the SNP process and through the Medicaid process once you leave the plan.

The financing is different. The plans are operating under SNP financial rules and Medicaid managed care rules. We have less latitude there. As I understand it when SCO was originally brought up, we had a frailty adjuster that was phased out over time. I think that the finances have gotten a little tighter than they used to be. I couldn't comment on whether that's a dangerous issue in Massachusetts. I think there are other states that are probably having a harder time with it than we are.

SUSAN REINHARD: There's another question maybe it gets more into besides what we're talking about here what else is going on and I'm not sure, Lindsay, whether you're in a position to answer this, but the question is what is the status of the independence at home demonstration project, which was authorized into health care law and does it offer any new

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direction in care for the dual eligibles? It's a great question.

LINDSAY BARNETTE: It is a great question and the independence at home demonstration is an exciting one and one I know several months ago staff from our office actually went down to look at a site, actually here in D.C. that might be an interesting candidate for the independence at home demonstration. It's a great opportunity. I'm not 100-percent sure what the status is. It's not run out of our office but I can certainly find out and report back. It should be coming out soon though I would imagine.

SUSAN REINHARD: The person who asked the question may want to give your card. I'm not sure if there's another way to follow up. Then one more for Massachusetts but it could be a broader question, which is we're focusing on stakeholder input and we've been focusing on a consumers but what about provider input I suppose? The question was besides education and outreach, what efforts are being taken to incentivize provider enrollment to ensure continuity of care, which we know consumers are very worried about continuity of care.

CORRINNE ALTMAN MOORE: We do have a wide swath of providers that have been participating in our stakeholder process. We have had a couple of public meetings. We'll continue having them as we move forward into implementation.

We do hear from a variety of perspectives in those meetings. As far as once we get to implementation, we are focusing a lot on how can we preserve continuity of care for people. we certainly don't want to disrupt anyone's care arrangements particularly if they're using daily support services like personal care assistance or perhaps going to a day program. we're going to be making sure that we're aware of what are someone's needs before they enroll and that we're working with them to transition their care plans. I'm not sure exactly on the ground what form that's going to take but we're certainly going to be paying attention to that and making sure that minimizing disruptions as much as possible.

We're also going to be doing a lot of outreach from Mass Health to the providers that are currently serving our target population. We're also going to be asking for our contracted ICOs to be doing the same, to be doing outreach to the providers, to have a robust network, and as I mentioned, to continually enroll providers in the network that meet network requirements. For example, if a new member wanted to sign up but was unsure if their current providers would be in the network, they could request that those providers be outreached to and then go through that process of enrolling the providers and then make their enrollment decision. We're going to be providing a lot of opportunities for people to work through

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those processes to make sure that they're preserving the relationships that are really critical to them.

ED HOWARD: Very good, thank you. the very last question?

VALERIE WILBUR: Thank you Ed. I'm Valerie Wilbur from the SNP Alliance and the National Health Policy Group. I just wanted to encourage you to perhaps consider for a future forum a session on barriers to integration whether it's partial integration or full integration. I say that because a number of issues have come up today that are of concern to consumers and providers that relate to whether it's federal or state laws or regulations that make it difficult to provide this seamless package of care. I just want to give a couple of examples. There were a couple different people who talked about network adequacy issues and our people from CHP didn't mention this, they said that they have a network group that goes out and finds providers to make sure that their beneficiaries have access to top quality care. I don't know whether the CHP folks have had problems with going into another service area or another state but I know something that some of the states have talked to us about and we've heard from some of our members in Minnesota and such is that they can't go over a service area line or a state line even though that's where these specialists that they would ideally have in their network is located.

There's things like that that I know the duals office could probably give them the waivers and they probably will under this 15-state demo but that would be an issue. On the balance billing, that's a huge problem that the AARP brought up. I would consider that to be a huge problem. A related issue that I'm curious about though is we talked a couple times about the maximum out-of-pocket costs that plans have to report the beneficiaries on even if they're duals. Duals will get these explanation of benefits notices that talk about the tracking of their maximum out-of-pocket costs even though they don't have any costs. Then they get a bill from their providers and they may think to themselves oh gee, that might be related to that maximum out-of-pocket cost thing on my explanation of benefits. We think if you're dual, there shouldn't be any mention of maximum out-of-pocket costs because we think it's confusing to beneficiaries when the state is paying those bills.

ED HOWARD: Valerie, I don't want to cut you off but I do want to emphasize the urgency of the hour.

VALERIE WILBUR: Okay, right I'm sorry. The three-way contract is the last thing I'll just mention because both Medicare and Medicaid plans have challenges in doing everything that the three-way contract allowed them to do through waivers. I just think that these are really important issues to bring up

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so that we can help sort out how to get to the seamless care at the end of the day. Thank you Ed.

LYNDA FLOWERS: Can I respond briefly?

ED HOWARD: Go ahead.

LYNDA FLOWERS: Valerie, I will point out to you in our paper we did highlight the explanation of benefits issue and consumers are totally blown away by it. We do ask that some research go into figuring out how to make it more useful and better understood by consumers.

ED HOWARD: I should say that as a Medicare beneficiary even for those of us for whom the out-of-pocket spending is a question, it's still too confusing for those of us who have to read them. Well thank you all. As you listen to me blather for a couple of minutes here, please pull out your blue evaluation forms and fill them out. We have a notice that I'm not quite sure how to deal with. Sue Nonamaker has lost a black leather glove with a red heart.

SUSAN REINHARD: Sounds lovely.

ED HOWARD: If you find it, I'll give you her number and if you forget it or lose it, you can call the Alliance at 202-619-0485. Good luck Sue.

SUSAN REINHARD: I think we're going to wrap up and I just want to note recently, the AARP public policy has released a score card, long-term services and support state scorecard.

Enid Kasner's in the audience smiling because she worked very hard on this with us. We had five dimensions and a high performing system for long-term services and supports and one of them is integration coordination and there were no data for it. It's our missing dimension. We are really grateful for everybody in this room that's working on this and we do hope that in the future we will have integration that we can even measure it. It would be great. Thank you. thank you on my behalf and Ed.

ED HOWARD: Thank you Susan, just a couple of things. thank you for bearing with us as we brought the winter weather inside for this discussion. I do want to thank our colleagues at AARP and particularly at the Public Policy Institute for really providing the grist for this session and a lot of the thought that went into its' planning. I want to take just a second if I can because as Susan mentioned, this is the last briefing of the calendar year to thank the Alliance staff. It takes a lot of work to make me look good and they do it regularly [APPLAUSE]. Last but not least, let me ask you to join me in thanking the panel for an incredibly good discussion before an incredibly good audience [APPLAUSE]. We'll see you next year. Have a great holiday.

[END RECORDING]
